NELFT became a foundation trust in 2008. This means that we work slightly differently from other NHS organisations.

NELFT has a core set of values outlining what is important to our staff and the people who use our services:
- People first
- Prioritising quality
- Progressive, innovative and continually improving
- Professional and honest
- Promoting what is possible – independence, opportunity and choice.

NELFT employs over 6,500 specialist staff.

With an annual budget of £380m we are still firmly part of the NHS and are subject to the same standards as all other NHS trusts, but we have greater freedom in how we use our resources to improve patient care.

NELFT provides an extensive range of integrated community and mental health services for people living in the London boroughs of Barking & Dagenham, Barnet, Havering, Redbridge and Waltham Forest, and community health services across Brentwood, Basildon and Thurrock. We also provide emotional wellbeing mental health services for young people in Essex. We are the provider of all age eating disorder services and child and adolescent mental health services across Kent and Medway.
Welcome to our Quality Report... another year of continuous learning and improvement in an ever complex health economy. As a large Trust both geographically and in terms of the array of services we provide, I never underestimate the challenges our workforce face in delivering the best possible care to the communities we serve.

The year has been no less challenging than we anticipated for all public services. As a Trust, our geographic footprint places us within six Sustainability and Transformation Plan (STP) regions, with three of these STPs requiring a lot of input and resource to ensure that NELFT services are at the forefront of improving the patient experience within the localities.

We are heavily involved in the NEL STP and one of the leading organisations within the BHR Provider Alliance, jointly with our acute partner BHRUT and the GP Federations. The focus of the Provider Alliance has been on developing the frailty pathway to improve outcomes for patients, supporting Care City, our innovative partner, in the roll out of the new Atrial Fibrillation Pathway as well as looking at ways for both health and social care providers across Barking and Dagenham, Havering and Redbridge to provide more integrated care in the community. Our Child and Adolescent Mental Health Services at Brookside continue to be recognised nationally for both the innovative service model and their improvement journey from a CQC “Inadequate” rating to a rating of “Outstanding”.

Across Essex we are linked in with the Mid and South Essex STP and supporting the work to relieve pressure on the acute care providers and look at how we can support more care in the community. We are working hard in Thurrock with our social care partners to change the model of social care support and working with GPs to support the development of a new model of primary care provision.

In Kent and Medway, we continue to work with our partners to reduce waiting times and deliver a new and improved model of care for young people who require mental health support, as well as people who need to use our eating disorder services. This is a challenging area of delivery both in terms of staffing and demand but we are determined, with the support of partners, to make improvements in this area.

In all of these areas we are leading the way in terms of innovation, collaboration and partnership. I am grateful to all our partners and stakeholders across our patch who support us to constantly strive to improve outcomes for patients.

We have continued to seek opportunities to grow our service portfolio and in the last year we have acquired services for young people in Barnet. This is part of our work to deliver high quality outcomes for patients in areas where we can make improvements.

All of these priorities and complexities in terms of integration, innovation and improvement have been captured in our refreshed corporate strategy which sets out a direction of travel for the Trust going forward. Thank you to everyone who was involved with this work.
refreshed corporate strategy which sets out a direction of travel for the Trust going forward. Thank you to everyone who was involved with this work. Our Trust Board will be monitoring progress each quarter and it is great to have a suite of strategies (including Best People – our workforce strategy and Best Care – our clinical strategy) that all work with each other to support our vision to actively shape, develop and deliver, integrated, locality based care for the populations we serve.

None of this work would be possible without a dedicated and committed workforce who are open to continuous learning and new ways of working. I am pleased that so many of our staff have shared their views not only via the NHS Staff Survey and Friends and Family Test but also through engagement in a number of initiatives across the Trust. At a time when recruitment is a national issue for the NHS and Brexit holds a lot of uncertainty for staff, I know it is crucial to support the health and wellbeing of those who work in NELFT. Our staff health and wellbeing programme has grown considerably throughout the year with over 90 ambassadors throughout the Trust and activities happening across all the localities to help staff focus on their health and wellbeing. All the evidence indicates that staff who feel valued and engaged in their workplace and are well supported deliver better quality outcomes for patients so this is crucial to us as an employer.

We have continued to make progress across the equality and diversity agenda and we are now one and we were the first Trust in the country to meet all of the national Workforce Race Equality Standards (WRES). We are focused on ensuring we support all protected characteristics and are learning from the success with our Ethnic Minority Network and strategy to apply a similar approach in other areas.

The year has seen further efforts to support the open and transparent culture within the Trust, making us a safe place for people to learn, improve and raise concerns. We have appointed a dedicated Freedom to Speak Up Guardian who has undertaken a large programme of staff engagement across the Trust. Staff, as well as patients and carers, being able to voice concerns and issues is crucial for us to be able to improve the quality of the services we provide.

We have continued our focus on quality improvement via the NELFT QI Programme and now have more than 3500 staff trained at various levels and 200 projects being delivered. We have tailored some of this work to areas of improvement highlighted by the Care Quality Commission to ensure we are focusing efforts in the right place. An example of this would be our Care Planning Quality Improvement Collaborative, looking to improve the quality of patient care plans.

Our CQC rating remains “Good” and I am proud that we receive positive feedback from patients, carers and staff about their experiences of our organisation. We will have our next CQC well-led review in 2019/20 and my hope is this reflects the work that has taken place both clinically and with the Governance review that has taken place across the Trust.

Whatever we achieve at NELFT is only possible because of the professional commitment, dedication and enthusiasm of our workforce. I would like to take this opportunity to say a heartfelt thank you to everyone in the organisation for their individual contributions. We are only making progress because of what you bring to our services day after day in often challenging circumstances.

Thank you.

John Brouder
Chief executive
21 May 2019

To the best of my knowledge the information presented to you in this document is accurate and provides a fair representation of the quality of service delivered within the organisation.
Statement from the Trust Chair

In this year’s statement I want to start by thanking everyone in NELFT for all your hard work and dedication in supporting our patients in so many positive ways. This is at the heart of our purpose as a Trust to support the wellbeing and health of all our local communities by delivering the very best care we can.

The challenging improvement goals we set ourselves in last year’s Quality Report are to be continued during 2019/20, to ensure we push forward in all domains of safety and quality. There are real challenges in the availability of capital, funding pressures, shortages of skilled clinicians and more, and yet we continue to excel and exceed most expectations.

I am particularly proud of our work to improve staff engagement and support diversity. We are the first Trust to achieve the Workforce Race Equality Standard (WRES) across all categories, with our work being acknowledged externally. We have increased our staff engagement which I see as fundamentally important to value our staff and improve patient care. Also of note we have initiated a pioneering initiative ‘Reverse Mentoring’ where our frontline operational staff work directly with Board members acting as their mentors. This is part of the delivery of our Ethnic Minority Strategy.

As well as working to change the landscape for ethnic minority staff working in NELFT, the Trust has been working hard across all protected characteristics. Achievements of note include the first draft of our Disability Staff Network Strategy and disability staff champion training, the launch of our LGBT+ Rainbow Lanyard Scheme and the start of our Women’s Network, working with both women and men across the Trust to improve career opportunities and experiences in the workplace. There is more to be achieved over the coming year but I am heartened by how much is happening to improve the working lives of our staff.

In order to meet system challenges, we are breaking new ground in collaboration and integrated working and to facilitate the transformation of services to be even more patient-centric and efficient. Importantly, to support this work, we are building ever stronger relationships with our commissioners, colleagues in local government and with our regulators. There is a real sense of

“Achievements of note include the first draft of our Disability Staff Network Strategy and disability staff champion training, the launch of our LGBT+ Rainbow Lanyard Scheme and the start of our Women’s Network, working with both women and men across the Trust to improve career opportunities and experiences in the workplace.”
NELFT as a leader and innovator within an emerging Integrated Care System for Barking & Dagenham, Havering and Redbridge (BHR). Similarly, as ‘chair in common’ at BHRUT I see the strongest ever links between both of our trusts and an environment of common purpose to work together to serve our patients in holistic care pathways that also serve to ensure we are as sustainable as we can be under available funding schemes.

In London we are working hard in Waltham Forest with partners on a range of projects from improving the urgent care response to integrating the end of life care provision for patients. We see tremendous progress continue in Essex and Kent with our emotional wellbeing services for young people as we look to improve the access to and quality of care for this group of patients and their families. In keeping with our focus on improving services for children and young people we have also successfully transferred specialist children’s services in Barnet to the Trust.

We are working in three main Sustainability and Transformation Partnerships (STPs) in North East London, Mid and South Essex and Kent and Medway and we have some involvement in as many as six. I particularly want to thank and praise our Board of Directors, both executive and non-executive colleagues, who have had to increase their commitments to meet the demands of this expanding field of work. This sense of leadership in care provision, with its associated innovation, improvement and transformation, ensures that we continue to grow our service base and organisation by delivering that which we are best at. I would also like to thank our Council of Governors who voluntarily give up their time and make significant contributions to the Trust, by representing the views of our patients and local population.

Beyond our front line services, we have back office expertise that sees NELFT supporting other provider trusts and commissioners in areas such as Procurement, IT, Estates and Quality Improvement (QI). Our journey with QI in the past two years has been truly amazing, with over 3,500 staff having had an introductory awareness session and over 200 trained to Facilitator or Mentor level. Staff from other organisations have enrolled onto our training and have also adopted principles of some of our care planning collaborative work. I am particularly proud that the majority of our QI projects are targeting direct improvements to patient outcome and/or experience.

My final comment here must be an ongoing appeal to the passion we have in NELFT to learn and improve. We make mistakes sometimes and get things wrong occasionally and when that happens we must be humble and transparent in accepting that and recommitting ourselves to our mission and the delivery of the best care by the best people. If we listen to and respect our patients, our colleagues and the tax payers that fund our work for the good of all, acting on what we hear, then we can be certain we are adding value and are truly improving care in our workplaces.

I thank you and all our stakeholders for your support and wish you every success in 2019/20.

Joseph Fielder
Trust Chair
21 May 2019
As a Trust we are continually looking to respond to the changing needs of the health and social care economies we work within, both locally and further afield. We are fully engaged with work across the STP footprints within which we sit and our priorities for service improvement are aligned to these as well as the delivery of the NHS Long Term Plan.

The key to our success and achievement going forward is integration and collaboration. This is something we have already been supporting with various partnerships across London, Essex and Kent and will continue to build on over the coming year. As well as improving the quality of care we provide, we want to improve outcomes for our patients and this is so often linked to the patient’s journey through the health and care system. We can only make improvements and operate more efficiently through co-production and working together with our partners.

The introduction of the CQC fundamental standards back in 2015 provided the framework we needed to monitor, review and transform the way we deliver care. We continue to use this framework to assure our Board on issues of safety and quality, particularly in light of the increasing pressure and demand on our services. I am proud of our CQC Good rating and I know all our staff work hard to continue to deliver high quality services. That’s not to say we can’t improve the services and care we provide to our patients and communities. As such, I am equally proud, if not more so, to say we have a workforce that is dedicated to continuous learning and improvement.

The Quality Report provides us with a platform to achieve this and sets out a number of areas that we must focus on. These have been influenced and identified by our patients, governors, staff and partner organisations; by listening to their views and comparing ourselves with others we ensure we focus on what matters to the people we serve. The Quality Report is a vital snapshot of our achievements and whilst it shows areas where we have progressed well, there are clearly areas where further improvement is still needed. As with previous years we have sought to set ourselves challenging improvement priorities in order to achieve the best outcomes for the people we serve. This year, whilst we have struggled to achieve a number of stretch targets, our Non-Executive Directors, through the process of scrutiny, have ensured we continue to push forward in all domains of safety and quality. Through this process, along with service visits and manual audits, we identified some weaknesses in data collection as opposed to practice, which we will tackle into 2019/20.

We welcome all opportunities to receive feedback on the services we provide and the delivery of the fundamental standards. If you have used our services and wish to get involved in their further development we would be delighted to work with you.

Stephanie Dawe
Chief Nurse and Executive Director of Integrated Care (Essex and Kent)
21 May 2019

“I am proud of our CQC Good rating and I know all our staff work hard to continue to deliver high quality services.”
Welcome to this year’s Quality Report.
We hope you find it an informative and useful read.

What is a Quality Report?
Annually all NHS healthcare providers are asked to write a report about the quality of services they provide. This is called the Quality Report.
The Quality Report enables us to engage with service users, carers, staff, stakeholders, partner organisations and the public in an open and transparent way. We look forward, identifying our key priorities for the year ahead and look back, showing the improvements we have made in the last year to improve the quality of care that we provide.

NELFT’s Quality Report is split into two parts, Part A and Part B.

PART A
- provides an introduction to NELFT
- looks at our awards
- looks forward at our priorities for improvement in the coming year
- looks back on our progress outlined in Quality Report 2017/18
- looks at how we performed in the annual staff survey

PART B
- provides detailed information regarding our statements of assurance from the board
- informs you of our progress with audit and data quality
- shows performance data against our core indicators
- provides an appendix, glossary and useful contact numbers list
Quality Report governance arrangements

The Chief Nurse and Executive Director of Integrated Care (Essex and Kent) has overall responsibility for the NELFT Quality Report. Production of the Quality Report is the responsibility of the Director of Performance and Business Intelligence.

Leads of our services are engaged in working with clinical and operational staff to deliver our key priorities. Progress reports on each of our priorities are reported to each locality leadership team on a bi-monthly basis and to our quality and safety committee, which is chaired by a non-executive director, every six months.

In addition, our Quality Senior Leadership Team (QSLT) oversees the Quality Report process and receives a formal update report once a quarter. This information is then reported to the Executive Management Team, which reports to the NELFT board.

Data quality is assured through NELFT’s data quality action group and through audit processes (both internal and external).

Our journey with QI in the past two years has been truly amazing, with over 3,500 staff having had an introductory awareness session and over 200 trained to Facilitator or Mentor level. Staff from other organisations have enrolled onto our training and have also adopted principles of some of our care planning collaborative work.

How to provide feedback on this Quality Report

We hope that you enjoy reading this year’s Quality Report.

If you would like to give us feedback on our Quality Report 2018/19, please contact:

Name: Jacky Hayter, Director of Performance and Business Intelligence
Email: jacky.hayter@nelft.nhs.uk
Address: NELFT NHS Foundation Trust
CEME Centre
Marsh Way
Rainham
Essex
RM13 8EU
Welcome to NELFT
NELFT is a growing organisation serving a population of 4.9m across North East London, Essex, Kent and Barnet. We employ in excess of 6,000 staff and have an annual turnover in excess of £380m.

NELFT provides mental health and community services for people living in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, Essex, Kent and Medway. Since September 2018 we have also delivered integrated therapy services to children in the London borough of Barnet. We deliver these services in a range of settings including hospitals, health centres, GP practices and people’s own homes. We work closely with a range of partners to ensure the best care is provided for our patients and service users.

Our services

Our values

NELFT has a core set of values outlining what is important to our staff and the people who use our services:

**People first**
We remember that patients, service users and carers are our top priority, and treat others how we would like to be treated

**Prioritising quality**
We provide the best service possible, following best practice and national developments

**Progressive, innovative and continually improving**
We listen and continually improve our services for the benefit of our patients, service users and carers

**Professional and honest**
We work to create relationships based on honesty, respect and trust, and meet the highest standards of professionalism and confidentiality

**Promoting what is possible – independence, opportunity and choice**
We help people achieve the best quality of life possible, giving them the information and support they need
NELFT celebrated its inaugural talent show, NELFT’s Got Talent, celebrating the creative talent of our colleagues to a packed house.”
NELFT attains Achievement level in the Healthy Workplace Charter

We are pleased to announce that we have now attained ‘Achievement level’ in the Healthy Workplace Charter.

Brookside receives accreditation

Brookside, our young people’s mental health inpatient unit, has been awarded an accreditation by the Quality Network in CAMHS which is overseen by the Royal College of Psychiatrists (RCPsych).

Improvements to Waltham Forest blood test service leads to more patients being seen

We are delighted to announce that our new community blood testing service in Waltham Forest has been praised in a review by local NHS commissioners.

Sue Burke gains prestigious Queens Nurse award

Sue Burke, Acting Head of Integrated Community Services in Basildon and Brentwood has been given the prestigious title of Queen’s Nurse (QN) by The Queen’s Nursing Institute (QNI).

NELFT nominated for two awards at the 2018 Inclusive Companies awards

Our equality and diversity manager, Harjit K Bansal and the EMN network were nominated for the Outstanding Diversity Network Award and Diversity Champion Award.

Brookside wins RCNi Award for Mental Health Practice Award

NELFT staff members recognised as inspirational women leaders as part of NHS70 celebrations

We are delighted to announce four of our staff have been recognised as inspirational women leaders across the NHS in London.

Significant 7 shortlisted for prestigious RCNi Nursing Award

Geraldine Rodgers and the Significant 7 project, set up to support care home staff to improve the physical health care of older people, have been shortlisted for a prestigious RCNi nurse award.

NELFT Finance department achieves NHS Future Focused Finance Level 1

The NELFT Finance department received an accolade recently from the NHS Finance Leadership Council (FLC). The Council awarded NELFT Future Focused Finance Level 1 accreditation. Currently, only NHS Improvement and NELFT have this level of accreditation in London. The accreditation was launched in December 2016 and aims to demonstrate the organisation’s commitment to the development of finance skills across the workforce.

Waltham Forest Memory Service commended by the Royal College of Psychiatrists

NELFT’s Memory Service in Waltham Forest has received an accolade from the Royal College of Psychiatrists. The service has been awarded a Sustainable Mental Health Service Commendation.

Two NELFT nurses have been nominated for the prestigious Nurse Awards

The Royal College of Nursing has nominated two NELFT nurses for the prestigious Nurse Awards. Geraldine Rodgers (Associate Director of Nursing, Clinical Effectiveness and Fellow for Older People) has been shortlisted in the Nursing Older People category and Rebekah Bewsey, Modern Matron – Brookside, Acute & Rehabilitation Directorate won the Mental Health Practice award.

Collaborative project in Barking & Dagenham has been shortlisted for an award

A project in Barking and Dagenham has been nominated for an award. The work of the Physical Health Care for patients with Psychosis (PHCP) project has been shortlisted in the Health Initiative of the Year for this year’s Chemist and Druggist Awards.
NELFT receives Healthy Workplace recognition for staff health and wellbeing initiatives

NELFT is delighted to announce that the Trust has achieved the London Healthy Workplace Charter Accreditation at Commitment Level. The Healthy Workplace Charter is a set of standards that organisations meet in order to receive an official accreditation (and award). The Charter is backed by the Mayor of London and provides clear and easy steps for employers to make their workplaces healthier and happier.

NELFT’s John Brouder has been included in the HSJ list of Top Chief Executives 2018

The Health Service Journal (HSJ) published their annual list of Top 50 NHS Trust Chief Executives on Monday 12 March. For the second year running, the list featured NELFT’s Chief Executive John Brouder.

Waltham Forest healthy child project received a UNICEF Baby Friendly Initiative certificate

NELFT Health Visiting Waltham Forest together with our partners, HENRY and the Lloyd Park Children’s Centres, received a UNICEF Certificate of Commitment to the Baby Friendly Initiative (BFI) at the ‘Celebrating two-year olds’ partnership event.

