Quality Account
2011-2012
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Delivering safe, clinically effective services that our patients value is at the core of what we do, and this account gives us an opportunity to share with you our on-going commitment to achieve better outcomes for our service users and carers. We will state what our quality priorities are for 2012/13 and explain how we have worked with our stakeholders to agree these.

In this Quality Account you will see that there are some areas where we did not achieve all that we set out to. We will continue to work hard to achieve what we committed to you and will continue to monitor and report our progress against these in the future. You will see in this Quality Account that, as well as reporting on last year’s quality priorities, we also include our current performance against quality priorities from previous years. We will continue to do this in the future as it helps us to continue to achieve and maintain the high quality standards that we set ourselves.

This last year has been one of major change for the Trust. We added to our portfolio of services to include community provider services across Hillingdon and Camden and also undertook major restructuring of our mental health and allied specialties into service lines to ensure consistency of care across the whole patient pathway. It is a credit to all our staff across the Trust that throughout this process we have continued to deliver high quality services to our service users and carers. It is also encouraging to see that throughout these changes to our organisation, our staff satisfaction levels have remained high as reflected in our staff satisfaction survey this year.
We believe that providing the breadth of services that we do, across a wide geography, provides us with a great opportunity to identify any gaps in the wider health and social system that supports our service users. We might not be in a position to provide services to fill these gaps, but we absolutely can and will feed this information into the right conversations locally about health and social care provision.

There is a great deal of focus nationally and locally about looking at health and social care together, and ensuring that healthcare (both physical and mental) and social care form a part of all conversations. As service users, patients and carers we know that you want this to be the case and we are committed to achieving this.

We are already working with our commissioners and other providers across Central and North West London in Integrated Care Pilots to further develop health and social care teams working together to deliver high quality care across all parts of the health and social care agenda, that ultimately delivers better outcomes for our service users. We are also keeping physical healthcare as a quality priority area as we know that we need to be more ambitious in this area, and there is more we can do to help deliver better outcomes for our service users and to achieve a joined up approach to healthcare.

Our quality priorities for 2012/13 broadly reflect the same themes from last year, and we think that this is appropriate as this is in line with the feedback from our stakeholders and reflects that our drive to deliver high quality services is ongoing. Last year we heard from our stakeholders that recovery should be included as a quality priority, and whilst we were unable to include this last year we did continue to work on focussing on recovery with a key achievement being setting up our CNWL Recovery College.

This year we heard again that recovery should be a quality priority and we are pleased to say that we have included recovery and involvement as one of the priority areas we will focus on in 2012/13, and will continue to build on the excellent foundations in place from the work undertaken to date.

We would like to thank all of you that have talked with us throughout the year, and in particular as part of the Quality Account process. The formal comments from LINks, commissioners and local authority Scrutiny Boards have helped shape this account. Where you have told us you wanted to see changes we have incorporated these as far as possible in this Quality Account. Our quality priorities over the upcoming year are as a direct result of your feedback and involvement and where we have been able to align our quality priorities with the CQUIN (Commissioning for Quality and Innovations) we have done so. This Quality Account represents our commitment to ensuring that we continue to embed quality improvement at the heart of our organisation. Moving forward, we are committed to strengthening our engagement processes with our LINks so that direct dialogue between the service directors and LINks takes place on matters of quality on a regular basis. We look forward to working with all of you to make this happen.

To the best of our knowledge and belief, this Quality Account is true and accurate. It will be audited by KPMG in accordance with Monitor’s audit guidelines.

Claire Murdoch

29 May 2012
Independent Auditor's Report to the Council of Governors of Central and North West London NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Central and North West London (CNWL) NHS Foundation Trust to perform an independent assurance engagement in respect of CNWL NHS Foundation Trust’s Quality Report for the year ended 31 March 2012 (the “Quality Report”) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Access to Crisis Resolution / Home Treatment
- CPA 7 day follow up

We refer to these national priority indicators collectively as the “indicators”.

Respective responsibilities of the Directors and auditors
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts (“Monitor”).

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;
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the sources specified below. The sources with which we shall be required to form a conclusion as to the consistency of the Quality Report are limited to:

- Board minutes for the period April 2011 to May 2012;
- Quality Report updates to the Board from April 2011 to May 2012;
- Feedback from the Commissioners dated 26 April 2012;
- Feedback from LINks dated 30 April 2012;
- The Community Mental Health Survey 2011
- The 2011 National NHS Staff Survey;
- Care Quality Commission quality and risk profiles dated 29 February 2012;
- The Head of Internal Audit’s annual opinion over the Trust’s control environment dated 24 May 2012; and
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;
- Testing key management controls;
- Analytical procedures;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less 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.

Feedback from other named stakeholders involved in the sign off of the Quality Report - Council of Members, dated 31 January 2012, feedback from commissioners, dated 24 April 2012 and feedback from LINks, dated 25 January 2012.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents. We refer to those sources, (collectively the “documents”). Our responsibilities do not extend to any other information.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Central and North West London NHS Foundation Trust as a body, to assist the Council of Governors in reporting Central and North West London 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 2012, to enable the Council of Governors to demonstrate that it has discharged its 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 Central and North West London NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.
Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact 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 thereof, 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.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts/organisations/entities. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Central and North West London NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

KPMG LLP, Statutory Auditor, London,
Date 30 May 2012
Staff at the Kingswood Centre learning disabilities service.
Part 2 - Priorities for improvement

Delivering quality services
Our commitment to delivering quality services, and approach to achieving this, is at the very heart of what we do. The Quality Account provides a useful opportunity to reflect on our performance over the last year and to agree our quality priorities for the year ahead based on what we have seen and heard over the last 12 months.

In this section we tell you how we did against the quality priorities that we set ourselves for 2011/12. We also explain how we have agreed our 2012/13 quality priorities with a wide range of stakeholders, and state what these quality priorities are and how we will measure our performance against them.

Summary of our performance against our 2011/12 quality priorities
For 2011/12 we had 12 quality priorities across CNWL, including Hillingdon Community Health and Camden Provider Services. Each of these quality priorities had one or more measures, and over the course of the year we tracked our performance against these measures. It is important to note that depending on the methodology utilised to measure each of the quality priorities, year end figures are either achievements by quarter four or year-to-date. Other measures that are systematically collected via our electronic systems and reported in part three are reported as cumulative or year-to-date positions. This will be made clear throughout the Quality Account.

In total there were 29 measures, and the chart below shows for what proportion of measures we achieved the target, and where we did not achieve the target. Of these 29 measures, 11 were also CQUIN.

Our achievement against our quality priority measures for 2011/2012
The detail about how we performed for each of these quality priorities and measures is included in the following pages.

We know that feedback from our staff and service users is absolutely vital in understanding how well we are performing so we have also included some information about our staff and patient survey results, and our response to complaints.
As a Trust, we look to measure our performance in terms of patient reported experience and outcome measures, as well as via process measures. The NHS Patient Experience Framework published by the National Quality Board, outlines what patients expect of their experience when receiving NHS services. Our quality priorities reflect these areas that patients have chosen. Over the next year we will look to improve the way that we monitor and report on our performance; we will be more innovative in the ways that we measure patient experience and seek to capture patient feedback so that we can understand the reasons for responses. This will help us to highlight specific areas that we need to focus on, and enable us to be more responsive and act quicker to make necessary changes.

This year we have monitored the performance of our mental health and allied specialities services against four quality priority areas as set out in last year’s Quality Account. In this section we will show how we performed for each of the measures against these four quality priorities, and will also explain what we have done to achieve this performance. All ‘service user reported’ measures were achieved by quarterly telephone surveys carried out by specially trained group of service users.

**Mental health and allied specialties performance against our 2011/12 quality priorities**

We have high aspirations for the quality of the services that we deliver, and deliberately set ourselves ambitious targets for our quality priorities. We know that it takes time to implement and embed changes to the way that we do things in order to sustain high quality across our services. We see the delivery of quality services as a long term commitment, and know that there will be certain aspects that take longer for us to achieve than others. However, we will continue to work hard to achieve, maintain and improve on good quality performance across our entire organisation.

This year has been very challenging for us as we have implemented our new service line structures. We recognise that this has been a significant change that has impacted on our staff, and may also have impacted on our service users and carers. We have been working to prepare for this change over the last three years and believe this will result in a longer term positive impact across the whole organisation. By ensuring service lines are both clinically and managerially led and by making our processes more efficient our service users and their carers will receive consistent, high quality standards of care across all our boroughs. We will continue to maintain our local links within the boroughs too as each directorate team will have local borough based responsibilities.
Access to services when in a crisis – helping service users when they need it most

*Measure A: At least 65% of community service users report that they have a phone number to call in a crisis.*

We want to make sure that service users in the community have a telephone number to contact us so that we have the opportunity to support them when they need it most.

This measure looks at how well we are doing at providing our service users with a crisis card including details of how to contact our services when in an emergency or crisis. These cards let our service users know who to contact when they are in a crisis and most in need of our services. Based on feedback from service users and carers the Trust published new updated crisis cards which allowed for the inclusion of more personalised information.

We are pleased with our performance against this measure, achieving 72% against a target of 65% at quarter four. This shows that whilst we transitioned to providing the new format crisis cards, our community service users are still being told how they can access our services in a crisis.

*Measure B: At least 85% of patients who are discharged from hospital or who are on a community mental health team case load report being given a crisis card with details of who to contact and what phone number to use in a crisis.*

There has been a Trust-wide drive to distribute these new cards, however this has not been reflected in the feedback from service users at quarter four where we achieved 53%. We recognise that we need to embed the process of crisis card distribution as these new cards were only introduced in the second half of the year. Our approach has been to provide crisis cards to our users when we see them; for inpatients this is done at discharge, and for community service users this is as part of their standard reviews/appointments. Based on feedback from service users and carers we have launched a new ‘Out-of-Hours’ project that includes a single out-of-hours telephone number across the all our mental health and allied specialty services.
Measure C: At least 65% of community service users who called the crisis number report that they definitely received the help they wanted.

It is not enough to provide a crisis card or telephone number. We also wanted to make sure that our service users receive the help they need when they contact our services.

Our aspirations in this area are ambitious and, based on feedback from service users, we chose to set ourselves the rigorous standard of measuring whether or not they ‘definitely’ got the help they wanted. Based on this, our performance falls some way below our target of 65% at quarter four achieving only 44%. We wanted to understand the true nature of the issue and also looked at service users who told us they got the help they wanted to ‘some extent’. When we include this our performance rose to 64%.

As the sample size for this measure is relatively small each quarter; we found it useful to look at our performance against this measure for all four quarters combined (the whole year). This analysis showed that 55% of respondents who had called the crisis numbers said they ‘definitely’ received the help they wanted, and 80% responded that they ‘definitely’ or ‘to some extent’ received the help they wanted.

