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ISLINGTON

Governance and Human Resources
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE HEALTH AND CARE SCRUTINY COMMITTEE

Members of the Health and Care Scrutiny Committee are summoned to a meeting, which will be held on **14 June 2018 at 7.30 pm.**

Yinka Owa
Director of Law and Governance

Enquiries to : Peter Moore
Tel : 020 7527 3252
E-mail : democracy@islington.gov.uk
Despatched : 06 June 2018

Membership

Councillors:
Councillor Osh Gantly (Chair)
Councillor Nurullah Turan (Vice-Chair)
Councillor Martin Klute
Councillor Jilani Chowdhury
Councillor Tricia Clarke
Councillor Sara Hyde
Councillor Anjna Khurana
Councillor Kadeema Woodbyrne

Co-opted Member:
Janna Witt – Islington Healthwatch

Substitute Members

Substitutes:
Councillor Satnam Gill OBE
Councillor Mouna Hamitouche MBE
Councillor Angela Picknell

Substitutes:

Quorum: is 4 Councillors

A.	**Formal Matters**	**Page**
1.	Introductions	
2.	Apologies for Absence	
3.	Declaration of Substitute Members	
4.	Declarations of Interest	

If you have a **Disclosable Pecuniary Interest*** in an item of business:

- if it is not yet on the council's register, you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent;
- you may **choose** to declare a Disclosable Pecuniary Interest that is already in the register in the interests of openness and transparency.

In both the above cases, you **must** leave the room without participating in discussion of the item.
If you have a **personal** interest in an item of business **and** you intend to speak or vote on the item you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent but you **may** participate in the discussion and vote on the item.

***(a)Employment, etc -** Any employment, office, trade, profession or vocation carried on for profit or gain.
(b)Sponsorship - Any payment or other financial benefit in respect of your expenses in carrying out
duties as a member, or of your election; including from a trade union.
(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body
in which one of you has a beneficial interest) and the council.
(d)Land - Any beneficial interest in land which is within the council's area.
(e)Licences- Any licence to occupy land in the council's area for a month or longer.
(f)Corporate tenancies - Any tenancy between the council and a body in which you or your partner have
a beneficial interest.
(g)Securities - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

This applies to **all** members present at the meeting.

5.	Order of business	
6.	Confirmation of minutes of the previous meeting	1 - 6
7.	Membership, Terms of Reference etc.	7 - 10
8.	Chair's Report	

The Chair will update the Committee on recent events.

9. Public Questions

For members of the public to ask questions relating to any subject on the meeting agenda under Procedure Rule 70.5. Alternatively, the Chair may opt to accept questions from the public during the discussion on each agenda item.

10. Health and Wellbeing Board Update

B.	**Items for Decision/Discussion**	**Page**
11.	Camden and Islington Performance update - Presentation	11 - 66
12.	Moorfields NHS Trust - Performance update	67 - 80
13.	New Scrutiny topic Approval - Verbal	
14.	Child Obesity	81 - 96
15.	Work Programme 2018/19	97 - 98

The next meeting of the Health and Care Scrutiny Committee will be on 12 July 2018

Please note all committee agendas, reports and minutes are available on the council's website:

www.democracy.islington.gov.uk

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London Borough of Islington

Health and Care Scrutiny Committee - Thursday, 1 March 2018

Minutes of the meeting of the Health and Care Scrutiny Committee held at Islington Town Hall on Thursday, 1 March 2018 at 7.30 pm.

Present:	**Councillors:**	Klute (Chair), Chowdhury, Heather and Turan (Vice-Chair)
Also Present:	**Councillor:**	Janet Burgess – Executive Member Health and Social Care

Councillor Martin Klute in the Chair

83 **INTRODUCTIONS (ITEM NO. 1)**
The Chair introduced Members and officers to the Committee

84 **APOLOGIES FOR ABSENCE (ITEM NO. 2)**
Councillors Court, Gallagher, Safi - Ngogo and Bob Dowd – Co- opted Member Healthwatch

85 **DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)**
None

86 **DECLARATIONS OF INTEREST (ITEM NO. 4)**
None

87 **ORDER OF BUSINESS (ITEM NO. 5)**
The Chair stated that the order of business would be as per the agenda

88 **CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING (ITEM NO. 6)**
RESOLVED:
That the minutes of the meeting of the Committee held on 22 January 2018 be confirmed as a correct record of the proceedings and the Chair be authorised to sign them

89 **CHAIR'S REPORT (ITEM NO. 7)**
The Chair stated that it is with regret that he had been informed that the co-opted Islington Healthwatch Member, Bob Dowd, was no longer able to serve as a Member of the Committee.

Members stated that they wished to place on record their appreciation of the hard work and service that Bob had given to the Committee and to wish him the best for the future

90 **PUBLIC QUESTIONS (ITEM NO. 8)**
The Chair outlined the procedure for Public questions and filming and recording at meetings

91 **HEALTH AND WELLBEING BOARD UPDATE (ITEM NO. 9)**
Councillor Janet Burgess, Executive Member Health and Social Care, was present for discussion of this item.

During consideration the following main points were made –

- It was noted that the LUTS clinic is planned to re-open, and whilst there will be some procedural delay in this, in the medium term it is anticipated that the service will operate from UCLH. Children's services will be provided at Great Ormond Street
- Whittington NHS Trust had coped well in accident and emergency given the high number of patients that had had to be seen recently

The Chair thanked Councillor Burgess for her report

92 MOORFIELDS NHS TRUST - PERFORMANCE UPDATE (ITEM NO. 10)

This item was deferred until the next meeting of the Committee on 14 June 2018 due to the representatives from Moorfields NHS Trust not being able to attend due to the adverse weather conditions

93 PERFORMANCE UPDATE - QUARTER 3 (ITEM NO. 11)

Councillor Janet Burgess, Executive Member Health and Social Care and Jonathan O'Sullivan, Deputy Director Public Health, were in attendance for discussion of this item.

During consideration of the report the following main points were made –

- The Delayed Transfer of Care performance indicator was good and Islington has been highlighted by ImPower as a beacon authority, and bed days had been reduced by 28 days per patient as a result of the new measures undertaken
- Feedback from the users on Direct Payments showed that DP recipients felt that they had the most choice and control over their care and support services, and had the highest percentage of those extremely or very satisfied with their service. Most people choose to use their Direct Payment to pay for a Personal Assistant (PA), which helps support better outcome. In order to improve the choice and speed of PA recruitment, staff training has been delivered and a new online PA finder has been introduced to make this process easier
- A Member referred to problems that could occur with housing benefit on discharge to care and the Executive Member stated that she would look into this
- In relation to public health indicators these were broadly similar to quarter 2 and it is hoped that the new drug and alcohol service would bring improvements in the future
- In respect of the target for MMR vaccinations and this being below target, it was felt that this may be due to a problem in data recording
- Reference was made to treatment of mental health and that there had been an improvement with accessing IAPT and that there had been significant progress made in people reporting their mental health concerns
- In response to a question the Executive Member stated that the age limit as proposed in commissioning services to combat social isolation in the 18-64 age group could be looked at

The Chair thanked Councillor Burgess and Jonathan O'Sullivan for attending

94 **SCRUTINY REVIEW - AIR QUALITY DRAFT REPORT (ITEM NO. 12)**

Ian Sandford, Public Health was present.

Following consideration of the report and discussion the following recommendations were agreed –

RESOLVED:

(a) That the Executive be recommended to –

1. Support the Mayor of London's Clean Air Strategy, in order to improve air quality and to reduce traffic, and to urge the Mayor to support additional funding for schemes to improve air quality in Islington
2. Lobby the Government – Work with other London Boroughs and campaigning organisations to lobby the Government to introduce a new Clean Air Act for London, which should include provision for canals and waterways, car tax penalties for diesel vehicles, the cessation of engine idling, and a scrappage scheme to support people to dispose of diesel vehicles. Provision for penalties for engine idling should be included in any new Clean Air Act introduced, and the Council should ensure rigorous enforcement of any such legislation. Put up signs in zones where idling is a common problem, requesting car users to switch off their engines. Investigate the use of Public Space Protection Orders, to give the Council greater powers to sanction engine idling
3. Request the Health and Wellbeing Board to incorporate air quality considerations into its future policies, given the impact of poor air quality on health and the costs of the provision of services to deal with combating respiratory disease
4. Having heard the evidence of the focus of the Whittington NHS Trust in its new Estates Strategy with regard to energy efficiency, Islington CCG and NHS Trusts should ensure that energy efficiency is considered and implemented, wherever possible, in all future strategies and proposals
5. Car Transport – Continue the 'roll out' of electric charging points, as speedily as possible, across the borough. Continue with the policy of increased parking charges for diesel vehicles and implement a staged introduction of higher charges for the higher polluting vehicles
6. Schools – Implement a 'zero tolerance' approach to parking around schools for parents dropping off and picking children up from schools (including abolishing the 10 minutes grace period, if there is no provision under existing legislation for this), with the only exception being disabled/blue badge holders. Close roads near schools, at the beginning and at the end of each school day, as already happens in Hackney and is being piloted in Camden. Support schools and develop a communications strategy to educate parents/residents/children on the benefits of cycling, walking, active travel utilising quiet routes and, together with the Mayor of London, promote and enable the use of public transport (less vehicles as well as less polluting vehicles). Continue the policy of measuring air quality outside schools, and use the results to leverage any funding available from TfL, to implement any recommendations made, which may include physical improvements to schools, in order to improve air quality
   Given the evidence that was considered in relation to the absorption of small particulates, especially PM2.5, and the extreme effects that these small particulates can have on residents, particularly young children whose lungs are still developing, consideration be given to the effects and improvements that can be made, especially in relation to schools

7. In conjunction with recommendation 6 above, to develop a Communications Strategy, to inform residents, and schools, of the effects of poor air quality. This should include information on the dangers of air pollution, especially whilst sitting in heavy traffic, and to promote the health benefits of more physical activity etc. as outlined in recommendation 6 above. The Communications Strategy should also contain details of AIRTEXT, LONDON AIR and CITYTEXT, in order that residents are aware of details of when there are poor air quality days, and also to inform drivers that on poor air quality days, they should not drive/restrict the use of vehicles to a minimum
8. Through traffic – Investigate a borough wide neighbourhood cellular zoning policy to reduce rat-running and overall traffic volumes
9. Officer Forum – Given that the work on air quality is often fragmented across different Council departments, an Officer Forum should be established, in order to more effectively co-ordinate the work on air quality, and that the establishment and implementation of new strategies be referred to the Executive/relevant Executive Member/s for approval
10. Wood Burning – Educate residents about the dangers of wood burning stoves and open fires, and the impact that these can have on air quality

(b) That, subject to the revisions to the recommendations above, the report be approved and referred to the Executive for consideration

The Chair thanked Ian Sandford for attending

95 **OTHER BUSINESS (ITEM NO.)**
Whittington Estates Strategy

Councillor Heather referred to the fact that local MP's, including Jeremy Corbyn, Catherine West and Emily Thornberry, had expressed their concern at the appointment of Ryhurst to assist in the developing the strategy with Whittington NHS Trust. In addition, he felt that there were still a number of issues, such as how schemes would be funded that still need clarification.

In addition, tit was understood that the Defending the Whittington coalition campaign had written to the Joint Overview Committee for Health and Social Care and Councillor Heather stated that he was concerned that they were still awaiting a response to the concerns raised. Councillor Heather stated that he hoped that there would be a response sent to them thereon in the near future.

The Chair stated that it had to be recognised that this was a difficult issue, and that the Trust had outlined some of its proposals at the last meeting of the Health and Care Committee. The Chair added that whilst he was reassured by the statements made at the meeting by the NHS Trust, it may be beneficial to discuss with the local MP's their concerns, and for the Committee to further discuss this issue and come to a position on the proposals.

RESOLVED:
That the Chair be requested to discuss with local MP's their concerns as to the appointment of Ryhurst, as the preferred partner of Whittington NHS Trust in the Whittington Estates Strategy, and report back thereon to Members of the Committee

96 **VOTE OF THANKS (ITEM NO.)**

It was proposed and duly seconded and –

RESOLVED UNANIMOUSLY:

That a cordial vote of thanks be accorded to the Chair and Vice Chair for the services that they have rendered to the Committee during the current municipal year

MEETING CLOSED AT 9.45 P.M.

Chair

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ISLINGTON

Corporate Resources
Town Hall, Upper Street, London N1 2UD

Report of: **Corporate Director - Resources**

Meeting of	**Date**	**Ward(s)**
Health and Care Scrutiny Committee	14 June 2018	All

Delete as appropriate		Non-exempt

SUBJECT: HEALTH AND CARE SCRUTINY COMMITTEE - MEMBERSHIP, TERMS OF REFERENCE AND DATES OF MEETINGS

1. Synopsis

1.1 The Committee is asked, to note the Committee's terms of reference and their meeting and working arrangements.

1.2 Scrutiny Committees carry out reviews of the council's policies, performance and practice and look at how external organisations conduct their business to ensure local, accountable and transparent decision making and shape future policy and practice.

2. Recommendations

2.1. To note dates of meetings of the Health and Care Scrutiny Committee for the municipal year 2018/19, the membership appointed by Council on 24 May 2018.

3. Background

3.1. The Health and Care Scrutiny Committee is established under the terms of the constitution of the London Borough of Islington.

3.2. The membership of the Health and Care Scrutiny Committee is attached below. The quorum is four councillors.

3.3. In addition to carrying out health related scrutiny reviews, the Committee invites local NHS trusts and health providers to the Committee to discuss their performance. This enables an ongoing dialogue to take place to enable the Committee to gain a better understanding of health service matters and to question the trusts on areas of concern throughout the year.

3.4. The following dates have been agreed for the remainder of this municipal year:

14 June 2018
12 July 2018
2 October 2018
15 November 2018
28 January 2019
7 March 2019
1 April 2019

Membership of the Committee 2018/19
Councillors:

Osh Gantly– Chair
Nurullah Turan Vice Chair
Jilani Chowdhury
Tricia Clarke
Martin Klute
Sara Hyde
Anjna Khurana
Kadeema Woodbyrne

Janna Witt– Islington Healthwatch

Subsitutes:
Satnam Gill
Mouna Hamitouche
Angela Picknell

3.5. **Financial implications**
The Director of Finance and Resources confirms that costs associated with the Review Committees have been budgeted for in the 2018/19 budget.

3.6. **Legal Implications**
The Council appoints Scrutiny Committees to discharge functions conferred by section 21 of the Local Government Act 2000.

3.7. **Equalities Implications**
The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account

of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

3.8. **Environmental Implications**

Papers are circulated electronically where possible and consideration given to how many copies of the agenda might be required on a meeting by meeting basis with a view to minimising numbers. Any agendas not used at the meeting are recycled. These are the only environmental implications arising from this report.

4.5 **Resident Impact Assessment**

There are no direct equality or other resident impact implications arising from this report

4. Conclusion and reasons for recommendations

The Committee are asked to note their terms of reference and working arrangements.

Background papers:
The Council's constitution
Programme of Meetings

Final Report Clearance

Signed by …….

…….
Director of Law and Governance Date

……. ….

Report author: Peter Moore
Tel: 020 7527 3252
E-mail: peter.moore@islington.gov.uk

APPENDIX A

HEALTH AND CARE SCRUTINY COMMITTEE

(This Scrutiny Committee is responsible in accordance with regulation 28 of the Local Authority (Public Health, Health and Wellbeing and Health Scrutiny) Regulations 2013) for the Council's health scrutiny functions other than the power under regulation 23(9) to make referrals to the secretary of state

Composition

Members of the Executive may not be members of the Scrutiny Committee.

Members of the Health and Wellbeing Board should not be appointed to this committee.

No member may be involved in scrutinising a decision which he/she has been directly involved.

The Scrutiny Committee shall be entitled to appoint a number of people as non-voting co-optees.

Quorum

The quorum for a meeting of the committee shall be four members.

Terms of Reference

1. To review the planning, provision and operation of health and care services in Islington area, invite reports from local health and care providers and request them to address the committee about their activities and performance

2. To respond to consultations by local health trusts and the Department of Health.

3. To consider whether changes proposed by local health trusts amount to a substantial variation or development.

4. To make reports and/or recommendations to a relevant NHS body or a relevant health service provider.

5. To recommend to the Council that a referral be made to the secretary of state under regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing and Health Scrutiny) Regulations 2013.

6. To make reports and/or recommendations to the Council and/or the Executive on matters which affect the health and wellbeing of inhabitants of the area.

7. To carry out the functions of an overview and scrutiny committee in respect of matters relating to the Public Health Directorate or to Adult Social Services.

8. To undertake a scrutiny review, of its own choosing and any further reviews as directed by the Policy and Performance Scrutiny Committee and, consulting all relevant sections of the community, to make recommendations to the Executive thereon.

9. To carry out any review referred to it by the Policy and Performance Scrutiny Committee following consideration of a Councillor Call for Action referral.

Camden and Islington
NHS Foundation Trust

Camden and Islington NHS Foundation Trust Quality Account 2017/18

DRAFT

Your partner in care & improvement

Table of Contents

DRAFT

Part 1

1. Statement on quality from the Chief Executive

It is my pleasure to present the Quality Account for 2017/18. This has been a strong year for us at Camden and Islington NHS Foundation Trust, with the highpoint of a successful endorsement by the Care Quality Commission in February with our overall rating of 'Good'.
I was delighted that all our hard work and progress in the previous 18 months was recognised and that two of our specialties - Substance Misuse Services and Community-based Older People Services - were rated 'Outstanding'.

We have continued to develop our Clinical Strategy in line with our three overarching strategic priorities that are now embedded in our organisation: early and effective intervention; helping people to live well; and research and innovation.

For 2017/18 we focused on nine specific quality priorities relating to the standard of care for our service users, across the three areas of patient safety, patient experience and clinical effectiveness.

These reflected a combination of the areas for necessary progress highlighted in the Care Quality Commission's previous inspection report in 2016, NICE-prescribed guidance, local health priorities or CQUINs (Commissioning for Quality and Innovation). They were selected after seeking the views of all our stakeholders and then putting a shortlist to a vote open to all stakeholders and the public.

With regard to patient safety we made significant progress, particularly in improving staff skills in risk assessment and tightening up policies. We also made important in-roads in reducing the poor physical health of those with serious mental health conditions, with adoption of a universal physical health screening tool across the Trust and wider staff training on physical health.

We ensured too better staff understanding, recording, assessing and prevention of violence on our wards. We have further work to do though and this remains a priority for improvement in 2018/19.

A focus in the wake of the 2016 Care Quality Commission inspection was to improve the safety of the environments at our acute hospital partners for those attending A&E with a mental health condition, as well as enhancing the experience for them and their families.

Considerable work was undertaken during the year to achieve this, including refurbishments, further removal of ligatures, management of excessive waits and better information for carers.

Following a new national framework for NHS trusts giving guidance on learning from deaths and a Care Quality Commission review of practice amongst trusts in England, we significantly tightened up governance around this issue and staff training. This will also remain a focus in 2018/19.

There was good progress on a number of key priorities relating to clinical effectiveness and its assessment.

Our award-winning approach to improving the physical health of our service users who have psychosis was further developed in its second year of a five year programme. Our aim is to reduce the mortality rate in this population and improve health and social outcomes.

A key strand has been the successful evaluation of outcomes reported by service users, as a measure of the effectiveness of our services.

During the year, we simplified the process for service user involvement in developing and reviewing their care plans, and introduced further training and guidance for staff.

The Annual Community Survey published in November 2017 by the Care Quality Commission showed we had made a number of improvements on the previous year's results and we performed better than the majority of trusts on several key indicators on service user involvement. We will continue work in this area in 2018/19.

Additionally, we made good progress on driving better understanding by staff of safeguarding and the Mental Capacity Act, after this was highlighted as an area for improvement in our 2016 Care Quality Commission inspection. Mandatory training will continue to be a focus.

DRAFT

The CQUIN results for 2017/18 showed significant steps in some areas, including reducing the number of attendances at A&E by those with mental health needs; improving the experience and outcomes for young people transitioning out of Children and Young People's Mental Health Services (CYPMHS); and improving the health quality of food at the Trust for service users, visitors and staff.

We encouraged more staff to have the flu vaccination, and improved collaboration with primary care clinicians to reduce premature mortality in those with serious mental health conditions.

However, work with regard to preventing ill health related to smoking and alcohol consumption, for instance through screening and providing advice, was inconsistent over quarters.

We consistently exceeded national improvement targets. These included those covering performance on seven day follow-up contact of Care Programme Approach (CPA) service users, admissions to inpatient services having access to crisis resolution home treatment teams and people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral.

In line with continually looking to enhance existing services or develop new ones, there were a number of developments relating to service quality and range.

These included the opening in November of Ruby Ward, our Psychiatric Intensive Care Unit for women – the only one in north central London – which will offer 24 hour care and support to women with the most severe mental health conditions. It aims to prevent women having to go out-of-area to get the specialist care they need, keeping them close to local support networks.

We also opened Lime Tree Gardens, a 24-bed new residential care service in partnership with One Housing, in October. The service is designed to help C&I meet the needs of our patients and address the economic realities of our sector.

Underpinning our delivery of service we introduced a Quality Improvement programme, with the aim of reducing avoidable patient harm, and improving both staff and service user satisfaction.

Other significant quality initiatives have been the introduction of a daily survey tool to help us better manage bed flow and ensure that no service user remains in hospital longer than they need to.

I believe these Quality Accounts strongly reflect our commitment to ensuring that we continue to improve service user and carer experience, and our priority of recovery-focused care and continuous quality improvement.

I am very pleased with the progress we have made during the year and very much looking forward to continuing to build on this, and sharing the outcome of our plans and our progress next year.

The Board is satisfied that the data contained in these Quality Accounts are accurate and representative.

Angela McNab

Chief Executive

24 May 2018

Introduction

What is a Quality Report?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Report. Quality Reports aim to increase public accountability and drive quality improvement within NHS organisations. They do this by ensuring that organisations review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

The safety and quality of the care we deliver at Camden and Islington NHS Foundation Trust is our utmost priority. Here we focus on three areas that help us to deliver high quality services:

- Patient safety
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience).

Scope and structure of the Quality Report

This report summarises how well we did against the quality priorities and goals we set ourselves for the last year and if we have not achieved what we set out to do, we have explained why and what we are going to do to make improvements. It also sets out the priorities we have agreed for the coming year and how we intend to achieve them and monitor progress throughout the year.

One of the most important parts of reviewing quality and setting quality priorities is to seek the views of our service users, staff and key stakeholders. This year we carried out a survey of all those involved with the Trust to discover what their concerns were. From this we drew up a long list of priorities which we put to a public vote. Our nine quality priorities for 2018-19 are the final result of this process.

The Quality Report also includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It also includes a description of audits we have undertaken, our research work, how our staff contribute to quality and comments from our external stakeholders.

In addition to complying with the Quality Accounts Regulations, NHS Foundation Trusts are required to follow the guidance set out by NHS Improvement, which includes reporting on a number of national targets set each year by the Department of Health. Through this Quality Account, we aim to show how we have performed against these national targets. We also report on a number of locally set targets and describe how we intend to improve the quality and safety of our services.

If you or someone you know needs help understanding this report, or would like the information in another format, such as large print, easy read, audio or Braille, or in another language, please contact our Communications Department.

If you have any feedback or suggestions on how we might improve our Quality Report, please do let us know either by emailing Communications@candi.nhs.uk

Language and terminology

It is very easy for people who work in the NHS to assume that everyone else understands the language that we use in the course of our day to day work. We use technical words to describe things and also use abbreviations, but we don't always consider that people who don't regularly use our services might need some help. In this section we have provided explanations for some of the common words or phrases we use in this report.