A NELFT team shortlisted for the Journal of Wound Care Awards 2018

The work of a NELFT team has been highlighted with the shortlisting in a category at this year’s JWC Awards. The Journal of Wound Care Awards ceremony will take place at Banking Hall in London on Friday 2 March.

Health Education England highlights the work of Aubrey Keep Library

The Aubrey Keep Library received national recognition recently when Health Education England reviewed four case studies for their Impact Case Studies Quality Group. The case studies were added to the HEE Impact Case Studies Database, which is a national database of case studies of library impacts.

Inaugural ‘NELFT’s Got Talent’ show a huge success

NELFT celebrated its inaugural talent show, NELFT’s Got Talent, celebrating the creative talent of our colleagues. Presented by the NELFT Communications Team to a packed house of colleagues from across London, Essex, Kent and Medway, attendees were indulged with great entertainment from singers, a ukulele player, an aerial hoop performer, a variety of dancers including traditional Indian dancing and body popping.

“... The Health Service Journal (HSJ) published their annual list of Top 50 NHS Trust Chief Executives... The list this year featured NELFT’s Chief Executive John Brouder.”
Priorities for improvement 2019/20

Development of our quality priorities for 2019/20

Continuous improvement remains a top priority for NELFT and we always look to develop meaningful quality indicators that can be monitored, reported and scrutinised by all.

In last two years’ Quality Reports, we focused on the outcomes of Care Quality Commission (CQC) inspections. The CQC is the independent regulator of health and social care in England. The CQC monitor, regulate and inspect health and social care services to ensure that fundamental standards of quality and safety are met. This includes inspecting services to see if they are safe, effective, compassionate and of a high quality. Findings are published nationally and include performance ratings to help patients and service users choose care.

The trust was inspected and measured against five key questions/domains:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive?
- Are they well-led?

In January 2018 NELFT was rated as ‘outstanding’ in four inspected service areas. We moved from a position of 48 services areas achieving ‘outstanding’ or ‘good’ in our previous CQC inspection, to 60 services in the latest inspection. It also demonstrates that the priorities in our Quality Report helped focus all our teams on improving quality and safety for our patients.

We are continuing to use the CQC domains to continue the good work and measure our achievements, future goals and indicators.

The table on the right provides a summary of our latest inspection results:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute wards for adults of working age and psychiatric intensive care units</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Child and adolescent mental health wards</td>
<td>Good</td>
</tr>
<tr>
<td>Community health inpatient services</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Community health services for adults</td>
<td>Good</td>
</tr>
<tr>
<td>Community health services for children, young people and families</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Community mental health services for people with learning disabilities or autism</td>
<td>Good</td>
</tr>
<tr>
<td>Community-based mental health services for adults of working age</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Community-based mental health services for older people</td>
<td>Good</td>
</tr>
<tr>
<td>Forensic inpatient/secure wards</td>
<td>Good</td>
</tr>
<tr>
<td>Long stay/rehabilitation mental health wards for working age adults</td>
<td>Good</td>
</tr>
<tr>
<td>Mental health crisis services and health-based places of safety</td>
<td>Good</td>
</tr>
<tr>
<td>Specialist community mental health services for children and young people</td>
<td>Good</td>
</tr>
<tr>
<td>Wards for older people with mental health problems</td>
<td>Good</td>
</tr>
<tr>
<td>Wards for people with learning disabilities or autism</td>
<td>Good</td>
</tr>
<tr>
<td>End of life care</td>
<td>Good</td>
</tr>
</tbody>
</table>
In January 2018 NELFT was rated as ‘outstanding’ in four inspected service areas. We moved from a position of 48 services areas achieving ‘outstanding’ or ‘good’ in our previous CQC inspection, to 60 services in the latest inspection.”
We are about to have a CQC Well Led Inspection and the organisation has to provide information and data to assist the inspection. As we have been focusing on our domains of safe, effective, caring, responsive and well led as an organisation we were in a position to provide the necessary requirements to support the visit. Since last year’s Quality Report we are pleased with the continued progress we have made with the ambitious targets set; however, as we did not meet all the targets we will continue to monitor them again this year to finalise the embedding of certain indicators. We have also added new priorities for ‘looking forward’ this year, these include Safeguarding Supervision, Staff Appraisals and monitoring Violence and Aggression training, using our staff survey results to monitor how many staff members report this in their working day.

As an organisation we like to look forward and be proactive in our approach to improving patients’ health and wellbeing, so in the coming year we are looking at how poor mental health impacts on physical health and could lead to worsening of some conditions. Also how poor physical health can negatively impact on mental health. We already have a service that supports those service users with Long Term Conditions with our Clinical Health Psychology Service. The aim would be to look at primary and secondary drivers to eradicate the mortality gap for people with serious mental illness in NELFT. The drivers will be across Health via monitoring, early referral, diet, exercise, primary care and early year’s health. In Social Care it will be viewed through employment, education and housing amongst a few drivers.

To update on last year’s special mention regarding Brookside NELFT’s adolescent mental health inpatient unit for 12-18 year olds. Over the last three years the unit has undergone an extensive environmental refurbishment and modernisation of the service offered. Praise and congratulations were given by the Mayor of Barking and Dagenham to the team on this transformation and the subsequent CQC rating of ‘Outstanding’. Also the unit was subsequently awarded the 2018 RCN Mental Health Practice Award and has recently been accredited by the Quality Network for Inpatient CAMHS (QNIC). Now, the Brookside unit is leading nationally in its model of inpatient care and is sharing good practice with other organisations.

In the following pages, we describe NELFT’s quality priorities for the coming year.
“As an organisation we like to look forward and be proactive in our approach to improving patients’ health and wellbeing, so in the coming year we are looking at how poor mental health impacts on physical health and could lead to worsening of some conditions.”
Priority 1
Safe

CQC definition:
Are services safe? By safe we mean that people are protected from abuse* and avoidable harm.

*people are protected from physical, sexual, mental or psychological or discriminatory abuse
Aim
To ensure that care plans and risk assessments are consistent across the trust to deliver safe and effective patient care.

This involves standardising care plans to ensure they contain the five elements of care:
- consent and capacity
- social situation
- collaborative
- risk assessment
- recovery focused

Our Quality Improvement (QI) team has been leading a QI Collaborative: the Quality Improvement Accelerator Care planning (QIAC). The QIAC is based on the Institute of Healthcare Improvements (IHI) Breakthrough Series Collaborative methodology.

Staff attend QI training and are taught QI methodology that they apply to projects in their own service areas, focusing on developing the five elements of care planning. This programme continues to produce positive results and good engagement with clinicians. During 2018/19 more team members have registered for the QIAC programme and we have seen some re-joining.

The Quality Improvement work has continued, supported by the development of a peer audit tool that teams can use to identify their own progress and ensure that the NELFT 5 elements of care planning are being implemented.

Care planning and risk assessment is also monitored with individual clinicians through monthly supervision and this is done looking at live caseloads in the electronic patient records.

Alongside the QI work, NELFT has updated its electronic patient record systems (EPR), namely Rio and SystmOne, to enable care planning to be consistently and accurately recorded by all clinicians into patient records. Compliance and engagement with the systems has been monitored throughout the year. The Clinical Effectiveness Team have implemented training sessions across NELFT to ensure that the correct information is captured and that care planning continues to be recorded consistently. The Clinical Risk Assessment Training, which became mandatory for all clinicians in 2017, is now fully compliant across the organisation.

The Quality and Safety Committee have received monthly updates on work regarding care planning and clinical risk assessments, the data has been provided by the Performance Team directly from the electronic patient records.

Alongside this a manual audit took place in December 2018 and this has enabled work to be focussed in specific areas to support staff to further improve.

NELFT’s performance regarding the completion of risk assessments and care planning has been measured in our annual record keeping audit. For each service Trust-wide, a sample of records is audited helping us to understand our compliance in certain areas of patient notes. The audit looks at the quality of our record keeping, from data capture through to the quality of clinical notes.

The data above gives an overview of our performance in regards to care plans and risk assessment from 2014 to 2018. During this time, services used both paper and electronic means for recording information. The Trust now primarily uses electronic patient record systems and is increasing its deployment of agile devices to access these systems.
% mobile access to an electronic system

- yes
- no

% where clinical notes/records are recorded

- RIO
- SystemOne
- paper
- other electronic system
A total of 1,995 records were audited in 2016/17, 2,127 records in 2017/18 and 2,360 in 2018/19. Not all patients audited required a care plan or risk assessment to be completed.

The data below shows the percentage of care plans and risk assessments that were carried out against the percentage of people who these were applicable to. This demonstrates where improvements have been made and where we aim to improve.

The electronic recording* of care plans for adults has remained fairly static while in children has reduced slightly. NELFT has acquired new contracts in the past year for children and young people’s services in Barnet where, in some services, a high percentage of paper records were used. A lot of training has been undertaken to ensure new staff understand how to capture data on NELFT systems and we expect the compliance rate to improve in future.

Is there evidence that an up-to-date risk assessment has been undertaken on the patient’s needs where required?

*The electronic recording of care plans in children has reduced slightly. NELFT has acquired new contracts in the past year for children and young people’s services in Barnet where, in some services, a high percentage of paper records were used. A lot of training has been undertaken to ensure new staff understand how to capture data on NELFT systems and we expect the compliance rate to improve in future.
It should be noted that this is a small sample of approximately 30 patients year-on-year which equates to 1.3% of the records audited. We have noted* a slight fall in compliance. On investigation, this relates to how data is captured and in some cases staff were recording ‘unknown’ in the electronic patient record, which was unclear.

As a result, fresh guidance has been issued to clinical teams to ensure they are aware of how to record the data in future.

In addition, the NELFT EoLc strategic priorities this year include improving inputting, capturing and recording EoLc specifically regarding preferred priorities of care/ death and care planning for the last days of life.

*Data taken from NELFT clinical record keeping audit 2018
Goal 1

1. to ensure that by quarter 4 (Q4) 2019/20 75% of care plans and risk assessments are completed and recorded in our EPR systems and that all staff will be aware and deliver care in accordance with the plans and level of risk

Area applicable to:

We will continue with embedding:
- acute wards for adults of working age and psychiatric intensive care unit
- wards for older people with mental health problems
- child and adolescent mental health wards
- community mental health services for adults of working age
- community mental health services for older people
- emotional wellbeing mental health services in Essex
- Children and Adolescence Mental Health Services (CAMHS) in London

What do we expect to achieve?

1. care plans and risk assessments are monitored and updated when needed and recorded on EPR systems achieving compliance rate of 75% and above by quarter 4 2019/20:

| Trajectory: Q1 25% Q2 35% Q3 50% Q4 75% |
|---|---|---|---|
| Area | Risk assessments | Care plans | Q4 |
| Adult PICU | Data not available | 75% |
| MHS wards for older adults | 93.9% | 11.1% |
| Children and adolescent mental health wards | 55.3% | 13.2% |
| Community-based mental health service for adults of working age | 68.8% | 15.4% |
| Community-based mental health services for older people | 61.2% | 10.5% |
| EWMHS services in Essex | 77.3% | 24.9% |
| CAMHS in London (excluding inpatients) | 50.5% | 14.9% |

How progress will be monitored and measured:
- through monthly monitoring of the quality dashboard

How progress will be reported:
- reported monthly through locality leadership team meetings
- reported monthly to Quality Senior Leadership Team (QSLT)
Goal 2

1. to continue monitoring and frequently auditing risk assessments ensuring consistency across services using QIAC methodology

Area applicable to:
We will continue with embedding:
- community health services for adults
- emotional wellbeing mental health services in Essex
- Children and Adolescence Mental Health Services (CAMHS) in London

What do we expect to achieve?
1. to carry out an audit reviewing risk assessments in the clinical notes of patient records, achieving a compliance rate of 75% completed and recorded on our electronic patient record systems across those applicable teams listed below by the end of quarter 4 2019/20

Baseline data

<table>
<thead>
<tr>
<th>AREA</th>
<th>Target</th>
<th>Achieved on average</th>
<th>55%</th>
</tr>
</thead>
</table>

During 2018/19, there were 2 cohorts of QIAC training.
Our goal this year continues to be to encompass teams across the whole of community and mental health services.

How progress will be monitored and measured:
- through audit using the QIAC quality improvement care planning audit tool

How progress will be reported:
- reported monthly through locality leadership team meetings
- reported quarterly through Quality Senior Leadership Team (QSLT)

Goal 3

1. for patients over the age of 65 to automatically receive a falls risk assessment on admission to hospital and recorded on an EPR

Area applicable to:
We will continue with embedding:
- older adult’s mental health wards
- community inpatient wards across London and Essex

What do we expect to achieve?
1. a falls risk assessment to be completed for every patient who meets the threshold on admission to the older adult mental health ward or community inpatient wards

Baseline data

During 2018/19 NELFT undertook a programme of work to roll out an EPR solution for recording this data electronically. During this time, it has become apparent that the data quality needs to be improved. Data suggests that compliance has dropped to 81% as at Q4. Therefore a new trajectory has been agreed to encourage working towards better data quality and compliance.

How progress will be monitored and measured:
- through quarterly clinical audit and reporting of incidents
- through weekly clinical data audit and managed through supervision and staff team meetings

How progress will be reported:
- reported monthly through locality leadership team meetings
- reported monthly to Quality Senior Leadership Team (QSLT)
**Priority 2**

**Effective**

CQC definition: Are services effective? By effective, we mean that people’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
Aim
To ensure that clinical staff are competent to deliver safe and effective patient care through the use of effective care planning
We want to ensure that everyone who requires a care plan receives one, that risk assessments are effective and that the people we see are involved in their care and treatment. We also want to ensure that our staff have the information they need to make informed decisions about patient care.

Goal 1
1. That 85% of patient care plans include the five elements of care planning - consent and capacity, social situation, collaborative, risk assessment, recovery focused - using the QIAC audit tool, by the end of Q4 2019/20

Area applicable to:
We will continue with embedding:
- acute wards for adults of working age and psychiatric intensive care unit
- child and adolescent mental health wards
- community mental health services for adults of working age
- emotional wellbeing mental health services in Essex
- children and adolescence mental health services (CAMHS) in London

What do we expect to achieve?
1. Care plans include the five elements of care planning by the end of quarter 4 2019/20

Trajectory: Q1 10%   Q2 35%   Q3 60%   Q4 85%

Baseline data
NELFT achieved an average of 70% for 2018/19 in:
- acute wards for adults of working age and psychiatric intensive care unit
- child and adolescent mental health wards
- community mental health services for adults of working age
- CAMHS London

There is currently no baseline data for emotional wellbeing mental health services in Essex as QIAC audits were not undertaken previously for these services.

How progress will be monitored and measured:
- through monthly audit of the quality of care plans ensuring they contain the five elements of care, using the QIAC quality improvement care planning audit tool

How progress will be reported:
- reported monthly through locality leadership team meetings
- reported monthly to Quality Senior Leadership Team (QSLT)
Goal 2

1. All care plans for mental health patients are recovery orientated and reflect the personal views and preferences of patients.

Area applicable to:

We will continue with embedding:
- acute wards for adults of working age and psychiatric intensive care unit
- child and adolescent mental health wards
- community mental health services for adults of working age
- emotional wellbeing mental health services in Essex
- Children and Adolescence Mental Health Services (CAMHS) in London

What do we expect to achieve?

1. That staff work collaboratively with patients to include their preferences and views in their care plan.

Trajectory: Q1 25%  Q2 50%  Q3 75%  Q4 100%

Baseline data

NELFT achieved an average of 68% compliance for ‘recovery focused care plans’ and 77% compliance for ‘collaborative care plans’ for quarter 4 2018/19 in:
- acute wards for adults of working age and psychiatric intensive care unit
- child and adolescent mental health wards
- community mental health services for adults of working age
- CAMHS London

There is currently no baseline data for emotional wellbeing mental health services in Essex as QIAC audits were not undertaken previously for these services.

How progress will be monitored and measured:

- through monthly audit of the quality of care plans ensuring they include personal preference of patients using the QIAC quality improvement care planning audit tool.

How progress will be reported:

- reported monthly through locality leadership team meetings.
- reported monthly to Quality Senior Leadership Team (QSLT).

85% of patient care plans include the five elements of care planning - consent and capacity, social situation, collaborative, risk assessment, recovery focused - using the QIAC audit tool, by the end of Q4 2019/20.
CQC definition: Are services responsive to people's needs? By responsive, we mean that services are organised so that they meet people's needs.
**Aim**

To ensure that where appropriate, referrals to treatment (RTT) waiting times are achieved.

We are continuing to monitor the Young Persons Wellbeing Service (YPWS) Medway and Children/Young People Mental Health Services (CYPMHS) Kent. There are still a number of young people waiting for either assessment or treatment for longer than the national target of 18 weeks. Additionally, some young people are still waiting over a year for their treatment. NELFT remains focussed on ensuring the waiting lists are dealt with as quickly as possible to allow young people access to care.

**Goal 1**

1. **to ensure that more than 92% of the young people who are waiting for assessment and/or treatment are seen by the appropriate clinical team by end Q2 2019/20 (dependent on the allocation of additional resources by commissioners)**

**Area applicable to:**

- Kent and Medway (excluding ADHD and ASD waiters)

**What do we expect to achieve?**

1. by the end of Q2 2019/20, no young person will be awaiting assessment or treatment for more than 18 weeks (dependent on the allocation of additional resources by commissioners)

**Baseline data**

As at the end of Q3 2018/19 there were 1,376 children (excluding ADHD and ASD waiters) waiting over 18 weeks to begin treatment.

As an average, those children seen and started treatment within 18 weeks was 78.46%.

The benchmark is the national target for waiting times, set out as follows:

NHS Constitution standard sets out that patients on incomplete pathways should have been waiting no more than 18 weeks from referral to the time of their first treatment or intervention. Incomplete pathways, often referred to as waiting list times, are the waiting times for patients waiting to start treatment, as at the end of each month.

The incomplete waiting time standard was introduced in 2012 and states that the time waited must be 18 weeks or less for at least 92% of patients on incomplete pathways.

**How progress will be monitored and measured:**

- through daily MIDAS dashboards
- through weekly and monthly progress reports provided by the performance team

**How progress will be reported:**

- monthly through department patient and quality safety group meetings
- monthly through locality leadership team meetings
Goal 2

1. to ensure that 92% or more of the young people waiting for an attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD) assessment are waiting less than 18 weeks to be assessed by a specialist clinical team by end Q4 2019/20

Area applicable to:
- Kent and Medway

What do we expect to achieve?
1. by the end of quarter 4 2019/20 more than 92% of the young people waiting for treatment will be waiting less than 18 weeks for an ADHD or ASD assessment.

Trajectory:
- Q1 30% under 18 weeks
- Q2 50% under 18 weeks
- Q3 75% under 18 weeks
- Q4 92% under 18 weeks

Baseline data
By the end of quarter 3 2018/19, there were 1816 young people waiting over 18 weeks. At the end of quarter 3 2018/19 we had 26.8% waiting under 18 weeks. Funding has been agreed with commissioners to employ additional resource and trajectories are in place.