To provide a wider picture of our performance in this area, we also undertook a mystery shopper exercise across all of our out-of-hours services in January 2012. This involved two CNWL senior nurses calling the out-of-hours numbers and posing as service users to gather information about the speed and quality of response to their call. The audit was very useful in identifying specific areas for improvement, but overall, the results were positive. For example, the audit found that, for out-of-hours numbers that are managed by the Trust, mystery shoppers had excellent response times and direct access to a mental health professional who could offer support.

What this tells us is that our performance in this area is varied and we need to do more work. To this end we have commissioned and are implementing the results of our new Out-of-Hours Project. This aims to provide a consistent, reliable and clinically safe response to urgent situations for service users and carers regardless of the time of day. We will have one telephone number for service users, carers and GPs. We are presently setting standards and systems in place to monitor response times and the quality of our responses.

As we continue to measure our performance over the next 12 months we will look at using different methods to gather much more detailed qualitative feedback from service users. This could include independently conducted focus groups to give us a better understanding about what users found helpful or not so helpful, about the patient experience. We will share this with the relevant staff teams so that they can act on any feedback given.
Focus on crisis cards for service users

This year we have designed, in conjunction with service users and carers, crisis cards and distributed these to our service users.

These cards let service users know how to access services out of hours when in an emergency, and have helped facilitate discussions between staff and service users on the most appropriate support service users may require.

In order to raise awareness of these cards we ran a poster campaign both to remind staff to ensure users received a card and to act as a prompt to service users to ask for one.

We have also added crisis cards to the discharge checklist as a reminder for staff when a patient is discharged from inpatient care.

Our carers have identified the need for a Carers Contact Card to support the cards that service users hold, and this is part of our plans for the next 12 months.

Have you been given your crisis card?
Respect and involvement – respecting and involving people who use our services

Measure A: At least 65% of community service users report that they were definitely involved as much as they wanted to be in decisions about their care plan.

We want to ensure that we involve service users in their care planning so that they can understand and feel empowered to make decisions about their care and recovery. This measure looks at the percentage of our service users that report being involved as much as they want to be in this process.

Involvement in care planning is key to achieving a recovery oriented focus to our delivery of care, and we have included this measure as part of our recovery and involvement quality priority for the upcoming year.

Work to improve service user involvement is taking place across a number of fronts:

- We introduced new CPA care and support plans, designed to be written in partnership from the service user’s point of view, in December 2011;

- health and wellbeing plans are being introduced across the Trust for all our service users. These are wholly owned by service users and can help them record their own ideas about their needs and wishes;

- we are introducing a new assessment format which helps service users express their views about their own needs more easily, and integrates CPA and social care budget arrangements, streamlining the process for service users, carers and staff, and reducing duplication. This needs to be agreed individually with each of our local authority partners and will continue to be rolled out across the Trust this year; and

- with the support of our new CNWL Recovery College we are continuing to deliver training for staff and service users about CPA, recovery and personalisation, with recovery at the heart of the process. This has already had a positive impact on our service user experience and will help to ensure that our focus on recovery and collaborative care planning continues.

This year we set ourselves the challenge of ensuring that we got this right for both service users on Care Programme Approach (CPA) and those on Lead Professional Care (LPC). Our performance was 41% in quarter four when asking if service users felt ‘definitely’ involved. Again to understand the true nature of the issues we looked at the number of service users who also responded ‘definitely’ or ‘to some extent’ when asked this question, we then achieved 74%.
Focus on:
Involvement in care planning
We are continuing our work to enhance the benefits of the Care Programme Approach for service users. The core of this is ensuring joint care planning that absolutely involves service users, and embeds a recovery focus through an approach that is more flexible and adaptable to their needs.

Care planning should not be just a snapshot from a single large meeting; it should be something the service user is actively a part of over time, bringing together services and support to meet service user needs. This is what our new approach seeks to achieve.

The structure of our new care and support plan and the language used are more service user focused, and new assessment forms will extend this approach to the whole process.

Measure B: At least 80% of community service users report that they had been given (or offered) a written or printed copy of their care plan.

It is important that our service users are supported and empowered to make decisions about their care, and their recovery, as far as possible, and sharing their care plan with them is an important part of this. This measure assesses whether our service users report they have been given (or offered) a copy of their care plan, demonstrating whether or not we have been working in partnership with our service users.

Denotes CQUIN target
Focus on: Patient information

This year we have worked with service users and carers to review our medication patient information leaflets. Based on this consultation, we have radically revised the previous leaflets to produce 51 adult leaflets and six leaflets for children. The information leaflets provide a useful guide for service users on their medication and possible side effects. They have been written to consider the reader who may want to find quick answers to their medication questions. The side effects section of the adult leaflets have been re-written in a solution focused, easy read format.

The leaflets will be promoted through an internal marketing campaign including a series of medication information for patient’s newsletters, poster campaign and a road show taking the leaflets to services. Posters will be put in staff areas informing staff of availability and waiting rooms encouraging service users to ask about their medication. Links with carers will be made through the Trust’s Carers Network. Articles will be placed in CNWL magazines to link with staff and Trust members.

Measure C: At least 75% of patients reported that they felt safe during their most recent inpatient stay in hospital.

We want to ensure that we deliver a good patient experience for our service users. This measure looks at our inpatient settings and whether our patients feel safe during their admissions with us.

We set ourselves a target of 75% for this measure, and are pleased to report that we have met or exceeded this target in every quarter this year, achieving 75% at quarter four. An important part of our work to achieve this has been through sharing the results from our inpatient surveys with ward staff so that they have been able to act on any concerns.
Physical health - taking care of physical health as well as mental health

Measure A: At least 75% of patients have had their medications cross-checked against more than one source within 72 hours of admission.

This measure is an important patient safety measure, and looks at whether or not inpatients have had their medications cross checked with their GP and/or other sources to ensure that they continue to get the right medicines that they were prescribed before admission and avoid any harm through medications interacting with each other. This data was collected through internal audit.

We set ourselves a target of 75% based on feedback from our stakeholders. This was a stretch from our performance the previous year according to the POMH-UK (Prescribing Observatory for Mental Health) audit for 2010 where we achieved 68%. We are delighted to say that the hard work of our staff, in particular our pharmacy teams, has enabled us to achieve a very high result here of 96%.

We will work to maintain our high performance in this area, and will continue to monitor this.
This year we raised our targets to 65% for both inpatients and community service users. We have seen a good performance for inpatients, exceeding our target in quarter two (69%) and quarter three (68%) but in quarter four we achieved 59%, slightly below our target. We are pleased that for community service users on CPA we have slightly exceeded our target, achieving 66% in quarter four.

We have a physical healthcare team who provide advice, training and support regarding physical healthcare issues. On each inpatient ward we also have physical healthcare link practitioners who receive physical healthcare training to support the needs of their patients.

Our community teams work with GP practices to help ensure that the physical healthcare needs of our service users are met – this may be with the GP themselves, or with a nominated nurse from the GP practice.

We will continue to work on improving the physical health of our service users, within the Trust and also through improved communications with GPs over the next year. As such, we have once again decided to include physical healthcare as one of our quality priorities for next year.

**Focus on:**

**Physical health**

This year we set up a Physical Healthcare Strategy Group that is in place to review all physical health activities that happen within the Trust and look at how we can develop and deliver good practice Trust wide. One role of the group is to identify areas of local good practice and disseminate across the Trust. One area of focus next year will be to build on the work already undertaken in individual services to develop a trust-wide approach to smoking cessation.

Physical health has always featured on care plans but may not have always had the focus it requires. Increasingly it is recognised that physical health is everyone’s responsibility and therefore our training and supervision of staff will reiterate this importance. This is in line with the Department of Health White Paper ‘No Health Without Mental Health’, in particular objective three, that more people with mental health problems will have good physical health.

**Introducing clozapine ‘one stop shop’**

Brent and Harrow clozapine clinics have relocated and offer a ‘one stop shop’ for the patients attending. This now means all patients will have their bloods taken, physical health checks and medicines all within a 20 minute appointment, no longer having to attend on two separate occasions. Feedback from patients and carers has been excellent “The new clinics provide everything at once - much improved” [a patient], “The staff are welcoming and very efficient, this is a good comprehensive service provided to my partner and myself as a carer” [a carer].

Further sites have been identified to roll out this model across the Trust in 2012/13.
Carer involvement – working in partnership with carers and promoting carer involvement

**Measure A: establish a baseline for the percentage of service users that have a carer identified**

This measure is about recording the number of our service users that have a carer identified, or recording that there is no carer. It is important for us to record this information so that we can contact carers to provide carer’s assessments and look at what support they need.

We conducted a baseline audit during quarter two that showed 55% of service users had a carer identified, or no carer involvement stated. In quarter four we completed an audit that showed an improvement from our baseline to 78%. We will continue to monitor our performance against this measure on our quality dashboard.

**Measure B: establish a baseline for the percentage of carers recorded as having been offered a carers assessment**

This measure assesses those carers that are recorded who have been offered a carer’s assessment. The carer’s assessments are an important tool in helping us to understand what support our carers need.

In quarter two and three we reviewed Local Authority RAP data (this looks at referrals, assessments and provision for carers) and established a baseline of 40%. This was aligned with our CQUIN target for this measure.

We are pleased to report that we achieved 98% against this baseline for quarter four. The feedback that we have received is that whilst the carer’s assessments are useful in identifying needs, the most important thing for carers is receiving the support they require. Therefore, this year we will continue to monitor the number of carers offered a carer’s assessment on our quality dashboard, but we will focus our quality priority measure on whether our carers report being supported by CNWL staff.

**Measure C: establish a baseline for the percentage of carers that report feeling supported in looking after the person they care for**

We recognise that carers who support our service users can play an important role when our service users experience a crisis, and therefore can play an important role in crisis care planning for the person that they care for. This measure assesses whether carers report feeling involved in crisis care planning for the person they care for.

We undertook a survey in quarter four and were pleased that 67% of carers reported that they felt involved in crisis care planning for the person they cared for. We have taken this figure as our baseline and will continue to monitor this on our quality dashboard next year.

We will continue to measure whether carers feel involved in crisis planning for the person they care for, and report it via our quality dashboard. Furthermore, as a result of our crisis card work this year we have identified a need for carers to have information that tells them how they can access services out-of-hours when the person that they support experiences a crisis, and this will therefore form one of our quality priority measures for next year.

Denotes CQUIN target
Focus on:
Carers

In response to the feedback we received at last year’s Quality Account stakeholder consultation event we have worked hard to deliver against the carer quality priory that we set.

An important aspect of our work with carers is identifying carers, and we have completed a lot of work to improve our computer systems to enable us to record this information. We have also used reminders on our computer system to help prompt staff to record this information.

This year we will look at how we can develop our computer system further to help record more about our work with carers.

Carers are also included as part of our work through the CNWL Recovery College, with carers invited to take part in the courses on offer and we have publicised this in all of our boroughs.