Benchmarking
Benchmarking is the process of comparing our processes and performance measures to the best performing NHS Trusts or best practices, from other Trusts. The things which are typically measured are quality, time and cost. In the process of best practice benchmarking, we identify the other Trusts both nationally and/ or locally and compare the results of those studied to our own results and processes. In this way, we learn how well we perform in comparison to other hospitals.

Care Quality Commission (CQC)
The CQC is the independent regulator of health, mental health and adult social care services across England. Its responsibilities include the registration, review and inspection of services and its primary aim is to ensure that quality and safety standards are met on behalf of patients.

Care Records Service (CRS)
The NHS has introduced the NHS Care Records Service (NHS CRS) throughout England and Wales. This is to improve the safety and quality of your care. The purpose of the NHS Care Record Service is to allow information about you to be safely and securely accessed more quickly. Gradually, this will phase out difficult to access paper and film records. There are two elements to your patient records:

- Summary Care Records (SCR) - held nationally
- Detailed Care Records (DCR) - held locally

CQUIN
A CQUIN (Commissioning for Quality and Innovation) is a payment framework that enables commissioners to reward excellence, by linking a proportion of the hospital's income to the achievement of local quality improvement goals.

Datix

Datix is a patient safety body that produces web-based incident reporting and risk management software for healthcare and social care organisations.

Carenotes
Carenotes is an Electronic Patient Records system that is able to store more in-depth clinical information. All staff who are directly involved with a service user/patient's care will have some level of access to this system.

Foundation Trust
NHS Foundation Trusts in England have been created to devolve decision-making to local organisations and communities so that they are more responsive to the needs and wishes of local people.

Friends and Family Test
This is a survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

Improved Access to Psychological Therapies (IAPT)
IAPT is a national programme aimed at increasing the availability of talking therapies, such as cognitive behavioral therapy, on the NHS. It is primarily for people with mild to moderate mental health difficulties such as depression, anxiety, phobias and post-traumatic stress disorder.

Information Governance (IG) Toolkit
The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It also allows members of the public to view participating organisations IG Toolkit assessments.

Mental Capacity Act
The Mental Capacity Act 2005 is designed to protect and empower individuals who lack the mental capacity to make their own decisions about their care and treatment. Examples of conditions that might affect someone's mental capacity are dementia, severe learning disability, brain injury or a severe mental health condition. The law applies to people in England and Wales aged 16 or over.

Mortality
Mortality rate is a measure of the number of deaths in a given population.

The National Institute for Health and Care Excellence (NICE)
NICE provides national guidance and advice to improve health and social care. NICE's role is to improve outcomes for people using the NHS and other public health and social care services. Its main activities are:

- Producing evidence based guidance and advice for health, public health and social care practitioners.
- Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services.
- Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care.

Patient Safety Incident
A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

Quality improvement (QI)
Quality improvement is a structured approach to improving performance by first analysing the current situation and then working in a systematic way to improve it. It is now an integral part of the quality agenda and aims to make health care safe, effective, patient-centred, timely, efficient and equitable.

Risk Adjusted Mortality Index
Hospital mortality rates refer to the percentage of patients who die while in the hospital. Mortality rates are calculated by dividing the number of deaths among hospital patients with a specific medical condition or procedure by the total number of patients admitted for that same medical condition or procedure. This risk adjustment method is used to account for the impact of individual risk factors such as age, severity of illness and other medical problems that can put some patients at greater risk of death than others. To calculate the risk-adjusted expected mortality rate (the mortality rate we would expect given the risk factors of the admitted patients), statisticians use data from a large pool of patients with similar diagnoses and risk factors to calculate what the expected mortality would be for that group of patients.
These data are obtained from national patient records.

Risk management
Risk management involves the identification, assessment and prioritisation of risks that could affect or harm the organisation or staff and patients. The aim is to minimise the threat that such risks pose and to

maximise potential benefits.

Serious incident investigation
Serious incidents in healthcare are adverse events where the consequences to patients, families, carers, staff or organisations are so significant that they require some form of investigation. These cases will be investigated thoroughly and lessons highlighted to ensure similar incidents do not happen again.

Serious mental illness (SMI)
An adult with a serious mental illness will have a diagnosable mental, behavioural or emotional disorder that lasts long enough to meet specific diagnostic criteria. SMI results in serious functional impairment which substantially interferes or limits one or more major life activities.

Part 2

2. Priorities for improvement in 2018-19

This part of the report describes the areas for improvement that the Trust has identified for the forthcoming year 2018-19. The quality priorities have been derived from a range of information sources, including wide-ranging consultations. We have also been guided by our performance in the previous year and the areas of performance that did not meet the quality standard to which we aspire. Finally, we have been mindful of quality priorities at national level, not least the increased focus on mortality reviews within mental health and learning from deaths.

In order to make the final selection, the Trust carried out a survey to gather the views of patients, staff, volunteers, members, governors and other stakeholders on what they felt we needed to focus on to ensure ongoing improvements to the quality of care. From this we drew up a long list of potential quality priorities for 2018-19 based on local and national feedback and performance information.

This long list was then put to a public vote, open to all stakeholders and the public. As a result, the following priorities were selected:

Priorities for improvement in 2018-19

PATIENT SAFETY		
Priority 1	**Promote safe and therapeutic ward environments by preventing violence**	**Builds on last year's Quality priority**
Priority 2	**Provide comprehensive risk assessment**	**Builds on last year's Quality priority**
Priority 3	**Ensure mandatory training targets are achieved**	**New Priority CQC Action**
PATIENT EXPERIENCE		
Priority 4	**Learning from deaths and serious incidents**	**New priority**
Priority 5	**Improved communication with Carers and families**	**Builds on last year's Quality priority**
Priority 6	**Involve service users in the Trust's Quality Improvement Programme**	**New priority**
CLINICAL EFFECTIVENESS		
Priority 7	**Engage service users and staff in suicide prevention strategies**	**Builds on last year's Quality priority**

Priority 8	**Better involvement of service users in developing and reviewing their care plans**	**Builds on last year's Quality Priority**
Priority 9	**Improving physical health care**	**New priority**

How these priorities will be delivered

We are confident we can deliver these priorities, as there will be a project plan in place to support their achievement. Each of the quality priorities above will be monitored at local governance meetings and subsequent reports scrutinized at the Trust Quality Governance Committee. Members of the Board will sponsor relevant priorities and implementation leads will be assigned for each quality priority. This will ensure accountability in terms of oversight for each priority throughout the year with a final update to the Board in Quarter 4 of 2018-19.

How will these priorities be monitored to ensure achievement?

The quality priorities for 2018/19 will be monitored via our governance framework within the Trust. Each Divisional Quality/Governance Forum will monitor activities for each priority at operational level. The overview of the achievement of these will be through the Trust Quality Governance Committee chaired by the Director of Nursing. The overall assurance for the achievement of the quality priorities will be taken to the Quality Committee which is a sub-committee of the Trust Board. Any risks to the achievement of the quality priorities will be reported via the governance structure within the Trust.

Patient safety

Priority 1: Promote safe and therapeutic ward environments by preventing violence

Description of the quality issue and rationale for prioritising

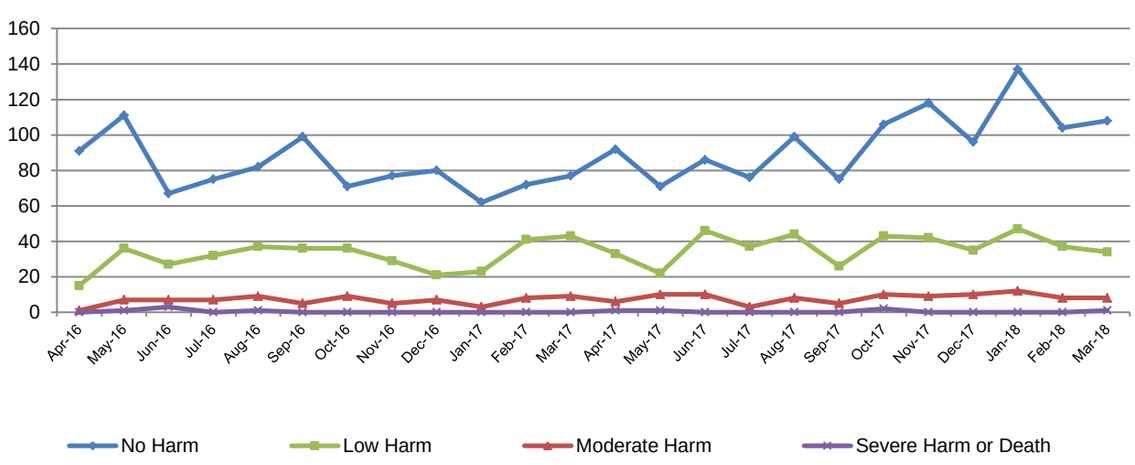
All staff, service users and visitors are entitled to feel safe on the wards at the Trust. Violent incidents are potentially harmful and impact on staff and patient wellbeing. We want to promote safe and therapeutic ward environments by preventing violence, reducing restraints and supporting staff and patients following assault incidents. Whilst progress has been made within this area, unfortunately we have not been able to achieve the level of improvement we would like to achieve. Therefore we would like to suggest a new violence reduction strategy is developed and implemented.

Current picture

Data collection on staff assaults has been challenging in terms of categorising the seriousness of an assault. The trust ran a trial of a full digital assault scale developed using intuitive programming to categorise the severity of assaults. This has proved very positive in terms of accuracy and gives us confidence going forward. It would enable us to accurately and objectively use violence information to improve learning and change practice.

The graph below shows violence and aggression incidents by harm on a monthly basis over the last year.

Violence and Aggression incidents by Harm



The Trust will continue to embark on measures to reduce the number of incidents and level of harm.

Identified areas for improvements

- Continuous reduction of the level of violence in in-patient areas
- Reducing the level of harm from violence
- Ensure the types of verbal abuse used on wards are captured and categorised

How we will improve

- Reduction of harm from violent incidents
- Embedding lessons learnt from incidents and monitoring practice
- Monitoring types of abuse e.g. abuse against those protected characteristics

How we will measure success

- Analysis of incidents
- Formally collecting feedback from staff and patients involved in violent incidents

Priority 2: Provide comprehensive risk assessment

Description of the quality issue and rationale for prioritising

Learning from serious incidents has shown us that good Clinical Risk Assessment is a key part of providing the best care to service users and preventing incidents of self-harm and harm to others. Risk assessments need to be comprehensive and include all relevant information. It is essential staff have the right skills and tools to carry out effective risk assessments.

Current picture

Last year we focused on staff skills and risk assessment tools. We have made significant progress on both. The Trust's training on 'keeping the patient safe' now runs bi-monthly for all clinical staff. Monthly workshops examining lssons learned are facilitated by the Governance teams for divisions. The Clinical Risk policy was updated and launched in 2017. Further improvements have been made:

- The risk assessment document includes triggers to consider when formulating a risk management plan.
- Risk assessment and care planning are included in the trust clinical supervision template

Identified areas for improvements

- Quality and timeliness of risk information

How we will improve

- Ensure staff adhere to the processes in the policy to inform their practice
- Undertake a quarterly randomised audit on the use of the tools and the quality of completed assessments
- Review documentation on a quarterly basis
- Discussion in clinical supervision

How we will measure success

- Feedback from staff after risk assessment training
- Feedback from staff on carrying out risk assessments on a regular basis
- Learning from the quarterly randomised audit evidenced in practice
- Audit of clinical supervision

Priority 3: Ensure core skills (mandatory) training targets are achieved

Description of the quality issue and rationale for prioritising

The Trust has not been able to consistently reach and maintain mandatory training targets in the past 12 months. This was highlighted by the CQC as part of its inspection. Mandatory training supports staff to provide safe and effective care to service users and is at the core of safe care.

Current picture

In the main we are compliant with most of our Core skills training targets. However, as identified by the CQC and evident in the data below, we need to take steps to not only increase the compliance rate for Breakaway, Cardiopulmonary Resuscitation (CPR) and Immediate Life Support (ILS) training, but to be compliant.

Core Skills	Target	Compliance
NHS|CSTF|Fire Safety - 1 Year|	80%	84.77%
NHS|CSTF|Infection Prevention and Control - Level 2 - 2 Years|	80%	87.74%
NHS|CSTF|Moving and Handling - Level 1 - 3 Years|	80%	92.22%
NHS|CSTF|Information Governance - 1 Year|	95%	86.68%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	80%	89.26%
NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	80%	85.10%
NHS|MAND|Conflict Resolution - Dealing with Violence and Aggression - 2 Years|**(Breakaway)**	80%	51.05%
NHS|MAND|Conflict Resolution - Physical Intervention Skills - 2 Years|**(PMVA)**	80%	77.45%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year| **(CPR)**	80%	61.26%
NHS|CSTF|Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year| **(ILS)**	80%	57.70%*
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	80%	88.60%
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	80%	83.96%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	80%	83.20%
455|LOCAL|Safeguarding Adults Level 4 - 3 Years|	80%	100.00%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	80%	89.34%
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	80%	90.10%
NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|	80%	92.41%
NHS|MAND|Safeguarding Children Level 4 - 3 Years|	80%	100.00%
NHS|CSTF|Preventing Radicalisation - Levels 1 & 2 (Basic Prevent Awareness) - No Renewal|	85%	85.16%
NHS|CSTF|Preventing Radicalisation - Levels 3, 4 & 5 (Prevent Awareness) - No Specified Renewal|	85%	84.56%
NHS|MAND|Mental Capacity Act - 3 Years|	80%	73.57%
NHS|MAND|Mental Health Act - 3 Years|	80%	60.91%

The ILS training is a relatively new course and this will be showing at a lower level of compliance as this is rolled out to our staff and this is on a trajectory to achieve 80%.

Identified areas for improvement

- Increase accessibility for Breakaway training
- Increase the number of days available for CPR and ILS training
- Plan dates well in advance to accommodate all staff and increase uptake
- Reduce number of non-attendance

How we will improve

- Breakaway training easily accessible at one of C&I sites
- Make provision to accommodate staff bookings and Increase uptake
- Timeliness of response by managers when concerns raised

How we will measure success

- Compliance with all core skills target

Patient experience

Priority 4: Learning from deaths and serious incidents

Description of the quality issue and rationale for prioritizing

The 2017 Care Quality Commission (CQC) review of the way NHS trusts review and investigate the deaths of patients in England found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that more can be done to engage families and carers and to recognise their insights as a

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vital source of learning.

Current picture

There continues to be a national focus on how the NHS deals with unexpected death and serious incidents. In response the Trust has set up a mortality review process at the hospital. We have focused on implementing the Learning from Deaths national guidance and strengthening our serious incident process. We are now reporting deaths to the Board in our public papers. It is important that we continue to build on this work so that lessons are learned and shared. We will look at how we inform service users and families about incidents and include them in the investigation as well as provide support during the process.

Identified areas for improvement

- Being open with service users, families and carers and including them in setting the scope of investigations

How we will improve

- Consistently engage and involve service users
- Share and embed learning from deaths

How we will measure success

- Feedback from service users
- Learning from Deaths audit

Priority 5: Improved communication with Carers and families

Description of the quality issue and rationale for prioritising

Serious incident reports and feedback from carers and service user surveys tells us that we need to be consistent in making contact with families and carers and involving them. We need to ensure we record information on next of kin and service user preferences for contact with families. Another aspect of this is ensuring that carers and families have positive contacts with teams when they contact the Trust and staff act in accordance with Trust values.

Current Picture

The Trust has recently been accepted for membership to the Triangle of Care. A national scheme which recognises NHS trusts for their quality of care to carers. Implementing the Triangle of Care demonstrates that all services have a genuine commitment to the service user, the professional and the carer and this promotes safety, supports recovery and sustains well-being for all. In order to achieve full accreditation to this scheme the Trust will carry out assessments of our inpatient and community services against these six principles.

Over the coming weeks all teams in the Trust will be contacted and asked to complete a self-assessment within their Service. Carer Champions across the Trust will be on hand to help them so that by the end of year we will have a Trust wide picture of our strengths and areas of excellence in working with carers, and also the gaps and where we need to invest more time and resources. Our local carer organisations and some local carers have also agreed to help us with this challenge. The Head of Social work and Social Care is leading this work.

Identified areas for improvement

- Recording of next of kin
- Recording arrangements and preferences for involving carers and families
- Improving the experience of families and carers when contacting the Trust

How we will improve

- Recording of next of kin for all service users
- Recording arrangements and preferences for involving carers and families for all service users
- Improve patient experience

How we will measure success

- Audit service users' records
- Feedback from service users

Priority 6: Involve service users in the Trust's Quality Improvement (QI) Programme

Description of the quality issue and rationale for prioritising

Involving service users in quality improvement is a key component of QI. The Trust plans to offer QI training to service users and have them actively involved in the QI project during 2018/19. The aim is to have service user involvement in all projects. Our project platform Life QI allows the level of service user involvement to be described in each project. We are aiming for high level of service user involvement at every stage of improvement work.

Current picture

Our QI programme is advancing and is impacting positively in the delivery of our services. To make it more inclusive, we have organised bespoke training for service users and are engaging with them to be involved in QI work. This training is also extended to carers.

Identified areas for improvement

- Train service user volunteers in QI
- Involve service user volunteers in new QI projects

How will we improve

- Recruit service user volunteers
- Develop bespoke training
- Maintain a register of Service user volunteers that have been trained
- Ensure trained service users are involved in QI projects

How we will measure success

- Evaluation of bespoke training and feedback from service users
- Service users involved in every project
- Increase number of service users on the register on a quarterly basis
- Audit of trained volunteers involved in QI projects

Clinical effectiveness

Priority 7: Engage service users and staff in suicide prevention strategies

Description of the quality issue and rationale for prioritising

The Government has recently made a public commitment to reducing self-harm and suicide and asking all agencies to work together to reduce suicide. The Trust will focus on implementing the local suicide prevention strategy and making staff aware of the best approaches to detecting risk and targeting help and support to prevent suicide.

Current picture

This priority is carried forward from last year. We have not achieved what we set out to do in its entirety, particularly in implementing the local prevention strategy. However, we have embedded our focused training and guidance, briefing and de-briefing sessions and, sharing learning from investigations into suicide.

Identified areas for improvement

- Implement the local suicide prevention strategy
- Set up a group to specifically look at reducing self-harm and suicide

How we will improve

- Embed the local prevention strategy in practice
- Ensure that high risk service users are risk assessed appropriately
- Ensure care plans reflect comprehensive risk assessment
- Embed learning from suicide in practice

How we will measure success

- Evaluate impact of the strategy in practice
- Audit the quality of risk assessments and care plans
- Reduction in the number of avoidable deaths due to suicide

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Priority 8: Better involvement of service users in developing and reviewing their care plans

Description of the quality issue and rationale for prioritising

Since the CQC inspection in February 2016, there have been a number of improvements to care planning and co-ordination. However, because of the importance of this area, we will continue to develop and improve care planning to make sure we are getting it right. Service user feedback tells us that they do not always feel involved in developing or reviewing their care plans. Although the feedback has been more positive in the past year there is still room for improvement.

Current picture

We have simplifed the Care Planning process. Since the introduction of Carenotes (Electronic Patient Record), there have been several scoping exercises exploring its functionality as part of the Carenotes revamp project. As a result there have been several changes made to the Care Plan Template on Carenotes; there were two key themes in mind:

1. What does the service user want in their care plan (personalised care)
2. How can we make care planning as easy to use as possible for staff and patients

The Care Plan Template has been the subject of extensive consultation with service user groups and staff which, was led by Dr. Vincent Kirchner, Medical Director. The final agreed template went live as of 04/10/17

Pilot
A full pilot was run across varying services to test for usability and feedback on potential improvements, major overhauls of the template was not considered but minor changes were completed. The pilot was successful with good staff and service user feedback. The template has now gone live for services.

Training and Guidance
Video guidance was completed and available via YouTube, this is in the form of five 3 minute videos using screen shot software. This essentially is to show the use of the template on Carenotes with an overlaying audio narrative, the links to the videos are displayed at the end of the care plan on Carenotes.

Identified areas for improvement

- Recording that service users have agreed their care plans and received a copy
- Ensuring that the service users voice is “heard” throughout the care plan
- Care plans should reflect the service users mental and physical care needs identified by the assessment process
- Ensuring that all Camden and Islington service users regardless of setting should have an up to date care plan

How we will improve

- Staff engage with service users in developing and reviewing care plans
- Staff ensure that discussions with service users are recorded appropriately
- Staff ensure that service users understand their care plan and a copy handed to them

How we will measure success

- Feedback from service users
- Audit of service users’ records

Priority 9: Improving physical health

Description of the quality issue and rationale for prioritising

The National Early Warning Score (NEWS) determines the degree of illness of a patient. This is based on six key indicators that help to identify and respond to patients at risk of deteriorating. The parameters include respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of

consciousness. It is important that we accurately and timely record these measurements and respond appropriately where indicated. This simple and practical approach can identify those service users at risk of acute illness and improve patient outcomes.

Current picture

There were over 1000 physical health screenings completed in the Trust and over 600 completed in primary care (Camden) so far in this year. This covers over 26% of the total patients with SMI in both Camden and Islington. The physical health screening includes various checks such as blood pressure, weight, height, pulse, smoking cessation, diabetes screening, spirometry screening, alcohol and drug screening. This screening is taking place in all the psychosis community teams, inpatient wards and community rehabilitation teams. Once the screening is completed, it is then sent to the relevant GP practice and also any onward referrals are made after the wellbeing clinic. The care co-ordinator in the team will be aware of the physical health condition and the care plan is updated accordingly. A discharge summary is then sent to the GP after the service user is discharged from the inpatient ward.

All the physical health checks are stored in the screening tool and any gaps are highlighted to the Community Nurse Managers on a regular basis.

Physical health screening tool

The Trust has now developed one standard physical health screening tool. In the past there were several tools used by different services. By standardising the tool service users can now expect even better management of their physical health in the Trust. The new Physical Health Screening Tool is now being used Trust wide supporting referral, intervention and care planning, it underpins the revised Physical Health Policy due to be re-launched in May 2018

Identified areas for improvements

- Embed the revised Physical Health Policy and the new Physical Health Screening Tool
- All service users to have their NEWS recorded appropriately
- Elevated NEWS scores escalated appropriately and in a timely manner
- NEWS e-Learning training compliance to be above 80% by April 2019

How we will improve

- Completion of physical health screening and assessment recorded appropriately
- Referrals done appropriately
- Advice received from experts acted on appropriately
- Discharge summaries include physical health

How we will measure success

- Physical health dashboard
- CQUIN data
- Incidents, complaints and claims

Part 3

3. What we have achieved in 2017-18

What we have achieved in 2017-18

Progress against the quality priorities that we set for 2017-18
This section describes the Trust's progress against the quality priorities that we set for 2017-18. The Trust had nine quality priorities for the year, reflecting both CQUIN targets and progress towards the CQC action plan.