How progress will be monitored and measured:
- through weekly and monthly progress reports provided by the performance team

How progress will be reported:
- monthly through department patient and quality safety group meetings
- monthly through locality leadership team meetings

The NHS constitution gives patients in England the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer patients a range of suitable alternative providers if this is not possible. Patients should wait no longer than 18 weeks from referral by a GP to treatment.

MIDAS is a performance reporting tool to help integrate, validate and present data from multiple systems we use. Managers can see their team’s performance in different areas, for example appraisal compliance or mandatory training. They can also look at the activity that is happening within the team to ensure that all patients are seen and they receive the right treatment in a timely fashion. MIDAS helps managers to performance manage their services and enables us to extract data from a central source which can then be shared with our commissioners.
Priority 4
Well-led

CQC definition:
Are services well-led? By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.
Aim
To ensure that all leaders and managers within the trust have the tools required to lead and manage safe and effective services. We want to ensure that all of our staff at NELFT have the tools and training required to deliver excellent patient care.

Goal 1
Appraisals and Personal Development Plans
Appraisals are incredibly important for both a human resource management tool and an individual performance management process. Appraisals can have a significant influence on the Trust’s culture, employee engagement, staff morale, and therefore staff productivity. If a member of staff feels valued then they transfer that value to other staff members and service users. If staff understand their role, objectives, benefits and purpose then they have a focus to drive forward for their own development and this will impact on the Trust’s values. A good appraisal system and the joint approach for personal development plans also aid retention of key and committed staff. NELFT has launched a new appraisal and mandatory training system called STEPS, to support evaluation and learning.

1. to increase the percentage of staff with an up to date appraisal and Personal Development Plan

Area applicable to:
• NELFT wide

What do we expect to achieve?
1. to work towards a compliance of 85% of staff having an up to date appraisal and Personal Development Plan.

Baseline Data
NELFT’s Trust wide (all services, including corporate teams) appraisal compliance as at the end of December 2018 was 77.99%

How progress will be monitored and measured:
• through monthly reporting via the performance team.
• line Managers using MIDAS, a performance reporting tool that integrates, validates and presents data.

How progress will be reported
• through monthly reporting to Leaderships Teams, Senior Leadership Teams and the Executive Management Team, via the governance cycle in place within the trust.
Goal 2
Violence and Aggression in the workplace

Levels of violence against staff working in mental health trusts remain much higher than other types of trusts within the NHS. A health service journal paper analysis suggested that there are 200 reported physical assaults on NHS staff every day in England. Violence and aggression is a concern in most health care settings and can be directed from both patients, visitors and colleagues. Repeated exposure to violent and aggressive behaviour can have a highly negative effect on staff morale and performance. It can leave staff feeling vulnerable, and undervalued. The trust also has policies covering Violence and Aggression and is part of the Health and Safety mandatory training module. So NELFT are committed to support staff with training in Violence and Aggression and there are four questions in our staff survey relating to physical violence and four questions relating to harassment, bullying or abuse.

1. as a Trust we wish to support and encourage our staff to be open and honest to report any violent or aggressive behaviour, whether experienced or witnessed. We would therefore like to increase the % of reporting such behaviour

Area applicable to:
- NELFT wide

What do we expect to achieve?
1. use of staff survey results to understand the areas reporting physical violence, harassment, bullying or abuse, where improvement can be made.
2. to work towards a compliance of 85% of staff completing Prevention and Management of Violence and Aggression Training.

Baseline Data
- percentage of staff/colleagues reporting most recent experience of violence
  - In 2016/17 staff survey 87%
  - In 2017/18 staff survey 83%
- current validated training position is 78.23% for Prevention and Management of Violence and Aggression.

How progress will be monitored and measured:
- through monthly reporting via the performance team and using MIDAS, a performance reporting tool that integrates, validates and presents data.
- staff survey findings and the review of Datix incidents.

How progress will be reported:
- through monthly reporting to Leaderships Teams, Senior Leadership Teams and the Executive Management Team, via the governance cycle in place within the trust.

“ In most cases people are treated in hospital or a mental health service and they are known as a voluntary patient as they have agreed to attend. However, there are cases when a person has to be detained under the Mental Health Act (1983) and they are provided treatment without their consent. This is sometimes referred to as being sectioned. The Mental Health Act is legislation that covers the assessment and treatment of people and helps them to understand their rights when detained.”
Governor selected local indicator

This year, the governors have selected Safeguarding Children: safeguarding supervision uptake and compliance. Percentages of staff receiving: 1:1 and group supervision effectiveness should be >90% and maintained at that level.

This indicator will look at the percentages of staff receiving 1:1 and group supervision.

Safeguarding supervision is embedded within the organisation and has clear evidence for improving the outcomes for vulnerable children, young people and their families. Continuing professional development and supervision underpin the delivery of high quality care. NELFT acknowledges that an effective supervision structure will benefit children because it will have a direct impact on the quality of the work practitioners undertake. NELFT is committed to ensuring that both supervisors and supervisees are clear about their roles, responsibilities and accountabilities in the protection of vulnerable children, young people and their families.

Supervision is essential to help practitioners to cope with the emotional demands of work with vulnerable children and their families.

Safeguarding supervision is a process whereby an appropriately qualified, experienced supervisor, either a Named Nurse Safeguarding Children, Specialist Nurse for Safeguarding Children and/or professionals who have completed the NSPCC Supervisors training course or other recognised course, meets regularly with staff members to reflect upon their safeguarding practice and review cases. It is also an opportunity to raise any concerns or identify areas in which improvements can be made.

We seek to ensure that the individuals we provide services to, are effectively safeguarded against abuse, neglect and discrimination, are supported to achieve their potential and are treated with dignity and respect in all aspects of care.

The current NELFT performance for safeguarding supervision compliance (as at 31.03.2019 based on Q4) is:

<table>
<thead>
<tr>
<th>LOCALITY</th>
<th>1:1 COMPLIANCE</th>
<th>GROUP COMPLIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute &amp; rehab</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Barking &amp; Dagenham</td>
<td>91%</td>
<td>96%</td>
</tr>
<tr>
<td>Basildon, Brentwood &amp; Thurrock</td>
<td>100%</td>
<td>97%</td>
</tr>
<tr>
<td>EWMHS</td>
<td>90%</td>
<td>93%</td>
</tr>
<tr>
<td>Havering</td>
<td>90%</td>
<td>85%</td>
</tr>
<tr>
<td>Redbridge</td>
<td>88%</td>
<td>92%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>90%</td>
<td>96%</td>
</tr>
</tbody>
</table>
How do our priorities impact on patient safety, clinical effectiveness and patient experience?

**Patient safety will be enhanced through:**
- Comprehensive care plans and risk assessments being completed for patients and recorded on EPR ensuring continuity of, and safe, care.
- Falls assessments being completed for all patients over 65 on admission to hospital, regardless of reason for admission.
- Effective supervision promotes good standards of practice and the delivery of a high quality service.

**Clinical effectiveness will be enhanced through:**
- Care plans containing the five elements of care planning: consent and capacity; social inclusion; collaborative; risk assessment; recovery focused.
- Care plans reflecting the personal views and preferences of patients.
- All staff have the relevant and up-to-date mandatory training completed.
- Safeguarding supervision provides a process of professional learning and support to enable practitioners to develop their knowledge and competencies.

**Patient Experience will be enhanced through:**
- Services having an effective means to monitor service efficiency, including waiting times, through the MIDAS performance management tool.
- Patients will wait a maximum of 18 weeks to be treated.
- Care plans will be recovery orientated and reflect the personal views and preferences of patients, ensuring their voice is heard and care is tailored to their individual needs.
- The delivery of a high quality service.
- To ensure that practice is soundly based and consistent.

During 2019/20, we will continue to monitor the indicator that directly impacts patient experience: patient waiting times. This is a national indicator and our focus again in the coming year is the waiting times for our children’s mental health services in Kent, where young people have been waiting longer than they should be. This work stream continues to require particular targeted attention to ensure we improve the patient experience.

Statements of assurance from the board

The statements of assurance from the board for our Trust are in Part B of this document. Please therefore refer to Part B where you will see information regarding our registration, participation and progress in these areas.

Part B can be found on page 56 or on our website at www.nelft.nhs.uk/about-us-publications.
Progress against each of our priorities

Considerable progress has been achieved against our targets for 2018/19 and our achievements are noted below.

Last year NELFT’s priorities focused on:

• Safe
• Effective
• Responsive
• Well-led

Progress against each of our 2018/19 priorities
Priority 1
Safe

Goal 1
1. to ensure that by Q4 2018/19 75% of care plans and risk assessments are completed and recorded in our EPR systems and that all staff will be aware and deliver care in accordance with the plans and level of risk

Area applicable to:
- acute wards for adults of working age and psychiatric intensive care unit
- wards for older people with mental health problems
- child and adolescent mental health wards
- community mental health services for adults of working age
- community mental health services for older people
- EWMHS Services in Essex (additional area for 2018/19)
- CAMHS in London – Excluding inpatients (additional area for 2018/19)

What we achieved:

<table>
<thead>
<tr>
<th>AREA</th>
<th>Trajectory</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>10%</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>Adult PICU</td>
<td>Risk assessments</td>
<td>Not currently recording on EPR</td>
<td>7.9%</td>
<td>18.6%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Care plans</td>
<td>Not currently recording on EPR</td>
<td>N/A</td>
<td>1.5%</td>
<td>3.6%</td>
</tr>
<tr>
<td>MHS wards for older adults</td>
<td>Risk assessments</td>
<td>5.1%</td>
<td>8.1%</td>
<td>33.3%</td>
<td>55.3%</td>
</tr>
<tr>
<td></td>
<td>Care plans</td>
<td>12.2%</td>
<td>5.4%</td>
<td>17.2%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Children and adolescent mental health wards</td>
<td>Risk assessments</td>
<td>36.4%</td>
<td>35.8%</td>
<td>58.9%</td>
<td>68.8%</td>
</tr>
<tr>
<td></td>
<td>Care plans</td>
<td>11.4%</td>
<td>11.9%</td>
<td>14.2%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Community-based mental health service for adults of working age</td>
<td>Risk assessments</td>
<td>36.7%</td>
<td>39.1%</td>
<td>51.4%</td>
<td>61.2%</td>
</tr>
<tr>
<td></td>
<td>Care plans</td>
<td>6.0%</td>
<td>5.7%</td>
<td>7.1%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Community-based mental health services for older people</td>
<td>Risk assessments</td>
<td>24.1%</td>
<td>27.6%</td>
<td>83.7%</td>
<td>77.3%</td>
</tr>
<tr>
<td></td>
<td>Care plans</td>
<td>15.4%</td>
<td>19.2%</td>
<td>23.6%</td>
<td>24.9%</td>
</tr>
<tr>
<td>EWMHS services in Essex</td>
<td>Risk assessments</td>
<td>28.7%</td>
<td>30.1%</td>
<td>41.1%</td>
<td>50.5%</td>
</tr>
<tr>
<td></td>
<td>Care plans</td>
<td>6.2%</td>
<td>6.5%</td>
<td>9.9%</td>
<td>14.9%</td>
</tr>
</tbody>
</table>

N/A : No data available
Goal 2

1. To implement a system for monitoring and frequently auditing risk assessments ensuring consistency across services using QIAC methodology

Area applicable to:
- Community health services for adults
- CAMHS in London

What we achieved:

<table>
<thead>
<tr>
<th>AREA</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance of audited electronic patient records</td>
<td>55%</td>
</tr>
<tr>
<td>Achieved on average:</td>
<td></td>
</tr>
</tbody>
</table>

The data includes new teams that joined in the second half of the year. When new teams join the QIAC there is an initial phase of learning sets, this can lead to lower recording compliance whilst learning embeds.

To ensure we continue with the embedding of this work, the priority remains in the Quality Report for the coming year.

Goal 3

1. For patients over the age of 65 to automatically receive a falls risk assessment on admission to hospital and recorded on an EPR

Area applicable to:
- Older adults mental health wards
- Community inpatient wards in London and Essex (additional for 2018/19)

What we achieved:

Electronic Patient Records (EPR) were newly rolled out to the community inpatient wards in London and Essex in 2018/19.
Priority 2

Effective

Goal 1

1. that 85% of patient care plans include the five elements of care planning - consent and capacity, social situation, collaborative, risk assessment, recovery focused, using the QIAC audit tool, by the end of Q4 2018/19

We have seen some positive signs of improvement but more work is needed. Through 2018/19 we saw favourable compliance with quarter 1 results being at 84%, but by Q4 there is an overall small drop. During Q3 and Q4 we have seen new teams joining and some teams re-joining having acknowledged that they need to refocus on care planning. In most cases this is due to staffing changes and the requirements to reinforce the importance of care planning and its procedures. For others, they are being more stringent with their audits and are scrutinising more closely. Of the teams joining and re-joining, across the five elements, there is significant percentage increase in compliance for each element.

To ensure we continue with the embedding of this work, the priority remains in the Quality Report for the coming year.

Area applicable to:
- acute wards for adults of working age and psychiatric intensive care unit
- child and adolescent mental health wards
- community mental health services for adults of working age
- EWMHS services in Essex (additional for 2018/19)
- CAMHS in London (additional for 2018/19)

What we achieved:

<table>
<thead>
<tr>
<th>AREA</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target compliance by the end of Q4</td>
<td>85%</td>
</tr>
<tr>
<td>All care plans to include 5 elements by end Q4</td>
<td>70%</td>
</tr>
</tbody>
</table>

Goal 2

1. all care plans for mental health patients are recovery orientated and reflect the personal views and preferences of patients

Area applicable to:
- acute wards for adults of working age and psychiatric intensive care unit
- child and adolescent mental health wards
- community mental health services for adults of working age
- EWMHS services in Essex (additional for 2018/19)
- CAMHS in London (additional for 2018/19)

What we achieved:

<table>
<thead>
<tr>
<th>AREA</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery focused</td>
<td>81%</td>
<td>77%</td>
<td>70%</td>
<td>68%</td>
</tr>
<tr>
<td>Collaborative</td>
<td>87%</td>
<td>83%</td>
<td>75%</td>
<td>77%</td>
</tr>
</tbody>
</table>

NELFT achieved an average of 68% compliance for ‘recovery focused care plans’ and 77% compliance for ‘collaborative care plans’ for Q4 2018/19. The drop in Q3 and Q4 is reflective of new teams joining and the re-joining of some teams due to a change in staffing and more stringent auditing, highlighting a need for refreshed training and focus.

To ensure we continue with the embedding of this work, the priority remains in the Quality Report for the coming year.
**Priority 3**

**Responsive**

**Goal 1**

1. to ensure that all young people who have waited in excess of 52 weeks for assessment and/or treatment are seen by the appropriate clinical team by end Q3 2018/19 (dependent on the allocation of additional resources by commissioners)

**Area applicable to:**
- Kent and Medway

**What we achieved:**

<table>
<thead>
<tr>
<th>AREA</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>By end Q3 no young person will be awaiting assessment or treatment for more than 52 weeks</td>
<td>95.17% achieved</td>
</tr>
</tbody>
</table>

As at the end of Q3, 4.83% of the children waiting have been waiting over 52 weeks.

Of those waiting for neuro development treatment 36% of the waiters at the end of Q3 have been waiting over 52 weeks.

---

**Goal 2**

1. to ensure that all young people who have waited for an attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD) assessment to have been assessed by a specialist clinical team by end quarter 3 2018/19

**Area applicable to**
- East Kent

**What we achieved:**

<table>
<thead>
<tr>
<th>AREA</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target compliance by the end of Q3</td>
<td>100%</td>
</tr>
<tr>
<td>By end Q3 every young person needing an ADHD or ASD assessment will have been clinically reviewed</td>
<td>50.5%</td>
</tr>
</tbody>
</table>

As at the end of quarter 3, an average of 50.5% of children on the neurodevelopment pathway of those seen, were seen within 18 weeks.

Funding has been agreed with commissioners to employ additional resource and trajectories are in place.

This will remain a priority in the Quality Report for the coming year.

---

"By end Q3 no young person will be awaiting assessment or treatment for more than 52 weeks. **95.17%** achieved."
Priority 4
Well-led

Goal 1
1. to ensure that all staff are up to date with mandatory training, including clinical risk assessment and mental health act training where applicable

Area applicable to:
- NELFT wide

What we achieved:

<table>
<thead>
<tr>
<th>AREA</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target compliance by the end of Q4</td>
<td></td>
<td></td>
<td></td>
<td>85%</td>
</tr>
<tr>
<td>Staff up to date with mandatory training including clinical risk assessment &amp; MHA</td>
<td>88.88%</td>
<td>88.42%</td>
<td>90.85%</td>
<td>91.08%</td>
</tr>
</tbody>
</table>

Overall NELFT compliance for mandatory training has met and exceeded target. Kent and Medway staff compliance had been noted as particularly low in the past. In 2018/19 Kent and Medway achieved a compliance rate of 99.65% at the end of quarter 3.

Goal 2
1. to ensure that teams have access to MIDAS to support their management of services

Area applicable to:
- East Kent, West Kent, and Medway CYPMH Services

What we achieved:

<table>
<thead>
<tr>
<th>AREA</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target compliance by the end of Q4</td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of teams have access to MIDAS to support their management of services</td>
<td>87%</td>
<td>82%</td>
<td>94%</td>
<td>100%</td>
</tr>
</tbody>
</table>

We are delighted to report that this goal has been achieved. We will continue to offer training to new staff and to offer support to all staff in the use of MIDAS.
**Goal 3**

1. **continue to develop an effective performance analytical tool which provides the executive management team with forecasting information and highlights any risks or areas of underperformance**

**Area applicable to:**
- NELFT wide

**What we achieved:**
Business Intelligence are continually developing the analytical tool and are now in the position to distribute licences to publish data internally for analysts and teams to start using and viewing data. This process will be rolled out in Q1 2019/20.

**Governors’ selected local indicator for 2018/19: Clinical Risk Training**

The governors selected clinical risk training as the indicator to be audited by KPMG, as this complements the priorities set out in the Quality Report.

The audit was aimed to test the compliance reporting methodology and reporting via Quality Report updates is accurate.

The existing NELFT performance for clinical risk training was 56.44% which relates to the following services:
- acute wards for adults of working age and psychiatric intensive care unit
- wards for older people with mental health problems
- child and adolescent mental health wards
- community mental health services for adults of working age
- community mental health services for older people

During the course of 2018/19 NELFT has significantly increased compliance, as at the end of quarter 4 we are pleased to have achieved 91.14%.

“Percentage of teams have access to MIDAS to support their management of services in Q4: **100% achieved.**”
Annual staff survey

Each year, NHS England requires MHS service provider organisations to facilitate the completion of a staff survey. This survey gives our colleagues the opportunity to feedback about their experience of working in the Trust, across a range of indicators.

From the survey results, we then put together Trust-wide and local improvement plans to help better the staff experience of engagement, health and well-being. The information taken from the survey also enables us to review our performance against other similar NHS organisations as well as how we compare nationally.

We value the feedback from our colleagues and this survey is one of numerous ways of gauging their opinions. We continue to pride ourselves on an open and honest culture that embeds the Trust values in everything that we do and demonstrates that we actively listen to our staff and act upon their opinions.