Over the last year carer contact cards were piloted in Westminster and were well received by carers. This year we will look at extending provision of carer contact cards for each borough and place these in carer centres and services.

Whilst we recognise that there is more work to do to support carers we are very pleased with the feedback we have had from carers this year.

“Attending the carer workshop is a great help. I get to talk with other people who are also caring for someone.”

Mother
Borough breakdown – a review of our performance in 2011/12 against last year's mental health and allied specialties priorities

<table>
<thead>
<tr>
<th>Quality area</th>
<th>Ref</th>
<th>Quality priorities 2011/12</th>
<th>Adult Service</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access in a crisis</td>
<td>1A</td>
<td>Community service users report that they have a phone number to call in a crisis</td>
<td>Q4 &gt;65% 82% 73% 71% 88% 75%</td>
<td>71% 43% 36% 50% 83%</td>
</tr>
<tr>
<td></td>
<td>1B</td>
<td>Discharged patients or those on a community caseload report being given a crisis card</td>
<td>Q4 &gt;85% 69% 56% 55% 56% 54%</td>
<td>44% 13% 25% 8% 38%</td>
</tr>
<tr>
<td></td>
<td>1C</td>
<td>Community service users who called the crisis number report that they definitely got the help they wanted</td>
<td>Q4 &gt;65% 20% 44% 67% 33% 67%</td>
<td>25% - 0% 0% -</td>
</tr>
<tr>
<td>Respect &amp; involvement</td>
<td>2A</td>
<td>Community service users report that they were definitely involved as much as they wanted to be in decisions about their care plan</td>
<td>Q4 &gt;65% 56% 47% 24% 48% 58%</td>
<td>12% 53% 14% 40% 83%</td>
</tr>
<tr>
<td></td>
<td>2B</td>
<td>Community service users report that they had been given (or offered) a written/printed copy of their care plan</td>
<td>Q4 &gt;80% 69% 46% 50% 55% 65%</td>
<td>41% 36% 36% 30% 0%</td>
</tr>
<tr>
<td></td>
<td>2C</td>
<td>Patients reported that they felt safe during their most recent inpatient stay</td>
<td>Q4 &gt;75% 73% 70% 71% 60% 83%</td>
<td>100% 100% 100% 100% 100%</td>
</tr>
<tr>
<td>Physical healthcare</td>
<td>3A</td>
<td>Inpatients who have had their medication cross-checked against more than one source within 72 hours of admission</td>
<td>Q4 &gt;75% 96% 93% 100% 98% 93%</td>
<td>100% 100% 100% 90%</td>
</tr>
<tr>
<td></td>
<td>3B</td>
<td>Inpatient service users report that they got enough advice or support for their physical health</td>
<td>Q4 &gt;65% 25% 67% 44% 90% 50%</td>
<td>100% - 100% 0% -</td>
</tr>
<tr>
<td></td>
<td>3C</td>
<td>Community service users report that they got enough advice or support for their physical health</td>
<td>Q4 &gt;65% 63% 50% 56% 74% 85%</td>
<td>100% 100% - - 50%</td>
</tr>
<tr>
<td>Carer involvement</td>
<td>4A</td>
<td>Establish a baseline for the percentage of service users that have a carer identified</td>
<td>Q4 &gt;55% 82% 69% 90% 75% 80%</td>
<td>50% 100% 80% 57% 67%</td>
</tr>
<tr>
<td></td>
<td>4B</td>
<td>Establish a baseline for the percentage of carers recorded as having been offered a carers assessment</td>
<td>Q4 &gt;40% 100% 100% 86% 100% 99%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4C</td>
<td>Establish a baseline for the percentage of carers that report feeling supported in looking after the person they care for</td>
<td>Q4 &gt;67% 54% 100% 75% 67% 100%</td>
<td></td>
</tr>
</tbody>
</table>

Key:  Not applicable  Data not available by directorate/data not collected in the quarter
<table>
<thead>
<tr>
<th>Quality Area</th>
<th>Ref</th>
<th>Quality priorities 2011/12</th>
<th>Period</th>
<th>Target</th>
<th>LD</th>
<th>CAMHS</th>
<th>Addictions</th>
<th>Offender Care</th>
<th>Rehabiliation</th>
<th>Eating Disorders</th>
<th>Q4 Trust Position</th>
<th>Q3 Trust Position</th>
<th>Q2 Trust Position</th>
<th>Q1 Trust Position</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access in a crisis</td>
<td>1A</td>
<td>Community service users report that they have a phone number to call in a crisis</td>
<td>Q4</td>
<td>&gt;65%</td>
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<td></td>
<td>72%</td>
<td>67%</td>
<td>66%</td>
<td>61%</td>
<td>(381)</td>
<td>(482)</td>
<td>(710)</td>
<td>(395)</td>
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<tr>
<td></td>
<td>1B</td>
<td>Discharged patients or those on a community caseload report being given a crisis card</td>
<td>Q4</td>
<td>&gt;85%</td>
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<td>53%</td>
<td>52%</td>
<td>55%</td>
<td>62%</td>
<td>(463)</td>
<td>(668)</td>
<td>(567)</td>
<td>(495)</td>
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<tr>
<td></td>
<td>1C</td>
<td>Community service users who called the crisis number report that they definitely got the help they wanted</td>
<td>Q4</td>
<td>&gt;65%</td>
<td></td>
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<td>44%</td>
<td>55%</td>
<td>53%</td>
<td>69%</td>
<td>(39)</td>
<td>(66)</td>
<td>(66)</td>
<td>(36)</td>
<td></td>
<td></td>
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<tr>
<td>Respect &amp; Involvement</td>
<td>2A</td>
<td>Community service users report that they were definitely involved as much as they wanted to be in decisions about their care plan</td>
<td>Q4</td>
<td>&gt;65%</td>
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<td>41%</td>
<td>46%</td>
<td>51%</td>
<td>52%</td>
<td>(383)</td>
<td>(478)</td>
<td>(704)</td>
<td>(395)</td>
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<tr>
<td></td>
<td>2B</td>
<td>Community service users report that they had been given (or offered) a written/printed copy of their care plan</td>
<td>Q4</td>
<td>&gt;80%</td>
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<td>51%</td>
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<td>71%</td>
<td>(378)</td>
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<td>(688)</td>
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<tr>
<td></td>
<td>2C</td>
<td>Patients reported that they felt safe during their most recent inpatient stay</td>
<td>Q4</td>
<td>&gt;75%</td>
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<td>75%</td>
<td>84%</td>
<td>79%</td>
<td>76%</td>
<td>(89)</td>
<td>(198)</td>
<td>(107)</td>
<td>(99)</td>
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<tr>
<td>Physical Healthcare</td>
<td>3A</td>
<td>Inpatients who have had their medication cross-checked against more than one source within 72 hours of admission</td>
<td>Q4</td>
<td>&gt;75%</td>
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<td></td>
<td>96%</td>
<td>97%</td>
<td>86%</td>
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<td>(232)</td>
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<td>(266)</td>
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<tr>
<td></td>
<td>3B</td>
<td>Inpatient service users report that they got enough advice or support for their physical health</td>
<td>Q4</td>
<td>&gt;65%</td>
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<td>59%</td>
<td>68%</td>
<td>69%</td>
<td>61%</td>
<td>(37)</td>
<td>(82)</td>
<td>(42)</td>
<td>(41)</td>
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<td></td>
<td>3C</td>
<td>Community service users report that they got enough advice or support for their physical health</td>
<td>Q4</td>
<td>&gt;65%</td>
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<td>66%</td>
<td>63%</td>
<td>71%</td>
<td>69%</td>
<td>(86)</td>
<td>(98)</td>
<td>(178)</td>
<td>(150)</td>
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<tr>
<td>Carer Involvement</td>
<td>4A</td>
<td>Establish a baseline for the percentage of service users that have a carer identified</td>
<td>Q4</td>
<td>&gt;55%</td>
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<td></td>
<td>78%</td>
<td>45%</td>
<td>55%</td>
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<td>(320)</td>
<td>(316)</td>
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<tr>
<td></td>
<td>4B</td>
<td>Establish a baseline for the percentage of carers recorded as having been offered a carers assessment</td>
<td>Q4</td>
<td>&gt;40%</td>
<td></td>
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<td></td>
<td>98%</td>
<td>34%</td>
<td>40%</td>
<td>no</td>
<td>(368)</td>
<td>(801)</td>
<td>(879)</td>
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</tr>
<tr>
<td></td>
<td>4C</td>
<td>Establish a baseline for the percentage of carers that report feeling supported in looking after the person they care for</td>
<td>Q4</td>
<td>&gt;67%</td>
<td></td>
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<td></td>
<td></td>
<td>67%</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>(63)</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td></td>
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</tr>
</tbody>
</table>

Key: Not applicable Data not available by directorate/data not collected in the quarter

Figures in brackets represent sample size.
Hillingdon Community Health performance against our current quality priorities

1 Reducing errors in the administration of medication by Hillingdon Community Health staff

The organisation on a year-to-date basis has reduced medication administration errors and has managed to remain below monthly target in most months. The target was for us to achieve a 10% reduction from last year where 53 medication errors took place, which meant our target was to have less than 47.70 errors. We are pleased to report that we have achieved this target with only 36 medication administration errors by HCH staff were recorded, significantly exceeding our 10% reduction target.

We achieved this performance through a number of means, including the planning and implementation of a Medicines Management Programme, which allows clinical staff to access awareness or training sessions. All new staff attend an induction training day and for clinical staff medicines management is included in this programme. For other staff there is a compulsory half day medicines management training programme which includes completing a competency framework and mandatory drug calculations. This will continue to be mandatory for all nursing staff as a three yearly update. These are new programmes for the year and attendance and compliance will continue to be monitored in the future, under mandatory training compliance.

We have successfully introduced a community health services pharmacist, who works closely with clinical staff, the Learning and Development Team and the Quality Governance Team. The pharmacist reviews all incidents relating to medicines management and reports monthly to the Quality Governance Group.

The pharmacist reports incident reviews through the Quality Governance Group and the information is cascaded via the heads of services for adults, children’s and dental services. The information is also monitored centrally in the Trust.

2 Increasing the number of women who sustain breastfeeding at six to eight weeks post delivery

Denotes CQUIN target
We are pleased to report that we have achieved a year-to-date position of 60%, exceeding the 58% target. The Breast Feeding Co-ordinator has continued to work with the community engagement team and the Breast Feeding Steering Group has met throughout the year to monitor and report on activity in this area.

Hillingdon has a multiagency breastfeeding policy, joint training, and close working with maternity, health visiting and children’s centres. In the coming year it is hoped that general practice will embrace training by accessing the new (UNICEF) e-learning package for GP’s.

Hillingdon has an in-house breastfeeding peer support training programme, which is highly cost effective considering the expected high turnover of volunteers who have their own families. There are currently 30 registered volunteers.