Priorities for improvement in 2017-18

PATIENT SAFETY		Achievement
Priority 1	Promote safe and therapeutic ward environments by preventing violence	Partly achieved
Priority 2	Provide comprehensive risk assessment	Achieved
Priority 3	Reduce poor health outcomes for people with serious mental illness	Achieved

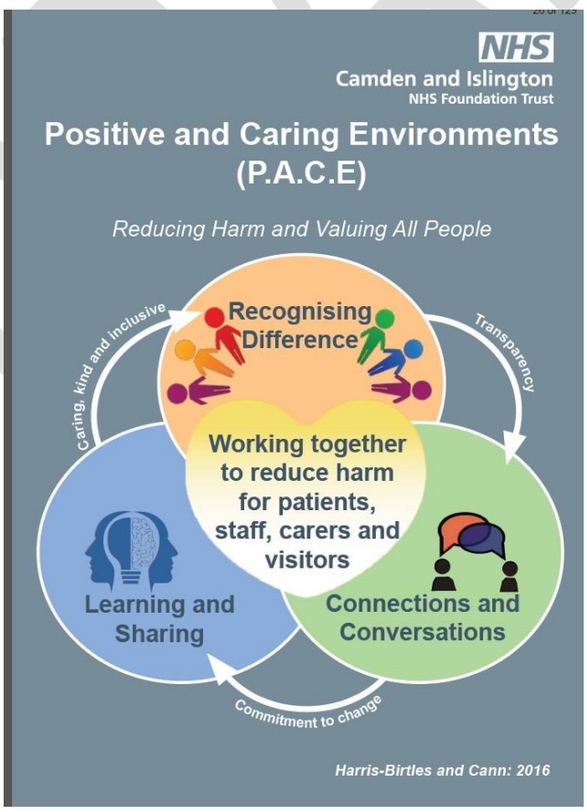
PATIENT EXPERIENCE		
Priority 4	Engage service users and staff in suicide prevention strategies	Partly achieved
Priority 5	Better communication and involvement with families	Partly achieved
Priority 6	Improve privacy and dignity for those with mental health needs who present to A&E	Achieved
CLINICAL EFFECTIVENESS		
Priority 7	Ensure effective services by evaluating the outcomes from the Integrated Practice Unit for Psychosis	Achieved
Priority 8	Better involvement of service users in developing and reviewing their care plans	Achieved
Priority 9	Enable staff to protect service users through a good understanding of safeguarding and the Mental Capacity Act	Partly achieved

Patient Safety

Priority 1: Promote safe and therapeutic ward environments by preventing violence - Partly achieved

Description of the quality issue and rationale for prioritising

All staff, service users and visitors are entitled to feel safe on the wards at the Trust. Violent incidents are potentially harmful and impact on staff and patient wellbeing. We want to promote safe and therapeutic ward environments by preventing violence, reducing restraints and supporting staff and patients following assault incidents. The reduction of assaults by a patient on staff can potentially be achieved as a secondary gain from reducing restrictive practice. NHS Protect (2013)



Identified areas for improvements

- Reducing levels of violence in inpatient areas
- Reducing prone restraints
- Ensure physical observations are recorded when restraint has been used
- Embedding PACE

What we have achieved

Keeping staff safe

Data collection on staff assaults has been challenging in the past in terms of capturing and categorising the seriousness of the assault. A full digital assault rating scale has been developed using intuitive programming to categorise the severity of the assaults that are happening. The trial ran from November 2017 – March 18 and showed 93% accuracy compared to subject expert interpretation of the incident.

This will greatly improve our understanding of violence and the impact it is having on our staff. It will also allow the Trust to more accurately and objectively look at violence to improve learning and change practice if necessary.

Additionally the Trauma at Work Pathway is now fully functional and being actively promoted to staff. We have seen a steady uptake of the initiative as well as sustained use of the recovery days project that has been extended for a further 12 months. We now provide direct support to all staff that have been assaulted from the Local Security Management Specialist (LSMS) and ward manager, with an immediate plan established to protect the victims of violent behavior at work. The use of recovery episodes has increased steadily from April to December 2017. There was a spike in recovery leave days taken in July and October, 1.15 days on average were taken per recovery leave episodes. Following a period of recovery leave 76% of staff returned to work with no subsequent sickness. Psychology group and/or individual debrief is also available.

Return to work interviews must now be completed for all staff that experience assault to ensure the staff member has not been unduly affected by the incident, managers must put in place an action plan where necessary in order to avoid prolonged trauma. All managers will be trained in brief treatment of trauma, by the trusts lead psychologist

Unfortunately the rate of violence and aggression has not fallen. In part we have been promoting the importance of reporting all incidents of violence and aggression including verbal abuse and threats which means we have raised awareness about reporting. The future focus will be on reducing harm levels.

Service User involvement

Peer debrief is now fully implemented into Highgate Mental Health Centre and Ruby Ward, provisional data shows that patients feel there needs to be greater gender diversity in the restraint team and that they feel that they have not had enough input on how restraint should happen for them. Feedback on the experience of peer debrief has been very positive.

We now have ten peer de-brief staff fully trained with an additional four planned for January. All systems appear to be in working order and the data is presented to Positive and Proactive Care Group.

Restraint and seclusion

- The use of seclusion and prone restraint has fallen
- 79% of all restraints are less than five minutes across a 12 month period
- All restraints that last longer than 15 minutes are reviewed by the Prevention and management of Violence and aggression (PMVA) Lead to see if there are interventions that could be used to reduce the need for restraint.
- Fifteen minute restraints account for 6% of all restraints and almost exclusively include with I/M medication or seclusion.
- None of the 25 incidents of prolonged restraint was a prolonged restraint in the prone position
- Alternative site injection technique training shows that since the training has been rolled out there has been a significant decline in prone injections
- The long term trend for offering physical health checks after restraint has increased.

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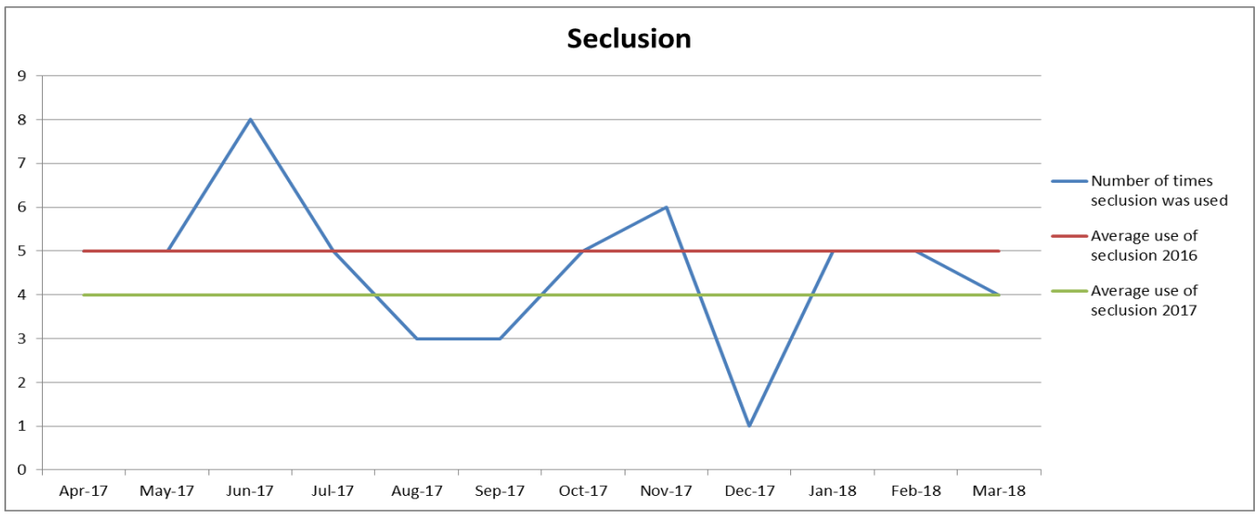
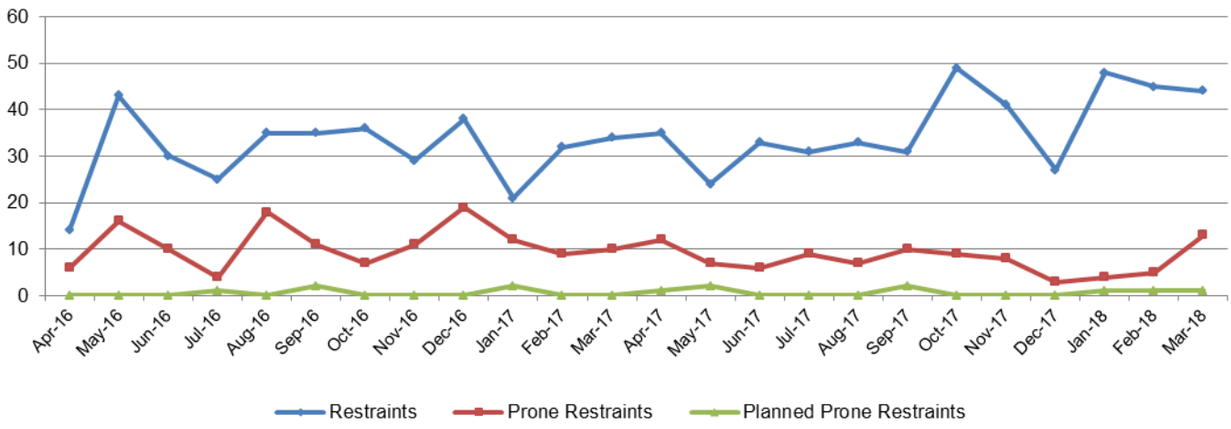
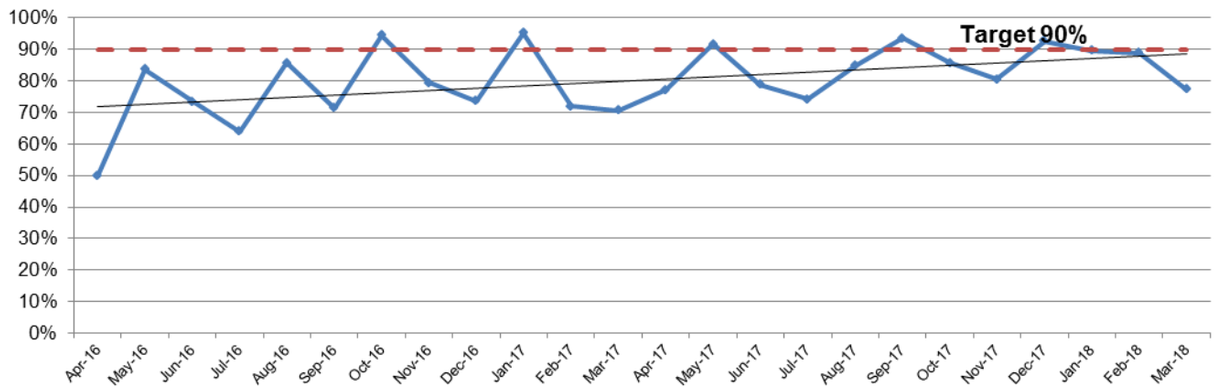
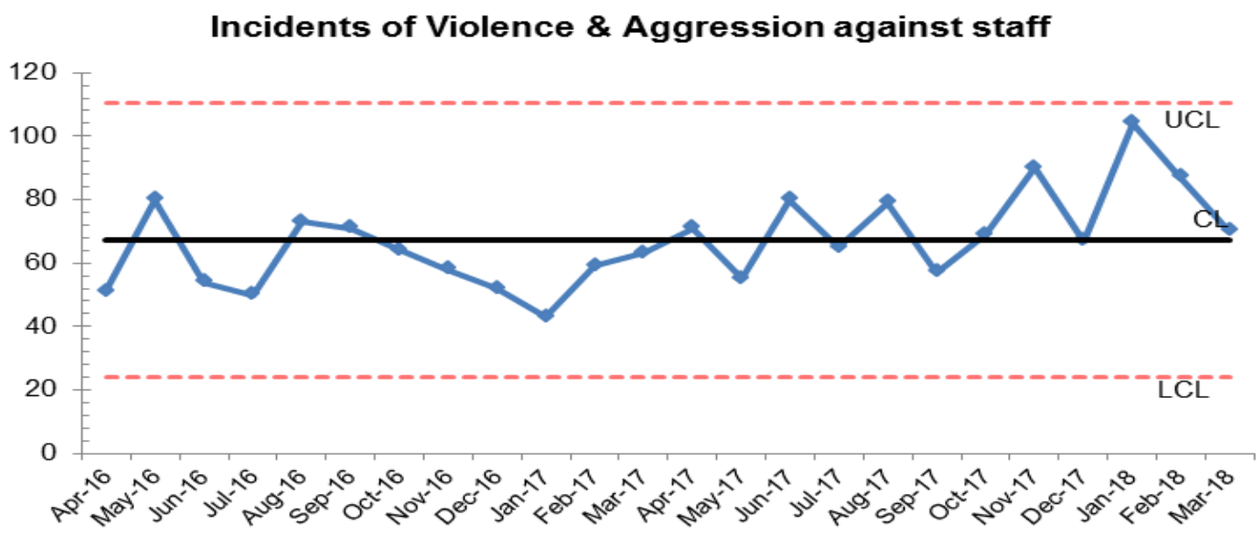


Number of restraints, prone restraints & planned prone restraints incidents



Proportion of Physical health checks offered following restraints





Control limit (CL) Upper control limit (UCL) lower control limit (LCL)

Next steps/future challenges

- Reducing harm from incidents of violence and aggression
- Categorizing verbal abuse in relation to protected characteristics
- Reducing over all levels of restraint

Priority 2: Provide comprehensive risk assessment - Achieved

Description of the quality issue and rationale for prioritising

Learning from serious incidents has shown us that good clinical risk assessment is a key part of providing the best care to service users and preventing incidents of self-harm and harm to others. Risk assessments need to be comprehensive and include all relevant information. It is essential staff have the right skills and tools to carry out effective risk assessments.

Identified areas for improvements

- Staff skills in risk assessment
- Risk assessment tools

What we have achieved

Training on keep the patient safe now runs bi-monthly for all clinical staff. Monthly workshops exploring lessons learned are facilitated by the Governance teams for divisions. The Clinical Risk policy was updated and launched in 2017. Further improvements have been made:

- The risk assessment document includes triggers to consider when formulating a risk management plan.
- Risk assessment and care planning are included in the trust clinical supervision template

Future challenges
Risk assessment project to be commissioned with the trust practice development team; this will focus on adhering to processes, risk skills in practice using applicable tools.

Priority 3: Reduce poor health outcomes for people with serious mental illness Achieved

Description of the quality issue and rationale for prioritising

Reducing premature mortality for people with serious mental illness is a national priority. The importance of monitoring and managing physical health care has featured in service user feedback, incidents and complaints. There is a national recognition of the need to take a holistic and joined up approach to caring for the physical and mental health needs of those with serious mental illness.

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Identified areas for improvement

- How physical health is recorded and monitored to ensure consistency for service users with psychosis
- Communication with GPs

What we have achieved

We have completed over 1000 physical health screenings and over 600 completed in primary care (Camden) so far this year (2018). This covers over 26% of the total patients with serious mental illness (SMI) in both Camden and Islington. The physical health screening includes various checks such as blood pressure, weight, height, pulse, smoking cessation, diabetes screening, Spirometry screening, alcohol and drug screening.

Physical health screening is taking place in all our psychosis community teams, inpatient wards and community rehabilitation teams.

All the physical health checks are stored in the screening tool and any gaps are highlighted to the Community Nurse Managers on a regular basis.

Nutrition and Hydration Week was held in March 2018 with education events.

Physical health screening tool

The Trust has now developed one standard physical health screening tool. In the past there were several tools used by different services. By standardising the tool service users can now expect even better management of their physical health in the Trust. The new Physical Health Screening Tool is now being used Trust wide supporting referral, intervention and care planning, it underpins the Revised Physical Health Policy due to be re-launched in May 2018

Training for staff

We have provided face to face training and an E-Learning Package on deteriorating physical health conditions, NEWS and NEWS2. “Breaking Down the Barriers Training” across specialties /divisions is underway – topics covered include Chronic Obstructive Pulmonary Disease and Diabetes. Positive feedback has been received from delegates at the training sessions and their contributions have been positive.

Next steps/future challenges

- Physical health checks are not always being carried out consistently in the wellbeing clinics.
- A lead phlebotomist role will be created to work in the wellbeing clinics to improve support

Future challenges

Standardising the use of NEWS and auditing to identify gaps in practice.

Patient experience

Priority 4: Engage service users and staff in suicide prevention strategies Partly achieved

Description of the quality issue and rationale for prioritising

The Government has made a public commitment to reducing self-harm and suicide and is asking all agencies to work together to reduce suicide.

Identified areas for improvements

- The Trust will focus on developing and implementing a local suicide prevention strategy
- Making staff aware of the best approaches to detecting risk and targeting help and support to prevent suicide
- Involving service users, carers, and families in suicide prevention

What we have achieved

There have been meetings with local stakeholders with preliminary discussions on developing a cross sector suicide prevention strategy. The Trust has not been able to progress this priority as much as was hoped. There has been work on suicide prevention in services as part of our risk assessment and management improvements. Best practice, local and national trends as well as learning from recent suicides is discussed

and shared with teams. The creation of suicide prevention and self harm group at the Trust has now been agreed with a remit to bring together current best practice and learning and share this with staff and service users in a comprehensive and accessible format.

Next steps/future challenges

- Repeat priority next year to make further progress on the areas of improvement
- Bringing together current best practice in suicide prevention to share with staff and service users.

Priority 5: Better communication and involvement with families after serious incidents - Partly achieved

Description of the quality issue and rationale for prioritising

The Care Quality commission (CQC) Community Survey (2016) showed that we needed to improve communication and involvement with families. There is also a national drive to improve contact with service users, families and carers when there has been a serious incident. Serious incident and complaints feedback as well as service user surveys tells us that we need to be consistent in making contact with families and carers, and involving them.

The 2017 Care Quality Commission (CQC) review of the way NHS trusts review and investigate the deaths of patients in England found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more that can be done to engage families and carers and to recognise their insights as a vital source of learning.

Identified areas for improvements

- More consistent recording of information on next of kin and service user preferences for contact with families
- Update the policy to reflect the approach to communicating with service users, families and carers

What we have achieved

In March 2017 the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the new framework is to introduce a standardised approach to the way NHS Trusts report, investigate and learn from patient deaths. This is intended to support higher quality investigations and embedded learning. It covers how trusts respond to deaths in care generally, not just those classed as serious incidents.

The framework focuses on:

- Improving governance processes around patient deaths
- New board leadership roles
- A new system of case record reviews
- Quarterly reporting of specific information about deaths in care
- Producing a Trust policy
- Involving at every stage the families/carers of patients who have died in care

What the Trust has done to meet the requirements of the new framework:

1. Identified a Trust lead and NED lead for learning from deaths to ensure robust governance around deaths.
2. Produced a Learning form Deaths Policy which is on the public website and clearly identifies the process for reviewing and learning from deaths.
3. Introduced a system of case record review incorporating a structured judgment review and an avoidability of death scoring system. This has been incorporated into the Preliminary Review tool used at the Trust. The Trust Mortality Review group reviews all reported deaths.
4. A quarterly Mortality Report to the Board is published.
5. Training completed in November 2017 has trained 21 staff. This bespoke training skills in investigation and case record reviews.
6. Developed templates to ensure consistent communication with families and carers when deaths are being reviewed.

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Next steps/future challenges

- Repeat this priority next year to make further progress on the areas for improvement
- Review policy

Priority 6: Improve privacy and dignity for those with mental health needs who present to A&E Achieved

Description of the quality issue and rationale for prioritising

Improving services for people with mental health needs who present to A&E is a national and local priority. The 2016 CQC inspection also identified this as a priority, in particular that the environments were safe and enhanced to improve the experience of service users and their families

Identified areas for improvements

- Privacy and dignity for service users using section 136 suites
- Keeping service users and their families comfortable and occupied during waits
- Keeping service users and their families informed about what will happen next

What we have achieved

In partnership with our acute trust partners there have been a number of improvements in Health Based Places of Safety to ensure patients are in a safe environment when they attend A&E. A joint working group has been set up to work with the local trusts to ensure progress. The recent CQC inspection highlighted some improvements were still necessary and in February and March this year further improvement works were carried out.

- Ligature points have been removed in section 136 suites and toilet facilities.
- Introduced Self-Occupying packs
- Environments refurbished
- Monitoring plans in place to manage excessive waits.
- Information for carers in place

Next steps/future challenges

- The Trust has submitted plans to build a bespoke mental health act section 136 suite in one of our sites to provide a much better experience for service users.

Clinical effectiveness

Priority 7: Ensure effective services by evaluating the outcomes from the Integrated Practice Unit (IPU) for Psychosis - Achieved

Description of the quality issue and rationale for prioritising

Implementation of the IPU has been a significant step in transforming the way in which we deliver person-centred care and will result in better outcomes for our service users. The IPU will have a strong focus on prevention and self-management. Through the IPU we aim to reduce the death rate in the psychosis population and improve health and social care outcomes. This was year 2 of the five-year programme.

Identified areas for improvements

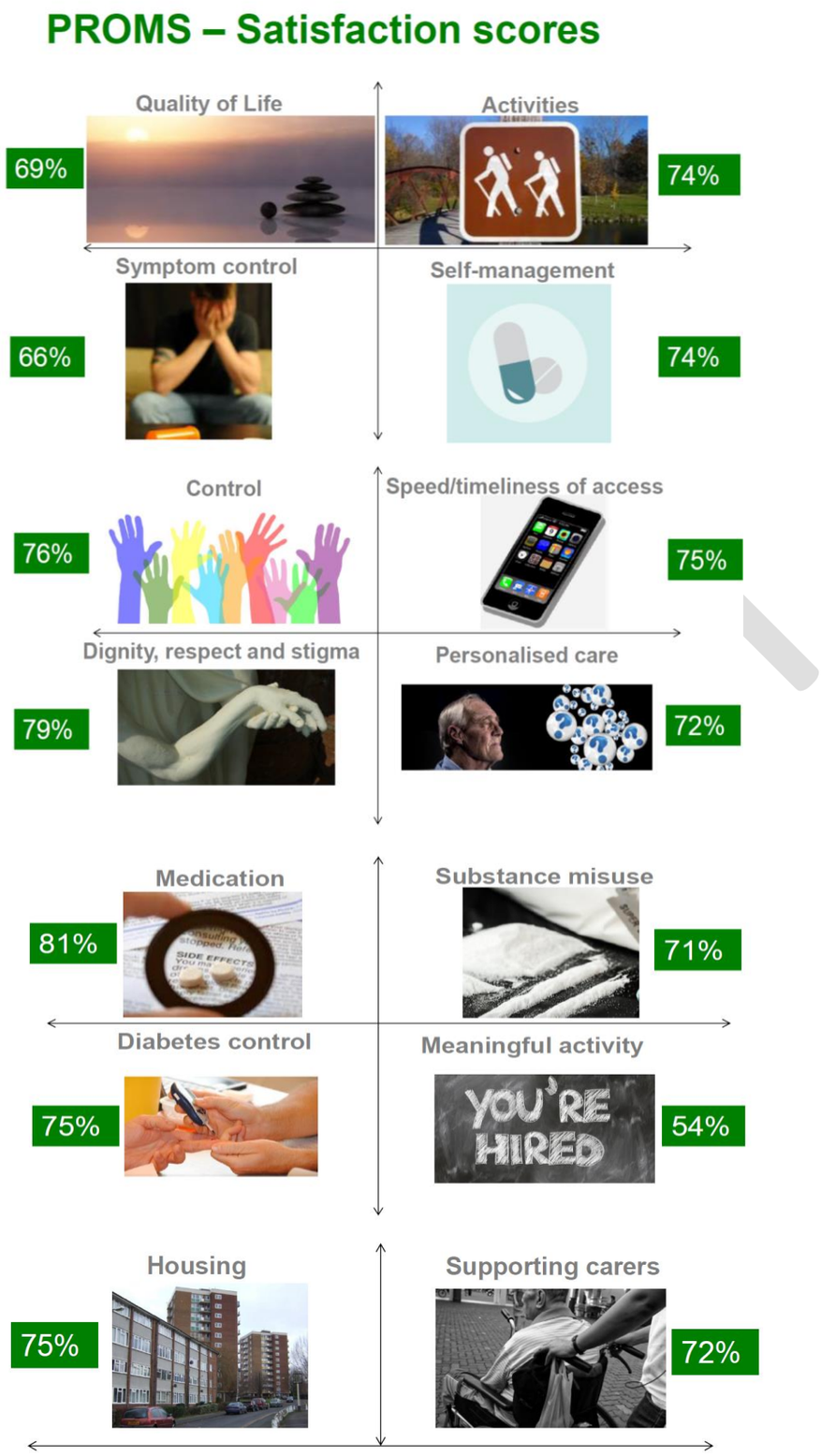
- Care planning for long term conditions
- Engaging service users in self-management

What we have achieved

Patient reported Outcome Measures (PROMS)

For the last two years the Trust has been developing innovative ways of treating service users' physical and mental health care together. This award-winning initiative is known formally as our "Integrated Practice Unit (IPU) for Psychosis". It includes detailed physical health screening of service users, additional physical health training for staff and extending our wellbeing clinics network. As part of this work, our Community teams have been focusing on the 3,000 service users with psychosis, in order to reduce the high number of early deaths in this vulnerable group, compared with the general population. We have been measuring progress to see if

this approach is making a difference to the health and quality of life of our service users.
Last year, just over 1,000 service user questionnaires were sent out to our Community teams, with a range of questions about health and care-related issues, for instance on leisure activities, satisfaction with symptom control, access to crisis services, and prevalence of alcohol and drug misuse. Overall, 69% of the 470 service users who responded were satisfied with the quality of their life. The results for 2017 can be seen below:



Service user involvement
The IPU project has a service expert by experience group and receives regular input from the Evolution service user group. Service user input has been used to develop the outcome measures.