This has been yet another challenging year for the Trust in terms of its collaborative input into multiple integrated care systems, the impending CQC well-led review and managing resources effectively. We have worked tirelessly over the past year to act upon the findings of the last year’s survey, which yielded some very encouraging results and demonstrated unprecedented levels of workforce engagement and enthusiasm of colleagues to influence the leadership of the organisation. A communications plan was developed to share the results across the organisation and ensure that all staff had the opportunity to participate in making improvements to their working lives. We engaged thoroughly and positively throughout the whole workforce to demonstrate that we had listened to what they had to say and had acted upon their wishes.

We repeated the more user friendly online questionnaire and introduced a bespoke survey for our Bank workers as a further commitment to our inclusivity. We also built upon the embedding of engagement and well-being matters as agenda items for all team meetings and have centrally co-ordinated a range of activities on a regular events calendar in each directorate. These activities include yoga, massage therapy, mindfulness and mental health first aid.

Building on the engagement work undertaken across the organisation, the 2018 survey attracted an impressive 61% response rate from a full census; which benchmarked in the top 10 percentile of response rates for the second successive year. The vast majority of responses to the questions showed either a positive shift from the previous year, or remained the same. The results and recommendations have been disseminated across the organisation much earlier than in previous years and locality leadership teams are already working on action plans to both celebrate the success and prioritise areas for further development.

The following response areas showed a plus 5% or more improvement from last year:

- the recognition I get for good work.
- the extent to which my organisation values my work.
- my organisation treats staff who are involved in an error, near miss or incident fairly.
- we are given feedback about changes made in response to reported errors, near misses and incidents.
- I would recommend my organisation as a place to work.

The following response areas showed a 3% or more deterioration from last year:

- the last time you experienced physical violence at work; did you or a colleague report it?
- I receive regular updates on patient / service user experience feedback in my directorate / department (e.g. via line managers or communications team).

This latest survey is memorable in that it demonstrates year on year commitment from the Trust to ensure that colleagues feel safe in having their say and are confident with how we will act upon their opinions.

A full copy of our annual staff survey results can be found on the National NHS Staff Survey Co-ordination Centre website:

www.nhsstaffsurveys.com
Building on the engagement work undertaken across the organisation, the 2018 survey attracted an impressive 61% response rate from a full census; which benchmarked in the top 10 percentile of response rates for the second successive year. The vast majority of responses to the questions showed either a positive shift from the previous years.
ADHD
Attention deficit hyperactivity disorder
Attention deficit hyperactivity disorder (ADHD) is a behavioural disorder that includes symptoms such as inattentiveness, hyperactivity and impulsiveness.

ASD
Autism Spectrum Disorder
Autism Spectrum Disorder (ASD) is a term used to describe a number of symptoms and behaviours which affect the way in which a group of people understand and react to the world around them. It’s an umbrella term which includes autism, Asperger syndrome and pervasive developmental disorders.

BFI
Baby Friendly Initiative
The initiative is a global effort for improving the role of maternity services to enable mothers to breastfeed babies for the best start in life. It aims at improving the care of pregnant women, mothers and newborns at health facilities that provide maternity services for protecting, promoting and supporting breastfeeding.

BHR
Barking & Dagenham, Havering and Redbridge
Refers to the geographical areas of Barking and Dagenham, Havering and Redbridge.

BHRUT
Barking, Havering and Redbridge University Hospitals Trust
Barking, Havering and Redbridge University Hospitals NHS Trust is an NHS trust which runs King George Hospital in Goodmayes and Queen’s Hospital in Romford. It also operates many clinics at a number of sites in the nearby area including Barking Hospital and Brentwood Community Hospital.

BI
Business Intelligence
Business intelligence comprises the strategies and technologies used by enterprises for the data analysis of business information. BI technologies provide historical, current and predictive views of business operations.

CAMHS
Child and Adolescent Mental Health Service
CAMHS is used as a term for all services that work with children and young people who have difficulties with their emotional or behavioural wellbeing.

Clinical Audit
Clinical audit is a process that has been defined as a quality improvement process that seeks to improve service user care and outcomes through systematic review of care against explicit criteria and the implementation of change.

COP
Community of Practice

CQC
Care Quality Commission
The care quality commission is the health and social care regulator for England. The CQC looks at the joined up picture of health and social care. Their aim is to ensure better care for everyone in hospital, in a care home and at home. They provide the essential standards for quality and safety against which organisations must demonstrate compliance.

CYPMHS
Children and Young People’s Mental Health Service
Kent CYPMHS provides emotional wellbeing and mental health advice and support for young people and their families across Kent.

EMT
Executive Management Team

EPR
Electronic Patient Record
Electronic Patient Record refers to the electronic capture and storage of patient health information.

EWMHS
Emotional Wellbeing and Mental Health Service
Emotional Wellbeing and Mental Health Service (EWMHS) provides emotional wellbeing and mental health advice and support for young people and their families across Southend, Essex and Thurrock.

FLC
Finance Leadership Council
HEE
Health Education England
The function of Health Education England is to provide national leadership and coordination for the education and training within the health and public health workforce within England.

HSJ
Health Service Journal
Health Service Journal is a news service which covers the British National Health Service, healthcare management and health policy.

HTT
Home Treatment Team
The Home Treatment Team provide acute home treatment for adults whose mental health crisis is so severe that they would otherwise have been admitted to hospital.

IHI
Institute of Healthcare Improvements

LGBT
Lesbian, Gay, Bisexual, Transgender

NEL
North East London
Refers to the geographical area of north east London.

NELFT
North East London NHS Foundation Trust
NELFT is a community and mental health services trust serving the health needs of residents in Essex, Havering, Redbridge, Waltham Forest and Barking & Dagenham, Barnet, Kent and Medway.

PSLT
Performance Senior Leadership Team

QI
Quality Improvement
Improving quality is about making healthcare safer, effective, patient centred, timely, efficient and equitable.

QIAC
Quality Improvement Accelerator Care

QN
Queen’s Nurse
The title of Queen’s Nurse is available to nurses who have worked in the community for at least five years and who are committed to learning and leadership.

QNI
The Queen’s Nursing Institute
The Queen’s Nursing Institute is a charity that works to improve the nursing care of people in their own homes in England, Wales, and Northern Ireland.

QNIC
Quality Network for Inpatient CAMHS
The network aims to demonstrate and improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of review against the QNIC service standards.

QSLT
Quality Senior Leadership Team

RCPsych
Royal College of Psychiatrists
The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

RTT
Referral To Treatment
Referral to Treatment or RTT is the term used to describe the amount of time that a patient has waited from the point of referral to the time that they receive treatment.

STP
Sustainability and Transformation Partnership
Sustainability and Transformation Partnership is a new planning framework for NHS services. STPs are intended to be a local blueprint for delivering the ambitions NHS bodies have for a transformed health service, which is set out in a document called Five Year Forward View.

WRES
Workforce Race Equality Standard
The Workforce Race Equality Standard is a requirement through the NHS standard contract. It focuses on supporting the system to understand the nature of the challenge of workforce race equality and to enable people to work comfortably with race equality.

YPWS
Young Peoples Wellbeing Service
The Young Persons’ Wellbeing Service provides emotional wellbeing and mental health advice and support for young people in Medway, Kent.
Welcome to PART B of the Quality Report

As outlined in Part A, Part B provides statements of assurance from the Board regarding the review of our services.

We highlight our contributions to data quality and clinical audit and provide some detailed information in our appendices.

Should you wish to provide feedback on our Quality Report, please refer to Part A where our contact details for feedback are provided on page 11.
During 2018/19 NELFT provided and/or subcontracted 294 relevant health services (provided across multiple localities). NELFT has reviewed all the data available to them on the quality of care in 294 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by NELFT for 2018/19.

Freedom to speak up
NELFT has a full time Freedom to Speak up Guardian who has been actively promoting the Freedom to Speak Up role and process within the organisation.

In order to embed the role and encourage staff to raise their concerns, information has been provided through the following mechanisms: weekly newsletters, computer screen savers, information stalls, monthly presentations at the staff induction, posters, leaflets and attendance at team meetings and other engagements.

The Trust has seen a significant increase in the number of staff members approaching the Freedom to Speak Up Guardian, showing that a Freedom to Speak Up culture is being embedded successfully within NELFT.

A Freedom to Speak Up Policy is available on NELFT’s Intranet and explains the process of raising concerns. To ensure an open and transparent culture within NELFT, executive and non-executive, Freedom to Speak Up leads have been identified.

A strategy is being developed and Freedom to Speak Up champions are being recruited.

The concerns that staff may raise are (this list is not exhaustive):

- unsafe or unprofessional patient care
- unsafe working conditions
- inadequate induction or training for staff
- lack of, or poor response to a reported patient safety incident
- physical abuse
- abuse of power, position or authority
- suspicions of fraud, theft or bribery
- bullying or harassment across a team
- concerns about service provision or the conduct of NELFT staff

Staff may raise concerns openly, confidentially or anonymously. There are a range of individuals who can be approached by staff raising concerns: line managers, senior managers, the Freedom to Speak Up Guardian, a Union representative, the Human Resources department, the Safeguarding Team, a member of the Senior Leadership Team or an
External organisation listed in the policy. Staff may raise concerns in writing, through the Freedom to Speak Up email address or on the phone, and may also request to have a private meeting off site.

Individuals receiving the concern are responsible for informing the staff member about the actions planned and the timescales; ensuring that feedback is provided. Staff members are also invited to share their feedback on the process of raising concerns.

The Freedom to Speak Up Policy assures staff that if a concern is raised, the person who raised it will not be at risk of losing their job or suffering any form of reprisal as a result. The Policy states that NELFT will not tolerate the harassment or victimisation of anyone raising a concern, nor will it tolerate any attempt to bully staff into not raising concerns. Any such behaviour is a breach of NELFT’s values and, if upheld following investigation, could result in disciplinary action. Staff members are encouraged to contact the Freedom to Speak Up Guardian if they feel that they have been victimised or any harm has come to them following raising a concern.

Progress with audit and data quality

Participation in national clinical audit and confidential enquiries

To meet the expectations of the NHS Constitution, NELFT has in place an Annual Clinical Audit programme aimed at continuously improving the quality of care, safety and standards provided by its services. The programme is designed to monitor compliance with relevant national standards, including NICE, and ensure a robust system of quality assurance reporting. The programme for 2018/19 included both local and national clinical audits, as well as confidential enquiries.

Clinical audit is undertaken to review systematically the care the Trust provides to patients against best practice standards. NELFT utilises participation in national clinical audit programmes and confidential enquiries as a driver for improvements in quality. Participation in audits like these not only provide opportunities for comparing practice nationally, they play an important role in providing assurance about the quality of our services. The Trust is committed to ensuring that all clinical professional groups participate in clinical audit.

During the period 2018/19, NELFT participated in 14 (100%) national clinical audits and 2 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The Trust also participated in 7 CQUIN audits which covered relevant health services that NELFT provides.

The national clinical audits and national confidential enquiries that NELFT was eligible to participate in during 2018/19 are listed in Appendix 2a. The national clinical audits and national confidential enquiries that NELFT participated in during 2018/19 are listed in Appendix 2a. The national clinical audits and national confidential enquiries that NELFT participated in, and for which data collection was completed during 2018/19, are listed in Appendix 2a alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The number of patients receiving relevant health services provided or sub-contracted by NELFT in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1,967.

Learning from national clinical audits

National Clinical Audits are designed to measure healthcare practice on specific conditions against accepted standards, providing patients, the public and clinicians with a clear picture of the standards of healthcare being achieved for specific specialities. Its purpose is to engage all healthcare professionals from across the UK in a systematic monitoring process of their clinical practice. The aim is to support and encourage quality and
deliver better outcomes in the care we provide to our patients and service users.

NELFT intends to continue to improve the processes for monitoring the recommendations and outcomes of National Audits and Confidential Enquiries by ensuring:

- national clinical audits and national confidential enquiries continue as on-going components to the development of the Annual Clinical Audit Programme. Priority will be assigned to all national and mandatory audits and approved at Board for review, thus maintaining our gold standard 100% participation rate with these studies.

- local level audit summary reports for national clinical audits to be completed with recommendations and action plans, encouraging shared learning

- performance outcome and updates for all national audits are presented at senior Quality Safety Committee Meetings (QSC) and corporate level meetings ensuring the Trust is involved and aware of national audits undertaken in the Trust.

- clinical and senior leadership to remain integral to ensure national audit completion and reflection.

National audit participation by the Trust also includes receiving benchmarked reports on our performance, with the aim of improving the care provided. National audits are related to some of the most commonly-occurring conditions. Data for these audits are supplied by local clinicians to provide a national picture of care standards for a specific condition. On a local level, National Clinical Audits and Patients Outcome Programme (NCAPOP) audits provide local trusts with individual benchmarked reports on their compliance and performance, feeding back comparative findings to help participants identify necessary improvements for patients. Our Trust actively participates in these audits and will continue to use these reviews to improve the quality of care we provide to our end users.

The reports of 14 national clinical audits and 2 confidential enquiries were reviewed by NELFT in 2018/19. This included national audits for which data was collected in earlier years with the resultant report being published in 2018/19. NELFT intends to take the actions detailed in appendix 2b to improve the quality of healthcare provided.

The Trust has a demonstrable and clear process that supports shared learning and improvement from national clinical audit findings as follows:

- the Trust produces a local summary and SMART action plan based on the findings of the national audit

- national and local Trust findings are shared across service teams to identify gaps in performance, and this information is used to produce a Trust wide action plan to improve the quality of its services.

- implementation of the action plan is monitored by the Trust’s clinical audit team via the Trust’s robust Clinical Audit Action Plan Tracker (CAAPT)

- progress of action implementation is discussed locally in the specialty clinical audit group meetings on monthly or bi-monthly basis

- progress and completion status of actions against the CAAPT are reported to the Trust’s Quality

During 2018/19, there were 1,967 patients recruited, who received relevant health services provided or subcontracted by NELFT, to participate in research approved by a research ethics committee.
and Safety Committee (QSC) on a quarterly basis.

- the Clinical Audit & Effectiveness Manager provides quarterly reports to the Trust’s Quality & Safety Committee, which includes a summary of national audit findings relevant to the Trust, identifying emerging themes or areas requiring action for improving the quality of service provided by the Trust. Thus providing assurance to the leadership that quality improvement of care, standards and safety is continuous.

Learning from local clinical audits

A snapshot of 110 local clinical audit reports were reviewed by NELFT in 2018/19 out of which 38 audits have been completed (35%) to date. These completed audit reports were reviewed by NELFT in 2018/19 and areas that require improvement were flagged up; the findings were placed into SMART action plans, with designated action completion dates. These actions may vary, from improving the quality of documentation, to the issuing of new guidelines or amending relevant policies. These findings and smart plans are then shared with service leads, who in turn would share with their staff, to learn from the findings and in so doing improve the quality of healthcare provided by NELFT.

Our clinicians are strongly encouraged and supported to set up local relevant in-depth audits as a follow up to national audit findings, based on local quality and safety priorities. The reports of 38 local clinical audits were reviewed and actions agreed by the services. These audits cover various services provided by NELFT and details are provided in appendix 2c.

Care Quality Commission (CQC) and Clinical Audit

The CQC uses clinical audits as one of the quality improvement processes or cycle of events that helps ensure patients receive the right care and treatment. Care and services are measured against evidence-based standards and changes are implemented to narrow the gap between existing and best practice. At NELFT we regularly measure and improve our clinical audit during each cycle. Examples of clinical audit improvements can be found in Appendix, page 78.

From the 10th – 14th December 2018, the Trust celebrated its 4th annual Trust-wide Clinical Audit Awareness Week (CAAW). It was a great opportunity to share local and national clinical audit findings, including outcomes from clinical audits implemented in the Trust to address concerns and implement change. The event was very well attended and it was an informative week. To date, the number of Clinical Audit Champions (CAC) stands at 1392 across the Trust, fully trained and improving the quality of patient care and safety Trust wide using the clinical audit process. This figure captures data up until January 2019.

Clinical audit remains an established quality improvement (QI) activity in NELFT, demonstrating ongoing, continuous improvements in the quality of care that the Trust provides. The CQC had in their previous (2016) inspection report acknowledged that:

“The Trust used a number of nationally recognised tools and audits to measure and improve the outcomes of patients and people using their services.”

“Staff participated in clinical audit to measure and improve on practice. The Trust had completed a number of national and local audits in areas such as use of family intervention therapy, national asthma audits and prescribing of combined oral contraceptives. The findings of these were used to make improvements to the services. For example, in the older people’s community mental health, teams participated in clinical audits, such as the national clinical audit for antipsychotic medication. The last audit identified the need to improve recording and teams had developed new templates for this.”
One of the requirements of the Care Quality Commission is for all healthcare organisations to consider nationally agreed guidance when planning and delivering treatment and care. Implementing NICE guidance can help patients, carers and service users receive care in line with the best available clinical evidence and cost-effectiveness. This also enables people to be accountable for their care, knowing how they will be cared for in a consistent evidence-based way, thus building patients’ confidence in the Trust.

NELFT has a robust and efficient process of NICE guidance dissemination in place that ensures monthly review, and determination of the applicability of each NICE guideline to our services. Immediately after publication, each NICE guidance is assessed for their relevance to the Trust by the clinical / service leads. Further, there is a highly efficient operational process in place, which ensures that all relevant NICE Baseline Assessment Tools and guidelines are made available to the appropriate service leads monthly. All these processes and systems are in place to monitor the level of NICE compliance within services. Each year, the Trust undertakes a range of audits specific to NICE guidance, which are included in the annual Clinical Audit programme. This practice also helps us monitor and measure our services against national guidance, to ensure compliance is being maintained.

Commissioning for quality and innovation (CQUIN) is a payment framework enabling commissioners to award excellence by linking a proportion of the income they give to providers such as NELFT to the achievement of national and local quality improvement goals.

A proportion of NELFT income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between NELFT and any person or body that they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available on request from:

Performance and business intelligence team

Email: jacky.hayter@nelft.nhs.uk

Address:
NELFT NHS Foundation Trust,
CEME Centre,
West Wing,
Marsh Way,
Rainham,
Essex
RM13 8GQ

The total amount of income in 2018/19 conditional upon the achievement of quality improvement and innovation goals was £7.1m. The monetary total for achievement of goals in 2017/18 was £6.8m.
Registration with the Care Quality Commission (CQC)

NELFT has been a Foundation Trust since 1st June 2008.

NELFT is required to register with the Care Quality Commission (CQC) and its current registration status is that it is registered to carry out the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- family planning
- personal care - this is a new regulated activity in relation to the acquisition of the reablement service
- treatment of disease, disorder or injury

Overall NELFT is now rated by the CQC as good.

There is a Well-led CQC visit due in March 2019. All requested information has been supplied.

NELFT has not participated in any special reviews or investigations by the CQC during the reporting period and the CQC has not taken enforcement action against NELFT during 2018/19.

NHS number and general medical practice code validity

NELFT submitted records during 2018/19 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:

- 99.8% for admitted patient care
- 100% for outpatient care

95.6% Accident and Emergency which included the patient’s valid General Medical Practice Code was:

- 99.9% for admitted patient care
- 99.9% for outpatient care
- 99.0% Accident and Emergency

Information Governance Assessment Report

NELFT’s progression in regards to the new Beta Version of the Data Security and Protection Toolkit is currently at 83 out of the 100 mandatory requirements for 2018/19.