The Hillingdon Hospital has a part-time Infant Feeding Co-ordinator (specialist midwife) who works in collaboration with a full-time Breastfeeding Co-ordinator within Hillingdon Community Health (Specialist Health Visitor). The joint strategy has developed an in-house training programme for volunteers, who are based within the maternity unit, or in one of the many children’s centres in Hillingdon. Since 2010 training has been delivered to children’s centre staff to enable staff to roll out antenatal classes along with being trained to support women to breastfeed throughout the week in the centre. The engagement with families in the antenatal period was identified as pivotal to initiation and continued breastfeeding in Hillingdon. This is in addition to all appropriate community health professionals being trained on a two day breastfeeding management course (compliant with UNICEF Baby Friendly Initiative).

Feedback from service users:

“Started at hospital today, and just had the most wonderful time there, I learnt so much (from the Infant Feeding Coordinator), it was great to finally get that much needed practical hands on approach with the new mums. Can’t wait to get back there on Monday. I almost didn’t want to go home!”

Jo - volunteer, following her first shift on the maternity unit (usually volunteers in a children’s centre)

“As a result of all the help and support I have received, I have continued to breastfeed and I’m really enjoying it now, Thanks so much.”

From breastfeeding support – delivered within the children’s centre settings
3 Supporting service users with diabetes to better understand and manage their condition (through DESMOND training)

Feedback from service users:

“It was a very informative useful day. I wasn’t too sure about going on the course, but found it helpful. The course leaders were very friendly and encouraging and you didn’t feel silly voicing concerns.”

Anonymous feedback

“It thoroughly enjoyable and what was needed as a basis on which to manage diabetes.”

Anonymous feedback

Denotes CQUIN target

All individuals who completed the DESMOND training last year received a questionnaire six to eight weeks following attendance to ascertain their views as to whether the training had improved their understanding of diabetes and their ability to manage the condition better.

Response rates to the questionnaire were excellent and 98% of respondents stated that the course had both provided them with a greater understanding and given them more confidence to manage their condition better.

The Diabetic Team will build on this work in the coming months in order to continually review and adapt the programme so that it meets individual needs and further empowers self-management.
4 Offering and providing interpreting support to service users when they express a need for it

Throughout the year the organisation has continued to raise awareness and ensure that staff know the correct access to interpreting services. Posters are available in all areas to notify staff and service users of the service. Also the PALS co-ordinator has continued to work closely with clinicians in maintaining the advice related to accessing the interpreting service.

The PALS co-ordinator has monitored the use of interpreting services through patient surveys. The majority of patients surveyed responded that they have access to the interpreting service if they need it. The present way of capturing data in the annual patient survey will be reviewed to provide more data, as the numbers captured this year were small.

Whilst not achieving the 90% target there was no negative feedback either through PALS or from those using the service. We will however continue to monitor service provision in this area.
Camden Provider Services performance against our current quality priorities

Priority 1 Improving telephone access

To ensure that users and carers can access services by telephone quickly and effectively and take into account any special needs of the caller.

Measure A: percentage of service users surveyed (or asked using the Patient Experience Tracker (PET) or equivalent real time feedback tool) report finding it ‘easy’ or ‘very easy’ to get through to services on the phone

Surveys were undertaken in adult community services, health visiting, school nursing services and podiatry. The results from the school nursing survey highlighted that there were some issues that need to be addressed. A link to school websites was introduced and school Heads were surveyed further. An action plan has been agreed and is being implemented.

We set ourselves a target of 80%. The results from each of survey are shown below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult community services</td>
<td>94.7%</td>
</tr>
<tr>
<td>Health visiting</td>
<td>95.0%</td>
</tr>
<tr>
<td>School nursing services</td>
<td>61.0%</td>
</tr>
<tr>
<td>Podiatry</td>
<td>78.0%</td>
</tr>
</tbody>
</table>

These surveys combined show that 80% of service users report finding it ‘easy’ or ‘very easy’ to access services on the phone, achieving our target.

Measure B: percentage of calls to the key telephone contact points for services are picked up within one minute when assessed by mystery shopping survey

We conducted two telephone surveys across all services. The first, undertaken in November 2011, involved a total of 35 calls of which 34 were answered within one minute. Of these, four calls went on to a message leaving service and two calls were put through to a message informing the caller that the clinic was closed and provided details of opening times.

The second audit, undertaken in February 2012, involved a total of 33 calls of which 30 were answered within one minute. Both surveys achieve the target with an overall achievement of 94%.

Measure C: percentage of relevant staff receive practical training on handling phone calls from service users or their carers

All (31) relevant members of staff have attended practical training on telephone customer care.
**Priority 2 Introducing safer ambulatory syringe drivers**

To implement the recommendation made in a National Patient Safety Agency report to introduce syringe drivers across our services that all have rate settings in millilitres per hour to prevent confusion and have additional safety features.

**What are our measures and targets for 2011/12?**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2011/12</th>
<th>2011/12</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. To have completed all actions required in response to the patient safety alert before the first deadline of the 16 December 2011</td>
<td>Complete all actions</td>
<td>Achieved</td>
<td>N/a</td>
</tr>
<tr>
<td>B. To identify a preferred new model of ambulatory syringe driver to be used in CPS services (device selection to be undertaken in conjunction with the North Central London Palliative and Supportive Care Network) and an end date to complete the transition between existing ambulatory syringe drivers and ambulatory syringe drivers with additional safety features (CPS will be seeking to complete the transition to safer syringe drivers as soon as possible and within a time period shorter than the five year maximum specified by the NPSA)</td>
<td>Identify preferred new model and agreed end date</td>
<td>On track for May 2012</td>
<td>N/a</td>
</tr>
<tr>
<td>C. To revise the syringe driver policy, training programme and competency assessments to support the safe operation of all designs of ambulatory syringe driver in use during the transitional period.</td>
<td>Revise policy to be undertaken in 2012/3</td>
<td>N/a</td>
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</tr>
</tbody>
</table>

**Measure A**

A risk reduction plan was put in place by 16th December to mitigate any potential risks through the use of different syringe drivers in hospitals and in the community.

**Measure B**

This action forms part of the National Patient Safety Agency (NPSA) alert guidance and action plan that formed measure A. Camden Provider Services (CPS) has been working with North Middlesex Hospital who are leading the exercise for the North Central London Sector. A sector wide approach is being taken as it will increase safety through using the same device across the whole sector. There will also be a cost benefit because of bulk orders. A suitable device has now been agreed upon and the procurement process is now under way. It is anticipated that the procurement process will be concluded in May 2012.

**Measure C**

These actions will be undertaken during the coming year as part of the implementation planning for introducing the new device.
Sexual and reproductive health services.
Priority 3 To provide intensive stroke rehabilitation in accordance with NICE quality standards

It should be noted that CPS did not set targets in the Quality Account for measures A, B and D because it is working with the Stroke Network to set targets for a community non acute care unit. The unit will continue this work in 2012/13 and the measurements undertaken so far will inform the Stroke Network standards.

Measure A
Patients with stroke are assessed and managed by all relevant members of the specialist rehabilitation team within 72 hours with documented multidisciplinary goals agreed within five days (relates to NICE Stroke Quality Standard Statement 5).*

- 100% of clients are screened and risk assessed within 24 hours for appropriate seating and management guidelines
- 89% of clients are seen by occupational therapy and 84% are seen by physiotherapy within 72 hours of admission (Q4 results)
- 60% of clients are provided with documented MDT (multidisciplinary team) goals within one week (Q4 results).

The latter percentage is an area the unit would like to improve upon. The explanation for this low percentage is often due to the nature of the condition of the patient during the first week and the difficulty of calling members of the family together for a conference within a week. The unit will continue to work with the Stroke Network on this in terms of benchmarking performance and setting appropriate standards for a community rehabilitation unit.

Measure B
Patients with stroke are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of five days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it (relates to NICE Stroke Quality Standard Statement 7).*

- 89% of occupational therapy (85% at quarter two and 90% at quarter three)
- 88% of physiotherapy (89% at quarter two and 91% at quarter three)
- 65% of speech and language therapy (SLT) (77% at quarter two and 76% at quarter three)

The result for quarter four for SLT is lower this quarter because there is only one SLT assigned to the unit and in quarter four there was a significant increase in the numbers of patients with a greater dependency requiring this therapy. The unit is looking at how to better utilise specialist staff to meet the peaks and troughs of demand.

Measure C
Patients with stroke who have continued loss of bladder control two weeks after diagnosis are reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers (relates to NICE Stroke Quality Standard Statement 8).*

The project concerning the assessment of bladder function and continence care plans has been focussed on our complex care and neurology-nursing teams. The team have developed an assessment tool that is currently

*NICE (National Institute for Health and Clinical Excellence) quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions, derived from the best available evidence. See http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp
being piloted. The assessment tool is an on-going method of assessing and planning the care, and enables the team to map the patients’ journey in relation to this. It is designed to involve patients and families where it is achievable to do so. Depending on the outcome of the pilot, we will continue to use the assessment tool for all patients with bladder or bowel dysfunction, and it will be kept under review by the multi-disciplinary team.

**Measure D**
All patients after a stroke are screened within six weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment (relates to NICE Stroke Quality Standard Statement 9).*

All patients are being screened within six weeks to identify mood disturbance and cognitive impairment.

**Measure E**
All patients discharged from hospital who have residual stroke-related problems are followed up within 72 hours by specialist stroke rehabilitation service for assessment and ongoing management (relates to NICE Stroke Quality Standard Statement 10).*

The community team responsible for following up patients discharged out into the community are reporting that 100% of patients are being contacted within 24 hours and followed up within 72 hours for assessment and ongoing management.

**Priority 4 Communication with GPs about the care of HIV patients**
To achieve effective two way communication with GPs concerning the medication prescribed for HIV patients to reduce the risk of contraindications.

**Improving services for patients with HIV**

**Measure A:** At least 70% of patients diagnosed with HIV since 2000 are registered with, and have their HIV status disclosed to their GP.

Healthcare and monitoring of patients with HIV is of utmost importance. This measure was put in place to ensure patients, as far as possible, are registered with a GP and provide their consent for the HIV services to share important healthcare information with the GP. This is to ensure the patients receive coordinated care that is safe and effective. We are pleased to report that we have exceeded our target achieving 72% at quarter four.

![Graph showing the percentage of patients with HIV registered and having their status disclosed to their GP](https://example.com/graph)

* NICE (National Institute for Health and Clinical Excellence) quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions, derived from the best available evidence. See http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp
**Measure B: At least one communication each year with a patient’s GP for 90% of HIV patients who are registered with a GP and who have consented to letters being sent to their GP**

We implemented an action plan developed as a result of an evaluation of GP prescribing data and that held by CPS. One of the focuses was to ensure that patients were proactively asked whether it was ok to disclose their condition to their GP to inform them of their treatment and progress. If this consent was given a letter was sent to their GP enabling us to establish a system to cross reference GP and CPS prescribing information in the patient’s notes to reduce possible medication errors from occurring.