Next steps/future challenges

This year April-May 2018, the Trust aims to get even more feedback and is sending 1,300 questionnaires to relevant teams, including 400 to our GP colleagues

- Evaluate feedback and continue to engage Service Users
- Improve care planning for long term conditions to be monitored at the IPU's weekly meeting

Priority 8: Better involvement of service users in developing and reviewing their care plans – Achieved

Description of the quality issue and rationale for prioritising

Feedback from CQC visits and patient surveys told us that we needed to improve how we involved patients in developing care plans so that they were tailored to each individual. The practice development team has been supporting best practice based approaches to care planning and reviewing their care plans.

Identified areas for improvements

- Service user involvement in care plans
- Quality of Care plans
- Regular review of care plans

What we have achieved

Simplifying the Care Planning process
Since the introduction of Carenotes, there have been several scoping exercises exploring its functionality and if it meets both staff member and patients' needs as part of the Carenotes revamp project. As a result there have been several changes made to the Care Plan Template on Carenotes; there were two key themes in mind:

1) What does the service user want in their care plan (personalised care)
2) How can we make care planning as easy to use as possible for staff and patients

The Care Plan Template has been through extensive consultation with service user groups and staff which, was led by Dr. Vincent Kirchner. The final agreed template went live as of 04/10/17

Pilot
A full pilot was run across varying services to test for usability and feedback on potential improvements, major overhauls of the template was not considered but minor changes were completed. The pilot was successful with good staff and service user feedback. The template has now gone live for services.

Training and Guidance
Video guidance was completed and available via YouTube, this is in the form of separate short videos using screenshot software. This essentially is to show the use of the template on Carenotes with an overlaying audio narrative, the links to the videos are displayed at the end of the care plan on Carenotes.

The Annual Community Survey

The Annual Community Survey Results were published in November 2017 and showed the Trust had made a number of improvements on last year's results. This survey is published by CQC and is the national survey that all mental health trusts participate in.
The survey report uses standardised data to generate a score for each question requesting the respondent to rate the service they received. This score is then used to benchmark the Trust position in relation to all other responding organisations. The Trust significantly improved in a number of areas related to care planning

Questions where C&I scored better than the majority of other Trusts

C&I scored above the majority of Trusts (Upper 20%)	C&I	Min Score	Max Score
Q4 - Did the person or people you saw listen carefully to you?	8.6	7.2	8.7
Q15 - Were you involved as much as you wanted to be in discussing how your care is working?	8.0	6.2	8.4
Q16 - Did you feel that decisions were made together by you and the person you saw during this discussion?	7.8	6.5	8.3
Q3 - In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	6.5	4.4	7.1

Overall Domain Section scores change since the previous survey

Domain Section Name	C&I (2017)	C&I (2016)	Change since 2016		Min	Max
S3 - Planning Care	**7.2**	**6.6**	**0.6**	↑	**6.0**	**7.5**
S4 - Reviewing Care	**7.7**	**7.5**	**0.2**	↑	**6.2**	**8.3**

S6 - Crisis Care	**6.5**	**5.7**	**0.8**	↑	**5.1**	**7.3**
S7 - Treatments	**7.3**	**7.4**	**-0.1**	↓	**6.3**	**8.2**
S8 -Support and Wellbeing	**5.6**	**5.2**	**0.4**	↑	**3.5**	**5.9**
S9 - Overall views of care and services	**7.5**	**7.1**	**0.4**	↑	**5.9**	**7.9**
S10 - Overall experience	**7.2**	**6.8**	**0.4**	↑	**5.9**	**7.5**

Next steps/future challenges

- A full e-learning package comprising five modules has been developed via Care Academy and will be available on Training Tracker from May 2018. This will cover all areas of care panning, from principles to the practical elements of what services are required to be provided in a care plan. This will be hosted on training tracker and usage data will be provided to operational managers for information. Certificates for each module will be available as evidence of continuing professional development for appraisal and revalidation purposes.

- Auditing the quality of care plans and the discussion of care plans in clinical supervision.

Priority 9: Enable staff to protect service users through a good understanding of safeguarding and the Mental Capacity Act partly achieved
Description of the quality issue and rationale for prioritising

The CQC inspection in 2016 identified staff understanding of the Mental Capacity Act and safeguarding processes as an area for improvement. A number of improvements had already taken place to provide staff with training and ensure there is a clear process. This priority was to focus on continuing these improvements by sustaining training rates for staff and auditing the process to measure improvement.

Identified areas for improvements

- Guidance for staff
- Training compliance at levels 1-2

What we have achieved

As can be seen in the table below the compliance rates for safeguarding has consistently been above 80%. The figures for Mental Capacity Act and Mental Health Act training increased throughout the year but not above 80% by the year end. Both the safeguarding and MHA teams have been providing numerous training slots and visiting teams to ensure the training was accessible as possible. There is also online guidance and support for staff as well as MHA teams and a safeguarding hub where staff can get direct advice and support with any aspect of safeguarding and mental health law including the Mental Capacity Act.

Core Skills	Target	Compliance
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	80%	88.60%
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	80%	83.96%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	80%	83.20%
455|LOCAL|Safeguarding Adults Level 4 - 3 Years|	80%	100.00%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	80%	89.34%
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	80%	90.10%
NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|	80%	92.41%
NHS|MAND|Safeguarding Children Level 4 - 3 Years|	80%	100.00%
NHS|CSTF|Preventing Radicalisation - Levels 1 & 2 (Basic Prevent Awareness) - No Renewal|	85%	85.16%
NHS|CSTF|Preventing Radicalisation - Levels 3, 4 & 5 (Prevent Awareness) - No Specified Renewal|	85%	84.56%
NHS|MAND|Mental Capacity Act - 3 Years|	80%	73.57%

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NHS|MAND|Mental Health Act - 3 Years|	80%	60.91%

Next steps/future challenges

- The Trust is focusing on mandatory training in 2018 as has chosen this as a priority for 2018-19

4. Statements of assurance from the Board

During 2017-18, Camden and Islington NHS Foundation Trust provided and/or sub-contracted the following seven NHS services across approximately 30 Trust sites in Camden, Islington and Kingston; together with presence in GP practices for IAPT and PCMH in all three local authorities

- Acute Adult Mental Health
- Community Adult Mental Health
- Services for Ageing and Mental Health (SAMH)
- Recovery and Rehabilitation
- Substance Misuse Service (SMS)
- Learning Disability
- Practice Based Mental

Services delivered in each sector above include:

- Urgent assessments and care for those experiencing episodes of severe illness
- A&E Liaison service in partnership with Acute Trusts
- Alcohol and Drug Misuse
- Alcohol Assertive Outreach teams
- Blood borne virus services
- Integrated Practice Unit for Psychosis and Chronic conditions Early Intervention Service for first episode of psychosis
- Day Care services
- Intensive support service and liaison with partners in the non-statutory supported housing sector and other non-statutory organisations
- Personality Disorder service
- Psychotherapy service
- Traumatic Stress Clinic
- Neuro-Developmental Disorders Service for people with Attention Deficit and Hyperactivity Disorder and Autism Spectrum Disorders
- Veterans' Mental Health TIL (Transition, Intervention and Liaison) Service – London and South East England
- Improving Access to Psychological Therapies (IAPT) services
- Integrated Health and Social Care Services

Camden and Islington NHS Foundation Trust has reviewed all the data available to it on the quality of care in each of these NHS services.

The income generated by the NHS services reviewed in 2017-18 represents 100% of the total income generated from the provision of NHS services by Camden and Islington NHS Foundation Trust for 2017- 18.

The Trust has been able to review data for each of these services in the areas of patient safety, patient experience and clinical effectiveness, and the Board has received regular comprehensive updates and reports on quality throughout the year.

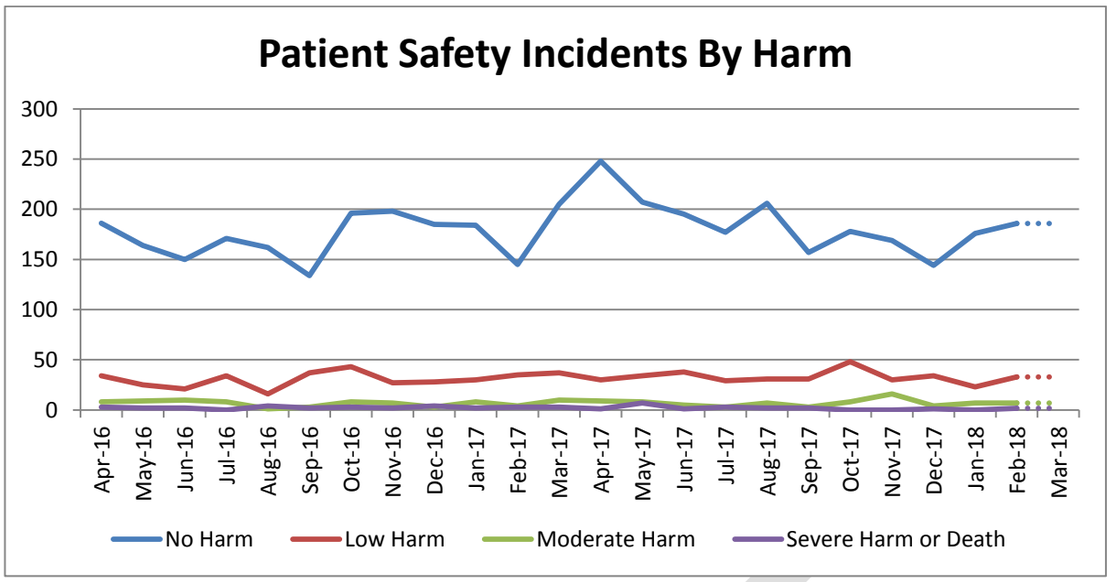
An overview of the quality of care offered by the NHS foundation trust: Key indicators of safety, effectiveness and patient experience

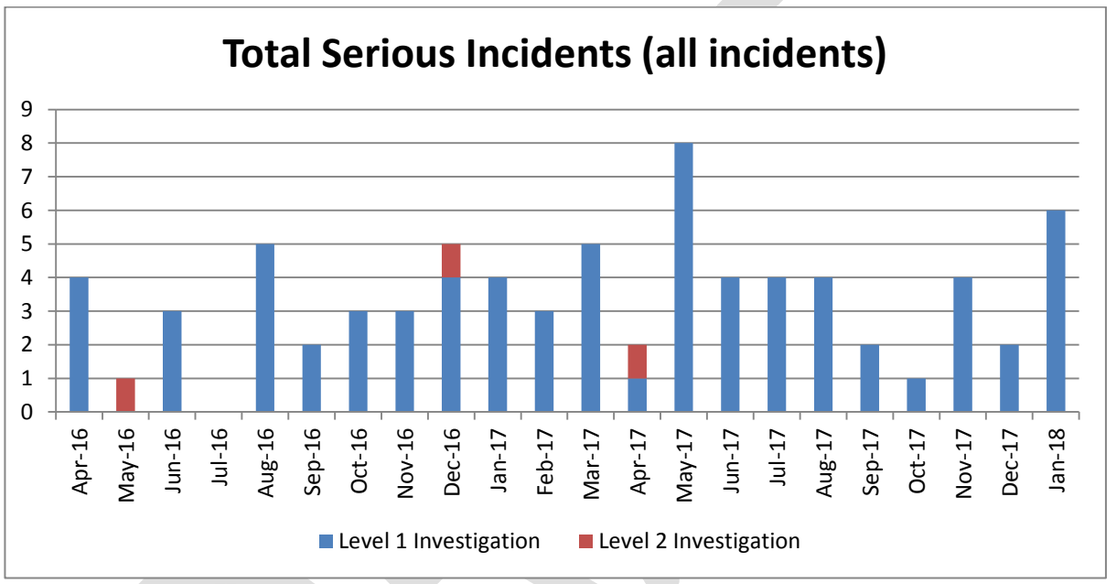
Patient safety

Overall incident reporting rates have remained consistent when compared to the previous year. Less than half (45%) of the total number of incidents reported are classified as a patient safety incidents and this proportion is also consistent with the previous year. The majority (82%) of patient safety incidents reported resulted in no harm and only a small fraction (less than 1%) of patient safety incidents resulted in severe harm.

The number of serious incidents has also remained consistent when compared to the previous year.

Incidents:

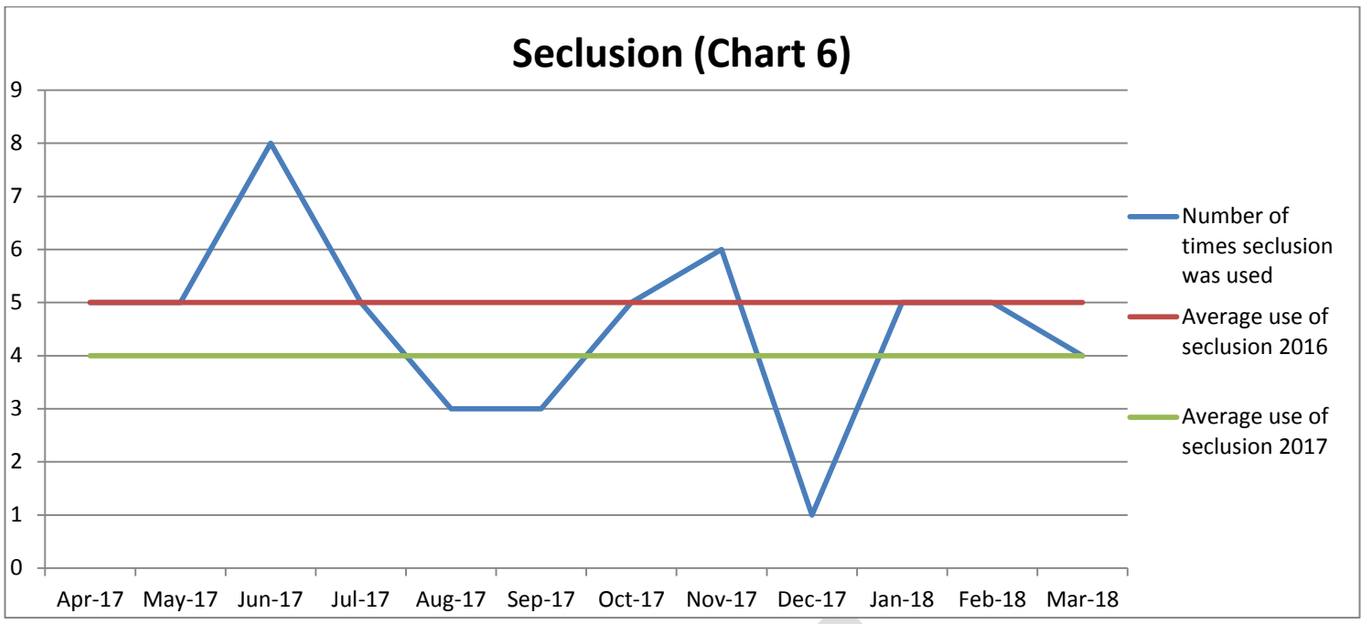




Seclusion:

There continues to be a sustained reduction in the use of seclusion in 2018 and the aim is to maintain that position. The following key points for seclusion in 2017are stated below:

- Seclusion use increased by 4%
- The digital seclusion form has now been initiated, this will allow us to fully audit all seclusions and improve practice around seclusion



Patient experience indicators

Friends and Family Tests (FFT) responses have improved. However we need to continue to increase the response rate. The patient experience strategy is being refreshed to provide new impetus and influence the response rate.

FFT 2016/17 - 2017/18

Financial Year	2016/17				2017/18			
Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
FFT Responses	516	470	697	789	662	860	645	525
% Recommend	88%	92%	89%	89%	90%	91%	89%	94%

Community Mental Health Service User Survey

Survey Year	2016/17	2017/18
Overall Experience Score	68%	72%

Complaints

Survey Year	2016/17	2017/18
Number of complaints	172	127

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Clinical effectiveness

Financial Year	2016/17				2017/18			
Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Bed Occupancy	98.8%	99.1%	98.4%	99.0%	99.1%	97.1%	97.7%	96.7%

Financial Year	2016/17				2017/18			
Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Assessment ward LOS	13.6	14.5	12.6	10.8	12.7	12.0	13.6	15.2

	Area	Target	2017/18			
			Q1	Q2	Q3	Q4
Emergency Psychiatric Re-admission (30 days)	Camden	<6.2%	6.1%	9.7%	9.6%	7.5%
	Islington	<10%	9.9%	11.8%	8.1%	11.5%

	Area	Target	2017/18			
			Q1	Q2	Q3	Q4
Emergency Psychiatric Re-admission (90 days)	Camden	<6.2%	14.2%	19.0%	18.6%	**
	Islington	<10%	23.8%	23.0%	17.6%	**

	Area	Target	2017/18			
			Q1	Q2	Q3	Q4
Emergency Psychiatric Re-admission (30 days)	Trust	<6.2%	7.2%	10.0%	8.6%	8.7%

	Area	Target	2017/18			
			Q1	Q2	Q3	Q4
Emergency Psychiatric Re-admission (90 days)	Trust	<10%	18.0%	20.7%	17.0%	**

**** Q4 figures will not be available until 90 days after the end of the reporting period (July 2018)**

Participation in clinical audits

National audits

In 2017-2018 the following nationally mandated clinical audits were applicable to Camden and Islington NHS Foundation Trust:

a) The Prescribing Observatory for Mental Health (POMH-UK) facilitates national audit-based quality improvement programmes open to all specialist mental health services in the UK. The results for different audits will be published intermittently throughout the year based on the POMH–UK schedule
b) The National Clinical Audit of Schizophrenia
c) The Early Intervention in Psychosis Audit (AEIP).
d) The National Audit of Intermediate Care

The Trust will continue to participate in the next round of POMH-UK audits in line with the schedule. Results of completed audits will be reviewed once published and improvements to prescribing practices Implemented in line with recommendations. Audit results will also be disseminated locally to share Learning.

The table below summarises the national audits that the Trust participated in, the data collection periods and the number of cases submitted for each one:

Audit Title	Data Collection Period	Number of cases submitted	Actions
Topic 17a Use of depot/LA anti-psychotic injections for relapse prevention	May-17	140	Guidance and support are provided to ensure appropriate prescribing
Topic 15b - Prescribing valproate for bipolar disorder	Oct-17	82	Guidance and support are provided to ensure appropriate prescribing
Topic 16b - Rapid Tranquilisation	Mar-18	In progress	Guidance and support are provided to ensure safe practice
National Clinical Audit of Psychosis	Nov-17	70	Reflected in improvements planned as part of the clinical strategy
EIPN	February -18	Camden 248 Islington 182	Reflected in improvements planned as part of the clinical strategy
National Audit of Intermediate Care	Jun-17	Service based questionnaire	This report highlights the organisation's position on a number of key metrics across home, bed, re-ablement0 and crisis response.

Local audits

In 2017-2018 the Trust participated in a number of local audits both through divisional led audits and the quarterly balanced scorecard. The Trust also introduced a number of compliance audits including Care Planning and NEWS audits.

In July 2017 the Trust held a clinical audit event at St Pancras Hospital. There were eleven entries across the Trust from a varying group of professions and specialties including, pharmacy and psychology. The topics included the use of antidepressants in pregnant women, NEWS monitoring and prescribing of Pregabalin. The winning audit was conducted on Rosewood Ward looking at information given and requested regarding contraception.

Actions taken in response to local audits

Audit participants are encouraged to share the learning with relevant teams and services. This often occurs at local team meetings and divisional quality forums. Trust wide compliance audits are generally linked to particular committees and reported there. For example pharmacy and POMH audits are discussed at the Trusts Drugs and Therapeutics Committee (DTC) and Ligature Risk audits are discussed

and reported within the Safe Environment Group.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - 2017/18

Young People's Mental Health

The Trust participated in the Young People's Mental Health Study in 2017-2018. The aim of the study is to identify any remediable factors in the quality of care provided to young people who are treated for depression, anxiety, eating disorders and self harm. The study examines the transition of care and look at the interface of different care settings.

During 2017/18 hospitals were eligible to enter data in up to 5 NCEPOD studies.

Below is the table of questionnaires submitted for Camden and Islington.

	Cases included	Cases Excluded	Clinical Questionnaire returned*	Excluded Clinical Questionnaires Returned *	Case notes returned *	Excluded care note returned *	Organisational Questionnaire Requested*	Organisational questionnaire returned *
Admission Questionnaire	9	2	8	1	7	1	2	1

*** Number of questionnaires/case notes returned including blank returns with a valid reason, questionnaires marked "not applicable", and case notes missing with a valid reason.**

Participation in National Confidential Enquires

Audit Title	Data Collection Period	Survey requests
Homicide	17/18	0
Suicide	17/18	13

Findings from confidential enquiries inform the work on prevention on deaths

Participation in clinical research

The Trust continues to have a strong track record of participating in clinical research and is the highest recruiting mental health Trust in the North Thames region. Recruiting 1,310 participants from 36 research studies in 2017-18 **(Figures as at 25 April 2018).**

The Trusts continues to work closely and influence the strategic direction of the Clinical Research Network; North Thames. The Trust's Associate Director for Research and Development is the mental health specialty lead for the region.