Clinical coding error rate

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

Audit – areas for improvement

NELFT will be taking the following actions to improve data quality:

All staff receive training on electronic recording systems prior to being given access. E-learning packages have been developed to provide more timely and efficient access to systems and support the face to face learning that is available. New starters to the Trust undergo appropriate systems training and mandatory training as part of the new streamlined induction process during their first two weeks of employment. This is maximising compliance.

The data quality / information governance mandatory e-learning programme is now an annual requirement and the training programme has been revised to include further guidance around registration of death and associated record management, synchronisation of records and recording of diagnosis, particularly within inpatient records applicable to Secondary Uses Service submissions. Further work around recording of Diagnosis is being undertaken with Community staff.
Both the Record Keeping and Data Quality policies are currently under review and will include guidance around areas identified within the annual healthcare records audit.

The 2018/19 annual healthcare records audit included an increased focus on the assessment of data quality practices, risk and those areas that impact on them. More use was shown of electronic systems for recording activity and clinical information as well as increased access via mobile devices. This information informs an action plan for improvement of data quality and record keeping which is reviewed by the Data Quality Action Group (DQAG) on a regular basis.

Data quality prompts have been expanded within the electronic patient records to include missing high priority information including mandatory dataset and families information. The results of the annual record keeping audit have identified improvements in these areas. PC login messages have also been used to inform all staff of their record keeping and data quality responsibilities.

Data quality issues are identified and reported to Localities on a monthly basis, highlighting areas where improvement is required (at both Locality and Team level) to support progress in completing the minimum required data. Data quality information is available to all staff through both the clinical activity reports and performance dashboards produced on the business intelligence tool, MIDAS.

Data quality has been key in our RTT workstream and the 3 C’s (Care Plans, Clinical Risk Assessments and Clinical Harm Reviews) ensuring that data is correct to support clinical quality and patient safety.

Work is also taking place with NELFT’s EIP Teams to ensure an improvement in data quality, including a review of the electronic patient record templates to support accurate recording of clinical processes.

Maintenance and improvement of data quality across both clinical and corporate services is a function of the Data Quality Action Group who report to senior leadership team monthly via the Chairperson. The group identify priorities to target in the coming financial year, review the impact to financial performance in regards to data quality issues and agree the annual healthcare records audit, corporate records audit and information governance toolkit clinical coding audit.

Information assurance framework assessments and spot checks are agreed each year to monitor the quality and accuracy of our reported data against source data.

In addition to the above, NELFT continues to monitor the capture and quality of information submitted as part of datasets and commissioned activity.

“...The 2018/19 annual healthcare records audit included an increased focus on the assessment of data quality practices, risk and those areas that impact on them. More use was shown of electronic systems for recording activity and clinical information as well as increased access via mobile devices."
### Learning from Deaths

<table>
<thead>
<tr>
<th>NHSI DETAILED REQUIREMENTS GUIDANCE NUMBER</th>
<th>PRESCRIBED INFORMATION</th>
<th>FORM OF STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.1</td>
<td>The number of its patients who have died during the reporting period including a quarterly breakdown of the annual figure.</td>
<td>During 2018/19, 7,399 of NELFT patients died. (of which 29 number were neonatal death, and 22 were people with learning disabilities and 441 had a severe mental illness). This represents 1.29% of NELFT’s caseload for 2018/19. This comprised the following number of deaths which occurred in each quarter of that reporting period.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Q1</strong></td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>2,030</td>
</tr>
<tr>
<td></td>
<td>of which:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neonatal</td>
<td>NELFT unable to provide this due to the nature of the services the Trust provides</td>
</tr>
<tr>
<td></td>
<td>Stillbirths</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Learning disabilities</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Severe mental illness</td>
<td>97</td>
</tr>
<tr>
<td>27.2</td>
<td>The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.</td>
<td>Within NELFT all unexpected deaths are reviewed against the serious incident framework through a systematic case review. Those that meet the criteria are investigated under the serious incident investigation policy. NELFT concerns itself with other levels of investigation including, local internal, safeguarding, LeDer and CDOP. All unexpected deaths that are not subject to any of the above investigations are subject to a review by NELFT’s Mortality Review Group. In 2018/19 63 serious incident investigations have been carried out in relation to the 7,399 deaths included in item 27.1. The number of deaths in each quarter for which an investigation was carried out was:</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Q1</strong></td>
</tr>
<tr>
<td></td>
<td>Deaths</td>
<td>10</td>
</tr>
</tbody>
</table>
An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

11 serious incidents representing 0.15% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

54 Case reviews using the Confidential Enquires of Stillbirths and Infant Deaths (CESDI) methodology identified that 0 deaths were more likely than not to have been due to problems in the care provided to the patient. In 8 of the cases suboptimal factors were identified during the case reviews but were unlikely to have contributed to the fatal outcome.

A total of 33 serious incidents were reviewed and scored using the CESDI methodology. A total of six were excluded as they had been deescalated as a serious incident during the investigation process. The scoring of an additional seven has been deferred until the outcome of the coroner’s inquest where it was not possible to determine a cause of death at the stage the serious incident investigation concluded. A remaining 15 investigations are still under investigation and will be CESDI scored at the conclusion stage. From this review the number of serious incidents and percentage of patient deaths during the reporting period that are judged to be more likely than not to have been due to problems in the care provided were assessed as the following:

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>CESDI score of 2</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>investigations ongoing</td>
</tr>
<tr>
<td>CESDI score of 3</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>investigations ongoing</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3</td>
<td>7</td>
<td>1</td>
<td>investigations ongoing</td>
</tr>
</tbody>
</table>

These numbers have been estimated using the Confidential Enquires of Stillbirths and Infant Deaths (CESDI) methodology and the Serious Incident Framework 2015. A score of 2 represents suboptimal care - different care MIGHT have made a difference (possibly avoidable death). A score of 3 represents suboptimal care WOULD REASONABLY BE EXPECTED to have made a difference (probably avoidable death). All deaths where the CESDI score was 2 or 3 have an accompanying robust action plan in place to ensure learning is embedded and in addition these were subject to a Coroners review.
<table>
<thead>
<tr>
<th>NHSI DETAILED REQUIREMENTS GUIDANCE NUMBER</th>
<th>PRESCRIBED INFORMATION</th>
<th>FORM OF STATEMENT</th>
</tr>
</thead>
</table>
| **27.4**                                  | A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3. | • improving how we work in partnership and listening to the voice of carers and relatives  
• improving recording of formal risk assessments  
• improving recording of Next of Kin details in patient records  
• improving adherence to policy and guidance |
| **27.5**                                  | A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4). | • following the National Quality Board Guidance for NHS trusts on working with bereaved families and carers, a task and finish group has been set up to review the support provided to families and carers following bereavement. The findings and recommendations are due in March 2019.  
• following the publication of NHS Resolution - Learning from suicide related claims the Serious Incident team are completing a benchmarking exercise against the findings and the review is planned for completion in March 2019 and an action plan will be developed against any shortfalls identified.  
• the Acute and Rehabilitation Directorate undertook an SI learning event on 14th November; two recent Serious Incident investigation cases were presented and discussed. There were approximately 150 practitioners in attendance and they examined the learning from the investigation including the root causes and the care and service delivery issues identified.  
• the Children & Young People Community of Practice undertook a learning event in November that included a focus on the learning from Kent & Essex CYP Suicide report, and Mental Health Transition. |
| **27.6**                                  | An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period. | Audits of patient records and NEWs recording and actions are demonstrating the staff are more aware of the need for early intervention.  
Where there is evidence of domestic abuse this needs to be raised in line with the policy and risks and managed accordingly.  
Support for carers, offering of carer’s assessment.  
Signposting to support individual risk assessments to take account of carers stress |
In 2017/18, 26 of the deaths reviewed or investigated during that year were judged to be more likely than not to have been due to problems in the care provided to the patient. This represented 0.30% of the deaths that occurred during that financial year.

In addition, 9 case record reviews and 14 investigations that related to deaths that took place during 2017/18 were completed after 31st March 2018. Of these, following an SJR and then a subsequent judgement, 3 deaths were judged to be more likely than not to have been due to problems in the care provided to the patient. Therefore, of all the deaths that occurred in 2017/18 and which were reviewed or investigated, a total of 29 deaths were judged to be more likely than not to have been due to problems in the care provided to the patient. This represents 0.37% of the patient deaths that occurred during 2017/18.
### Reporting against our core indicators 2018/19

NHS Improvement requires foundation trusts to report on a set of quality indicators through the single oversight framework (SOF)

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>MEASURE</th>
<th>NATIONAL AVERAGE</th>
<th>NHS TRUST HIGHEST</th>
<th>NHS TRUST LOWEST</th>
<th>NELFT 2017/18</th>
<th>NELFT 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period</td>
<td>Percentage</td>
<td>95.5% (as at Q3)</td>
<td>100%</td>
<td>81.6% (Q3)</td>
<td>97.63%</td>
<td>95.78%</td>
</tr>
<tr>
<td>The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Teams (HTT) acted as a gatekeeper during the reporting period</td>
<td>Percentage</td>
<td>97.8% (As at Q3)</td>
<td>100%</td>
<td>78.8% (Q3)</td>
<td>94.6%</td>
<td>96.42%</td>
</tr>
<tr>
<td>i. 0 -15</td>
<td>Percentage</td>
<td></td>
<td></td>
<td></td>
<td>11.76% (4 of 34)</td>
<td>5.56% (2 of 36)</td>
</tr>
<tr>
<td>ii. 16 and over</td>
<td>Percentage</td>
<td></td>
<td></td>
<td></td>
<td>5.0% (201 of 3,917)</td>
<td>4.86% (166 of 3,417)</td>
</tr>
<tr>
<td>readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The trusts ‘Patient experience of community mental health services’ indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period</td>
<td>Number</td>
<td>Not available</td>
<td>7.7</td>
<td>5.9</td>
<td>8.0</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>Rate per 100,000 population</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q1 2,375 Q2 2,381 Q3 2,472 Q4 2,271
## Core Indicator Assurance of data in table in 2.3 above

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

NELFT considers that this data is as described for the following reasons:
- NELFT continue to perform strongly against the CPA follow up; there are robust systems and processes in place to monitor performance. The close working across the acute care pathway between wards and our home treatment teams enables timely follow up.

NELFT has taken the following actions to improve this indicator, and so the quality of its services, by:
- All locality directorate areas are now responsible for monitoring CPA follow up for patients discharged directly back to a community team hence this is now closely managed and reported locally.

The percentage of admissions to acute wards for which the Crisis Revolution Home Treatment Teams (HTT) acted as a gatekeeper during the reporting period

NELFT consistently works to closely monitor this indicator, and the quality of its services, by:
- continuing to improve data capture in NELFT EPR (RIO). The Performance team provide monthly reports to ensure compliance; clearer understanding between clinical and performance teams of terminology to ensure correct reporting criteria.
<table>
<thead>
<tr>
<th>The percentage of patients aged:</th>
<th>NELFT considers that this data is as described for the following reasons: the numbers of patients readmitted remain low and so are individually reviewed and discussed at directorate monthly meetings to ensure correct data recording.</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. 0 -15</td>
<td>NELFT has taken the following actions to improve this indicator, and so the quality of its services, by: reviewing each case individually with the ward managers and responsible assistant director. Readmission rates for 16 and over remains very low. For young people aged under 16, NELFT has transformed the model of care, providing greater treatment options for young people at home. The acuity of inpatients is therefore greater and this has led to the increase in readmissions when compared with last year. Each case continues to be individually scrutinised.</td>
</tr>
<tr>
<td>ii. 16 and over</td>
<td></td>
</tr>
<tr>
<td>readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period</td>
<td></td>
</tr>
<tr>
<td>The trusts ‘Patient experience of community mental health services’ indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period</td>
<td>NELFT considers that this data (in table above) is as described for the following reasons: this is a CQC commissioned survey carried out by an independent contractor. The latest survey findings were published in November 2018. The data is in the public domain on the CQC website <a href="http://www.cqc.org.uk/provider/RAT/survey/6">http://www.cqc.org.uk/provider/RAT/survey/6</a>. NELFT continues to improve this indicator, and so the quality of its services, by rolling out a Quality Improvement Accelerator Care planning (QIAC) programme to ensure patients are actively involved in decisions about their own care.</td>
</tr>
</tbody>
</table>
Patient safety incidents

Patient safety incidents that resulted in severe harm or death

NELFT considers that this data is as described for the following reasons: this data is published nationally by NHS Improvement. The data is taken from the National Reporting and Learning System (NRLS) which is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

NELFT has taken the following actions to improve this indicator, and so the quality of its services, by:

- delivering training in the Training and Development Centre at CEME, using the computer suites so staff can access the system as part of their training
- the publication of quarterly newsletters which provide guidance on what to report, how to report and the proper codes to use for the most frequently reported incidents. The newsletters also share what has been learnt from incidents
- a screen saver for all staff with the key message of ‘if in doubt, report it’.
- the development and embedding of the use of Datix quality dashboards. Datix dashboards contain up to date information on incident numbers, types and reporting patterns. These are now available at every level within the organisation. This means that teams can see all this information in one place which helps to identify areas for improvement and good practice
- feedback is automatically given to staff who report incidents. This feedback includes the result of the investigation and any lessons learned
- all new starters receive information on incident reporting and how this contributes to everyone’s safety as part of their induction

NELFT intends to take the following actions to improve this number and so the quality of its services by

- continuing to review the data quality standards set by NHS Improvement for uploads to the National Reporting and Learning System. This includes making sure the coding of the harm matches the definitions provided by NHS Improvement
- visiting teams to help them in identify, report and review incidents
- develop a Datix User Group which will share how we can make it easier for staff to report incidents
- scope the use of mobile devices for incident reporting
### NELFT performance indicators for 2017/18 and 2018/19

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>MEASURE</th>
<th>TARGET</th>
<th>NATIONAL AVERAGE</th>
<th>NHS TRUST HIGHEST</th>
<th>NHS TRUST LOWEST</th>
<th>NELFT 2017/18</th>
<th>NELFT 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum time of 18 weeks from point of referral to treatment (RTT)</strong></td>
<td>Percentage</td>
<td>92%</td>
<td>88.8%</td>
<td>100%</td>
<td>73.9%</td>
<td>99.1%</td>
<td>100%</td>
</tr>
<tr>
<td>in aggregate – patients on an incomplete pathway</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A&amp;E</strong>: maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>Percentage</td>
<td>95%</td>
<td>91.7%</td>
<td>100%</td>
<td>59.4%</td>
<td>99.1%</td>
<td>99.6%</td>
</tr>
<tr>
<td><strong>Early intervention in psychosis (EIP)</strong>: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (audited by KPMG)</td>
<td>Percentage</td>
<td>50%</td>
<td>Jan 2019 Ave 77%</td>
<td>100%</td>
<td>0%</td>
<td>82.1%</td>
<td>81.7%</td>
</tr>
<tr>
<td><strong>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Inpatient wards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Early intervention psychosis services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community mental health services (people on care programme approach)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improving access to psychological therapies (IAPT)</strong></td>
<td>Percentage</td>
<td>50%</td>
<td>51.9%</td>
<td>88%</td>
<td>29%</td>
<td>50.5%</td>
<td>50.77%</td>
</tr>
<tr>
<td>a) Proportion of people completing treatment who move to recovery (from IAPT dataset)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Waiting time to begin treatment (from IAPT minimum dataset):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Within 6 weeks of referral (audited by KPMG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>ii) Within 18 weeks of referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Admissions to adult facilities of patients under 16 years old</strong></td>
<td>Number</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Inappropriate out-of-area placements for adult mental health services (bed days)</strong></td>
<td>Number (whole year data)</td>
<td>38 34 in Feb 2018 4 in Mar 2018</td>
<td>1,816</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendices
Quality Report Glossary

CAAPT
Clinical Audit Action Plan Tracker

CAAW
Clinical Audit Awareness Week

CAC
Clinical Audit Champions

CCG
Care Quality Commission
The care quality commission is the health and social care regulator for England. The CQC looks at the joined up picture of health and social care. Their aim is to ensure better care for everyone in hospital, in a care home and at home. They provide the essential standards for quality and safety against which organisations must demonstrate compliance

CESDI
Confidential Enquiries of Stillbirths and Infant Deaths
CESDI is an ongoing UK enquiry which assesses the risks of death in late foetal life and infancy, and identifies risks attributable to suboptimal clinical care

Clinical Audit
Clinical audit is a process that has been defined as a quality improvement process that seeks to improve service user care and outcomes through systematic review of care against explicit criteria and the implementation of change

CPA
Care Programme Approach
The term 'care programme approach' describes the framework for supporting and coordinating effective mental health care for people with severe mental health problems in secondary mental health services

CQC
Care Quality Commission
The Care Quality Commission is the health and social care regulator for England. The CQC looks at the joined up picture of health and social care. Their aim is to ensure better care for everyone in hospital, in a care home and at home. They provide the essential standards for quality and safety against which organisations must demonstrate compliance

CQIN
Commissioning for Quality and Innovation
The CQIN payment framework was introduced in 2009 to make a proportion of providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of care. The framework helps make quality part of the commissioner-provider discussion everywhere. The framework has been designed based on feedback from partners in the NHS

Datix
Datix is the Trust wide web based incident and risk management system. It is used to report and manage incidents, to manage risks on the risk register and to manage complaints, concerns and compliments

DQAG
Data Quality Action Group

EIP
Early Intervention in Psychosis
A clinical approach to those experiencing symptoms of psychosis for the first time

HTT
Home Treatment Team
The Home Treatment Team provide acute home treatment for adults whose mental health crisis is so severe that they would otherwise have been admitted to hospital

IAPT
Improving Access to Psychological Therapies
IAPT is a programme that began in 2008 with the direct objective to improve access for people with anxiety and depression to evidence based psychological therapies such as Cognitive Behavioural Therapy (CBT)

NCAPOP
National Clinical Audits and Patient Outcome Programme
Audits are commissioned and managed on behalf of NHS England by the Healthcare Quality Improvement Partnership (HQIP)

NELFT
North East London NHS Foundation Trust
NELFT is a community and mental health services trust serving the health needs of residents in Essex, Havering, Redbridge, Waltham Forest, Barking & Dagenham, Barnet, Kent and Medway
NHSi
NHS Improvement
Since 1st April 2016 Monitor and the NHS Trust Development Authority have merged. They now operate under the name of NHS Improvement

NICE
National Institute of Clinical Excellence
NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health

QI
Quality Improvement
Improving quality is about making healthcare safer, effective, patient centred, timely, efficient and equitable

QIAC
Quality Improvement Accelerator Care

QIP
Quality Improvement Programme
Quality improvement refers to bringing about changes that improve patient experiences and support staff to deliver person centred care that is better, safer, more effective and more efficient using a range of specific tools and methods. Quality improvement is an approach which enables everyone to get involved in improving quality.