We are pleased that we have achieved this target, achieving 90%.
Our quality priorities for 2012/13

We will now tell you about our quality priorities for 2012/13 and how we have agreed these.

CNWL provides mental health and allied speciality services across central and north west London, and community healthcare services in Hillingdon and Camden. We have developed a different set of quality priorities for mental health and allied specialities, and community services in Hillingdon and Camden. This is to make sure that the quality priorities for each are appropriate and specific to their work, and that they reflect the views of their local stakeholders.

For each quality priority we have identified indicators and targets to measure our performance in this area. These indicators help us to check how we are performing throughout the year and will be used to report on our performance in next year’s quality account. However, we are keen to emphasise that our work to deliver quality services is not limited to just delivering against these indicators.

Where we present our quality priorities and measures, we have highlighted if the measure is aligned to a CQUIN, is a new measure or is an extension of a measure from this year.

**How we agreed our quality priorities for 2012/13**

In agreeing our quality priorities for 2012/13 we considered a wide range of information available to us including a) our performance against our current performance quality measures, b) our organisational learning themes, and c) consultation with our internal and external stakeholders.
**Our quality data**

Throughout the year we look at how we are performing, and consider feedback from patients, service users, carers and staff (including complaints) to see how we can improve the quality of our services. Our clinical and service directors act on the findings and develop action plans for implementation at a local level where quality improvement needs to take place.

On a quarterly basis we publish our joint quality and performance dashboard and quality governance reports which include our quality priorities and other quality measures. We gather information for this dashboard through quarterly audits, patient and carer surveys as well as our electronic data systems.

Over the last two years all of our mental health borough based services moved over to the JADE electronic reporting system thereby creating consistency of reporting across the Trust in preparation for the move to service lines. The Change Programme Board is aware of and has mitigated against the risks to patient safety and confidentiality when planning the move to service lines.

The Quality and Performance Committee, chaired by a Non-Executive Director, oversees our progress in this area and provides assurance to our Board that we are working towards meeting standards. Performance against our quality and performance measures is shared with our Council of Members and published on our website.

One of the challenges we have faced this year is the very different response rates achieved through our current survey processes. Feedback from our service users includes ‘survey fatigue’. For this reason we are examining our data gathering processes for 2012/13, including consultation around questions and potentially new ways of gathering data, in order to reach the goal of using feedback to improve services.

**Organisational learning themes**

We also take stock of what we hear across the Trust to develop our organisational learning themes. These are key areas of focus for the Trust for our quality and improvement activities. Organisational learning themes are based on information received from complaints, claims, incidents, serious untoward incidents, PALS data, staff and patient surveys, and clinical audits. For 2010/11 these were:

- Information and communication about medication and treatment;
- access to help ‘out-of-hours’;
- GP communication;
- protecting staff from violence; and
- ‘Think Family’ - meeting the needs of children and families.

You will see that some of themes have informed our quality priorities for 2012/13.
Consultation with stakeholders

Discussions with our patients and service users, carers, LINks (Local Improvement Networks), commissioners and staff helped inform what our quality priorities should be. This year our LINks undertook to consult with our local communities to understand which areas should be prioritised for quality improvement. We used this information as our starting point and shared this with our commissioners and other stakeholders to build on these themes. We engaged with our commissioners to align and complement where possible these themes with the CQUIN (Commissioning for Quality and Innovation) to help arrive at our quality priorities. Eight of our 17 quality indicators are also CQUIN. We have highlighted this in the section below.

Our discussion throughout the year culminated in a large stakeholder event that provided an opportunity to comment on all the proposed quality priority areas and also comment on some of the work that we have done, and plan to do, to achieve these quality priorities. This event had more than 60 attendees with representation from service users/patients, carers, LINks, staff, commissioners, GPs, our Council of Members, and the Chair of our Board.

The feedback from our large stakeholder event helped to inform the final quality priorities for 2012/13 as shown over the next few pages.
A patient at St Pancras Hospital South Wing.
Mental health and allied specialities quality priorities for 2012/13

Recovery and involvement
Recovery describes the personal journey people with mental health problems take to rebuild and live meaningful and satisfying lives. We are committed to working with our service users to aid this recovery, and recognise the importance of involving service users in their care planning, as much as they want to be, in order to achieve this.

At last years’ Quality Account stakeholder event we heard that recovery should be a quality priority, and this was echoed at this year’s event. Recovery and involvement also forms part of the NICE quality standard for service user experience in adult mental health, and is recognised in national policy. As a Trust we see recovery and involvement as an essential part of care and will continue to work to deliver recovery focused mental health services.

Our measures for this year are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2012/13</th>
<th>Target 2011/12</th>
<th>Measure is a CQUIN this year</th>
<th>New measure this year</th>
<th>Measure same as last year but sample extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. At least 65% of community patients report that they were involved as much as they wanted to be in decisions about their care plan</td>
<td>65%</td>
<td>65%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. At least 50% of service users on CPA whose care plans contain at least one personal recovery goal</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why we have set these targets?
This year we are extending, where possible, the sample for measure A to all applicable service lines. This is based on consultation feedback and as requested by our Board. This remains a very important user experience measure for us and we are keen to remain focussed on our performance here. Our performance in quarter four of 2011/2012 was challenging as we chose to look at whether or not service users felt they were definitely involved in decisions about their care. We believe that keeping our target at 65% is ambitious and appropriate for us for 2012/2013.

Measure B is new this year and aligns with our CQUIN. Recovery goals are personal to an individual and are set in partnership with a service user. This measure will help to identify where personal recovery goals have been agreed, through collaborative care planning, for our service users.

How are we going to achieve them?
We will continue our work to review use of the new care plan, and ensure recovery focussed practice really is adopted across the organisation. This will be through staff supervision and training, and the CNWL Recovery College will be crucial to achieving this.
We have begun to introduce new assessment tools that are service user focussed. They are being introduced on a borough by borough basis, as each borough has a different approach to social care personalisation. These have been introduced in Westminster, and we will continue to roll out wider across the Trust over the next year and beyond.

**Focus on:**

**The CNWL Recovery College**

The CNWL Recovery College was formally launched Trust-wide on 18th April 2012. This was possible because our staff and service users worked together over the last few years to develop the college. The recovery college model is an innovative and inspiring way for our staff and service users to work and learn together, with staff and service users learning side by side in the same courses.

The curriculum of courses set each term is open to residents and staff of all the boroughs where CNWL deliver services.

All courses have all been co-produced with our service users, and will be co-facilitated by a mental health practitioner and a service user trainer. This means that all courses will benefit from the expertise of professionals and those with lived experience of mental health. Service users can apply to receive training to become peer recovery trainers at the college.

The college also trains service users to become peer support workers. These are new, and specialist roles, and peer support workers will form part of the multi-disciplinary teams within some of our services.

The first prospectus of courses was piloted January – March 2012 and received excellent feedback from staff, service users and trainers.

"For me the chance to work in a truly co-productive way in the co-productive environment of the college has played a big part in my own recovery journey. I really believe it is the same for peers and for the people who attend."

Waldo Roeg, Peer Recovery Trainer

"‘Taking Back Control’ training has been so inspirational. I’ve learnt so much from both the course facilitators and from everyone else in the group. It’s been amazing having time when everyone can feel comfortable and safe to share their story."

Joss Fleming, student
Physical health
The Government’s strategy ‘No Health Without Mental Health’ aims to improve the physical health of people with mental health problems. There is an increasing amount of evidence that clearly shows how important it is to consider the physical health, as well as the mental health, of all of our service users. We know that people with serious mental health conditions have a life expectancy 10 to 15 years lower than the UK average. When coupled with poor physical health the impact is greater and life expectancy is even further reduced largely due to preventable physical health conditions.

We recognise that there is more we can do in this area especially as we build our expertise through our community provider services arms. Therefore we have kept physical health as a quality priority this year.

Our measures for this year are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2012/13</th>
<th>Target 2011/12</th>
<th>Measure is a CQUIN this year</th>
<th>New measure this year</th>
<th>Measure same as last year but sample extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. At least 90% of service users with dementia prescribed anti-psychotic medication that have three-monthly reviews, and output sent to GPs and families/patients within two weeks</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. At least 65% of service users on CPA report that they got enough advice and support for their physical health</td>
<td>65%</td>
<td>65%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why we have set these targets?
Measure A focuses on our older adult service line, and in particular those service users with dementia. It is an important safety measure and communications with GPs will promote good practice on this issue across the wider health system.

We have included measure B again this year as we did not achieve all that we wanted to achieve in this area. This measure is important in assessing whether we provide advice and support for the physical health needs for our service users both in an inpatient setting, and in the community.

How are we going to achieve them?
We will continue to train our physical healthcare link practitioners to support our inpatients. Our new care and support plan highlights the importance of the physical health and prompts discussion on service users physical health needs and the support required. We will also continue our work to support other aspects of our service users physical health, for example through offering smoking cessation advice and support. We will enable this by continuing to train our staff to do this effectively.
Carer involvement

Last year we heard in our consultations that we needed to focus on addressing the needs of carers as part of our work to develop quality services. Carers play a vital role in supporting service users when required. We recognise that good working relationships between services and carers are fundamental to delivering high quality care and keeping service users safe. This year we continued to hear from our stakeholders on how important carers are and want to continue focussing on this as a quality priority as we recognise there is much more work to be done.

Our measures for this year are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2012/13</th>
<th>Target 2011/12</th>
<th>Measure is a CQUIN this year</th>
<th>New measure this year</th>
<th>Measure same as last year but sample extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Percentage of carers who report feeling supported by CNWL staff in a crisis</td>
<td>Baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Percentage of carers that report having information that tells them how to access services in a crisis</td>
<td>Baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why we have set these targets:

We have included measure A so we can understand whether our carers feel they are being supported. Analysis of this information, along with the information we currently provide to the local authorities regarding referral, assessment and provision for carers, will help us to identify if there is more we can do.

Measure B is included as we have heard a great deal through our consultation about the importance of carers knowing how to access our services out-of-hours in a crisis, as sometimes the service users that they care for are not able to do this alone when they are in a crisis.

How are we going to achieve them?

We will continue our work to ensure all of our staff are aware of the importance of carers. In particular we are asking our staff to identify carers and where it is appropriate, and agreed with the service user, to include them in the care planning process.

We have piloted carer contact cards in Westminster and these were well received so we will roll these out in the Trust. In this year, phase one will include adult services, and phase two will extend to older adult services.
Service pathway and access to services when in a crisis

During our consultation we heard a lot about the importance of a smooth transition between services, and getting the necessary support when both accessing, and being discharged from services. We recognise the importance of getting this right for all our service users which is why it has been included as a quality priority for this year.