Below is a table of the top 5 recruitment studies and a graph of the actual recruitment against the target recruitment for the year 2017/18

Fig 1 Table of the top 5 recruiting studies for the 17/18 FY

CandI top recruiting NIHR Portfolio studies FY17/18

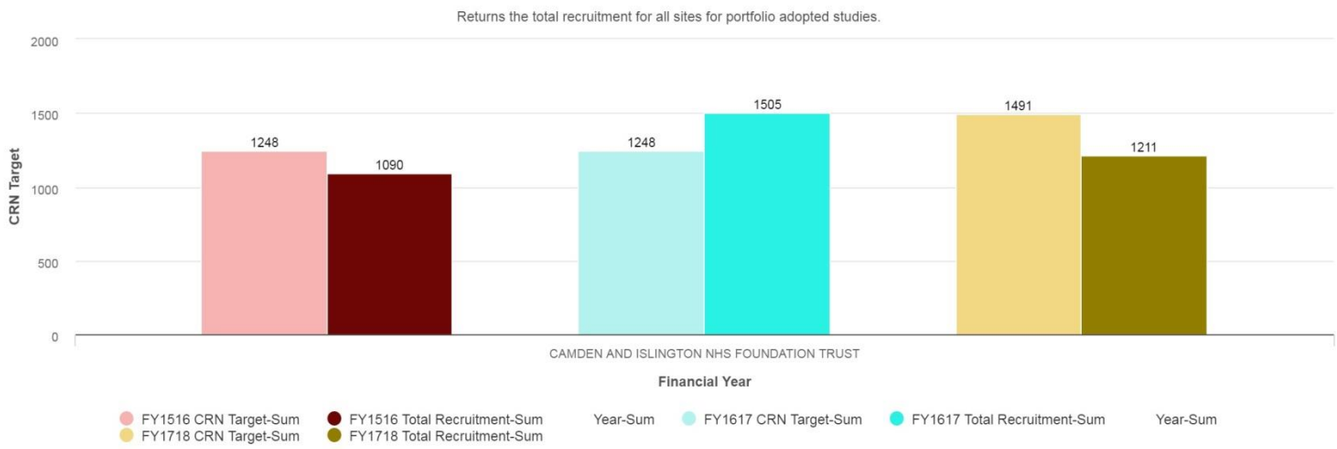
FY1718 Recruitment Rank	IRAS ID	Study - UKCRN ID	Study Name	Local Investigator	FY1718 Recruitment Grand Total
1	151423	17341	MARQUE: Improving agitation in people with dementia in care homes	Gill Livingston	416
2	191878	20643	Lifestyle Health and Wellbeing Survey	David Osborn	160
3	187558	20198	Measurement of quality of life in carers of people with dementia	Gill Livingston	128
4	201627	33093	Acute Day Units as Crisis Alternatives to Residential Care (AD-CARE)	David Osborn	87
5	226973	36377	Managing Agitation and Raising QUality of LifE (MARQUE): feasibility trial of an intervention to improve the management of agitation in severe dementia	Gill Livingston	61

1211 participants recruited for C&I Adopted studies during 2017-18*

This recruitment came from 34 different studies*

***= This data was cut from the open data platform (ODP) platform on March 29th 2018. Recruitment figures will not be 100% accurate on the ODP platform until April 20th 2018**

Fig 2 Actual recruitment vs the target recruitment graph.



Institute of Mental Health (IoMH)

A programme of research seminars has taken place throughout 2017-18, highlighting clinical areas of importance such as the management of treatment resistant depression, Psychological Therapies - Research, Practice and Policy and Advances in dementia in people with intellectual (learning) disabilities.

Biomedical Research Centre (BRC)

The Programme Director for the mental health theme of the BRC is Professor Rob Howard an old age psychiatrist in C&I. There has been the strategic development of three linked sub-themes over the past year:

1. Health informatics through linked clinical records, adoption of standardised outcome measures, biomarkers and genomics
2. Development and evaluation of new treatments
3. Precision medicine for mental health

There is a strong commitment from the BRC in partnership with C&I to building capacity through the support of early career clinical academic colleagues. The past year has seen £1M of investment into mental health research, giving eight awards to early career researchers, some of whom have been hosted and supported by C&I.

The Trust will continue to build on its strategy of developing key partnerships for example the development of a Patient Public Involvement (PPI) training programme, increasing access to high quality studies to its patients, as well as increasing the use of clinical data for research.

Quality and Innovation: the CQUIN Framework

The CQUINs agreed for 2017/18 between Camden and Islington Foundation Trust and our commissioners were in the following areas:

1. NHS staff health and well-being
2. Physical health
3. A&E
4. Transition
5. Risky behaviours

A proportion of Camden and Islington Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and local Clinical Commissioning Groups (CCGs). The income from the CQUIN
Schemes amount to £2.077 million total for income in 2017/8 conditional on achieving all quality improvement and innovation goals.

The monetary total for the associated payment in 2016/17 was:

- CQUIN total value - £ 2,031,851

CQUIN achievement - £1,627,567 (subject to confirmation by CCGs).

The table below summarises how the Trust has fared in delivering its CQUIN targets:

Indicator	Q1	Q2	Q3	Q4
NHS staff health and well-being				
1a Improvement of health and wellbeing of NHS staff 5 % improvement in two of the three NHS annual staff survey questions on health and wellbeing, musculoskeletal problems (MSK) and stress.	N/A	N/A	N/A	Not Met
1b Healthy food for NHS staff, visitors and patients Submitting data on the food suppliers operating on NHS premises and taking action in seven areas including: Banning price promotions, advertisements and sale at checkouts of food and drink high in fat, salt, sugar and saturates as well as ensuring healthy options are available for staff at night. Increase in sugar free drinks and calorie limits of pre-packaged meals, sweets and confectionary.	Met	N/A	N/A	Met
1.3 Improving the uptake of flu vaccinations for frontline clinical staff Achieving an uptake of flu vaccinations by frontline healthcare workers.	N/A	N/A	N/A	Partially Met
Physical Health				
3a Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychosis Demonstrating cardio metabolic assessment and treatment for patients with psychosis in the following areas: inpatient wards, early intervention psychosis services, Community Mental Health Services patients on care plan approach (CPA).	Met	N/A	N/A	Results will be available in June 18

3b Improving Physical Healthcare to reduce premature mortality in people with SMI: Collaboration with Primary Care Clinicians An updated CPA care plan or a comprehensive discharge summary to be shared with the GP.	N/A	Met	N/A	Partially Met
A&E				
4. Improving Services for people with mental health needs who present to A&E Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.	Met	Met	Met	Met
Transition				
5. Transitions out of Children and Young People's Mental Health Services (CYPMHS) This CQUIN aims to incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS).	Met	Met	N/A	Met
Risky Behaviours				
9a Preventing ill health by risky behaviours - Tobacco screening. Admitted patients receive a tobacco screen with results recorded.	Met	Met	Not Met	Not Met
9b Preventing ill health by risky behaviours - Tobacco brief advice Admitted patients who smoke are given very brief advice.	Met	Met	Not Met	Partially Met
9c Preventing ill health by risky behaviours - Tobacco referral and medication Admitted patients who smoke are offered a referral to stop smoking services and stop smoking medication.	Met	Met	Not Met	Not Met
9d- Preventing ill health by risky behaviours - alcohol screening Admitted patients are screened for alcohol drinking risk levels.	Met	Met	Not Met	Not Met
9e - Preventing ill health by risky behaviours - alcohol brief advice or referral Admitted patients who drink alcohol above lower-risk levels and are given brief advice or offered a specialist referral.	Met	Met	Not Met	Partially Met

Care Quality Commission (CQC)

Registration:

CQC register Camden and Islington NHS Foundation Trust services to carry out the following legally regulated activities.

Accommodation for persons who require nursing or personal care Stacey Street Nursing Home

Treatment of disease, disorder or injury St Pancras Hospital Stacey Street Nursing Home Highgate Mental Health Centre

Assessment or medical treatment for persons detained under the 1983 Act Registered services St Pancras Hospital Highgate Mental Health Centre

Diagnostic and screening procedures Stacey Street Nursing Home Highgate Mental Health Centre

Participation in reviews and

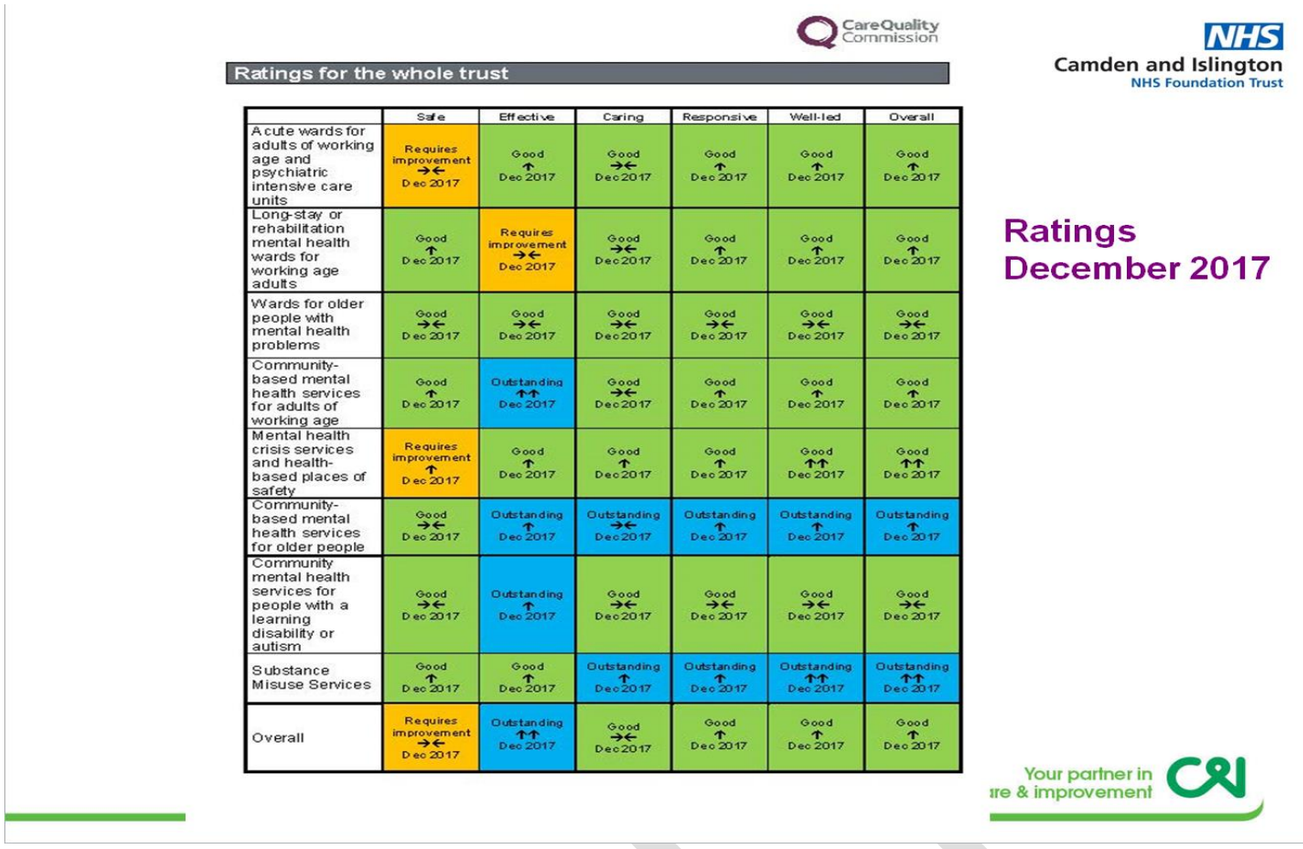
investigations CQC inspections

The Trust recently participated in a full inspection by Care Quality Commission in December 2017. The report was published in March 2018. Overall it rated the Trust as **Good**.

Ratings

Overall rating for this trust	Good
Are services safe?	**Requires improvement**
Are services effective?	**Outstanding**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.



	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Dec 2017	Good ↑ Dec 2017	Good →← Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017
Long-stay or rehabilitation mental health wards for working age adults	Good ↑ Dec 2017	Requires improvement →← Dec 2017	Good →← Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017
Wards for older people with mental health problems	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017
Community-based mental health services for adults of working age	Good ↑ Dec 2017	Outstanding ↑↑ Dec 2017	Good →← Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017
Mental health crisis services and health-based places of safety	Requires improvement ↑ Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017	Good ↑↑ Dec 2017	Good ↑↑ Dec 2017
Community-based mental health services for older people	Good →← Dec 2017	Outstanding ↑ Dec 2017	Outstanding →← Dec 2017	Outstanding ↑ Dec 2017	Outstanding ↑ Dec 2017	Outstanding ↑ Dec 2017
Community mental health services for people with a learning disability or autism	Good →← Dec 2017	Outstanding ↑ Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017
Substance Misuse Services	Good ↑ Dec 2017	Good ↑ Dec 2017	Outstanding ↑ Dec 2017	Outstanding ↑ Dec 2017	Outstanding ↑↑ Dec 2017	Outstanding ↑↑ Dec 2017
Overall	Requires improvement →← Dec 2017	Outstanding ↑↑ Dec 2017	Good →← Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017

CQC Achievements

We achieved 'Outstanding' in Substance Misuse Services, Community-based Older People Services and for effective Services across the Trust

Our clinical strategy, cultural pillars and engagement activities across the Trust collectively and with Service Users involvement were highly commended. Our research and innovation into practice was noted as really standing out.

The CQC has viewed us as having made a great deal of progress compared to the last inspection in February 2016.

We still have some challenges around staffing training and our Health Based Place of Safety (HBPoS) environments. We are getting on top of mandatory training by making it one of our key priorities and ensuring that risk assessment and care planning are of the highest quality, to meet the needs of our patients. However, we understand our challenges in other areas and have robust plans to address them. Our continued work together to ensure Quality Improvement is supported, everyone is engaged and locally people can make the necessary changes they want to facilitate our ongoing success.

Below is a table of our 'must do' as a result of the CQC inspection relating to the issues and we intend to take those actions to address the requirements reported by the CQC.

Must do Action required	Summary of key actions we are taking
The trust must ensure that the completion of mandatory training relating to patient safety reaches the trust target as a priority	The Trust must ensure that it reaches 80% compliance with mandatory training. The workforce plan is currently in place and extra capacity has been purchased
The trust must ensure that it employs sufficient staff to ensure that the shifts are covered, patients have access to regular 1:1 time with their named member of staff and that escorted leave takes place as planned	Audit to be completed regarding 1:1 supervision
The service must ensure that staff consistently complete comprehensive records after all incidents that involve	Monthly restraint audit to be completed

staff restraining patients	
The service must ensure that staff take all reasonable steps to ensure that physical health checks are carried out and recorded after patients receive rapid tranquilisation	Physical healthcare Matron to complete an audit of current practice. The Trust is currently completing a POMH Audit that looks at Rapid Tranquilisation
The trust must ensure that appropriate models of care are in place in all services across the trust to promote active rehabilitation including opportunities to develop skills to promote more independent living and access to community services	Appropriate scoping exercise to be completed and action plan developed by Divisional Director
The trust must ensure that patients on inpatient rehabilitation wards have access to sufficient occupational therapy input	Appropriate scoping exercise to be completed and action plan developed by Head of Occupational Therapy
The trust must take action to address high caseloads, and individual workloads for staff in the Islington CRHT, and the high turnover of staff across the CRHTs	Appropriate scoping exercise to be completed and action plan developed by the Associate Divisional Director

The Trust will continue to working closely with commissioners and the CQC to further progress our improvements in the next 6 months.

Mental Health Act monitoring visits
Mental Health Act Monitoring Visits
Each of our inpatient wards receives an unannounced visit from the CQC every 18 months as part of its regular cycle of MHA monitoring visits. In 2017-18 the following eight wards received a visit:

Domain Area	Laffan	Garnet	Sapphire	Topaz	Opal	Coral	Emerald	Dunkley
Care Plans								
S132 Rights								
S17Leave of absence								
Consent to Treatment								
General Healthcare								

Keys:

	Statutory requirements met
	Improvement required

Where recommendations were made by the CQC, the relevant division completed an action plan that is monitored by the Trust Mental Health Law Committee.

Data quality

The ICT department (Information and Clinical Applications Teams) continue to work to monitor and improve data quality by a variety of methods, including:

- A wider range of data quality reporting, including a particular focus on Ward Stays (Inpatient Episodes). This has benefitted from a closer working relationship between the Information Team and the Acute Division.
- Reconfiguration of the Carenotes Electronic Patient Record (EPR) to drive improved data quality – e.g. Restricting unnecessary ward edits, simplification of processes via the Carenotes Revamp project.

Our Mental Health Services Data Set (MHSDS) and improving access to psychological therapies (IAPT) submissions provide a wide range of quantitative and qualitative information about the services that the Trust offers. The Data Quality Maturity Index derived by NHS Digital for these submissions shows:

- The NHS Number has been recorded for 99.2% of our patients,
- GP details are recorded against 99.9% of our patients

It is hoped that the latest version of the Carenotes EPR will further improve the data quality by linking directly to the NHS Spine to lookup any changes to patients' addresses, GPs and other key demographic fields.

A new version of the MHSDS submission criteria has recently been implemented, so data quality is in focus. A new suite of MHSDS quality assurance reports are planned.

Clinical coding

Camden and Islington Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Information Governance Toolkit

Information Governance (IG) is about how NHS and social care organisations and individuals handle information.

The Information Governance Toolkit is a performance tool produced by NHS Digital. It draws together the regulations and central guidance related to information governance and presents them as one set of information governance requirements. For the 2017/18 submission, C&I's overall score was 81%, rated as a pass (green).

The Trust continually reviews its information governance framework to ensure all personal and medical information is managed, handled and disclosed in accordance with the law and best practice. The Trust is also in the process of ensuring General Data Protection Regulation compliance and has updated its fair processing notice.

In addition we attach great importance to training, data quality and clinical records management. As a result, we have seen improvements across the Trust.

Reporting against core indicators –

7 Day Follow up:

Indicator	2017/18	National Target	Top performer	Worst Performer	2016/17	2015/16
Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay	99.1% (Q4)	95%	100% (Q4)	68.8% (Q4)	96.3% (Q4)	95.2% (Q4)

Camden and Islington Foundation Trust considers this data is as described for the following reasons - performance is monitored via the a daily audit of the Trust's Business Intelligence systems which reports all discharges so that local performance teams can track patients who have or have not been followed up. Clinicians are alerted to those patients requiring follow up, ensuring focused and informed actions are taken.

Camden and Islington intends to maintain the high performance for this indicator, and the following actions to improve this are undertaken by upholding the CPA policy operational delivery of follow up contacts, publishing and sharing this information each month at Divisional Performance meetings and discussing this indicator at local management and team meetings.

Gatekeeping:

Indicator	2017/18	National Target	Top performer	Worst Performer	2016/17	2015/16
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	98.0% (Q4)	95%	100% (Q4)	88.7% (Q4)	100% (Q4)	98.8% (Q4)

Camden and Islington Foundation Trust considers this data to be as described for the following reasons - performance is monitored locally via the Trust's Business Intelligence systems which identifies all patients who were admitted with access to Crisis resolution Teams. The Trust supports staff with ongoing information on business rules ensuring activity is recorded and captured accurately.

Camden and Islington continues to meet the national target for this indicator and intends to take the following actions to improve the percentage score, and so the quality of its services, by developing robust systems to closely monitor this activity and alerts teams to any deterioration in performance.

Readmissions:

Indicator	2017/18	National Target	Top performer	Worst Performer	2016/17	2015/16
Proportion of emergency psychiatric re-admissions within 30 days.	8.7% (Q4)	<6.2%	N/A	N/A	7.2% (Q4)*	7.0%(Q4)*

Camden and Islington considers the data to be as described due to the following reasons - we have made further improvements too our electronic patient record system to ensure robust reporting systems are in place and have validation processes that assures data quality improvements. No comparable national benchmarking data has been available; please note that recovery data prior to 2017/18 is reflective of readmissions within 28 days instead of 30.

Camden and Islington Trust has not always achieved this target and intends to take the following action to improve this indicator, and so improve the quality of its services by auditing reasons for readmission, enhancing the quality of discharge planning documentation and share the lessons learned at operational management meetings and quality forums. We aim to continue to monitor and report on this indicator routinely to all relevant areas across the Trust.

Patient Experience of Community Mental Health:

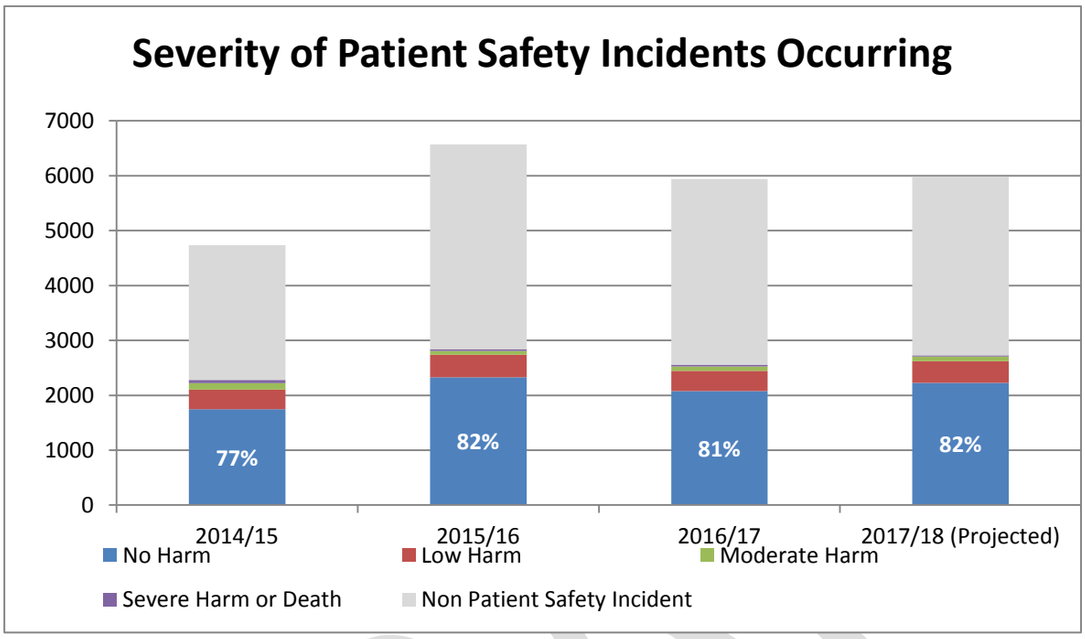
Indicator	2017/18	National Target	Top performer	Worst Performer	2016/17	2015/16
The trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	7.9	N/A	8.1	6.4	7.3	7.5

Camden and Islington considers the data to be as described due to the following reasons - the national Community Mental Health survey is compulsory for all Trusts. The data for this indicator is provided by the CQC and Department of Health.

Camden and Islington was reported as a high performing Trust in this area and plans take the following actions to further improve the percentage score, and so the quality of its services, by developing robust local systems to closely monitor this activity at increased frequencies and alert teams to any deterioration in performance.

Patient safety incidents and the percentage that resulted in severe harm or death

Camden and Islington considers the data to be as described due to the following reasons - the data for this indicator is derived from Datix our internal patient safety software. The majority (82%) of patient safety incidents reported result in no harm and only a small fraction (less than 1%) of patient safety incidents resulted in severe harm. The Trust is committed to implementing a process to learn from serious incidents.



Our achievements in quality improvement

Integrated Practice Unit

For the last two years the Trust has been developing innovative ways of treating service users' physical and mental health care together.

As part of this work, our Community teams have been focusing on the 3,000 service users with psychosis, in order to reduce the high number of early deaths in this vulnerable group, compared with the general population.

Key targets for this award-winning initiative – known formally as our "Integrated Practice Unit (IPU) for Psychosis" – are reducing smoking and the prevalence of Type 2 diabetes. This has entailed detailed physical health screening of service users, additional physical health training for staff and extending our wellbeing clinics network.

Last year, just over 1,000 service user questionnaires were sent out to our Community teams, with a range of questions about health and care-related issues, for instance on leisure activities, satisfaction with symptom control, access to crisis services, and prevalence of alcohol and drug misuse.

Overall, 69% of the 470 service users who responded were satisfied with the quality of their life.

This year, we aim to get even more feedback and we will send 1,300 questionnaires to relevant teams, including 400 to our GP colleagues.