QSC
Quality Safety Committee
This NEFLT committee is to assure the Board that the Trust’s quality governance model is robust and effective in identifying emerging risk and that there is leadership, governance and effective culture to improve the delivery of high quality person centred care

RTT
Referral To Treatment
Referral to Treatment or RTT is the term used to describe the amount of time that a patient has waited from the point of referral to the time that they receive treatment

SOF
Single Oversight Framework
The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of ‘Good’ or ‘Outstanding’

“ The Care Quality Commission is the health and social care regulator for England. The CQC looks at the joined up picture of health and social care. Their aim is to ensure better care for everyone in hospital, in a care home and at home. ”
<table>
<thead>
<tr>
<th>TITLE OF AUDIT</th>
<th>MANAGEMENT BODY</th>
<th>PARTICIPATION</th>
<th>IF COMPLETED, NUMBER OF CASES/RECORDS OR % SUBMITTED</th>
</tr>
</thead>
</table>
| National Audit of Intermediate Care (NAIC)                                   | NHS Benchmarking Network              | Bed based services  
• Redbridge: Foxglove & Japonica wards  
• Brentwood Community Hospital: Thorndon Ward  
• Waltham Forest: Ainslie Unit  
• Thurrock Community Hospital: Mayfield Ward  
Home based services  
• Waltham Forest: Community Rehabilitation Team  
• London & Essex: Intensive Rehabilitation Services  
Provider bespoke report published November 2018 | 226 bed based intermediate care services  
124 home based intermediate care services  
Community hospitals were asked to complete the Service User Questionnaire (SUQ) for up to 50 consecutive referrals. 28 forms were returned for NELFT (56%). (NELFT Bespoke Report Dec 2018) |
| National Chronic Obstructive Pulmonary Disease Audit Programme (COPD) PR     | Royal College of Physicians (RCP)     | NELFT pulmonary rehabilitation [PR] sites registered for audit participation  
• Barking & Dagenham  
• Havering  
• Redbridge  
• Waltham Forest  
• BB & Thurrock  
Organisational data collection delivered between 1st April 2019 – 1st July 2019 for both Asthma and COPD  
Continuous data collection - to run from March 2018 – February 2021  
For Patients assessed from 1st March 2019 and discharged by 31st August 2019, records are to be completed by 11th October 2019 on the national audit web tool | Ascertainment rate not available as audit not yet due. Audit to commence March 2019 |
<table>
<thead>
<tr>
<th>TITLE OF AUDIT</th>
<th>MANAGEMENT BODY</th>
<th>PARTICIPATION</th>
<th>IF COMPLETED, NUMBER OF CASES/RECORDS OR % SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Diabetes Foot care audit (NDFA)</td>
<td>NHS Digital</td>
<td>The 4th Annual report will include all foot ulcers where the first assessment took place prior to 31 March 2018 and report to be published spring 2019. Participating services - Waltham Forrest and Barking &amp; Dagenham. The NDFA audit is a continuous data collection audit. Currently gathering data for the 5th Annual report 2019/20</td>
<td>100% of eligible cases</td>
</tr>
<tr>
<td>National audit of Care at the End of Life (NACEL)</td>
<td>NHS Benchmarking Network</td>
<td>Audit commissioned over 3 years with the first data collection to take place in 2018. Trust site overview Adult Mental Health – submission 1 Community Mental Health – submission 1 Hospital site overview Adult Mental Health – submission 1 Community Mental Health – submission 1 Organisational level data Case note audit data June – Oct 18 Carer reported measure data Data validation and analysis – October - December 2018 Report publication due January – February 2019 NELFT Bespoke Dashboard report (for first round of submission) Community and Mental Health published February 2019</td>
<td>4 cases submitted NACEL office is distributing a survey for participants to provide feedback on the 1st iteration of the audit at present Awaiting info re submission from the national office</td>
</tr>
<tr>
<td>TITLE OF AUDIT</td>
<td>MANAGEMENT BODY</td>
<td>PARTICIPATION</td>
<td>IF COMPLETED, NUMBER OF CASES/RECORDS OR % SUBMITTED</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| UK Parkinson’s Audit                               | Parkinson’s UK                 | Continuous audit  
NELFT has registered for participation.  
Audit data submission deadline is the 31st of October 2019  
Ascertainment rate not available as audit not yet due.  
Audit to commence February 2019 | Ascertainment rate not available as audit not yet due.  
Audit to commence February 2019 |
| National Epilepsy 12 audit (Round 3)                | Royal College of Paediatrics & Child Health (RCPCH) | 3 year programme. Organisational data submitted  
Continuous clinical audit data collection ongoing until Oct 2020 |
| National Clinical Audit of Psychosis (NCAP) (EIP services) | Royal College of Psychiatrists (RCPsych) | The CCGs covered are Redbridge, Waltham Forest, Havering, Barking & Dagenham  
Adults 16 years and older who are being cared for by adult services in the community or as inpatients.  
Number of eligible patients for North East London NHS Foundation Trust is 2055  
192 community patients  
8 Inpatients selected randomly by RCPsych  
Returns for NELFT was 189 (95% approx) out of an expected 200 | 192 community patients  
8 Inpatients selected randomly by RCPsych  
Returns for NELFT was 189 (95% approx) out of an expected 200 |
<table>
<thead>
<tr>
<th>TITLE OF AUDIT</th>
<th>MANAGEMENT BODY</th>
<th>PARTICIPATION</th>
<th>IF COMPLETED, NUMBER OF CASES/RECORDS OR % SUBMITTED</th>
</tr>
</thead>
</table>
| **National Clinical Audit of Anxiety and Depression (NCAAD):** Core audit on inpatient wards. The Audit will focus on the following areas for improvement based on the NAPT findings:  • access,  • waiting times,  • training | Royal College of Psychiatrists (RCPsych) | Awaiting National report and recommendation estimated for publication between January – April 2019  
A retrospective audit of service users admitted to an inpatient mental health service for anxiety and/or depression  
Data collection for round 4 closed  
National report publication due spring 2019 | Awaiting info from the national audit office regarding data submission |
| **National Clinical Audit of Anxiety and Depression (NCAAD):** Psychological Therapies Spotlight Audit | Royal College of Psychiatrists (RCPsych) | The Psychological Therapies Spotlight Audit will focus on the following areas for improvement based on the NAPT findings  
Commenced August 2018  
Publication of report | All eligible cases submitted for WF Psychological Services  
Adult Psychotherapy Service has submitted 9 out of 28 eligible cases  
Havering MAP service has submitted 30 out of 35 eligible cases  
In addition, a total of 18 Therapist Questionnaires and 20 Service User Questionnaires (SUQ) have been submitted. (Figures provided by the national audit office) |
| **POMH-UK audit Topic 16b – Rapid Tranquilisation** | Royal College of Psychiatrists (RCPsych) | Data entry by NELFT teams, over the period 1st March – 31st May 2018 | Trust teams: 16  
Total submissions: 21  
By Adult Acute Services  
(POMH Trust Specific report published Oct 2018) |
<table>
<thead>
<tr>
<th>TITLE OF AUDIT</th>
<th>MANAGEMENT BODY</th>
<th>PARTICIPATION</th>
<th>IF COMPLETED, NUMBER OF CASES/RECORDS OR % SUBMITTED</th>
</tr>
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</table>
| POMH-UK audit Topic 18a – Prescribing Clozapine  | Royal College of Psychiatrists (RCPsych) | Data entry by NELFT teams, over the period 1st June – 31st July 2018 and submitted to POMH UK National report to be published January 2019 followed by the NELFT specific report published February 2019 | Trust teams: 13  
Total submissions: 62 |
| POMH-UK audit Topic 6d Assessment of the side effects of depot antipsychotics. | Royal College of Psychiatrists (RCPsych) | 1. antipsychotic side effects should be monitored routinely and regularly (NICE 2002, 2009)  
2. people receiving depot preparations should be maintained under regular clinical review, particularly in relation to the risks and benefits of the drug regimen (NICE 2002, 2009)  
3. the side effects associated with antipsychotic drugs should be ‘assessed using standardised methods and validated rating scales’ (Clinical Standards Board for Scotland 2001). | Participating teams for Redbridge: 4  
Total submissions: 70  
Participating teams for Barking & Dagenham: 4  
Total submissions: 28 |
<p>| POMH-UK audit Topic 7f Monitoring of patients prescribed lithium | Royal College of Psychiatrists (RCPsych) | The audit has consistently identified gaps between evidence-based recommendations and clinical practice in relation to the biochemical monitoring of patients who are receiving maintenance treatment with lithium. NHS Trusts UK wide have collected and entered data during February to March 2019. | A total of 54 cases have been submitted for NELFT |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| **Sentinel Stroke National Audit Programme (SSNAP) 2018/19**                    | Royal College of Physicians (RCP) | Participating services                                                        | Data submission (London)  
April – June 2018 65 cases submitted  
July – Sept 2018  
Data submission (Essex)  
During the periods Dec 2017- June 18 196 patients were referred due to stroke |
| The audit aims to continuously monitor the prospective national audit programme which monitors stroke services against evidence based standards to improve care. Data is collected using the SSNAP online collection tool. |                           |                                                                               |                                                      |
|                                                                               |                           | All patients with a primary diagnosis of stroke coded as I-61, I-63, I-64 should be submitted to SSNAP. The minimum age for patient submission to SSNAP is 16. |                                                      |
| **Child Health Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Mental Health Conditions in Young People – Continuous audit** | NCEPOD                    | Currently the report publication for previous audit is still delayed         | Data is not being collected in 2018/19 as detailed by national body |
| The aim of the audit is to identify the remediable factors in the quality of care provided to young people treated for mental health disorders; with specific reference to 1. Depression and anxiety 2. Eating disorders and Self harm. |                           |                                                                               |                                                      |
| **Mental Health Clinical Outcome Review Programme: National Confidential Inquiry into Suicide and Homicide for people with mental illness (NCISH) 2018/19** | NCEPOD                    | The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) is a project which examines all incidences of suicide and homicide by people in contact with mental health services in the UK.  
Publication of National report received October 2018 | 100% of eligible cases |
| The audit aims to monitor people with Mental Illness (NCISH). The National Inquiry will help NELFT by supporting health professionals, policymakers, and service managers with the evidence and practical suggestions they need to effectively implement change. |                           |                                                                               |                                                      |
National clinical audit and confidential enquiry — Requirements and actions taken

National audit of Intermediate Care (NAIC)
NELFT has participated in The National Audit of Intermediate Care (NAIC) which is now in its seventh iteration. The audit focuses on the care and support of usually frail, older people, at times of transition between different services in the health and care system, for example, when stepping down from acute hospital care or preventing them being admitted to longer-term care, until they really need to. These services are a crucial part of the solution to managing increasing demand in the health and social care system. The audit shines a light on intermediate care and provides a stocktake of current service provision.

A total of 124 provider organisations participated, supplying data for 469 intermediate care services. This comprised of 226 bed based services, 124 home based services, 53 re-ablement services and 66 crisis response services. In total, 11,707 service user questionnaires and 5,039 patient reports experience measures were returned.

National and NELFT outcomes:
- nationally, mental health workers rarely are included in MDT’s
- where NELFT was comparable the community bed provision NELFT has positive benchmarking with safe Occupancy and Average Length of Stay on average lower than 21 days
- service user experience of intermediate care - In NAIC 2018, 99% of people felt they had been treated with dignity and respect. (NAIC Provider Bespoke Report England Nov 2018)
- on average, 91% of service users were in receipt of harm free care.
- the Community Hospitals project evidences the improvement in service user dependency via the collection of a clinical standardised outcome measure. The Modified Barthel Index (MBI) clinical outcome measure is collected on admission and discharge to assess the change in dependency of the service user. In 2018, the mean score on admission was 52.0 and on discharge is 70.2, giving an average improvement in score of 18.2.

Actions taken:
- review of transdisciplinary working
- strengthen the MDT approach

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) (Pulmonary Rehab Audit (PR) Work stream) (NACAP)
The National Asthma and COPD Audit Programme aims to drive improvements in the quality of care, services and clinical outcome for patients with asthma and COPD. The pulmonary rehabilitation audit 2018/19 will be running a snapshot audit of organisation and resources of pulmonary rehabilitation services, as well as a snapshot audit of clinical care. Registration for this work stream opened in September 2018; however this is a continuous clinical audit of service provision and delivery, with a biennial snapshot audit of service organisation and resource in March 2019.

Multiple participating sites have registered to participate in the audit which is:
- Havering
- Redbridge
- Barking & Dagenham
- Waltham Forest

Data collection period for clinical audit components is March 2019. Data collection is reported in three phases. For patients assessed from 1st March 2019 and discharged by 31st August 2019 - Records to be completed by 11th October 2019 on the national audit web tool.

National Diabetes Foot Care Audit (NDFA)
The National Diabetes Foot care Audit (NDFA) enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease. The National Diabetes Foot care Audit (NDFA) is a continuous data collection audit.

National Diabetes Foot care Audit (NDFA) looks at the following key areas:
actions taken

- structures: are the nationally recommended care structures in place for the management of diabetic foot disease?
- processes: does the treatment of active diabetic foot disease comply with nationally recommended guidance?
- outcomes: are the outcomes of diabetic foot disease optimised?

NELFT outcomes:

- previous audit outcomes demonstrated that NELFT Podiatry is better than the national average for the healing rates of diabetic foot ulcers at both 12 weeks (65.7 per cent of the ulcer episodes the patient was reported to be alive and ulcer-free, compared to 44.8 per cent nationally) and 24 weeks (64.8 per cent of the ulcer episodes the patient was reported to be alive and ulcer-free at 24 weeks, compared to 58.3 per cent nationally).
- fourth annual report to be published 9th May 2019. Currently gathering data for fifth annual report 2019 – 20

Data collection period for clinical audit components is March 2018/19. **No data can be provided at present.**

**National audit of Care at the End of Life (NACEL)**
A three year project which focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. The scope of the audit will include the following elements:

- a case note review of inpatients in hospital in the last few days and hours of life
- an organisational level audit covering service models, activity, workforce, finance quality and outcomes
- the development and administration of an innovative Carer Reported Experience Measure
- the development and administration of a Staff Reported Measure, and
- topics for periodic, time-limited ‘spotlight’ audits (NHS Benchmarking Network, 2019)

**Data collection period is now complete and currently data is being validated and analysed. Report publication due January – February 2019, therefore outcomes and actions cannot be reported.**

**UK Parkinson’s Audit**
Audit aims to provide a clear picture of the state of Parkinson’s services, showcasing good practice but highlighting many areas for improvement. It was the first to include a Patient Reported Experience Measure (PREM), giving people with Parkinson’s a stronger voice in rating the services they receive. UK wide reports to be published May 2018 for 2017 audit.


**National Epilepsy 12 audit (Round 3)**
Epilepsy 12 was established in 2009 and has the continued aim of helping epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. Round 3 commenced in 2017 when the audit was recommissioned as part of National Clinical Audit and Patient Outcomes Programme (NCAPOP). 148 Health Boards and Trusts with a paediatric epilepsy service across England and Wales submitted data to the organisational audit.

Round 3 of the Epilepsy 12 audit has an expanded scope, and aims to:

- continue to measure and improve care and outcomes for UK children and young people with epilepsies.
- include all children and young people with a new onset of epilepsy
- enable continuous patient ascertainment
- use a pragmatic and concise dataset
- incorporate NICE Quality Standards, Mental Health, Educational and Transition metrics
obtain approval to include patient identifiers to allow local real-time individual and service dashboard elements within the audit reporting platform.

Outcomes from National Organisational report (Jan 2019)

It is encouraging that this report shows incremental improvements in some areas of paediatric epilepsy service provision, including:

- overall numbers of epilepsy nurse specialists
- overall numbers of paediatricians with expertise and
- the number of specific clinics for children and young people with epilepsies

Key Recommendations:

- all Health Boards and Trusts to ensure they have sufficient defined general paediatricians with expertise in epilepsies to correctly diagnose epilepsy and provide appropriate ongoing management for all children with epilepsy.
- all Health Boards and Trusts to ensure that when rescue medication is prescribed for use by parents and carers of children at risk of prolonged epileptic seizures that training and individualised emergency care plans are provided.
- Health Boards and Trusts to ensure provision of sufficient follow up epilepsy clinic capacity. Where appropriate, children with epilepsy currently in a general paediatric clinic should be identified and streamed through designated epilepsy clinics.
- Health Boards and Trusts to agree referral pathways to tertiary paediatric neurology services. Referral processes should ensure that after referral ongoing shared care is maintained. Referral pathways should also be clear to ensure appropriate timely referral for epilepsy surgery evaluation, ongoing complex epilepsy management or both.
- Health Boards and Trusts to consider whether Vagus Nerve Stimulation (VNS) review and programming could be achieved more locally via satellite specialist neurology/epilepsy clinics.
- Commissioners, Health Boards and Trusts to ensure that ongoing epilepsy care should include mental health assessment, diagnosis and treatment alongside management of seizures.
- Health Boards and Trusts to formally agree transition pathways from paediatric to adult services. Local arrangements should define how this is achieved for different young people with epilepsies with different associated problems, for example children and young people with an intellectual disability or neurodisability.
- optimisation of services and understanding of need as key to improving epilepsy management
- national initiatives are to be developed with the aim towards improving care and services, specifically for children with epilepsy (e.g. the NICE guidelines for the diagnosis and management of adults and children with the epilepsies (2004, 2012))
- epilepsy training courses developed by the British Paediatric Neurology Association
- incremental improvements in some areas of paediatric epilepsy service provision, including:
  - overall numbers of epilepsy nurse specialists
  - overall numbers of paediatricians with expertise and
  - the number of specific clinics for children and young people with epilepsies

Actions taken:

- regular Epilepsy training and guideline awareness sessions
- update and re-launch ‘First seizure guideline’ which should be available to paediatric doctors
- teaching sessions in Emergency Department and within Whipps Cross paediatric department and Specialist children’s service around the ‘First seizure guideline’ to be implemented.
National Clinical Audit of Psychosis (NCAP) (EIP Services)

NCAP is the next phase in the development of the National Audit of Schizophrenia, extended to include both inpatient and community care provided for people with a broader group of severe mental health problems. NCAP will measure provision of care against standards based on NICE Clinical Guideline CG178 and Quality Standard QS80 Psychosis and Schizophrenia in adults. Key areas of performance will include the assessment and treatment of physical health, health promotion, prescribing practice, use of evidence-based psychological treatments and access to services at times of crisis.

The CCGs covered are Redbridge, Waltham Forest, Havering, Barking & Dagenham

The audit looked at adults 16 years and older who are being cared for by adult services in the community or as inpatients. Number of eligible patients for NELFT was 2055. 192 community patients and 8 Inpatients selected randomly by Royal College of Psychiatrists (RCPsych) Returns for NELFT was 189 (95%approx) out of an expected 200.

Outcomes and findings for NELFT:

- performance was above average on majority of indicators
- use of polypharmacy (for patients not on Clozapine) is significantly higher than in many trusts.

Key Recommendations/ Areas for improvement:

- provision of written information about current antipsychotic
- intervention for smoking, abnormal glucose control and elevated blood pressure
- rationale documented where high dose is prescribed
- patients offered family intervention
- record that patient was involved in the prescribing decision
- record of discussion of benefits and adverse effects
- medication adherence has been investigated
- patients involved in work or study related activity outside the home

National Clinical Audit of Anxiety and Depression (NCAAD): Core audit on inpatient wards

The core audit includes the following key performance areas:

- access
- comprehensive assessment and care planning
- availability of appropriate psychopharmacological and psychological treatment
- crisis planning

- follow up and community care
- service user outcomes.