Our measures for this year are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2012/13</th>
<th>Target 2011/12</th>
<th>Measure is a CQUIN this year</th>
<th>New measure this year</th>
<th>Measure same as last year but sample extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Demonstrate the establishment of supported discharge processes and protocols to support service users who have been discharged to primary care</td>
<td>Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. At least 65% of individuals reporting that they received the help they wanted from CNWL crisis contact points when they contacted them in a crisis</td>
<td>65%</td>
<td>65%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why we have set these targets?

Measure A is important to us as a key step in developing a more robust approach to working with GPs. Adopting the recovery approach means that we need to get better at ensuring that when we have discharged service users back into the community we need to work with our GP colleagues to support service users as they continue to recover. We need to ensure that if discharged service users that require our specialist services again can access these quickly and GPs are confident that there care is being managed appropriately.

Access to services in a crisis was one of our quality priority areas for this year. We have done a lot of work this year to introduce crisis cards and ensure that service users know how to contact our services out of hours, however, we recognise that there is more to do in this area. We have commissioned a special programme of work on out-of-hours services to further improve the way in which these services are offered. Building on our results for this year we have retained this measure so that we can gather better qualitative information that will help us improve our response.
How are we going to achieve them?

We understand that the protocols alone do not deliver a change, nevertheless we must have the right foundations in place to build from and we think it is important that we invest our efforts in doing this now. We will seek to work with GPs to agree the most appropriate pathway to get back to secondary services, and what is needed to make this work in practice.

We have a wide programme of work that is looking at all of our-out-of hours services and how these can be improved to ensure that they meet the needs of our service users. We will continue to review service user feedback and will also look to undertake another mystery shopper exercise.

Focus on:

Developing a single telephone number to access our services out-of-hours in a crisis

As part of our on-going commitment to providing access to our services in a crisis, we are working hard to develop a single telephone number that all service users can contact out-of-hours in a crisis.

In order to achieve this we are reviewing how we manage out-of-hours access at present and are looking to develop a CNWL triage facility that links to all these services, across all of our boroughs, to provide a smooth and efficient service for our users.
Hillingdon Community Health: Quality priorities for 2012/2013

Use of care plans

It is important that patients who are nearing the end of their life are cared for appropriately and their needs and wishes are met. End of life and Advanced Care Plans allow patients to communicate their wishes and preferences, as well as providing a valuable tool to monitor the quality of care and to ensure patients and families/carers needs have also been met. This is also aligned with end of life care being an area of priority both nationally and across north west London.

Patients with learning disabilities can sometimes have more complex needs when undergoing health care. Sometimes these additional needs are not always addressed effectively. Personalised care plans ensure communication is effective between team members and also clearly address individual patient’s needs. All patients with learning disabilities should have a personalised care plan. The care of individuals with learning disabilities has been highlighted as a national priority.

Our measures for this year are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2012/13</th>
<th>Target 2011/12</th>
<th>Measure is a CQUIN this year</th>
<th>New measure this year</th>
<th>Measure same as last year but sample extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. At least 75% of end of life care patients on district nursing caseload with advance care plan</td>
<td>75%</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. At least 25% of patients with learning disability conditions using HCH services who have personalised care plans</td>
<td>25%</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why we have set these targets?

Measure A will build on work from 2011/12, and we believe that 75% is an ambitious target for us to work to achieve.

Measure B will also build on the work that we have done as part of our CQUIN programme in 2011/12

How are we going to achieve them?

Data will be collected monthly by staff who have patients on their caseload undergoing end of life care. Records will be checked to ensure a care plan in place for these patients and the data collated centrally. Records will be audited to ensure patients have the appropriate care plan in place. Families and carers will also be asked if our care has met their needs.

This work will support the move across London to the new ‘co-ordinate my care’ register. As this programme rolls out across Hillingdon, the teams will translate this to the multi-disciplinary care register.

We will build on our work to date that has focused on the identification of individuals with a learning disability, the introduction of a training package for staff and the evolvement of specific care planning. Monitoring will be take place centrally on a monthly basis. The category of patients with learning disabilities is now recorded on their electronic record and therefore a personalised care plan will be attached to that record.
Reducing the number of avoidable grade 2/3/4 pressure ulcers

Whilst the number of avoidable pressure ulcers is low there is still a high incidence of pressure ulcers being reported in the community. Therefore it is prudent to continue to monitor this quality target. This is also an area for national priority as identified in the operating framework for 2012/13.

Our measures for this year are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2012/13</th>
<th>Target 2011/12</th>
<th>Measure is a CQUIN this year</th>
<th>New measure this year</th>
<th>Measure same as last year but sample extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the number of avoidable grade 2/3/4 pressure ulcers</td>
<td>10% year on year reduction</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Why we have set these targets?
As of end of December 2011 we have had 53 avoidable ulcers. We believe that to achieve a 10% reduction on the number of avoidable grade 2/3/4 pressure ulcers is a good target for our staff to work to achieve this year.

How are we going to achieve them?
Performance will be monitored through the incident reporting process. All grade 3 and 4 pressure sores will be reviewed using a route cause analysis investigation and the information fed back through the Quality Governance Group and to clinical teams involved.

We will also review the involvement of the Tissue Viability Team in providing expert advice and assist with the management of patients with pressure ulcers.
Improving staff awareness in relation to carers

We recognise the significant contribution that carers play in supporting the health and wellbeing of the patients we care for. It is important that we are able to provide information and support to carers to enable them to remain well and continue this important role.

Our measures for this year are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2012/13</th>
<th>Target 2011/12</th>
<th>Measure is a CQUIN this year</th>
<th>New measure this year</th>
<th>Measure same as last year but sample extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>baseline</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>80%</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why we have set these targets?

Measure A will monitor whether we have achieved our objective of developing localised guidelines and delivery of training to our staff to help them signpost carers to available support.

Measure B is included as our wheelchair services have liaised with commissioners, local authority and carer organisations to identify a need for the carers and implement a service to address this need. They have recently completed a small pilot and recognise that this work to train carers should be continued. Therefore we are including as a quality priority for the first time this year to monitor our work in supporting carers in this way.

How are we going to achieve them?

We will develop local guidelines and put a training programme in place across all our services to raise awareness of this issue and to enable staff to be more effective in referring and signposting individuals to available sources of support.

We will continue to build on the foundations laid by the wheelchair services, and deliver further training to wheelchair users’ carers as proved beneficial through the pilot exercise.
Clinical quality in our HIV services

Our sexual health service is seeing an increasing number of patients, and the service wants to ensure optimal care is maintained. As such we have agreed the following measures of our clinical quality for this service.

Our measures for this year are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2012/13</th>
<th>Target 2011/12</th>
<th>Measure is a CQUIN this year</th>
<th>New measure this year</th>
<th>Measure same as last year but sample extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. At least 95% of HIV patients whose immune systems are maintained at a CD4 count greater than 200</td>
<td>95%</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. At least 95% of patients with a viral load less than 50 copies / ml within one year of treatment commencing</td>
<td>95%</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why we have set these targets?

Measure A shows that we correctly identify those patients in need of treatment, start them on treatment in good time, use effective treatments, monitor those treatments and help patients to continue to take them correctly.

Measure B is about how well controlled the infection is, and this level shows that the infection is very well controlled for that person and that damage to them from the virus is kept to a minimum. It also means that they are much less infectious to other people.

How are we going to achieve them?

As a measure of optimal care, the sexual health service will aim to successfully treat patients requiring HIV treatment when their routine blood test monitoring indicates that their immune function is low, to achieve an excellent response to treatment within one year i.e. the virus level in the blood becomes ‘undetectable’.
Patient experience

We have included the following measures around patient experience in response to feedback from patients and audits from the past year.

Our measures for this year are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2012/13</th>
<th>Target 2011/12</th>
<th>Measure is a CQUIN this year</th>
<th>New measure this year</th>
<th>Measure same as last year but sample extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. At least 80% of patients with an appointment with sexual health services, who arrive on time, that are seen within thirty mins of the appointment time</td>
<td>80%</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Number of responses stating poor responsiveness to call bells on inpatient wing of St Pancras hospital</td>
<td>0</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why we have set these targets?

Measure A has been set in response to patient complaints concerning waiting times in sexual health service clinics. We will measure this across all sites where we deliver sexual health service clinics.

Measure B has been set in response to a recent patient survey undertaken on the in-patient wing of St Pancras Hospital. This survey demonstrated evidence of good caring practice however there were four responses that concerned poor responsiveness to call bells.

How are we going to achieve them?

We will continually monitor waiting times through our recently introduced electronic booking system, identifying busy periods and matching staff to workload as closely as possible.

In addition we will look at working practices to continue to improve the patient journey through the clinic. Quarterly reports will be produced for the Quarterly Governance Report to monitor progress at executive level.

We will undertake further surveys of the inpatient wing of St Pancras hospital in May and November to establish whether improvements have been made following implementation of an agreed action plan.
Monitoring and sharing how we perform

**Record our performance**

We record our performance against our quality priorities against specific measures and targets. We also record our performance against a number of other indicators, including quality priorities from previous years and national indicators.

**Measure our performance**

We collect data on how we are performing that allow us to look at patient experience, outcomes and processes. We use a variety of methods that include performing spot checks on documentation, undertaking local service user and carer surveys and participating in national service user and staff surveys. We have also improved our computer systems that are used to record information so it is possible to capture more information on performance from these systems.

**Monitor our performance**

We formally monitor our performance every month through the Quality and Performance Committee chaired by a Non-Executive Director of the Board and made up of Executive Directors. We have quality and performance management groups across the Trust and these consist of our clinical and service directors. This allows us to identify and act on any issues relating to performance as part of our on-going commitment to ensuring the quality priorities result in on-going positive change in our organisation.

**Benchmarking**

We are members of the NHS Benchmarking Club which undertakes national benchmarking across all Mental Health and Community Trusts. We benchmark ourselves against other similar mental health and community services Trusts to compare how we are performing in comparison. This is a useful way to understand our performance compared to others, and identify areas for improvement. Where we find that we are not performing as well as we would like, we feed this back to services to find out why this is, and agree plans with timescales on how to improve. We then continue to monitor our performance ensure the plans are being implemented and that performance is improving as a result.

**Report our performance**

We report on our performance in this annual Quality Account, however we also share our joint quality and performance reports with our stakeholders every quarter that is broken down by borough. We have presented our performance at the Trust level in the body of our Quality Account to keep the flow of the document and not to overload our readers with too much detail, however you will be able to find borough level data on pages 132-135.
**Statements relating to quality of NHS services provided**

Our regulators need to understand how we are working to improve quality so the following pages include the specific messages that they have asked us to provide.

**Services**

During 2011-12 CNWL provided and/or sub-contracted seven NHS services.

These included mental health services (adult, older adult, CAMHS), learning disabilities, addictions, offender care, sexual health/HIV services, and community services in Camden and Hillingdon.

CNWL has reviewed all the data available to them on the quality of care in seven of these NHS services.