Ruby Ward

Our new Women's Psychiatric Intensive Care Unit – opened at the end of 2017 after a three month collaboration involving service users, clinical and operational staff, and colleagues in Facilities.
It is the only such unit in north central London and offers 24-hour care and support to women with the most severe psychiatric needs across Camden and Islington, as well as Barnet, Enfield and Haringey.

Named Ruby after a survey of service users and staff, it provides tailored, intensive treatment much closer to home, so service users no longer have to go out of borough and away from their families and loved ones to get specialist care of this kind.
Based on the ground floor of the Huntley Centre on our St Pancras site, the unit, offers clinical approaches that are specifically tailored to caring for women with severe mental health conditions.
This includes women service users being much more closely involved in their own care, receiving therapy that meets the particular needs of women. The aim is to support recovery and movement into a less restrictive setting as quickly as possible.
Additional capacity is offered through the innovative Extra Care Area that provides a specialist low stimulus space and is a calming environment for women when they feel stressed, with colour, lighting and music individually tailored to their preference.

Risk management

The Trust has an established process for managing risk and detecting and responding to quality concerns. Each division has a risk register that is monitored regularly to ensure any risks that cannot be managed within the division are escalated to the corporate risk register. The risk management strategy is reviewed annually, with the Audit and Risk Committee having oversight of this process.

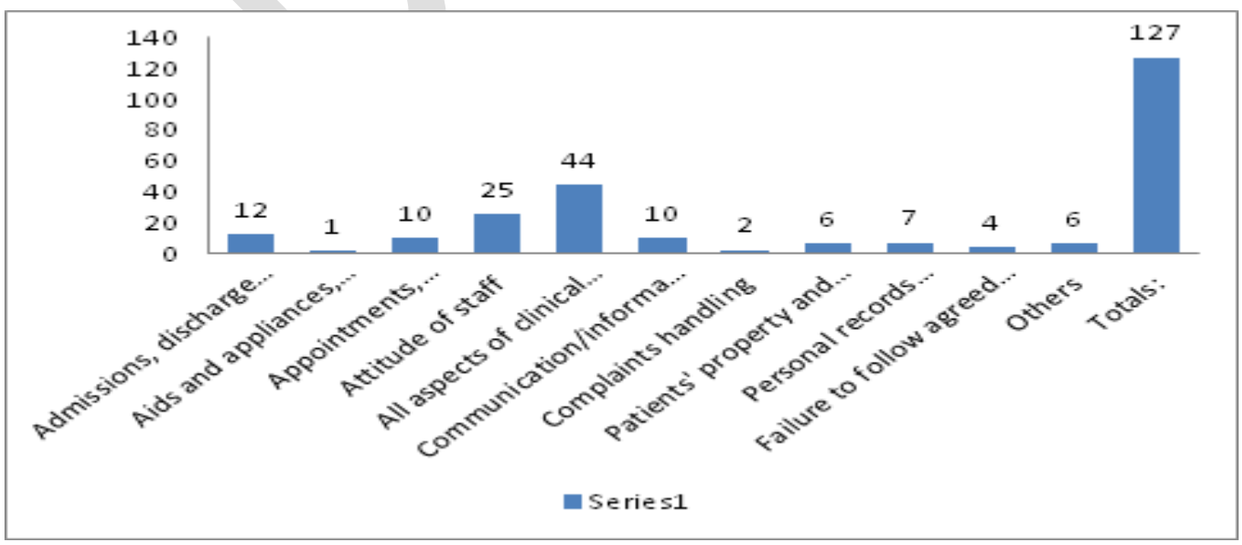
The most recent internal audit of risk management concluded that the Trust has a well-designed process for identifying strategic risk and escalating concerns for review. In 2017-18 the Trust further strengthened its operational and strategic risk management processes to help it identify significant risks and take appropriate action.

A regular divisional risk scrutiny process has been introduced which allows for in-depth scrutiny of the divisional risk registers in parallel. This process supports consistency of reporting and risk scoring as well as ensuring appropriate challenge is applied across all risk registers. The Audit and Risk Committee undertakes regular “deep dive” analysis into key areas of risks to enable scrutiny of risk trajectories and whether appropriate mitigating actions have been identified to manage the risk. In addition, the process for managing the Board Assurance Framework (BAF) has been redrafted in order to create a more useful and clearer assurance tool, with regular updates to the Board.

Complaints

The Trust received significantly fewer formal complaints this year than last year: There were 127 formal complaints compared to 172 in 2016/17. In addition, 211 concerns received via the Advice and Complaints Service were resolved informally. Of course, this only represents a proportion of the issues that staff resolve directly with service users on a daily basis Acute division received the most complaints, followed by Community Mental Health. Complaint numbers in substance misuse services and services for older people remain low.

The chart below shows the different categories of complaint



The complaints received cover a wide variety of issues often quite specific to the individual’s care or experience and it is not always possible to identify common themes. However, the following issues have been noted to recur this year:

In Community Mental Health division, some services continue to have long waiting lists due to mismatch between demand for the service and available resources. Also noted in this division is the challenge of providing support to a cohort of people who, whilst having significant mental health needs, do not meet the criteria for any services that the Trust is currently able to offer. There are ongoing discussions with our commissioners as to how to address both these issues.

Across the Trust, and particularly in the Acute Division, issues regarding communication with service users and their carers/relatives are noted. In Recovery and Rehabilitation services, managing both service user and carer expectations about the level of input that the Trust is able to provide remains challenging.

This business year around 65% of complaints responded to were either fully or partially upheld. Generally we see around half of complaints being upheld, so this is a significant increase. It may be that as we continue to get better at resolving concerns informally, only the more serious and valid matters are going through formal process. The Trust is committed to using the feedback we receive through complaints to improve our services. All staff have a regular slot at their team meetings where any complaints can be discussed and reflected on. Complaints which are either partially or fully upheld will have an action plan to ensure that recommendations are implemented. Action plans are discussed and reviewed at divisional quality forums.

The Advice and Complaints Service produces a newsletter which includes changes made in response to complaints, ensuring this information is shared across the organisation. These newsletters are now produced jointly with the Serious Incident team so that learning from both processes can be coordinated. This reflects the new-style Complaints and Incidents board report which is now being produced monthly with an emphasis on identifying common themes in investigations. This year, we have also explored different ideas for sharing learning, including use of computer screensavers and roadshows which were held at both St Pancras and Highgate sites. The Trust website also identifies lessons learned from complaints with examples of actions taken, so service users and carers can be assured their feedback really does make a difference.

Below are some examples of improvements made in the last year as a result of the feedback from complaints:

- We appreciate how frustrating it can be for people trying to contact staff when telephones are not answered and messages are out of date. Posters have been produced and circulated giving clear instructions about how to update answerphone messages.
- Staff have been reminded to be proactive in welcoming visitors to wards and establishing their identity. Signing in books for visitors have been introduced.
- Measures have been taken to ensure that when contractors are working on the wards, staff are available to support them and ensure safekeeping of any equipment being used.
- Some of the standard correspondence used by teams has been reviewed to make it clearer.
- In teams where there are waiting lists, staff continue to review how best to keep service users engaged and informed during the waiting period.

The Trust target is for 80% or more of complaints to be responded to within timeframe. This target has remained challenging this year, with around 60% of complaints meeting deadlines. To support improvement in this area, the complaints policy has been reviewed with the aim of building more flexibility into the process and ensuring that complainants are kept fully updated on the progress of their complaints.

Under the new arrangements all complaints have a 25-day timeframe unless they are identified as being complex, in which case the timeframe will be negotiated individually with the complainant. Extensions for the 25-day timeframe can also be agreed with complainants where necessary and appropriate. Divisional leads have been reminded of the need to allocate investigators promptly and increased quality checks by the complaints manager have enabled the chief executive to sign responses off more quickly. In addition we have continued to encourage prompt informal resolution of concerns at team level wherever possible.

At the time of writing the complaints team are supporting the launch of the updated policy with training sessions for staff and roadshows are planned.

Since April 2017 we have been using our own custom designed survey to monitor satisfaction with our processes. Here are some of the results for the year to date:

-70% of respondents felt that their complaint was handled well or very well
-84% of respondents felt comfortable or very comfortable with the staff who dealt with their complaint
-76% of respondents felt that the response was clear on what action would be taken to address the issues they had raised.

Compliance with NICE guidance

The National Institute of Clinical Excellence (NICE) produces guidance from the people who are affected by our work. This includes health and social care professionals, patients and the public in addition to guidance from the Department of Health. It is based on best evidence and designed to promote good health while preventing ill health.

Each Month, NICE released new and updated guidance. This is circulated to the Clinical Directors and relevant Heads of Professions i.e. Pharmacy, to identify which, if any of the guidance is relevant to the Trust, Division or Department. Any relevant guidance identified (whether partial or in its entirety) a baseline assessment is completed and an action plan is created to close any gaps in compliance.

There are currently 66 relevant guidelines to date, that have been identified as applicable to the Trust. These cover both mental and physical health. The current compliance rate is 71%. The following table illustrates the current position on NICE Guidance in relation to the Trust is illustrated in the table below.

Division	Guidelines Applicable from 2011 – 2018	Outstanding Baseline assessments	Partially Implemented	Completed
Acute	*2*	*0*	*0*	*2*
R&R	*3*	*0*	*0*	*3*
CMH	*8*	*1*	*1*	*6*
SAMH	*11*	*0*	*0*	*11*
SMS	*6*	*0*	*1*	*5*
Trust	36	1	15	20
Total	*66*	*2*	*17*	*47*
			Overall Compliance	*71%*

The Trust now has a NICE Compliance Policy that covers the process and monitoring of NICE guidance within the organisation.

Key quality initiatives in 2017/18

Clinical effectiveness tools

The Trust has now developed one standard physical health screening tool. In the past there were several tools used by different services. By standardising the tool service users can now expect even better management of their physical health in the Trust. The new tool will also allow more detailed and consistent assessment of alcohol use and smoking as well as cardio metabolic health.
The Trust has introduced a new National Institute of Clinical Effectiveness (NICE) policy to support safe and effective care. The new NICE policy provides guidance for staff on assessment and implementation of NICE guidance. Monitoring of the new policy and NICE will be undertaken by the Trust Quality Governance Committee.

Flu Campaign

The Trust was successful in vaccination 60.01% of its staff against seasonal influenza this year. This is great achievement for the Trust and the staff who were at the forefront of the flu campaign who achieved just 29% last year. The planning for the new flu campaign will being in May 2018.

Red2Green

The Trust launched a new initiative called Red2Green. It uses a daily survey tool to ensure that our patients do not stay in hospital longer than they need to be and this also helps to alleviate some of the pressures on our teams. The tool helps our clinicians and staff to consider the steps that need to be taken to turn every Red day Green.

A Red day is a day of no value for a service user - where they do not get a planned assessment or therapy session; where their medical care plan lacks a consultant-approved date of discharge; or where their care plan does not include details of what needs to happen clinically for them to be safely

discharged

A Green day is a day when a patient receives care that brings them closer to being discharged, or where everything that is planned or requested gets done; or where a patient receives care that can only be given in a hospital bed

The tool has already launched across the Acute and SAMH wards, with plans for it to be rolled out more widely.

Accreditation for Inpatient Mental Health Services (AIMS)

The Accreditation is conducted by the Royal College of Psychiatrists. The focus on inpatient services is for the following reasons:

- Recent developments in mental health services have focused on community-based services. This has often led to a diluted focus on improving inpatient services.
- Recent research has found that service users often find admission to hospital a distressing experience, leading to increased social exclusion and isolation.
- An unremitting focus on the negative aspects of inpatient care has meant that the excellent work staff often do under difficult circumstances has gone unrecognised.

Five of our inpatient wards at Highgate Mental Health Centre have been awarded AIMS accreditation. Sapphire, Coral, Opal, Emerald and Jade Ward were all successful in securing the Royal College of Psychiatry accreditation.

AIMS assesses the quality of Care provided to service users, carers and their wider organisation and commissioners. It focuses on excellence, users, aligned with performance management and regulatory frameworks. It is locally owned and engages the multidisciplinary teams.

The teams have worked really hard to demonstrate a high quality of care provision and we share and celebrate their success.

Quality Improvement

In 2017 the Trust officially launched its QI programme. The Trust has a QI Hub led by Dr Frederik Johansson , Consultant Psychiatrist in our Acute Division, Crisis Services, who train and provide coaching to staff across the trust to use the QI Methodology and

Many staff have had the opportunity to do the IHI (Institute for Healthcare Improvement) training online.

The Trust has three key targets form improvement over the next 5 years:

- Reduce levels of avoidable patient harm
- Improve staff satisfaction so that we are in the top 20% of providers
- Improve patient experience so that we're in the top 20% of Mental Health providers for the Friends and Family Test

Several projects are already taking place across the trust and we hope to see the positive impact on our service users and staff.

Recovery College

The Trust continues to offer a range of free courses and workshops at its Recovery College in the grounds of St Pancras Hospital. The sessions are open to any adult from Camden and Islington – whether staff, user or member of the public.

All the courses are based on our recovery principles and topics include understanding mental and physical health conditions, well being, building self-confidence and returning to work or study.

All our sessions – which have been running since 2014 - are created and delivered by two tutors, working together as equal partners, with one offering an expertise based on personal experience and the other based on professional experience.

In the last year the College has introduced several new courses in our ever-evolving curriculum. These include Anger Management, LGBT & Mental Health –no stigma, no barriers, Singing for health and Understanding BME cultures and mental health.

In 2017/18 the Recovery College identified an opportunity in the wider community to sell courses to organisations and has now sold its first course (Building Resilience via Tree of Life) to St John of God

refugee hostel. To mark the third anniversary of Recovery College an article was published on 'Fluidity of Self' which can be accessed via this link: https://www.knowledgequarter.london/fluidity-of-self-a-way-to-connect-by-ksenija-kadic/

5. Additional Information as stipulated by NHS England

Equality and Diversity, Staff Engagement and Organisational Development

Staff survey 2017 results – comparison with 2016 results

Our top 5 key findings

- KF12 quality of appraisals. This indicator is measured on a scale of 1 -5 where 5 if high quality and 1 is low quality. In 2016 we scored 3.42 and in 2017 we scored 3.44. This score is higher than the national average for Mental Health Trusts in 2017 which is 3.22.

- KF6 the percentage of staff reporting good communication between senior management and staff has continued to improve for three years in a row, this is very encouraging – in 2015 it was at 35%, rising to 42% in 2016 and it now stands at 43% in 2017. There are a number of communication platforms in the Trust including the monthly CEO briefing and weekly Bulletins.

- KF29 shows a 3% rise in the percentage of staff reporting errors, near misses or incidents witnessed and is testament to a culture of safety. It also shows that our staff feel empowered to report incidents, in line with our cultural pillars. This finding also shows that the Trust is continuing to strengthen governance.
- KF9 shows a positive improvement in staff reporting effective team working compared to 2016 responses. Effective team working has a correlated to positive patient experience. This outcome also demonstrates our cultural pillars of being connected.

- KF7 is the only key finding that was in the Top 5 for 2017 but had not improved since 2016, percentage of staff able to contribute towards improvement at work. This has dipped by 1%. The Trust is actively rolling out quality improvement (QI) programmes that allow staff on the shop floor to lead on identifying and delivering improvement projects within their areas of work.

Our bottom 5 key findings

- KF25 percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public. A small improvement noted in the last 12 months from 39% in 2016 down to 37% in 2017. The Trust has a policy in place for supporting staff. The EAP and OH services are also open to staff for additional support. Increased engagement with local community is also planned in 2018/19.

- KF21 percentage of staff believing that the organization provides equal opportunities for career progression or promotion. There has been a disappointing decrease from 76% in 2016 to 74% in 2017, which is also significantly lower than the 2017 average for Mental Health Trusts which report 85%. Our Staff First Strategy has been revised and the progress the Trust is making in respect of Equality and Diversity agenda will contribute towards addressing this finding.

- KF20 percentage of staff experiencing discrimination at work. Despite being in the Trust's bottom five, KF20 has improved from 22% in 2016 to 21% in 2017. A number of initiatives are in place including 'Our Staff First' Strategy to address issues relating to discrimination and unfairness at work. The Freedom to Speak Up Guardian for the Trust has also been appointed. An e-learning module on Unconscious Bias will be rolled out across the Trust in 2018/19.

- KF17 percentage of staff feeling unwell due to work related stress. There has been a disappointing increase in KF17 in the last 12 months from 43% in 2016 to 46% in 2017. The national 2017 average for Mental Health Trusts stands at 42%. A focus on the wellbeing agenda co-delivered by PAM partners is planned in 2018/19.

- KF28 percentage of staff witnessing potentially harmful errors, near misses or incidents has remained the same at 29%; this is 2% above the national average for Mental Health Trusts. The Trust is putting in place actions to improve this finding.

Developments HR & OD

Unconscious Bias training for all recruiting managers

The Trust procured an eLearning module in 2017 and this tender was awarded to a company called

Sponge UK. The Learning and Organisational Development and Resourcing teams within HR are currently reviewing the contents on this module with a view to having the completed eLearning module developed and signed off and ready for use within the organisation by end of Q1 2018/19. In the meantime, a face to face training session continues to be delivered within the Trust. It is the expectation that the e-Learning module will have a wide reach

Recruitment drive to attract ethnic minority candidates and those classified under the 9 protected characteristics

Roles are being advertised on 'www.vericida.com' to attract and recruit BME and the above category of applicants. In December 2018, we renewed the contract with Vercida for a further 1 year until 31 December 2018. Vercida is a media outlet for BME community and will widen our reach.

In the 2017/18 we recruited a total of 344 staff that were new to the trust, out of the 344 we recruited, 89 were from BME backgrounds. 6 of our senior 8a+ posts were filled by BME staff members

Career clinics

The Trust runs a clinic for all staff to receive information and advice about their career. These sessions continue to be delivered on a weekly basis. To strengthen sessions, professional leads including Nursing are now also involved in the delivery of these sessions alongside HR colleagues

Internal promotions

The trust had a total of 102 internal promotions (which went through a recruitment process) in the 2017/18 financial year, out of these 23 were for BME staff. From the 23 BME staff promoted 2 was for staff members in band 8a+ positions. The Trust Key Performance Indicator for BME Staff in senior roles is 15% and we are currently at 16%. For 2018/19 the target is set at 20%.

Staff Engagement

The Trust has launched its CandiConnect app to encourage staff discussion, touch points which include new joiners and Staff FFT. It would also be used for our NHS Staff survey along with exit interviews. Staff will receive birthday/anniversary messages. Essentially, it would be used as an innovation hub, social space and for health and wellbeing support.

The Chief Executive regularly meets with staff in scheduled forums which is our 'News and Views' platform. Staff gets to ask questions or make suggestions which the Chief Executive takes back for consideration to improve services and/or improve staff experience.

Learning from Death

	Prescribed information	Comments
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	Total 185* Q1- 90 Q2- 95
27.2	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.	Case Reviews Q1-25 Q2-20 SI investigation Q1- 8 Q2- 6
27.3	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.	The avoidability scale developed by the Royal College of Physicians has been incorporated into the Trust's Case Record Review Process. This scale scores from 1-6 with scores Scores 1-3 confirm that the investigator and review panels (SI and MRG) agreed that the death was definitely avoidable, strong evidence of avoidability or probably avoidable. Q1- 1 death scored as <=3 Q2- 2 deaths scored as <=3
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.	

Quarter 1:
Strong evidence of avoidability was found for one death during the first quarter of this year:
The service user was open to SAMH Islington Community Mental Health Team. He was found dead at home.
The review and investigation found:
There had been no known professional contact with him for the 21 days prior to the discovery of his death. At the time of his death he was living alone in poor domestic conditions and had lapsed treatment for a number of serious physical health conditions. Prior to this, concerns had been expressed about deterioration in his physical and mental health and by emergency services who had attended him.
The investigation found there was no single omission or decision that resulted in his death. His death may or may not have been preventable through medical intervention. However he died at home, untreated and in poor domestic conditions therefore a number of learning points and actions were recommended:

- Community teams need to ensure there is a plan to follow up service users while they are waiting for a Mental Health Act assessment, and in addition to consider what family support may be available to service users. (this is a valuable learning point for many teams which is being shared Trust wide as part of the learning lesson communications during October)
- A standard should be developed jointly with the Police as to the maximum length of time service users in Camden & Islington, judged in need of a Mental Health Act assessment, should have to wait for this.
- Guidance should be provided for referring teams by the AMHP service on the completion of Police Risk Assessment.
- A meeting was convened with Adult Social Care in Islington, C&I and Whittington Health in order to consider the relevance of adult safeguarding processes in this case and sharing of information with agencies and families.

Quarter 2:
One death was found to have 'Strong evidence of avoidability' (2):
An inpatient under s2 of the Mental Health Act 1983 was found unresponsive by a healthcare assistant. An emergency was raised however the service user was pronounced dead by London Ambulance Service shortly after they arrived at the ward.
The review and investigation found:
As yet, a single root cause has not been found as the cause of death is not yet known. There were however several contributing factors that impacted on the management of the service users deteriorating physical health.
There appeared to be a lack of clarity and consistency regarding the monitoring of Ms XX's physical health. There were issues with the handover of information at the ward round on this day and on the evening of the death; the ward was short staffed due to sickness, which impacted on the staff capacity to monitor the service users status more assertively. The Service user had a severe and enduring mental health condition and she was suspicious and guarded toward mental health staff and hence reluctant to engage in discussion regarding her physical health needs. As a result, assessment and monitoring of her physical health was limited.
Learning

- Enhanced training and instruction needs to be provided to ward staff and medical staff on the appropriate use of the NEWS.
- Enhanced life support training for all inpatient staff, with regular practice drills to be embedded into core training regimes.
- To develop a process whereby wards with a reduction in staff due to sickness or absence at late notice are not required to undertake additional tasks, such as finding a replacement member of staff.

A QI project has been started on Emerald ward for NEWS with the Practice development team.
One death was found to be 'Probably avoidable' (3) during the second quarter of this year:
As service user was found dead on his sofa. This followed discharge The Royal Free Hospital, after remaining in an A&E department for 40 hours due to no beds being available. He had been admitted to hospital following a suicide attempt by overdose due to the inability to cope with physical health problems and pain.
The review and investigation found:
The lack of beds available within the wider London area meant the service user remained in A&E for an extended period of time, 40 hours. He was considered to be in a safe place, was informal hence was managed accordingly within the trust's bed management policy. A&E can be a busy, noisy and challenging place to be when mentally unwell. This may have prompted the service user to want to return home.

Documentation in service users care plan indicated that he should not be discharged from A&E once medically cleared. The investigation found that the staff member had not fully consulted the

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notes nor did he explore the documented risks identified by the doctor in A&E when the decision was made to informally admit the service user to an in-patient ward for his safety. Learning • Improved communication of bed pressures and waiting times during high demand periods is advised. • In cases such as this or when the plan for admission is reconsidered, a second opinion, i.e., discussion with manager or consultant is advisable. • In cases where a long bed wait is anticipated, there should be regular reviews of patients' mental state and need for admission, and documentation in notes of actions to take if patient wants to leave. Capacity should be assessed. • Ensure that all staff (bank and agency staff included) is made aware and familiar with the escalation protocol and that this is followed, with the actions documented in notes with times, contacts, actions. • Bank/agency/non-permanent members of staff should be provided with supervision as a minimum. Bank/agency/non-permanent members of staff competence to be addressed by the employing trust at regular intervals.		
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).	As stated above
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.	As stated above
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	0
27.8	An estimate of the number of deaths included in item 27.7 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, with an explanation of the methods used to assess this.	N/A
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	N/A

***Only quarter 1 and 2 data are available**

NHS Improvement Targets

In 2017/18 the Trust continued to be assessed on a quarterly basis to meet selected national standards for access and outcomes.