This is a retrospective audit of service users admitted to an inpatient mental health service for anxiety and/or depression.

Data collection period for the core audit was June to September 2018; the local reports to trusts are to be published in Spring 2019.

National Clinical Audit of Anxiety and Depression (NCAAD): Psychological Therapies Spotlight Audit

This audit is a follow-up to the National Audit of Psychological Therapies (NAPT). The Psychological Therapies Spotlight Audit will focus on the following areas for improvement based on the NAPT findings:

- access
- waiting times
- training and supervision of therapists
- measuring and monitoring service user outcomes
- provision of the NICE recommended therapies of an appropriate modality and for a sufficient duration

All eligible cases have been submitted for WF Psychological Services.

Adult Psychotherapy Service has submitted 9 out of 28 eligible cases.
Havering MAP service has submitted 30 out of 35 eligible cases

In addition, a total of 18 Therapist Questionnaires and 20 Service User Questionnaires (SUQ) have been submitted.

(Figures provided by the National Audit Office)

Data entry period closed on 31st January 2019.

**Sentinel Stroke National Audit Programme (SSNAP)**

The Sentinel Stroke National Audit Programme (SSNAP) is a national rolling audit programme which started in December 2012. It aims to improve the quality of stroke care by auditing stroke services against evidence-based standards, and national and local benchmarks.

It is a national audit for which stroke services across England, Wales and Northern Ireland providing acute care, rehabilitation, or 6 month review follow-up, are asked to participate and provide routine continuous data on every stroke admission/stroke patient accessing their services. The clinical component of SSNAP collects a dataset for every stroke patient, including acute care, rehabilitation, 6-month follow-up and outcome measures in England, Wales and Northern Ireland.

The aims of the audit are:

- to benchmark services regionally and nationally
- to monitor progress against a background of organisational change to stroke services and more generally in the NHS
- to support clinicians in identifying where improvements are needed, planning for and lobbying for change, celebrating success and to empower patients to ask searching questions.
- to provide hospitals, commissioners, patients and the public with an unprecedented level of insight into the performance of stroke services.

**National and NELFT outcomes:**

**Community Rehab Services (CRS)**

- based on demographics of the boroughs covered by NELFT, the average age of those referred to the service is higher for CRS for the 65-74 age range, than the national average. With increasing age there is also the increased likelihood of co-morbidities and potential for lower ‘baseline’ function and subsequent outcome functional level post stroke.
- the Modified Rankin Scale (mRS) on discharge from inpatient services to Community Rehabilitation Service (CRS) reported on SSNAP illustrates that a large percentage of patients coming into the service have a higher level of disability compared to national statistics, with approximately 70% having moderate to severe disability on referral to the service compared to approximately 40% nationally.
- during the audited SSNAP period 80% of patients seen by the CRS either demonstrate an improvement or maintain their ability, when scored against the mRS.
- during the audited SSNAP period 76% of patients seen by the CRS either demonstrate an improvement or maintain their ability, when scored against the mRS.

**6 month review findings**

- the findings show that locally, most patients post stroke are suitable for a 6 month review
- 100% of 6 month reviews locally are completed face to face
- 36.8% of those screened were identified as requiring support. 85.7% of these have received psychological support locally compared to 66.6% nationally.
- significant improvement noted in Mood/Behaviour and cognitive screening as part of the 6 month reviews. Pro-formas for relevant assessments are now on RIO and since the SSNAP result of 2016 (for the same period) screening for this has increased from 35% to 61.3%
- contact has been made with the Stroke Association to streamline 6 month review processes across BHR economy.
- meeting/discussions have held to compare stroke review forms of Havering/B&D and Redbridge and share with Stroke Strategy groups
Communication between BHRUT and NELFT

- NELFT is now receiving a list of stroke patients discharged directly from BHRUT wards.
- Stroke discharge summaries are to be obtained directly from BHRUT of patients referred rather than via GP.

Actions taken:

- Psychological support - Lack of psychology is a known identified gap within the current stroke pathway and identified funding resourced for a 0.2wte neuro psychologist to sit within the stroke pathway. Successful candidate due to start in January 2019
- 6 month review - Proposed changes submitted to leadership to the stroke reviews in Havering and Barking & Dagenham. As a result all stroke reviews will be completed via home visits ensuring efficiencies within the review system.
- Stroke Nurse appointed substantively
- NELFT has increased their working relationship with NELFT’s Consultant Clinical Neuropsychologist in providing, not only support and intervention to patients but also support to staff.
- Boroughs participating in the audit (Havering, Barking & Dagenham) have been working on enhancing 6 month review process to ensure a more streamlined, equitable service is provided
- Locally, regular stroke standards meetings held across the stroke pathway to monitor and identify actions to continue to enhance adherence to National Stroke Standards.
- First meeting of stroke forum held in October 2018 (to be held 4 x years) to increase joint working across neuro psychology and stroke services within NELFT.

POMH UK audit Topic 16b - Rapid tranquillisation (RT) in the context of the pharmacological management of acutely-disturbed behaviour

During March to May 2018, 54 specialist Mental Health Trusts or healthcare organisations within the UK participated in this re-audit of rapid tranquillisation. Data was received for 2392 episodes of acutely-disturbed behaviour involving patients in acute adult, psychiatric intensive care or low, medium or high secure wards, under the care of 358 clinical teams.

The standards are derived from NICE Guideline NG10: Violence and aggression: short-term management in mental health, health and community settings.

Performance against practice standard 2

In NELFT for approx. 70% of episodes where intramuscular haloperidol was administered for which there was documented evidence of a recent ECG for the patient.

Performance against practice standard 3

3a In NELFT for 30% of episodes, where IM medication was administered, for which the mental and behavioural state of the patient was assessed (allowing for a BARS rating) at least once in the hour following the period of rapid tranquillisation.

NELFT % of episodes there was at least one documented test:

Pulse rate, Blood Pressure & Temperature = 20%
Respiration rate = 55%
3b Physical health measures recorded in the hour following rapid tranquillisation for episodes involving not-at-risk and at-risk patients

Standard was met for 15% of episodes with patients not at risk

NELFT achieved 97% compliance with the requirement for documented evidence of a debrief being undertaken within 24 hours where patients had been administered IM medication (compared to 42% for the total national sample).

The **SMART action plan** in place includes:

- reinforcing the requirement for documenting physical health monitoring of patients administered RT
- reinforcing the requirement for documented evidence of a recent ECG or a risk-benefit statement where patients refuse an ECG
- requirement for improving the quality of care plans so that they include post-RT discussions with the patient for management of future episodes of acutely disturbed behaviour

**POMH-UK audit Topic 18a Prescribing Clozapine (Baseline audit).**

The aim of this baseline audit is to monitor patients prescribed clozapine, including physical health monitoring, in line with NICE guidance QS80.

The data collection period was June to July 2018, a total of 74 cases have been submitted for NELFT with 16 participating teams.

**NELFT specific outcomes and findings**

**Treatment target**

- documented discussion with the patient, family and/or carers about potential benefits and side effects – 70%
- performance against Practice Standard 1 - Pre-treatment screening should include physical examination, with assessment of the cardiovascular system
- documented pre-treatment measures of blood pressure, pulse rate, body weight, plasma lipids, plasma glucose, and a general physical examination in patients treated with clozapine for less than 18 weeks: Trust sub-sample n=18

**Standard met for:**

- Blood Pressure – 100%
- Heart/ Pulse Rate – 100%
- Body weight/BMI/ Waist circumference – 80%
- Plasma lipids – 80%
- Plasma glucose – 65%

**General physical examination – 70%**

- performance against Practice Standard 3 - Monitoring in the first two weeks of treatment should include at least daily assessment of temperature, blood pressure and pulse
- documented daily measures of temperature, pulse rate and blood pressure in the first 2 weeks of clozapine treatment in patients treated with clozapine for between 2 and 18 weeks: Trust sub-sample N=15

**Standard met for:**

- Temperature – 90%
- Pulse rate – 95%
- Blood Pressure – 95%

- performance against Practice Standard 6 - Patients established on clozapine treatment for more than a year should have an annual medication review, taking account of therapeutic response and recognised side-effects
- documented blood pressure, pulse rate, body weight, plasma lipids, plasma glucose, and a general physical examination in the past year in patients treated with clozapine for more than 1 year: Trust sub-sample N=48

**Standard met for:**

- Blood Pressure – 90%
- Body weight/BMI/ Waist circumference – 90%
- Plasma lipids – 45%
- Plasma glucose – 50%

**General physical examination – 45%**


NELFT specific report published February 2019
POMH-UK audit Topic 6d Assessment of the side effects of depot antipsychotics.
The aim of the audit is to measure Trust compliance with NICE guidance CG178 & QS80:
1. antipsychotic side effects should be monitored routinely and regularly (NICE 2002, 2009)
2. people receiving depot preparations should be maintained under regular clinical review, particularly in relation to the risks and benefits of the drug regimen (NICE 2002, 2009)
3. the side effects associated with antipsychotic drugs should be ‘assessed using standardised methods and validated rating scales’ (Clinical Standards Board for Scotland 2001).
The data collection period was 3 Sep to 31 Oct 2018.
The data entry period was 1 Nov to 30 Nov 2018, a total of 98 cases have been submitted for teams and services across NELFT.
The National report is due for publication in April 2019.

POMH-UK audit Topic 7f - Monitoring of patients prescribed lithium
This re-audit will measure Trust compliance with NICE Guidance CG185 standards for the monitoring of patients prescribed lithium, including physical health monitoring. Participation in national POMH-UK audits benchmarks the Trust against other similar trusts.
NHS Trusts UK wide are collecting data at present, the data collection period is February to March 2019. Total number of cases submitted for NELFT is 54. The national report is due for publication in July 2019.

Child Health Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Mental Health Conditions in Young People – Continuous audit
No planned data collection during 2018/19 financial year (1st April – 31st March 2019). Audit to recommence in 2019/20

National Confidential Inquiry into Suicide and Homicide for people with mental illness (NCISH), National Annual Report 2018
The 2018 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) which is commissioned by the Healthcare Quality Improvement Partnership (HQIP) provides findings relating to people who died by suicide or were convicted of homicide in 2006-2016 across all UK countries. Additional findings are presented on sudden unexplained deaths under mental health care in England and Wales. (NCISH, 2018)

NCISH key themes derived from national report
- 28% people who died by suicide had contact with mental health services in the previous 12 months
- inpatient care – Services should make sure wards are a safe place for you to recover
- young people – A wide range of professionals should be able to help you if you are in crisis
- recent self-harm - Everyone should get a good assessment after self-harm
- woman - Services need to recognise why women can be at risk of self-harm and suicide

Actions taken:
- the 2018 National NCISH report has been shared with the AMD for Community of Practice adult mental health and Learning Disability Lead for onward dissemination
- local level summary and report to be developed for the Trust, taking into consideration key findings.
Pharmacy: Medicines Management audits

Mental Health Act (MHA) T2/T3 Spot check audit (re-audit)
This is a re-audit to measure compliance with standards for the accurate completion of the Consent to Treatment s58 forms T2 and T3.

Outcomes and Areas of Improvements:
• high dose antipsychotic was documented and covered under the forms in 100% of cases compared to 90% in the previous audit.

Actions undertaken:
• re-education for Nurses in regards to the importance of the T2, T3 and S62 forms to be attached to medicine card
• ensuring the right phrase ‘either an approved clinician or a SOAD’ is deleted appropriately on T2 form by the consultants
• ensuring medication listed on the T2 or T3 form by the consultants, including when required (PRN) is solely for the treatment of mental health disorder
• ensuring all medication for mental health disorder on the medicine card is listed on the T2 or T3 form by the consultants

Assessing compliance with VTE risk assessments and prescribing of appropriate anticoagulation across NELFT Community Health Service inpatient wards
The aim of the audit is to review the adherence and application of the Trust guidelines for the assessment and pharmacological prevention of venous thromboembolism (VTE)

Outcomes and Areas of Improvements:
• where VTE prophylaxis was not prescribed, 100% of patients had a reason documented as to why.
• 92% of VTE risk assessments were completed within 24 hours of patient admission
• 86% of prescribed pharmacological VTE prophylaxis was prescribed in accordance with Trust guidelines.

Actions undertaken:
• to consider making the templates for the London and Essex risk assessments as harmonised as possible.
• to ensure nursing and pharmacy staff are more vigilant in identifying non-completed risk assessments.
• to achieve an improvement in the number of risk assessments completed within 24 hours
• prescribers to improve awareness and application of Tinzaparin dosing guidelines
• to align dosing parameters in Trust guidelines with dosing guidelines in the Tinzaparin memorandum.
• to ensure all prescribers are aware of the dosing parameters outlined in the Tinzaparin memorandum, in particular how to prescribe according to renal function and weight.

Annual Antibiotic Audit
• the annual antibiotic audit is carried out as part of the national Antimicrobial Stewardship programme. Standards are derived from the NICE guideline NG15 Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use and Quality Standard QS121 Antimicrobial Stewardship. The pharmacy team implemented a programme of RAC (rapid audit cycle) audits to monitor compliance. Four RAC cycles were completed and there has been sustained improvement.

Outcomes and Areas of Improvement:
• 100% Compliance was maintained with Standard 2
• 100% of patients were on antimicrobial therapy within the appropriate Formulary

Actions undertaken:
• doctors to ensure that the allergy box, duration and indication are completed on the patient’s medicines chart/EPMA/EPR.
• pharmacists and nursing staff to continue to support the doctors in ensuring that the allergy box, duration and indication are completed on the patient’s medicines chart/EPMA/EPR.
• annual re-audit cycles are to be continued to ensure standards are maintained in line with the Trust’s Formulary.
Antimicrobial prescribing in the community for NELFT CHS and MHS NMPs

The audit aims to provide assurance that NELFT community Non-Medical Prescribers (NMPs) are compliant with local initiatives:

- issue a “treating your infection” leaflet to patients to support the prevention of antimicrobial resistance agenda where appropriate;
- provide assurance that where the above leaflet is not issued or re-enforced, there is good clinical reasoning for not doing so;
- provide assurance that where an antibiotic is prescribed, it is in line with local formularies;
- ensure that where a non-formulary antibiotic is prescribed, there is good clinical reasoning for doing so;
- formulary prescribing should account for the majority of prescribing that takes place;
- to determine percentage of patients having samples tested before antibiotics are started.

Outcomes and Areas of Improvement:

- two of the three standards achieved last year were achieved again this year at 100%
- six out of the nine standards set this year were achieved at 100%
- 100% of patients appropriate for re-enforcement of leaflet information already issued to them, had it re-enforced
- 100% compliance with local formularies
- 100% of patients had their drug history checked for previous antibiotic usage
- 100% of patients with UTIs already having the leaflet have it re-enforced where appropriate
- 100% of patients having their UTI symptoms correctly interpreted for antibiotic initiation
- 100% of patients having their Urine dipstick results correctly interpreted for antibiotic initiation

Actions undertaken:

- to raise awareness of reporting and UTI Leaflet
- to redesign of audit tool - Add male/female question for UTIs
- to raise awareness of broad spectrum antibiotic prescribing

Community Recovery & Assertive Outreach Services: The WHITE zone criteria are being refined to include only patients in Acute Services. An alternative zone/code is in the process of being created (to WHITE) for patients in planned long-stay specialist admissions. Creating a new zone is being considered for patients with Non-clinical and Social Needs so as not to over burden to AMBER zone. The re-audit has demonstrated significant improvements in the White Zone of which 57% of clients experiencing face-to-face contact compared to 37% in the baseline audit 2017, however the proportion of clients not seen but contacted by telephone dropped from 24% in 2017 to 11% in the re-audit 2018.

Improving access to psychological therapies (IMPART): People with a personality disorder (PD) diagnosis or PD traits require inpatient mental health care and it is important that they receive the support they need. IMPART service users who have received inpatient mental health care, to be recruited and interviewed for the study focusing on eliciting from the services users their thoughts, perceptions and views about their experiences with inpatient mental health care with a focus on what they found helpful and/or unhelpful. IMPART to provide training and consultation to inpatient staff. Information sheets and leaflets will be made available supporting staff members in dealing with service users on wards.

Children Targeted Services: Referral process, client experience and journey into and through the Autism Spectrum Disorder (ASD/C) service to be improved ensuring faster referral services. Areas of delay and inaccuracy identified so that the flow can be improved, including improved efficiency, as well as improved client and referrer experience. Best practice guidelines were reviewed (e.g. NICE, Autism Act) and specific
criteria created to compare to referrals into the service. Surveys are being created for clinicians who are making referrals and for clients to gain understanding of their experiences of the referral process.

- **Long Term Conditions Services:** Cognitive Stimulation Group has been implemented with the aim to improve the well-being of people with early stages of dementia. The pre and post measure scores suggest that the content of the cognitive stimulation group has been effective in helping the mental well-being of participants with early stage dementia.

- **Nutrition and Dietetics Service (N&D):** Training programmes on the dysphagia programme to be further adjusted to place greater emphasis on texture modified diets to improve participant knowledge of target areas pre and post training. Changes will include jargon free training and training which is made more accessible to non-native English speakers. Training sessions will be shorter and target more specific areas of dysphagia management; visual aids are incorporated to describe the difference between the texture modified diets and to aid explanation of aspiration. More time will be allocated to the explanation of risk feeding; and training to be offered on a cyclical basis to account for staffing levels and staff turnover.

- **Universal Children Services:** Team leaders and band 6 nurses have developed a new system for transferring records starting with the initial task requesting records to transfer out within 14 days. They support the training of admin staff to follow the process for transferring out universal caseload records, which involves recognition of a child’s records which are not routine universal service. The transfer out of records is actioned within 2 weeks and this is monitored on an ongoing basis. A designated member of staff has been appointed to review the tasks weekly and ensure transfers out are actioned. All staff working within Health Visiting Teams to be made aware of the transfer in and out process.

- **Acute & Rehabilitation Directorate:** ‘Readiness to Discharge’ (RTD) is described as the estimate of a patient’s ability to leave a service and the perception of being prepared or not prepared for discharge (Steele & Sterling, 1992). Development of a checklist to be designed to identify areas relevant to RTD which will capture information such as; DBT skills, goal achievement, reductions in behaviour targets, better understanding of difficulties, perceived loss of support, fears associated with coping alone, the future, dependency on a mental health service and the environment and personal views around endings. This will act as a reminder for therapists to address these aspects in sessions with clients.

- **Older Adults Mental Health & Memory Service:** Older Adults Home Treatment Team (OAHTT) staff to complete forms for every patient admitted including the admissions after MHA assessments.

- **Older Adults Mental Health & Memory Service:** The Young onset dementia network collaborative group have written a care pathway to guide services along with creating a GP decision making tool for young onset dementia. 100% of dementia diagnoses are now being followed up six monthly by memory advisors.

- **Child Health Services:** Look After Children (LAC) Health Service to continue to work with the Local Authority and Universal Services to identify reason in the delay of Review Health Assessment (RHA) timeliness and to improve the processes to reduce these delays. Training packages are revised to include the importance of achieving timeliness discussion on oral health with carer, health promotion activity, appropriate reference to Strength and Difficulties Questionnaire (SDQ) and for allowing the voice of the child throughout the RHA. Specialist LAC Nurses to continue to quality assure all RHAs using the updated tool.