The income generated by the NHS services reviewed in 2011/2012 represents 92% per cent of the total income generated from the provision of NHS services by CNWL for 2011/2012.

**Participation in clinical audit**

During 2011/12, four national clinical audits and two National Confidential Enquiries * covered NHS services that CNWL provides.

During that period CNWL participated in 100% national clinical audits and 100% National Confidential Enquiries of the national clinical audits and National Confidential Enquiries which it was eligible to participate in.

The national clinical audits and National Confidential Enquiries that CNWL was eligible to participate in during 2011/12 are as follows:

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- National Confidential Enquiry into the Patient Outcome and Death - Cardiac Arrest Study;
- National Parkinson’s Audit;
- Prescribing in mental health services (POMH);
- National Schizophrenia Audit; and
- Care of Dying in hospital.

The national clinical audits and National Confidential Enquiries that CNWL participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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* National Confidential Enquiries are designed to help assess quality of healthcare and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.
The reports of six national clinical audits were reviewed by the provider in 2011/2012 and CNWL intends to take the following actions to improve the quality of healthcare provided:

- National Falls and Bone Health in Older People (Hillingdon Community Health): Using ‘Patient Safety First - the ‘How to’ guide for reducing harm from falls 09/2009’ and in involving members of the multi disciplinary team, the necessary documentation and risk assessment tools were devised. The audits were carried out on a monthly basis. The aim of the audit was to assess if staff were completing all the necessary falls documentation and risk assessments. These audits continue bi-monthly;

- National Falls and Bone Health in Older People (Camden Provider Services): The report of the national audit of falls and bone health (2010-11) was reviewed locally and the following progress was noted since participation in the previous round of this audit:
  - Improved screening, specialist falls management and introduction of a validated home hazard assessment tool;
  - increased screening for falls by health care professionals working in the community;
  - assessment of clients placed on falls management pathway using a Multi Factorial Falls Risk assessment;
  - use of validated home hazard assessment (Home Fast) – used on all clients identified to have the environmental risk for fall;
  - improved structures and increased staffing: Falls Co-ordinator in post, Camden Falls Steering Group formed;
  - effective joint working with Care Homes: All Local Authority in-house operated care homes have falls registers, an agreed protocol for risk identification and protocols to manage residents who have fallen; and
  - training: Provided for a range of different health care professionals in the community re: risk identification and referral processes.

The Camden Falls action plan was updated to identify and address the following areas where further improvements could be made in our services and in partnership with other providers:

- Designated consultant time for the falls service;
- consider whether Camden Provider Services needs or could have access to a fracture liaison nurse/service and a specialist
• Lithium treatment (POMH). This report has been discussed by the Physical Health Steering group and will also go to the Medicines Management Group for further discussion about the action to be taken;

• use of antipsychotic medicine in children and adolescents (POMH). The report was received from POMH towards the end of March and will be discussed at the Medicines Management Group and disseminated to the relevant teams involved. This is the second iteration of this audit and CNWL has seen improvements in all standards.

The reports of approximately 230 local clinical audits were reviewed by the provider in 2011/12 and CNWL intends to take the following actions to improve the quality of healthcare provided:

Local quality governance structures are in place across the organisation to monitoring and take action on the results of audits. Through these groups, the results of clinical audit reports are discussed, and any actions required to improve practice are identified. Some examples are given opposite:

• Insulin Administration and Documentation Audit

  **Action:** Ensure team co-ordinators work with colleagues to identify where there is a need for increased training in the use of insulin administration devices to ensure insulin is being well administered.

• Pain Scales Audit carried out by podiatry.

  **Action:** Teams will be supported to complete pain scales at entry and end of care package to ensure that we have a record of measurable patient outcomes.
• **Improvements in Physical Activity**  
  **Outcome Measurements in Pulmonary Rehabilitation** carried out by REACH Pulmonary Rehabilitation team  
  **Action:** Develop a system for telephone follow up of pulmonary rehabilitation patients to try and retain the benefits achieved and to improve recruitment back into the program at one year.

• **Multi-Agency Child In Need Case File**  
  **Audit carried out by health visiting and school nursing**  
  **Action:** To hold specific training/workshops on the skills of providing evidence of decision making using the Common Assessment Framework when compiling a report for child protection case conferences. To hold generic training to address quality of report writing. Child protection supervision sessions to include oversight and analysis of case conference reports with a focus on barriers to information sharing with parents/carers/children.

• **Audit of physical health examination on admission to a mental health ward**  
  **Action:** Training for teams to increase the percentage of completion of physical health assessments

• **Shared Care Prescribing Audit**  
  **Action:** To inform involved clinicians in secondary care about the existing proforma for shared prescribing and how to access the form; to inform GPs regarding existing service and criteria for eligibility of share care prescribing policy.

• **Audit of Prolactin Monitoring in Patients on Antipsychotics**  
  **Action:** Costings for prolactin testing to be investigated to clarify whether it would be feasible to test prolactin of all patients.

• **Crisis Cards Audit**  
  **Action:** Posters placed on the back of consultation room doors in the community mental health team reminding staff to check they have a crisis card. Another set of posters has been displayed to prompt patients to ask for one, placed at reception and the main entrance.
Research
The number of patients receiving NHS services provided or sub-contracted by Central and North West London NHS Foundation Trust in 2011/2012 that were recruited during that period to participate in research approved by a research ethics committee was 966.

324 were recruited from 12 interventional studies and 642 were recruited from 19 observational studies. Throughout the year the trust has been involved in an additional 32 unfunded studies.

Over the past year researchers associated with the Trust have published 159 number of articles in peer reviewed journals.

 Goals agreed with commissioners
Use of the CQUIN payment framework
A proportion of CNWL’s income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between CNWL and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at: www.cnwl.nhs.uk/annual_report.html

Last year CNWL achieved 100% of its CQUIN goals, securing the total CQUIN income of £3,038,000. For 2011/12, CNWL’s CQUIN income equates to approximately £4.3 million. The specific goals for 2011/12 were being decided at the time of printing.

What others say about the provider
Statements from the Care Quality Commission
CNWL is required to register with the Care Quality Commission and its current registration status is unconditional registration. CNWL has the following conditions on registration – none.

The Care Quality Commission has not taken enforcement action against CNWL during 2011/2012.

CNWL has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011/12 (see table below for details of the Trust locations reviewed by the CQC).”

CNWL intends to take the following action to address the conclusions or requirements reported by the CQC. The Trust is committed to delivering high quality care and immediate action was taken to address any concerns raised by the CQC. Robust action plans are in place and the Trust reports back progress to the CQC.

CNWL has made the following progress by 31st March 2012 in taking such action (see table below for details of the Trust progress against the action plans).
<table>
<thead>
<tr>
<th>Location</th>
<th>Outcome of review</th>
<th>Progress with actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Beatrice Place (older adult inpatient)</td>
<td>Re-inspected to assess improvements as specified in the action plan submitted post the CQC’s first inspection in January 2011.</td>
<td>No further action required. All concerns were lifted and Beatrice Place is deemed fully compliant with the CQC standards.</td>
</tr>
<tr>
<td>Butterworth Centre (older adult inpatient)</td>
<td>Re-inspected to assess improvements as specified in the action plan post the CQC’s first inspection in April 2011.</td>
<td>No further action required. All concerns were lifted and Butterworth Centre is deemed fully compliant with CQC standards.</td>
</tr>
<tr>
<td>Northwick Park Hospital (adult and older adult inpatient)</td>
<td>Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns with Outcomes 4: Care and welfare of people who use services, and Outcome 10: Safety and suitability of premises.</td>
<td>An action plan has been devised and a report on progress with the actions has been submitted to the CQC.</td>
</tr>
<tr>
<td>Feltham HMYOP (young offenders prison)</td>
<td>Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns around Outcomes 2: Consent to care and treatment, 8: Cleanliness and infection control, and 10: Safety and suitability of premises, and one suggestion for improvement for Outcome 1: Respecting and involving people.</td>
<td>An action plan has been devised and a report on progress with the actions has been submitted to the CQC.</td>
</tr>
<tr>
<td>7a Woodfield Road (adult inpatient/rehabilitation)</td>
<td>Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns around Outcome 4: Care and welfare of people.</td>
<td>An action plan has been devised and a report on progress with the actions has been submitted to the CQC.</td>
</tr>
<tr>
<td>Trust Headquarters (all services provided in the community)</td>
<td>Fully compliant with the CQC Essential Standards assessed.</td>
<td>None required</td>
</tr>
<tr>
<td>Kingswood Learning Disability Service</td>
<td>Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns with Outcomes 4: Care and welfare of people who use services, and Outcome 7: Safeguarding.</td>
<td>An action plan has been devised and a report on progress with the actions has been submitted to the CQC.</td>
</tr>
<tr>
<td>Seacole Centre Learning Disability Service</td>
<td>Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns with Outcomes 4: Care and welfare of people who use services, and Outcome 7: Safeguarding.</td>
<td>An action plan has been devised and progress will be reported back to the CQC by April 10th 2012.</td>
</tr>
<tr>
<td>Park Royal Centre for Mental Health (adult and older adult inpatient)</td>
<td>Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns Outcome 2: Consent to care and treatment and Outcomes 4: Care and welfare of people who use services. No concerns were identified with Outcome 1 (respect and involvement) but improvement action was required.</td>
<td>An action plan has been devised and a report on progress with the actions has been submitted to the CQC.</td>
</tr>
</tbody>
</table>
Data quality
Statement on relevance of Data Quality and your actions to improve

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

- Undertake a review of all our information systems to ensure we meet the new challenges of reporting by service line and the inclusion of community services while maintaining and improving data quality;
- to continue to examine the market for new products which will support data quality;
- review the Information Assurance Framework on a quarterly basis. This has been developed to identify any gaps in data capture or processes across all service lines, including community services;
- in association with this, we will continue the development and testing of our monthly Community Information Data Set (CIDS) to examine and improve data quality in community services;
- continue with the distribution of weekly data quality reports with patient level data to identify any breach areas and ensure that systems are in place to capture and record information on a timely way;
- to expand the provision of the weekly QIS reports to mental health services, which provide front line data on KPIs and data quality;
- audits are developed in line with the standards set out in the Data Quality Policy and all staff are made aware of the importance of data quality and the need to keep accurate records;
- review and monitoring of benchmarking data (both internal and external) to ensure that

CNWL compares favourably with other leading mental health organisations;
- monthly red/amber/green (RAG) rating on the accuracy of all activity reports for every team down to staff member level – and moving to weekly reports as above; and
- internal audits to measure compliance of KPI reporting against clinical notes.

CNWL recognises good data as a key tool to support patient satisfaction and safety, to identify areas for improvement and to test our services for efficiency and effectiveness in an increasingly competitive market.

NHS Number and General Medical Practice Code Validity

CNWL submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient’s valid NHS number at quarter four of 2011/12 was:

- 92.99% for admitted patient care;
- 98.67% for out patient care; and
- N/A for accident and emergency care.