Single Oversight Framework

Service Performance Target	Target	Q1	Q2	Q3	Q4
CPA inpatient discharges followed up within seven days	95%	98.4%	95.5%	95.5%	99.1%
Proportion of admissions Gatekept by Crisis Resolution Teams	95%	99.6%	99.1%	99.2%	98.0%

Proportion of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral***	50%	76.1%	75.6%	77.4%	66.3%
Proportion of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral**	50%	83%	82.4%	85.1%	71.2%
MHSDS: Identifier metrics	95%	99.2%	99.3%	99.2%	99.2%
MHSDS: Priority Metrics	85%	86.5%	87.6%	88.3%	89.7%

*****Figures represent the proportion of both complete and incomplete pathways relating to this indicator. Compliance rates are submitted through a monthly Unify2 return.**

****Figures represent the proportion of completed pathways (completed within the reporting month)**

Improving access to psychological therapies (IAPT):
a) proportion of people completing treatment who move to recovery (from IAPT dataset)
b) waiting time to begin treatment (from IAPT minimum dataset):

IAPT Service Performance Indicator	Target	Area	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Waiting time to begin treatment within 6 weeks of referral	75%	Camden	84%	89%	85%	88%	88%	89%	87%	87%	87%	85%	83%	83%
		Islington	77%	87%	88%	96%	99%	84%	85%	88%	89%	90%	85%	87%
		Kingston	97%	97%	96%	98%	97%	95%	90%	91%	95%	95%	91%	91%
Waiting time to begin treatment within 18 weeks of referral	95%	Camden	98%	99%	99%	99%	100%	99%	98%	100%	98%	99%	96%	99%
		Islington	100%	100%	98%	99%	99%	99%	99%	99%	98%	100%	99%	99%
		Kingston	100%	99%	99%	100%	99%	100%	98%	97%	99%	99%	99%	98%
Proportion of people completing treatment who move to recovery	50%	Camden	50%	46%	52%	53%	55%	51%	50%	43%	41%	50%	47%	52%
		Islington	61%	46%	54%	48%	50%	47%	46%	47%	48%	52%	47%	57%
		Kingston	50%	50%	45%	42%	46%	45%	43%	46%	50%	57%	54%	56%

Inappropriate out-of-area placements for adult mental health services:
NB: Figures include Acute/PICU OAP placements:

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Inappropriate out-of-area placements for adult mental health services (Occupied Bed days):	1570	1208	2065	486

Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:
The Trust has developed a physical health screening tool to support staff in screening all patients and ensuring that they are assessed appropriately. The physical health policy and physical health initiatives provides guidance and further support for staff in all service areas.

Admissions to adult facilities of patients under 16 years old

No patients <16 within C&I

Admissions to adult facilities of patients under 16 years old
No patient in this group was admitted

6. Stakeholder involvement in Quality Accounts

The Trust's quality goals are co-developed with stakeholders and communicated within the Trust and the community it serves.

In order to finalise the selected Quality Priorities for 2018/19, the Trust carried out a survey to gather the views of patients, staff, Volunteers, Members, Governors and other stakeholders on what they feel the Trust needs to focus on to ensure ongoing improvements to the quality of care. The information from this survey is used to inform the development of the Quality Account.

A "long list" of potential priorities was developed using a range of sources including: quality and safety dashboards, various reports and feedback from Trust governance groups and patient groups.
Source of information included:

- Governance and management leads and groups
- Feedback received through user forums
- Commissioners and local authorities feedback
- Stakeholder consultation

7. Stakeholder Statements

Statement for Camden and Islington Foundation Trust 17/18 Quality Accounts

Commissioners' Statement

NHS Islington Clinical Commissioning Group (CCG) is responsible for the commissioning of Mental Health services from Camden and Islington NHS Foundation Trust on behalf of the population of Islington and all associate CCGs. In its capacity as lead co-ordinating commissioner the CCG welcomes the opportunity to provide a statement for the Camden and Islington NHS Foundation Trust Quality Account. The 2017/18 Quality Account has been reviewed within the CCG and by colleagues in NHS North East London Commissioning Support Unit.

Camden and Islington NHS Foundation Trust has engaged with the CCG to ensure that commissioner's views were considered and including that of associate commissioners.
We are pleased that our comments have been taken on board and incorporated into the Quality Account for 2018/19.

Commissioners reviewed the content of the Account and confirm that it complies with the prescribed information, form and content as set out by the Department of Health. We confirm that we have reviewed the information provided within the Account and have checked this against data sources available to us as part of existing contract/performance monitoring discussions. The data presented is accurate in relation to the services provided and represents a fair and balanced overview of the quality of care at Camden and Islington NHS Foundation Trust.

Over 2017/18 the CCG has further built upon the good working relationship that exists with Camden and Islington NHS Foundation Trust. In fostering a culture of openness and transparency and partnership continued progress has been made in providing assurance on the quality and performance of its services.

Camden and Islington NHS Foundation Trust was inspected by the Care Quality Commission in December 2017 and received an overall rating of 'Good'.

The CCG support the nine priorities identified by the Trust for 2018/19 which focus on:
Patient Safety
Priority 1 Promote safe and therapeutic ward environments by preventing violence
Priority 2 Provide comprehensive risk assessment
Priority 3 Ensure mandatory training targets are achieved

Patient Experience
Priority 4 Learning from deaths and serious incidents
Priority 5 Improved communication with Carers and families
Priority 6 Involve service users in the Trust's Quality Improvement Programme

Clinical Effectiveness

Priority 7 Engage service users and staff in suicide prevention strategies
Priority 8 Better involvement of service users in developing and reviewing their care plans
Priority 9 Improving physical health care

In addition to these nine priorities:
The CCG is looking forward to working with Camden and Islington NHS Foundation Trust as it implements the ambitious quality priorities set for 2018/19 and is keen to work with the Trust to strengthen:

- *Promotion of a safe and therapeutic ward environments by preventing violence*
- *Improvement in the use of a comprehensive risk assessment*
- *Reduction of poor health outcomes for people with serious mental illness*
- *Engagement with service users and staff in suicide prevention strategies.*
- *Better communication and involvement with families*
- *Improve privacy and dignity for those with mental health needs who present to A&E*
- *Better understanding of safeguarding and the Mental Capacity Act in the service of patient protection.*

We recognise that Camden and Islington have worked hard during 2017/18. The CCG will continue to foster an excellent working supportive relationship with the Trust. The CCG will continue to work towards greater collaboration and to provide the support and constructive challenge required.

The CCG look forward to working with the Trust during 2018/19 to support the delivery of the quality account priorities and CQC improvement actions.

Chief Operating Officer
NHS Islington Clinical Commissioning Group

Statement received on 25 May 2018
The Trust would like to thank commissioners for their response and comments and helpful feedback on the report. We look forward to working with them on quality and safety in the forthcoming year.

Comments from Camden Council

'The Camden Health and Adult Social Care Scrutiny Committee regrets that due to the local elections and the new Committee not meeting until July 2018, it is unable to formally review and comment on quality accounts this year. The Committee looks forward to receiving and commenting on the trust's 2018/19 quality account.'
Received: 15 May 2018

Comments from Islington Council

'The Islington Health and Care Scrutiny Committee regrets that due to the local elections and the new Committee not meeting until June 2018, it is unable to formally review and comment on quality accounts this year. The Committee looks forward to receiving and commenting on the trust's 2018/19 quality account.'
Received: 21 May 2018

Comments from Healthwatch Camden

"Healthwatch Camden congratulates Camden & Islington NHS Trust on the improvements in service quality that have taken place over the past year, which have been recognised in an improved CQC rating. We note there is still more to do on reducing violent incidents, and we hope that this receives strong focus in the coming year.

We are pleased to see a commitment to increasing service user involvement and better involvement of families. The Trust has responded positively to the lessons from our report on managing service change and we believe the Trust is working hard to involve service users in planned changes at the St Pancras site. We think that the same principles apply to service user involvement in other areas of work such as suicide prevention – being honest, consistent and treating service users' views seriously, because they are often very good predictors of what will happen."

We are keeping our comments short this year, which is no reflection on the Trust, simply an indication of the weight of work we are under.

Received: 4 May 2018

Comments from Healthwatch Islington

"We are pleased to have engaged with the Trust and patients around opportunities for decreasing waiting times for ADHD services.

We hope that the Trust can develop a meaningful and inclusive programme of engagement around the potential changes to its site and services over the coming months.

We note their improved CQC rating and the improvements made which have enabled the Trust to achieve this".
Received: 8 May 2018

The Trust would like to thank Healthwatch Camden, Healthwatch Islington, Islington Council and Camden Council for their response and comments. We look forward to working with them on quality and safety in the forthcoming year.

Lead Governor's comment

"I can confirm that as part of the processes involved in the production of this report I met with the Patient Experience Lead who confirmed to me that the priorities selected this year, took into account issues raised by Commissioners, the CQC and Service Users. Moreover Governors were directly involved in two ways.

1. By way of the Council of Governors' Quality and Governance Working Group. (There are a number of sub groups of the Council of Governors. They focus on different topics with different terms of reference: all Governors are required to serve on at least one group. Groups are chaired by a Governor and attended by the relevant NED. Groups are rather smaller than a full meeting of the Council, consist of Governors who have selected themselves for the group due to a particular interest or expertise, and are able to give topics detailed scrutiny in a way a plenary meeting of the Council of Governors would normally not attempt.)

2. Subsequently all Governors were circulated with the information and asked to respond by way of survey.

In addition the survey was published on the Trust Intranet and Trust Website. Information was sent out to Governors (again), Staff, Service Users, Carers and Volunteers.

This was also accessible by the public. A significant amount of additional work was carried out by way of consultations with various stakeholders and this was formally reported to me.

In particular I am satisfied that the opportunities available to Governors to participate in the process were sufficient to fulfil relevant statutory obligations".

David Barry

Lead Governor

Received: 22 May 2018

The Trust would like to thank the Lead Governor for the response and comments and look forward to working with governors on quality and safety in the forthcoming year.

Feedback

If you would like to give any feedback on aspect of the Quality Accounts 2017/18 or to ask questions, please contact the Governance and Quality Assurance Team. The team can be contacted by email at governanceandquality.assurance@candi.nhs.uk. If you would like to give feedback on services at Camden & Islington Foundation Trust, please contact feedback@candi.nhs.uk or call 020 3317 3117.

8. Annex 1: Statement of the Directors' responsibility for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts 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:

1. The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance

2. The content of the Quality Report is not inconsistent with internal and external sources of information including:
   - Board minutes and papers for the period April 2017 to May 2018
   - Papers relating to quality reported to the Board over the period April 2017 to May 2018
   - Feedback from commissioners dated 25 May 2018
   - Feedback from governors dated 22 May 2018
   - Feedback from local Healthwatch organisations – Camden dated 4 May 2018 and Islington dated 8 May 2018
   - Feedback from Overview and Scrutiny Committee – Camden dated 15 May 2018 and Islington dated 21 May 2018
   - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24 May 2018
   - The national patient survey November 2017
   - The national staff survey 2017
   - The Head of Internal Audit's annual opinion of the trust's control environment dated 15 May2018
   - CQC inspection report dated 06 March 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 Accounts 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

Leisha Tulloch

25 May 2018 .....Chairman

25 May 2018 .....Chief Executive

9. Annex 2: Independent Practitioner's Limited Assurance Report to the Council of Governors of Camden and Islington NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Camden and Islington NHS Foundation Trust to perform an independent limited assurance engagement in respect of Camden and Islington NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis (EIP): people experience a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) - approved care package within two weeks of referral.
- Improving access to psychological therapies (IAPT): Waiting time to begin treatment (from IAPT minimum dataset): within 6 weeks of referral.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

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 2017/18' and supporting guidance 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 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; 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 2017/18' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, 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 for the period 1 April 2017 to 24 May 2018
- papers relating to quality reported to the Board over the period 1 April 2017 to May 2018
- feedback from commissioners dated 25 May 2018
- feedback from governors dated 22 May 2018;
- feedback from local Healthwatch organisations – Camden dated 04 May 2018 and Islington dated 08 May 2018;
- feedback from the Overview and Scrutiny Committee – Camden dated 15 May 2018 and Islington dated 21 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated 24 May 2018
- the national patient survey November 2017
- the national staff survey 2017
- the Care Quality Commission inspection report dated 06 March 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 15 May 2018

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do

not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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 Camden and Islington NHS Foundation Trust as a body, to assist the Council of Governors in reporting Camden and Islington 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 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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 Camden and Islington 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 indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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 that 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 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Camden and Islington NHS Foundation Trust.

Our audit work on the financial statements of Camden and Islington NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Camden and Islington NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Camden and Islington NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Camden and Islington NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Camden and Islington NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Camden and Islington NHS Foundation Trust and Camden and Islington NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in

respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
30 Finsbury Square
London
EC2P 2YU
24 May 2018

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Acknowledgements

Camden and Islington NHS Foundation Trust would like to thank all the staff, service users and partner organisations that contributed to this report.

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Moorfields Eye Hospital NHS
NHS Foundation Trust

Islington Health and Care Scrutiny Committee

Review of 2017/18

Ian Tombleson,
Director of Quality and Safety

14 June 2018

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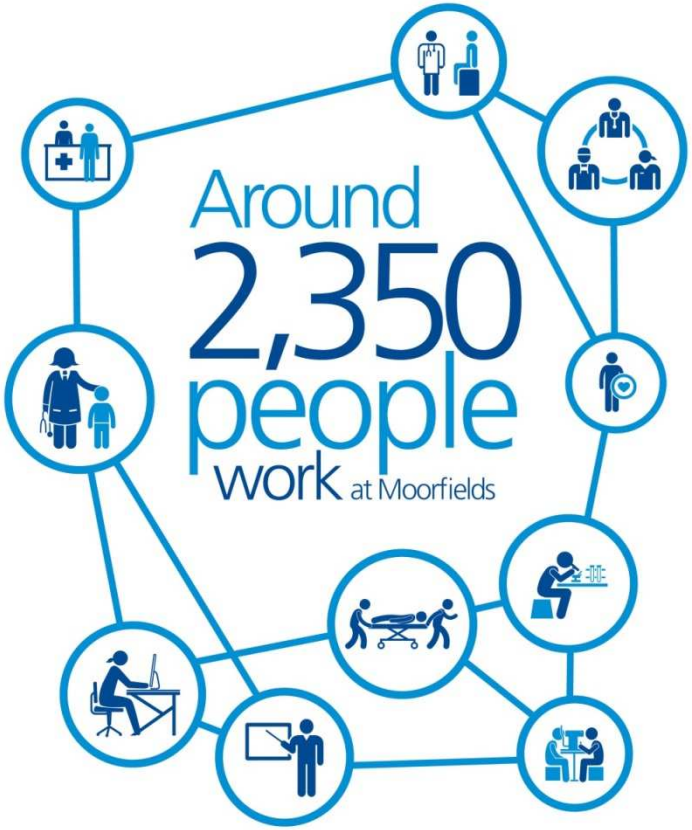


Confidence in our services

Staff **recommending** Moorfields as a place to receive treatment

95%

Staff **recommending** Moorfields as a place to work

77.97%

Moorfields ranks first in:

- **Staff satisfaction with the quality of work and care they are able to deliver**
- **Staff motivation at work**
- **Staff satisfaction with resourcing and support**

***Compared to other acute specialist trusts**

Patients and productivity

We had almost
730,000
patient contacts
in 2016/17

Across our
32
NHS sites

We saw more than
586,000 outpatients

102,000+
visits
to A&E

Almost
112,000
patients told us
what they think

Turnover: £224m

The CQC rate Moorfields as:

The CQC rate our services for children and young people as:

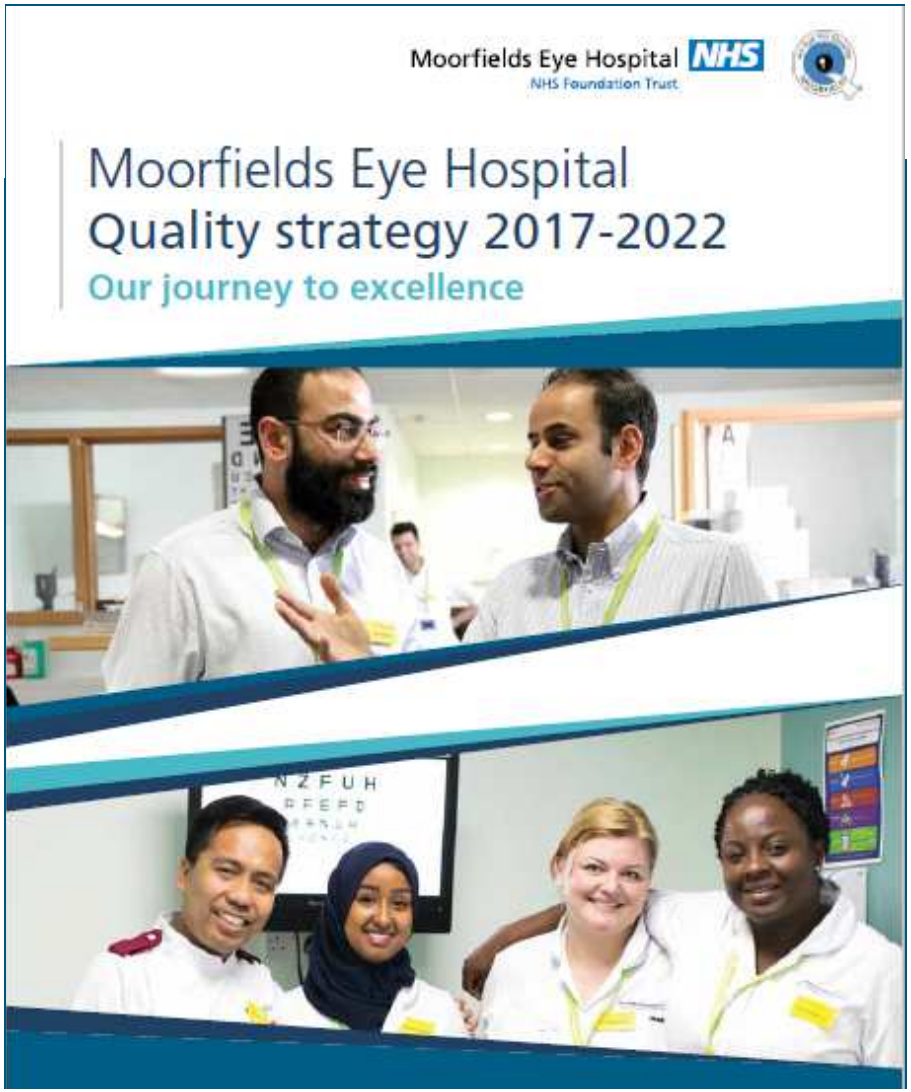
The CQC rate Moorfields at City Road:

CQC inspection outcomes – Report 6 January 2017

- **Overall rating: 'Good'** with sub-domains:

CQC action plan – progress update

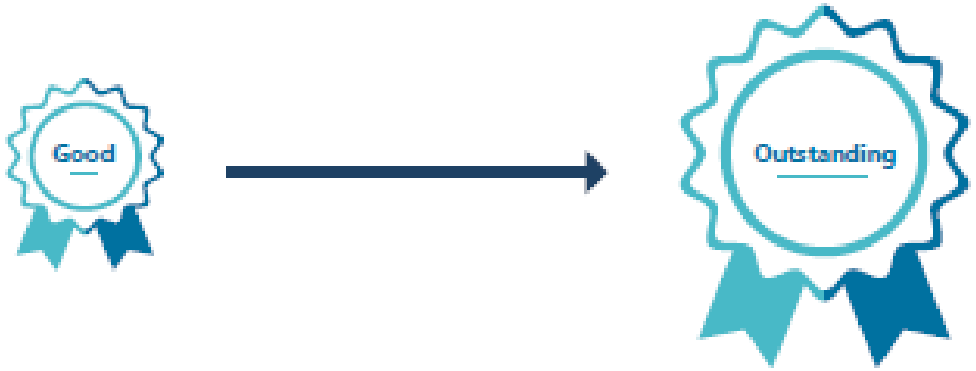
- **Report recommendations**: 78 recommendations grouped into 50 trust actions
- **Progress:** Action plan progressing well. 41/50 (82%) actions completed
- **Examples:** Solid WHO surgical checklist performance (>90% across all areas); Patient participation strategy launched December 2017; St George's Hospital ward and theatres redevelopment commenced January 2018; outpatients improvements at City Road in progress


Moorfields Eye Hospital NHS
NHS Foundation Trust
Moorfields Eye Hospital
Quality strategy 2017-2022
Our journey to excellence

5 year Quality Strategy
'Our journey to excellence' - November 2017

- Key priority in trust strategy 'Our vision of Excellence'
- Core belief that 'People's sight matters'
- Our ambition to deliver outstanding patient care
- Based on what patients, staff, governors, CQC told us
- Enable people to feel 'I can make a difference'
- Contains pledges, for example listening and engaging with staff in new ways & expanding our quality improvement programme

In January 2017, we were awarded a 'good' CQC rating, placing us in the top third of acute trusts. We are proud of our services and we know that overall, we are delivering great care and getting positive feedback from our patients. But we could be better. In particular, we know we need to do more to match the quality of our patients' experiences with their clinical outcomes. **We want to be outstanding.**



Compliance with national targets 2017/18

- Key national targets:

  A&E: 96,947 seen this year, slightly less than last year. Consistently achieving >98% within four hours (often >99%)

  RTT 18 (incomplete treatment pathway): Compliant against national target: achieved 95.3% against target = 92%

  Cancer: Slightly lower performance, meeting 3 of 5 targets; cancer 31 day target narrowly missed (95.7% against 96% target). The 5th (cancer 14 day internal referral target) not consistently met – issues mostly due to patient choice

  Six week diagnostic tests: 100%

  Infection control: Year on year no cases of MRSA or C Diff

Quality: Patient experience (1)

2016 CQC children's and young person's survey - good results

26/55 results better than other trusts

29/55 results scored 9/10 or better

29/55 results the same as other trusts

2016 CQC A&E survey - good results

11/33 results better than other trusts

20/33 results same as other trusts

22/33 results scored 8/10 or better

Worse for 2/33 questions

Quality: Patient experience (2)

- **Friends and Family test**

  Continues to be very good. Extremely likely or likely to recommend Q4 2017/18 results for A&E = 93.1%; Outpatients = 97.1%; Daycase = 99.9%

  Main feedback remains about length of patient journey in clinic

  The 'Moorfields Way' - a cultural/behavioural change programme. More staff have heard of this than ever, more staff think it is making a difference . Key links to the Quality Strategy

Launch of Patient Participation Strategy

Developed with patients

Launched December 2017

More activities with more patients participating

Signposting and recruiting

Financial and other matters

- **Solid year financially**
  - Net surplus was £5.7M
  - Satisfactory delivery against CIPs and commercial performance
- **Use of resources rating (NHSI) remains 1 (best)**
- **Expectations continue to be tough for 2018/19**

Moorfields Eye Hospital NHS
NHS Foundation Trust

Thank you

Any questions?