- **Children Services:** Autism Spectrum Disorder (ASD) pathway leads (medical and
therapy leads) identified to provide strategic leadership and drive improvements in the diagnostic process of Autism Spectrum Disorder (ASD) assessments and establishing the profile of the child’s strengths, skills, impairments and needs, translating this into post diagnosis intervention.

- **Early Intervention Service:** A business case is currently being developed to improve access to psychological services for patients with voice disorders across boroughs of Barking & Dagenham, Havering and Redbridge.

- **Intermediate Care Medical Team:** Documentation of indication in notes and drug charts is being discussed with doctors ward managers to improve compliance with sending of MSU before starting antibiotics.

- **A&E Liaison:** Further training delivered and provided to the Psychiatric Liaison Service and Out-of-hours staff regarding the completion of risk assessment proformas.

- **Access & Assessment:** Clients on initial medical assessment have their allergy status checked and documented in their progress notes. This increased from 27% to 62%, shifting the compliance from red zone to amber zone. All clinicians who incorporated allergies as a sub-heading into their proformas were documenting allergy status 100% of the time.

- **Patient Experience & Effectiveness:** Dementia Crisis Support Team (DCST) demonstrated compliance of 42% with DCST standard of assessing within 4 days from referral to initial assessment and discharge within 6 weeks. The DCST’s overall aim is to be able to assess in a shorter period of time, improving patient experience, therefore further reducing hospital admissions and team figures for ‘over stay’.

- **Patient Experience & Effectiveness:** All care co-ordinators encouraged to complete a questionnaire regarding reasons they struggle to see clients face-to-face once a week in the audited zones. This will help to identify key factors such as caseload or clients not attending meetings. Documentation to be improved to ensure all client contacts are captured on RiO.
Quality Report governance structure

NELFT Trust Board

Executive Management Team

Quality & Patient Safety Committee

Chief Executive Group

Communities of Practice

Mortality Review Group

Chief Nurse Group Inc AHP, Psychology & Social work

Audit Committee

Quality Senior Leadership Team

Medical Managers Meeting

Operational actions from CNG and MMM to go to QSLT for agreement & assurance

Senior Leadership Team

Divisional Business Meetings (DBM)

Team Business Meeting (TBM)

Service Business Meeting (SBM) (Acute & Rehabilitation only)
Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees
NHS Basildon and Brentwood and Thurrock CCGs welcome the opportunity to comment on the annual Quality Account prepared by NELFT.

As lead Commissioner for the south west Essex Community Services contract and to the best of NHS Basildon and Brentwood CCG’s knowledge, the information contained in the Account is accurate and reflects a true and balanced description of the quality of provision of services.

Commissioners in Mid and South Essex remain pleased with the delivery of services to our population and the constructive partnership that exists between CCG officers and our colleagues at the Trust.

Highlights from 2018/19

Commissioners commend the Trust’s hard work in maintaining an overall CQC rating of ‘Good’ and outstanding in four areas including child and adolescent and forensic in-patient ward areas. It is also noteworthy that the former unit was subsequently awarded the 2018 RCN Mental Health Practice Award.

The Trust should be commended for the great work being undertaken to ensure a culture of inclusiveness including the achievements in meeting the Workforce Race Equality Standard and LGBT initiatives.

Priorities for 2019/20

The use of QI methodology to deliver the safety priority, ensuring that care plans and risk assessments are consistent across the trust is a good development that will support sustainability.

The effectiveness priority two, ensuring care plans are complete and recovery focused will contribute to patient care and outcomes and is also welcomed by commissioners.

Commissioners note the effectiveness priority three is not applicable the Mid and South Essex STP.

The fourth priority, well led, focusses on the Trusts most important asset, the staff. Commissioners support the focus on appraisals and development plans, tackling violence in the workplace.

Participation in clinical audits

The CCGs are pleased to note that together with local audits, NELFT participated in 100% national clinical audits and 100% of the national confidential enquiries that it was eligible to participate in. The CCGs welcome the actions identified by the Trust to improve the quality of healthcare provided following the audits.

Progress against 2018/19 priorities

Commissioners note the following:

Priority 1: Safe

Goal 1 – The Trust achieved the goal to ensure 75% of risk assessments are recorded for EWMHS in Essex

Goal 2 – Implementing a system for monitoring and auditing risk assessments did not achieve the goal of 75% for community health services for adults

Goal 3 – Completion of falls assessment made good progress but failed to reach the 100% target.

Priority 2: Effective

(Not applicable to Mid and South Essex STP)

Priority 3: Responsive

(Not applicable to Mid and South Essex STP)

Priority 4: Well Led

Goal 1 – Commissioners note that compliance for mandatory training NELFT wide has been consistently above their 85% target.

Goal 2 – The Trust achieved the goal of supporting management through effective use of business intelligence.
Assurance

The lead CCG formally monitors and gains assurances about the standards of practice within the Trust through the Clinical Quality Review Group. This group meets monthly and consists of Executives from the provider and senior members of the CCG and associates to the contract. The overarching purpose of the group is to provide assurance to the CCGs regarding the delivery of clinical quality at NELFT by having an overarching view of quality standards within the Trust.

The CCGs agree with the key priorities for improvement to be undertaken during 2019/20 and are committed to working collaboratively with the Trust to support the continually improve of patient safety and quality of care.

Dear John

Thank you for sending the Quality Account. The report reads well, and it is good to see transparency regarding what has been achieved and what is a goal that still needs to be achieved. As is often the case when you begin a new contract and take on a service which requires some realignment and a dependency on former records, particularly when these are paper records, the movement to electronic data systems which is essential to good patient care and clinical monitoring can take time. However, again progress is being demonstrated.

We particularly support the new priorities of Safeguarding supervision and monitoring Violence and Aggression training and the use of the staff survey to help identify and support staff. The continued drive to ensure care plans include the five elements of care planning – consent and capacity, social situation, collaborative, risk assessment, and recovery focused are at the centre of the work. To continue to embed this for in-patients across adults, child and adolescent and psychiatric intensive care bed.

Again, it was very pleasing to see so many staff, two full pages, congratulated nationally and given awards for their work. Healthwatch Havering would like to congratulate you and recognise all staff for the hard work and dedication that they have show to patients, families and friends in our borough.

We wish you well with your CQC Well Led Inspection.

Best,

Anne-Marie Dean
Chairman

Havering Healthwatch Limited - A company limited by guarantee - Registered in England & Wales no.08416383

Registered Office and postal address: Queen’s Court, 9-17 Eastern Road, Romford RM1 3NH
Telephone 01708 303300 (24hr voicemail)
https://www.healthwatchhavering.co.uk
Kent County Council
Health Overview and Scrutiny Committee

Dear Stephanie

Quality Accounts

Thank you for offering Kent County Council’s Health Overview and Scrutiny Committee the opportunity to comment on NELFT’s draft Quality Account. HOSC has received a number of similar requests from Trusts providing services to Kent, and we may well receive more.

Given the number of Trusts which will be looking to KCC’s HOSC for a response, and the window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Please be assured that the decision not to comment should not be taken as any reflection on the quality of the services delivered by your organisation and as part of its ongoing overview function, the Committee would appreciate receiving a copy of NELFT’s Quality Account for this year once finalised.

Kind regards,

Sue Chandler
Chair, Health Overview and Scrutiny Committee
Kent County Council
Members Suite, Kent County Council
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ
Direct Dial: 03000 416512
Email: HOSC@kent.gov.uk
Date: 20th May 2019

Statement from West Essex Clinical Commissioning Group

West Essex Clinical Commissioning Group is responsible for the commissioning of the Emotional Wellbeing and Mental Health Service (EWMHS) from North East London NHS Foundation Trust (NELFT). The service provides early intervention, support and mental health services for children and young people living in all of Essex.

During 2018/19 NHS West Essex CCG carried out quality visits to the EWMH services throughout Essex, along with the standing monthly quality and contract review meetings and continuous informal dialogue with the Trust, Commissioners are able to comment on the information provided within the quality account.

NELFT’s priorities from 2018/19 were broadly achieved, and had specific EWMHS components. These priorities and their application within the service are being carried forward into a second year to work on the areas where further improvements can be made and to consolidate progress from year one.

The Trust is adding the following priorities for 2019/20; staff appraisals, addressing staff safety/monitoring violence and aggression training and the Board of Governors priority covers the uptake and compliance with child safeguarding supervision in all localities.
Commissioners are completely supportive of the continuation of last year’s priorities in the EWMHS service, particularly where there are improvements that can be delivered.

We confirm that we have reviewed the information contained in the draft account and checked this against data sources where these are available; it is accurate in relation to the service provided. Some data in relation to required information is still being collated (so is not included in this draft) and will be added to the final version.

The Quality Account requirement for the inclusion of specific information to demonstrate the organisations learning from deaths has been included in detail and the Trust has identified learning from their review of patient deaths during the year.

NELFT have clearly stated the process for staff to be able to speak up through their Freedom to Speak up Guardian, the themes of issues being raised and how these are being managed.

Currently the Trust have not included a statement/report regarding junior doctors safety with regard to rota gaps and plans for improvement to reduce these gaps, which was a requirement for this year’s account. We are confident this will be added to the final version.

The Trust has explained the governance process in relation to the production of the Quality Account and how readers can give feedback. The structure of the account, Part A and Part B makes it easy to navigate and understand.

The information on national and local audits with the detail of how NELFT have responded to national reports is particularly comprehensive and provides assurance that the Trust process for learning from national reports is robust.

We would be grateful if NELFT would review whether the views of children and young people could specifically be sought in preparation for the 2020/21 priorities.

Dr Rob Gerlis, Chair
Andrew Geldard, Chief Officer

Commissioners will continue to work collaboratively with NELFT to ensure sustained and embedded improvements within community mental health services for children in Essex.

Jane Kinniburgh
Director of Nursing Quality
West Essex Clinical Commissioning Group.
May 2019
London Borough of Waltham Forest – Health Scrutiny Committee Feedback on NELFT NHS Foundation Trust Quality Account 2018/19

The Health Scrutiny Committee is pleased to see the Trust’s focus on continuous learning and improvement and its commitment to integrated care, as set out in the new Corporate Strategy.

In 2018/19 the Health Scrutiny Committee reviewed Child and Adolescent Mental Health Services (CAMHS) and the access to mental health services experienced by homeless people in the borough. These reviews were supported by the Trust’s staff throughout the year, who provided us with their time and input.

The review of Waltham Forest CAMHS was prompted in April 2018 by an increase in waiting times and a rise in the thresholds for support. The Committee recognises that this had a detrimental impact on children and their families. The Health Scrutiny Committee received a number of updates from the Trust from October 2018 to April 2019 detailing access to CAMHS and the actions taken to address the issues identified. We are pleased to hear that the Trust has been successful in securing additional funding to increase capacity and that waiting times have decreased as a consequence. The Committee is also pleased to note that Priority 1 for of the Quality Account is to improve performance in regards to care plans and risk assessment, including that of CAMHS across London. The Committee will continue monitoring the situation closely to support children and adolescents in Waltham Forest receive the mental health services they need, including prevention services.

As part of its Themed Review report into Health Outcomes for People who are Homeless, the Committee received input from the Trust noting that “there are no systems in place within mental health services to monitor homelessness and individuals throughout the care pathway who are homeless”. The Committee would like to express its concern regarding the lack of specific support offered to homeless patients with their mental health needs. The Committee has included a recommendation in its themed review report regarding inreach housing support for all mental health inpatients.

The Committee would like to congratulate the Trust on its 2017 CQC ‘Good’ rating and on having four service areas rated as ‘Outstanding’ in 2018. It particularly notes the overall ‘Outstanding’ rating of child and adolescent mental health wards at the last inspection. The improvement priorities for 2019/20 – focused on safety, effectiveness, responsiveness and leadership – build on the outcomes of the inspection and are a positive step in continuous improvement.

In addition to the CQC inspection and 2019/20 priorities, the Committee would like to emphasise the positive outcome of NELFT’s performance against the Single Oversight Framework. The Trust has demonstrated it performs strongly against most indicators, having set out future actions to improve its performance further.

The Committee applauds the Trust’s efforts in improving its compliance, performance and capacity over the last year, and it looks forward to hearing how the Trust’s improvement priorities will continue supporting its service users in 2019/20.
Thurrock Council

We continue to work very closely with NELFT as key partners in the Thurrock Alliance. We have signed off a Memorandum of Understanding (MoU) between all organisations across the NHS and the Council during 2018/19 which clearly laid out how we would continue to work together jointly to improve services locally and not hide behind organisational boundaries. We see this as a significant step on our integration journey that lays out how we will all be working together much more closely over the next 3 – 5 years.

Roger Harris
Thurrock Council
Civic Offices
New Road
Grays
Essex
RM17 6SL

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

This takes up a large amount of time, so we have taken the decision to prioritise our resource on making a difference to services rather than reading Quality Accounts.

However, we’d like to support the Trust by setting out the areas we have worked together on in the past year:

- in 2016 we published a reported detailing feedback from over 300 people about the Children & Adolescent Mental Health service. Our recommendations were then incorporated into the new service specification which NELFT are now delivering against. We’ve met with them to understand how they are progressing our recommendations.
- we’ve met with key staff members to keep updated about the service and understand the challenges.
- following the recent Ofsted report on services for children with special educational needs, we will be working with NELFT as part of the resulting action plan.
- we will shortly be publishing a report detailing the feedback we’ve heard about autism services. We look forward to working with the Trust on our recommendations.
- we will continue to share what we are hearing about NELFT services with the Trust.

We look forward to continuing our constructive working relationship with the Trust in the next year.

Healthwatch Kent
May 2019

Healthwatch Kent response to the North East London NHS Foundation Trust Quality Account
The directors are required under the Health Act 2009 and the National Health Service (Quality Reports) Regulations to prepare Quality Reports for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period 19/05/2018 to 21/05/2019
  - papers relating to quality reported to the Board over the period 19/05/2018 to 21/05/2019
  - feedback from commissioners dated 17/04/2019 to 17/05/2019
  - feedback from governors dated 17/05/2019 and 20/05/2019
  - feedback from local Healthwatch organisations dated 23/04/2019 and May 2019
  - feedback from Overview and Scrutiny Committee 08/05/2019 and 20/05/2019
  - the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - the 2018 national patient survey 22/11/2018
  - the 2018 national staff survey 26/02/2019
  - the Head of Internal Audit’s annual opinion over the Trust’s control environment 23/04/2019
- CQC inspection report dated 18/01/2018
- the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Reports regulations) as well as the standards to support data quality for the preparation of the Quality Report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board
Date 21.05.2019
Signature

Trust Chair

Date 21.05.2019
Signature

Chief Executive
The Quality Report has been prepared in accordance with NHS Improve- ment’s annual reporting manual and supporting guidance (which incorporates the Quality Reports regulations) as well as the standards to support data quality for the preparation of the Quality Report.
Auditors limited assurance report

Independent auditor’s report to the Council of Governors of North East London NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of North East London NHS Foundation Trust to perform an independent assurance engagement in respect of North East London NHS Foundation Trust’s Quality Report for the year ended 31 March 2019 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- inappropriate out-of-area placements (IOAP) for adult mental health services

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2018/19 (‘the Guidance’); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 17 April to 17 May 2019;
- feedback from governors, dated 7 and 20 May 2019;
- feedback from local Healthwatch organisations, dated 23 April 2019 and May 2019;
- feedback from Overview and Scrutiny Committee, dated 8 May 2019 and 20 May 2019;
- the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2018 national patient survey, dated 22 November 2018;
- the 2018 national staff survey, dated 26 February 2018;
- Care Quality Commission Inspection, dated 18 January 2018;
• the 2018/19 Head of Internal Audit’s annual opinion over the trust’s control environment, dated 23 April 2019; and
• any other information included in our review.

We consider the implications for our report if we become aware of any apparent mis-statements or material inconsistencies with those documents (collectively, the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of North East London NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and North East London NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

• evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
• making enquiries of management;
• testing key management controls;
• limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
• comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
• reading the documents.

“We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’).”
A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by North East London NHS Foundation Trust.

**Basis for adverse conclusion**

As set out in the Statement on Quality from the Chief Executive of the Foundation Trust on pages 3 and 4 of Part A of the Trust’s Quality Report, the Trust currently has concerns with accuracy and completeness of the data concerning the early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral indicator and the Inappropriate Out of Area placements indicator.

When calculating the performance for both indicators the Trust considers each case in the reporting period and manually classifies it as compliant, non-compliant or exempt. For both indicators our testing over a sample of these cases found a number of cases to have been mis-classified. As a result the completeness and accuracy of the numerator and denominator cannot be confirmed, as the error rate was 7/13 cases in our sample for EIP testing and 11/27 cases in our sample for IOAP testing.

As a result of these issues, we have concluded that the EIP and IOAP indicators for the year ended 31 March 2019 have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

**Adverse conclusion**

Based on the results of our procedures, except for the effects of the matters described in the ‘Basis for adverse conclusion’ section above, nothing have come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance.

**KPMG LLP**

Chartered Accountants
15 Canada Square
London
E14 5GL
24 May 2019
Useful contact numbers

Trust Head Office
CEME Centre
Marsh Way, Rainham,
Essex RM13 8GQ
Tel: 0300 555 1200
Email: communications@nelft.nhs.uk

Service user advice and liaison service
If you require information, support or advice, you can call us on the numbers below:

Essex & Kent
Linda Morcombe
0300 555 1201 Ext 52708

Barking & Dagenham
Sheila Wright
0300 555 1201 Ext 65075

Havering
Lisa Askew
0300 555 1201 Ext 66234

Redbridge
Jenny Cook
0300 555 1201 Ext 54422

Waltham Forest
Bernadette Duffy
0300 555 1201 Ext. 68502

Acute and Rehabilitation
Sharon Clennell
0300 555 1201 Ext: 65408

Accessibility
If you require this report in another language or in a different format, e.g. large print, easy read, braille or audio, please contact:
Harjit Bansal
Head of Equality, Diversity and Inclusion
Email: harjit.bansal@nelft.nhs.uk
Tel: 0300 555 1200 ext. 64231

Trust membership
Members get information on local health services and shape how these develop. Members can also stand as governors and take part in key activities. Membership is free.
For more information contact NELFT on 0800 694 0699

Careers
For the latest information on vacancies at NELFT please visit our website at www.nelft.nhs.uk

NELFT is a growing organisation serving a population of 4.9m across North East London, Essex, and Kent. We employ in excess of 6,000 staff and have an annual turnover in excess of £380m.

You can follow us for news and upcoming events for our users and members:

Twitter: twitter.com/nelft
Facebook: facebook.com/nhsnelft
YouTube: youtube.com/user/nelft
LinkedIn: linkedin.com/company/north-east-london-nhs-foundation-trust
Instagram: instagram.com/nelft_nhs
"Today I will do my best. If I have a good day, I will be proud of myself. If I have a bad day, I will not dwell on it, I will forgive myself, I will put it behind me and I will continue to move forward in my recovery."
NELFT provides community and mental health services for people of all ages in Essex and the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, as well as Barnet and Kent and Medway.