ISLINGTON

UPDATE ON CHILDHOOD OBESITY (17/18)

Includes:-

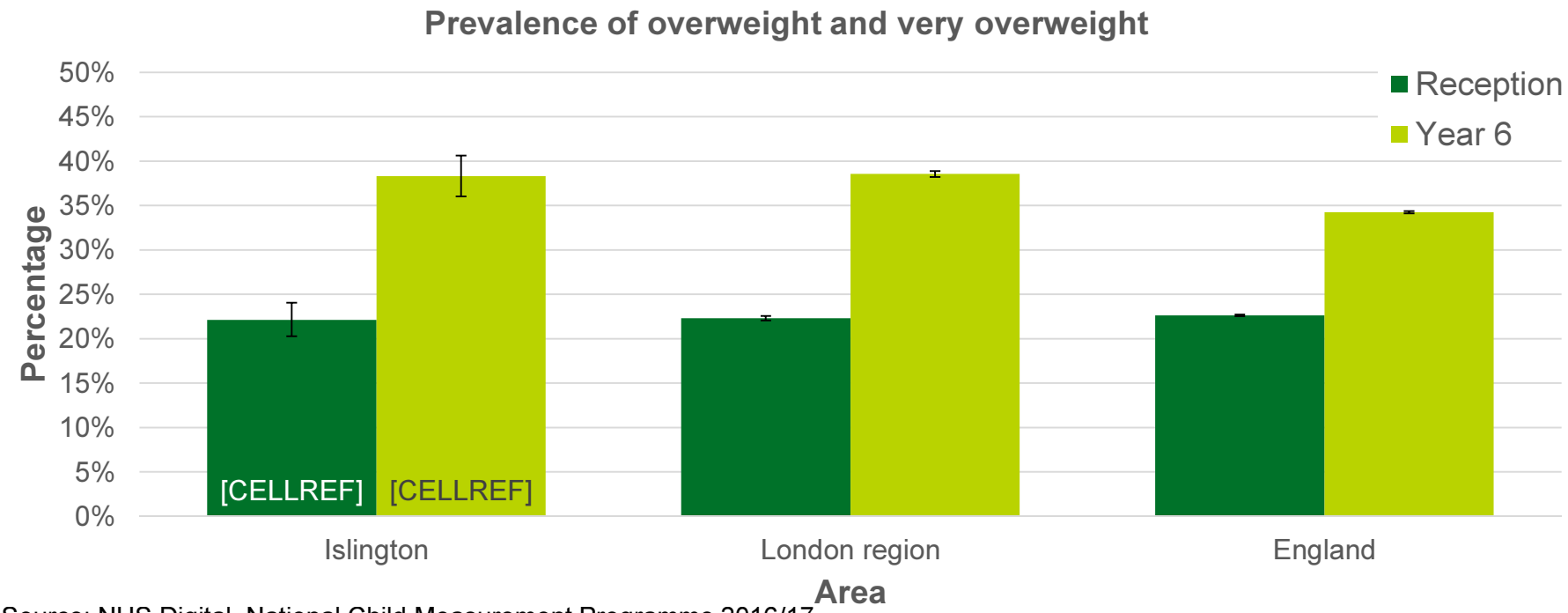
- National Child Measurement Programme – latest data
- Update on Islington's Healthy Living Programmes (Families for Life, Healthy Living Programme and Enhanced Tier 2 Weight Management Service).
- Local Government Declaration on Sugar Reduction and Healthier Foods

Wider Islington Context

ISLINGTON

- Islington Council takes a holistic, whole system approach to tackling obesity which includes:
- Creating an environment that supports good health and wellbeing by
  - Improving the food environment
  - improving the food offer
  - promoting physical activity.
- Long established multi-sectoral partnerships including Proactive Islington, the Islington Food Strategy Group and more recently work on the Local Government Declaration (jointly with Haringey) overseeing action in these key areas.
- Encouraging settings such as workplaces, schools and children's centres to promote good health (eg NICEF baby friendly, healthy schools/children's centres, Healthy Workplace charter).
- Supporting children and families to maintain a healthy weight. These include the Families for Life programme, healthy living nurses and a psychology service for children with complex needs.

16/17 National Child Measurement Programme update



Source: NHS Digital, National Child Measurement Programme 2016/17

BMI ≥99th percentile is the most commonly used to define severely obese children who are at risk of developing a number of serious acute and chronic health problems.[1]

- **2.52%** of Reception pupils had **severe obesity** which is similar to the England average (2.35%)
- **5.9%** of Year 6 pupils had **severe obesity** which is higher than the England average (4.07%)

Services and interventions for children and families

ISLINGTON

Families for Life

- Families for Life is a universal healthy lifestyle programmes for families with a child aged 2-11 years. Activities include 4 or 6 week programme focusing on healthy eating, active games and cook and eat activities.
- 21 programmes ran in 17/18 and 98 unique families were reached (212 total attendees)
- Currently developing an early years and primary parent champion offer to increase referrals into the programmes and allow for parent champions to support sessions
- From April 2019, these programmes will be delivered by Islington's School Improvement Service

Healthy Living Service (Weight Management for 5-16 year olds)

- Overweight children and their families are offered one to one support including home visits if needed.
- In 16/17, **1038 children** were identified as overweight and obese via the National Child Measurement Programme (NCMP). Of these **613** were classified as very overweight BMI>96 percentile.
- The Healthy Living Service, delivered by Whittington Health, provides follow up support to those children identified via NCMP and also takes referrals from GPs, school nurses and other professionals.
- Vacancies within the service, coupled with the numbers of overweight children exceeding service capacity, mean that the service has had to target its resources to focus on supporting those children who are very overweight.
- Future models for the delivery of tier 2 child weight management services are being developed.

Enhanced Tier 2 Weight Management Service

ISLINGTON

- Since October 2017, public health has commissioned an enhanced child weight management service to help develop and evaluate the type of weight management intervention that best supports children with co-morbidities and/or complex needs. This involves working collaboratively with CAMHS, dieticians and community paediatricians via a MDT.

- Since its launch in October 2017, there have been 16 referrals to the pilot service with 9 children / families seen so far

- With a small amount of financial support from Islington CCG the pilot has been extended to run until March 2019 to help build up the evidence and develop the model.

- Discussions are ongoing with the CCG regarding funding beyond April 2019, but this service could be aligned to the CAMHS transformation work locally

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LOCAL GOVERNMENT DECLARATION ON SUGAR REDUCTION AND HEALTHIER FOOD

Update on Local Government Declaration on Sugar Reduction and Heathier eating pledges

ISLINGTON

The LGD was signed by Haringey and Islington HWBB in October 2017.

Summary of activity against each pledge:-

1. Tackle advertising and sponsorship

Draft policy has been agreed. Need to clarify policy in relation to alcohol and process in place for agreeing corporate leadership.

2. Improve the food controlled or influenced by the council

Develop a Food Standards Policy (planned for completion by Sept 18)

Piloting healthier vending machines - in progress with key local employers/organisations

3. Reduce prominence of sugary drinks and promote free drinking water

Pledge aligned to work across LBI on plastic waste, includes 'Refill Islington' and installation of water fountains in public places.

Refill Islington will launch in July. On 8th June, a 'Day of Action' will take place to get businesses signed-up

Update on Local Government Declaration (cont..)

ISLINGTON

4. Support businesses and organisations to improve their food offer

- Recent achievements: GLL & Whittington Trust (Sodexo) awarded; Delaware North (Emirates) expression of interest received.
- LGD pledge written into new Laycock catering procurement process

5. Public events

- Working with Greenspace team on the Council's event application procedure; safer food is embedded and provider must be rated 3 or higher as part of events policy and this year will embed "must provide a range of healthier offerings e.g. caterers have Healthy Catering Commitment"

6. Raise public awareness

- Progress slowed due to Local Elections and need to brief new members (Haringey).
- Launch scheduled for July 18

ISLINGTON

Public Health
Municipal Offices, Upper Street

Director of Public Health

Meeting of:	**Date**	**Agenda item**	**Ward(s)**
Health and Care Scrutiny Committee	14th June 2018		All

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: An update on tackling child obesity in Islington

1. Synopsis

1.1 This paper and the accompanying presentation provide a brief overview of the issue of childhood obesity in Islington, and an update on key interventions and approaches being taken locally to support children and families to achieve and maintain a healthy weight. It has a particular focus on actions being taken following Islington Council becoming a signatory to the Local Government Declaration on Sugar Reduction and Healthier Food.

2. Recommendations

The Health and Care Scrutiny Committee is asked to note this update.

3. Background

3.1 Obesity is an important driver of preventable poor health in Islington, including cardiovascular disease and diabetes. Over 1 in 3 children aged 10-11 are classed as overweight or obese, and more than half of all adults are either overweight or obese[1].

3.2 Obesity, and associated diseases including type 2 diabetes, cancer and cardiovascular disease, is one of the most pressing public health issues of our day. Obesity costs the NHS alone £5.1bn every year[2], as well as leading to significant losses to the economy (through ill health, disability and early death). An estimated 7.1% of deaths in England and Wales are attributable to elevated Body Mass Index (BMI), with obese individuals losing an average of 12 years of life[3]. It can also have a significant impact on daily life and wider wellbeing for those individuals affected.

[1] PHE Fingertips data 2013-5. Haringey – 54.2%. Islington 52.8%.
[2] PHE (2015) Sugar reduction: the evidence for action www.gov.uk/government/uploads/system/uploads/attachment_data/file/470179/Sugar_reduction_The_evidence_for_action.pdf
[3] IEA (2017) Obesity and the Public Purse, citing figures from the Office for National Statistics https://iea.org.uk/wp-content/uploads/2017/01/Obesity-and-the-Public-Purse-PDF.pdf

3.3 Obesity is also a pressing health inequalities issue. More deprived wards have higher rates of obesity, and obesity is highly correlated with deprivation. For example, in Islington, nearly twice as many children leaving primary school in Clerkenwell ward are overweight/obese (47%) as in St. Georges ward (24%).

3.4 Locally, more than a fifth of children start primary school overweight, and more than a third leave for secondary school overweight[4], which is in line with the national picture. Recently released figures on children with severe obesity shows that 5.9% of Year 6 pupils had severe obesity which is higher than the England average (4.07%). BMI ≥99th percentile is the most commonly used to define severely obese children who are at risk of developing a number of serious acute and chronic health problems.[1]

3.4 Guidelines on sugar consumption were issued in July 2015 by the Scientific Advisory Committee on Nutrition (SACN). They recommended that sugar should account for a maximum of 5% of energy intake for adults and children. However it is estimated that sugar currently accounts for three times this proportion of children's energy intake, with sugar sweetened soft drinks being the largest single source of sugar for children[5].

3.6 An important reason for this is because of the profound changes to the food environment over the last three decades. Food is now more readily available and heavily promoted, marketed and advertised. Combined with increasing consumption of meals from the out of home sector (coffee shops, cafes, fast food outlets) people have been pushed towards overconsumption through a food environment which normalises the provision of unhealthy food and drink in everyday life and settings.

3.7 A recent evidence review by Public Health England of sugar reduction interventions also outlined the significant changes to the food environment over the last thirty to forty years[6]. The report recommended a strong focus on the food environment and in particular:

- Strong controls on price promotions of unhealthy food and drink
- Tougher controls on marketing and advertising of unhealthy food and drink
- A centrally led reformulation programme to reduce sugar in food and drink
- A sugary drinks tax on full sugar soft drinks, in order to help change behaviour, with all proceeds targeted to help those children at greatest risk of obesity
- Improved education and information about diet

3.8 The need for action on obesity is well recognised and supported by our residents. The most recent survey of residents on the subject of obesity was the Great Weight Debate (GWD), undertaken in October 2016 as part of a London-wide programme of engagement. Although from a relatively small sample size locally (79 participants in Islington), the insights from the GWD show that Islington residents are concerned about the number of fast food outlets in their area and the ready availability of unhealthy food and drink. It also found significant demand for local action to improve the food environment to promote healthier choices. For example:-

- 32% of respondents were aware of the childhood obesity epidemic
- 33% of respondents felt that tackling childhood obesity should be a top priority
- 56% of respondents felt that tackling childhood obesity should be a high priority
- Islington residents told us that the top 3 things that made it hard for children to lead healthier lives were: too many cheap unhealthy food and drink options ; too many fast food outlets; and the cost of healthy food and drink
- Islington residents told us that the top 3 things in the local area that encouraged children to lead healthier lives were: parks ; local leisure facilities ; and local sports and youth clubs

[4] National Child Measurement programme 2015/16. .

[5] Public Health England, Public Health Matters blog, Exper interview: New sugar recommendations, 17 July 2015 (accessed 30 May 2017).

[6] Public Health England (2015) Sugar reduction: the evidence for action

- Islington residents told us that in order for children to be better supported to lead healthier lives there needed to be:
    - Support or families to cook healthier food
    - Cheaper healthier food and drink options
    - Limit on the number of fast food outlets

4.0 Islington's approach to tackling obesity and joint work with Haringey Council

4.1 Islington Council takes a holistic, whole system approach to tackling obesity which recognises the complexity of the drivers and determinants of overweight and obesity, and the need for action across the system focused on a) Improving the food environment and the food offer and b) promoting physical activity. There are long established multi-sectoral partnerships established in the borough which oversee the implementation of key strategies and action in these areas – namely the Proactive Islington partnership, focused on physical activity and the Islington Food Strategy Group, focused on the food environment and access to healthy food.

4.2 The remaining sections of this paper provide a brief overview of the services and interventions currently commissioned by Islington Council, which are designed to support families to maintain a healthy weight, or provide more targeted support to children and their families who are overweight or obese. The paper then goes onto describe work being taken forward in conjunction with Haringey Council, through the Wellbeing Partnership, which is focused on some of the key policy levers available to both councils in creating and shaping healthy environments, and which support action to tackle obesity at a whole population level, rather than working with particular individuals or families.

4.3 Locally commissioned services

4.3.1 ***Families for Life (universal Tier 1 Service)*** is a 4-6 week programme on cooking and healthy lifestyles. From April 2018, this programme will be delivered directly by the Islington School Improvement Service and better integrated within with the Council's Early Years and School/s offer.

4.3.2 ***Healthy Living Practitioner Service*** (Tier 2 service) is delivered by Whittington Health. Owing to pressure on the service from the number and complexity of referrals, compounded by some staffing issues within the service, the service's limited resources are currently targeted towards those who are very overweight (>BMI 98 percentile). Islington's Child Measurement Programme identified 613 children in this BMI category who should all be offered this service by 1.0 FTE nutritionist. The future service model for tier 2 services will need to be reviewed in light of both these demand pressures and financial pressures on the Council.

4.3.3 ***Enhanced Tier 2 Service***. This pilot service is provided by the Brandon Centre and supports children and families with more complex needs who need support in relation to overweight and obesity. It has shown promising outcomes for children engaged with the service. Taking a psychological approach to obesity has generated some detailed case-studies, showing how obesity is strongly linked to mental health. Islington CCG is looking at options for recommissioning this service from April 2019, potentially aligning it with the transformation of local CAMHS.

4.3.4 The above services make up the local child weight management pathway, and is designed to work as part of a tiered pathway in which children and their families are able to access the right type and intensity of support depending upon their needs. A multi-disciplinary team, chaired by a Consultant Paediatrician from UCLH, was established in October 2017 to help with the assessment and triaging of cases suitable for the enhanced service. The revised pathway has been circulated to all GP Practices in Islington.

4.4 The Local Government Declaration on Sugar Reduction and joint work with Haringey

4.4.1 At a joint meeting of Haringey and Islington's Health and Wellbeing Boards in January 2017, obesity was agreed as a shared priority and an area for joint action across the two boroughs. A focus on obesity prevention was also seen as an important part of the Wellbeing Partnerships' commitment to

focusing on prevention, early intervention and focusing on the determinants of poor health, as well as on improving and integrating health and care services for residents.

4.4.2 In October 2017, following further work by officers, both Councils agreed to sign the Local Government Declaration on Sugar Reduction and Healthier Food, and committed themselves to taking forward a series of actions and pledges focused on creating a healthier food environment in both boroughs, and to monitoring progress with implementation.

4.4.3 The Local Government Declaration on Sugar Reduction and Healthier Food (LGD, or the Declaration) is a voluntary initiative developed by Sustain, which aims to help local authorities tackle the proliferation and marketing of unhealthy food and drink. To sign the Declaration, a local authority must make pledges across six different areas:

- tackling advertising and sponsorship
- improving the food controlled or influenced by the council
- reducing the prominence of sugary drinks and promote free drinking water
- supporting businesses and organisations to improve their food offers
- public events
- raising public awareness.

4.4.4 In addition, the local authority must commit to report on progress annually. The Declaration supports a whole-systems approach, helping to address unhealthy eating through targeted action across these six key areas of commitment. By signing the Declaration, the Council makes clear its commitment to tackling the causes of obesity. The aim of signing the Declaration and making these pledges is not to ban sugar or eliminate choice for our residents. Instead, it is about making a range of changes to the wider food environment which make it easier, more convenient and / or more affordable for residents to make healthier choices

4.4.5 Since October 2017, good progress has been made across Islington Council implementing the pledges that were presented to the joint HWB in October 2017. An update on each pledge is given in the presentation attached.

4.4.6 There has been particular success on developing a policy on corporate advertising, sponsorship and commercial partnerships, which legal services have now approved. The next steps are to get this agreed at a corporate level, with a clear framework for maintaining and implementing the policy across the council.

4.4.7 Joint commissioners and procurement officers have also been looking at ways to embed healthy eating into new contracts and procurement processes. All environments where the food on offer is controlled by the council have been considered and mapped, and good progress has been made with piloting healthy options in vending machines in Council controlled premises.

4.4.8 As part of their joint commitment/pledge to raising public awareness, both Councils agreed to take forward the Sugar Smart campaign – a vehicle for engaging our local communities and businesses to take their own action on sugar reduction, and which has been used successfully by other areas and local authorities, such as Brighton and Hove, Lewisham and Greenwich. This work has been slower to get off the ground as a joint endeavour between the two Councils, and due to the pre-election period in the run up to local elections in May 2018. The official launch for Sugar Smart is now planned for later in Summer 2018, and some key local organisations have already given their commitment to signing up and to taking action.

4.4.9 The “Refill Islington” initiative has been very positively received by colleagues across the Council, owing to its dual focus on and benefits for both health/obesity as well as tackling plastic waste/recycling. It will be launched in July 2018. Work on increasing the availability and awareness of water refill stations in the borough has been embedded into the Council’s work on reducing plastic waste and a day of action is planned for the 8th June as part of ‘World Oceans Day’. Bids have also been submitted by colleagues to the GLA to support the installation of water fountains in public

places, in order to enhance the original pledges made around increasing access to drinking water in the borough.

5. Implications

Statutory Officers Comments (Legal and Finance)

5.1 Legal

Under Section 2B National Health Service Act 2006 (as amended by Section 12 of the Health and Social Care Act 2012) each local authority must take steps as it considers appropriate for improving the health of people in its area. The steps that may be taken include providing information and advice; providing services or facilities designed to promote healthy living; providing financial incentives to encourage individuals to adopt healthier lifestyles and making available the services of any person or any facilities. The recommended pledges falls within the statutory duty to improve public health.

The Sugar Reduction and Healthier Food initiatives fall within the Terms of Reference of the Joint Sub-Committee to encourage joint consideration and co-ordination of health and care issues that are of common interest to the population of Haringey and Islington.

The Finance Act 2017 has established a new tax called the Soft Drinks Industry Levy (the Levy) and provides that HM Revenue & Customs (HMRC) will be responsible for its collection and administration. The levy is intended to apply from April 2018 and is aimed at producers and importers of soft drinks containing added sugar. It is intended to tackle childhood obesity by encouraging the reformulation of drinks to reduce levels of added sugar, as well as portion size reduction and marketing of low sugar alternatives.

5.2 Chief Finance Officer (ref: CAPH58)

There are no financial implications arising from the recommendations in this report. Officers will need to ensure the implications of accepting any grant funding are understood before entering into any new commitments. This might include any requirements for matched funding or prescribed use of monies or clauses relating to repayment in particular circumstances.

5.3 Environmental Implications

This report has limited environmental implications; however it should be noted that a campaign to promote the availability of free drinking water and refill drinking points would deliver environmental benefits (reduced plastic waste, reduced waste going to landfill and reduced carbon emissions from transporting bottled water).

5.4 Resident and Equalities Implications

Both councils have a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share those protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not.

The three parts of the duty applies to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status applies to the first part of the duty.

This report sets out a summary of the need in Haringey and Islington to create healthier environments with the aim of tackling obesity, specifically for children, and possible interventions to meet this need.

Analysis by both councils has demonstrated that some groups are disproportionately affected by obesity and the health problems which are associated with being overweight. More people are obese in more deprived areas, and children from Black African, Caribbean and "White Other" backgrounds are more affected than those of White British backgrounds.

The proposals outlined in this paper aim not only to reduce overall levels of obesity and overweight in the borough, but also to close these health inequalities, by focusing action in schools and other educational settings and in more deprived areas, and by building the public-facing Sugar Smart campaign in collaboration with a range of partners, including small voluntary and community organisations.

In addition, consultation undertaken to date (see "The demand for action" in Section 2 above) via the Great Weight Debate demonstrates that residents in the two boroughs are keen to see action taken to improve the local food environment as a way to tackle obesity.

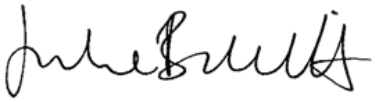
6. Conclusion and reason for recommendations

Appendices

Background papers: Presentation:

Final report clearance:

Signed by:



Director of Public Health Date

Received by:

Head of Democratic Services Date

Report Author: Julie Edgecombe Date
Tel: 020 7527 1253

Email: Julie.edgecombe@islington.gov.uk

HEALTH AND CARE SCRUTINY COMMITTEE – WORK PROGRAMME 2018/19

14 JUNE 2018

1. Camden and Islington Mental Health Trust - Performance update
2. New Scrutiny Topic – Decision on topics- Main review/mini review
3. Health and Wellbeing Board update
4. Work Programme 2017/18
5. Child Obesity
6. Membership, Terms of Reference
7. Moorfields NHS Trust – Performance update

12 JULY 2018

1. NHS Whittington Trust – Performance update
2. Scrutiny Review – New topic – Approval of SID/witness evidence
3. Health and Wellbeing update
4. Quarter 4 performance report
5. Work Programme 2018/19
6. Scrutiny Review – Health Implications of Damp Properties – 12 month progress report

02 OCTOBER 2018

1. Health and Wellbeing update
2. Work Programme 2018/19
3. Scrutiny topics – witness evidence
4. Whittington Estates strategy – update
5. London Ambulance Service – Performance update
6. IAPT Scrutiny Review – 12 month progress update
7. Healthwatch Annual Report/Work Programme

15 NOVEMBER 2018

1. Scrutiny topic – witness evidence
2. Health and Wellbeing Update
3. Work Programme 2018/19
4. Presentation Executive Member Health and Social Care
5. Public Health/Performance Annual Report 2017/18/Performance update Quarters 1 and 2
6. Local Account
7. Alcohol and Drug Abuse update
8. Interim findings on Scrutiny Reviews re:Budget implications

28 JANUARY 2019

1.Scrutiny topics – witness evidence/ Consideration of additional mini review
2 Health and Wellbeing update
3. Work Programme 2018/19

07 MARCH 2019

1. Moorfields NHS Trust - Performance update
2. Scrutiny Reviews – Draft recommendations
3. Health and Wellbeing update
4. Work Programme 2018/19
5. Possible additional mini scrutiny review – witness evidence

01 APRIL 2019

1. Scrutiny Reviews – Final Reports
2. Scrutiny Review - Health Implications of Poor Air Quality – 12 month progress report
3. Health and Wellbeing update
4. Work Programme 2019/20
5. Possible additional mini scrutiny review – witness evidence

02 MAY 2019

1. Scrutiny Review – mini topic – witness evidence

FORTHCOMING MEETING JUNE/JULY

Scrutiny mini review – Draft recommendations/Final report
Performance report – Quarters 3 and 4