The percentage of records in the published data which included the patient’s valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for out patient care; and
- N/A for accident and emergency care.
Information Governance Toolkit attainment levels
CNWL Information Governance Assessment Report overall score for 2011/12 was 84% and was graded green.

Clinical coding error rate
CNWL was not subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission.
Part 3 – Other information

Our performance against national and local indicators

In this section we will report on how we have performed against indicators as required by Monitor (our regulator), The Operating Framework for the NHS in England, for 2011/12, and against those indicators that we have set as quality priorities in previous years.

Service user safety

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>2011/12</th>
<th>2010/11</th>
<th>2009/10</th>
<th>Benchmark (where available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CPA 7-day follow-up</td>
<td>JADE scan</td>
<td>95%</td>
<td>95.2%</td>
<td>96%</td>
<td>97%</td>
<td>96%*</td>
</tr>
<tr>
<td>2. Risk assessment and management</td>
<td>Internal audit</td>
<td>95%</td>
<td>96%</td>
<td>92%</td>
<td>95%</td>
<td>Not available</td>
</tr>
<tr>
<td>3. Infection control</td>
<td>Internal database</td>
<td>0</td>
<td>0***</td>
<td>3***</td>
<td>9***</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>Internal database</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0***</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>Internal database</td>
<td>&lt; 7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Internal database</td>
<td>&lt; 7</td>
<td>3</td>
<td>11</td>
<td>0***</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>Internal database</td>
<td>&lt; 7</td>
<td>4</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>4. Crisis/contingency plans</td>
<td>Internal audit</td>
<td>90%</td>
<td>91%</td>
<td>97%</td>
<td>-</td>
<td>Not available</td>
</tr>
<tr>
<td>5. HCH falls</td>
<td>Datix scan</td>
<td>10% reduction per annum</td>
<td>10% reduction</td>
<td>No change</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>6. HCH medication errors</td>
<td>Datix scan</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>7. HCH incident reporting</td>
<td>Paper reports vs Datix</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>8. HCH hand hygiene</td>
<td>Annual HCH patient survey</td>
<td>90%</td>
<td>85%</td>
<td>87%</td>
<td>Not available</td>
<td>Not available</td>
</tr>
</tbody>
</table>

* This was a QP for 2009/10. ** This was a QP for 2010/11. *** This figure is for CNWL Mental Health and Allied Specialities services only
†Source: CQC National Priorities Indicator Benchmarking 2009/10 (Regional average)

The quality indicators are grouped in to the quality dimensions set out in Lord Darzi’s High Quality Care for All report. These dimensions are Safety, Effectiveness and Experience.
Measure 1: This is important as we want to ensure our service users remain safe when they are discharged from hospital into community care. In 95.5% of cases we completed a follow-up within seven days for service users discharged from hospital on CPA. This is slightly above our target of 95%.

Measure 2: This measure assesses whether a risk assessment has been completed, and how risks identified will be incorporated into the care plan to be effectively managed. We are pleased to report that our performance has increased from last year to 96%. We will continue our efforts to maintain and improve our performance further.

Measure 3: Reducing healthcare acquired infections is a priority for all Trusts. We have a duty to ensure our patients do not get any healthcare acquired infections whilst they in our care and / or in contact with any of our services. We are very pleased to report that at the end of quarter four we met both our targets for both MRSA and Clostridium Difficile.

Measure 4: This measure shows if our service users have a crisis/contingency plan as part of their CPA care plan. Whilst we are pleased to report that the target was achieved at 91% on this measure, it is a slight decrease from the previous year, and as such will continue to be monitored.

Measure 5: This measure looks at the number of falls of our patients in Hillingdon Community Health Northwood and Pinner Community Unit. This is an important safety measure and an area of focus nationally. Through the measures we have put in place, we have achieved our target of a further 10% reduction in the number of falls. In future years, we will continue now to focus on maintaining this current low level.

Measure 6: This measure looks at medication errors and incidents in Hillingdon Community Health and is an important patient safety measure. Our focus on this important area has resulted in us meeting our set target of achieving no serious/red medication incidents in 2011/12. We will endeavour to maintain this level of performance in future years.

Measure 7: This assesses how compliant Hillingdon Community Health are with online incident reporting. Having moved to an online incident reporting system in 2009, we now consider that this change is now fully embedded within our services with 100% compliance for the last two years with all incidents reported via the online system. Going forward this will not be reported in future reports.

Measure 8: It has been well documented that good hand hygiene is an effective way to prevent transmission of infection. This measure assesses what percentage of our patients were happy with our healthcare professionals (HCP) hand hygiene. Our performance has stayed consistent with the previous year although we have not achieved the full 90% planned improvement target. However, we have high levels of attendance from our staff on infection prevention and control training and have an audit programme of unannounced spot checks across services, undertaken by the Specialist Infection Control team, to check compliance with hand hygiene which has demonstrated good results. Nevertheless, further work needs to continue to ensure that patients perceptions are in line with our spot check audits.
## Clinical effectiveness

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>2011/12</th>
<th>2010/11</th>
<th>2009/10</th>
<th>Benchmark (where available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Re-admission rates</td>
<td>JADE scan</td>
<td>&lt;11%</td>
<td>4.1%</td>
<td>5%</td>
<td>5.7%</td>
</tr>
<tr>
<td>2. Outcome measures</td>
<td>JADE scan</td>
<td>60%</td>
<td>87%</td>
<td>Adults: 23/25; Older Adults: 24/25; CAMHS: 13/13</td>
<td>All targets met</td>
</tr>
<tr>
<td>3. Crisis resolution team gate keeping</td>
<td>JADE scan</td>
<td>90%</td>
<td>98%</td>
<td>95%</td>
<td>94.5%</td>
</tr>
<tr>
<td>4. Crisis resolution home treatment episodes</td>
<td>JADE scan</td>
<td>5</td>
<td>5/5</td>
<td>5/5</td>
<td>Not measured</td>
</tr>
<tr>
<td>5. Early intervention teams</td>
<td>JADE scan</td>
<td>95%</td>
<td>99.5%</td>
<td>100%</td>
<td>Not measured</td>
</tr>
<tr>
<td>6. Mental health minimum data set (data completeness)</td>
<td>JADE scan</td>
<td>99%</td>
<td>99.18%</td>
<td>99%</td>
<td>99.6%</td>
</tr>
<tr>
<td>a. Identifiers</td>
<td>JADE scan</td>
<td>99%</td>
<td>99.18%</td>
<td>99%</td>
<td>99.6%</td>
</tr>
<tr>
<td>b. Outcomes</td>
<td>JADE scan</td>
<td>50%</td>
<td>97.2%</td>
<td>87.5%</td>
<td>59.6%</td>
</tr>
<tr>
<td>7. Physical health checks</td>
<td>Internal audit</td>
<td>95%</td>
<td>99%</td>
<td>99%</td>
<td>Not measured</td>
</tr>
<tr>
<td>a. Inpatient service users with physical health assessment after admission (either nursing or medical)**</td>
<td>Internal audit</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
<td>Not measured</td>
</tr>
<tr>
<td>b. Inpatient service users with physical health assessment after admission (Nursing)**</td>
<td>Internal audit</td>
<td>95%</td>
<td>80%</td>
<td>89%</td>
<td>Not measured</td>
</tr>
<tr>
<td>c. Inpatient service users with physical health assessment after admission (Medical)**</td>
<td>Internal audit</td>
<td>90%</td>
<td>92%</td>
<td>90%</td>
<td>78%</td>
</tr>
<tr>
<td>8. HCH Edinburgh Post Natal Mood Assessment</td>
<td>RIO scan</td>
<td>90%</td>
<td>92%</td>
<td>90%</td>
<td>78%</td>
</tr>
<tr>
<td>9. HCH wheelchair initial assessment waiting time</td>
<td>RIO scan</td>
<td>13</td>
<td>24</td>
<td>11</td>
<td>Not measured</td>
</tr>
<tr>
<td>10. HCH ambulatory wound care services</td>
<td>RIO scan</td>
<td>Target not set for 11/12</td>
<td>4256</td>
<td>2545</td>
<td>Not measured</td>
</tr>
</tbody>
</table>

* This was a QP for 2009/10. ** This was a QP for 2010/11. 2Source: CQC National Priorities Indicator Benchmarking 2009/10 (Regional average)
Measure 1: Some service users may get re-admitted to hospital shortly after leaving and this is important for us to measure and monitor as high re-admission rates may indicate that service users were discharged too soon or not given the appropriate support in the community. We are very pleased that our readmission rates within 28 days of discharge are significantly below target, 4.1% against a target of 11%.

Measure 2: This indicator helps us assess the degree to which the services we provide improve the health and social functioning of our service users. To date, we have been working to ensure that every service user has their condition assessed and scored on admission and discharge. During 2011/2012 we developed reports that paired these scores, and presented the result back to the services to identify areas of improvement. This measure was worded as ‘What percentage of our service users have had their condition formally assessed at a key point in their care pathway using HoNOS?’ in our 2010/11 Quality Account.

Measure 3: When service users experience a crisis, they may or may not need an admission. Crisis resolution teams can assess if home treatment is a suitable option for service users before the decision to admit is made. We feel it is important to ensure that we treat patients in the most appropriate settings hence this is an important indicator for us to monitor. We are proud of our performance in this area, achieving 98% this year, against our target of 90%.

Measure 4: This indicator is a way in which we measure that we can offer 24 hour services to people in a crisis. The targets are locally set by commissioners and are set according to how they have resourced these services, and the size of their local population. This year, five out of five boroughs (5/5) have met their locally set target.

Measure 5: This indicator assesses whether we have met our commitments, set by our commissioners, to serve new cases of First Episode Psychosis. We are proud of our 99.5% performance against this measure, against our target of 95%.

Measure 6: These indicators are important as they relate to the information that we collect to ensure that we are delivering services that meet the needs of our population, and that we can plan and re-design services where necessary to meet any changing needs. We are pleased to report that we significantly exceeded our target for the completeness of our outcomes data set, and met our target for completeness of our identifiers data set. These are Trust-level indicators and we therefore do not present performance at the borough level.

Measure 7: This measure assesses whether service users have a physical health check when they are admitted to our wards. Indicator 7a shows those that had either a medical or a nursing physical health check, 7b shows the percentage that had a physical health check by our nursing staff, and 7c shows the percentage that had a physical health care by our medical staff. We are broadly pleased with our performance, but recognise that we need to look at what we can do to improve the number of physical health checks conducted by our medical staff upon admission to ensure that we deliver against our target of 95% next year.

Measure 8: Offering HCH mothers Edinburgh Postnatal Depression Scale screening is important as it is recognised the post natal depression is
undiagnosed and can have a significant impact on women and their families. We are pleased that we have achieved and sustained our planned improvement in this area during 2011/12 against our set target of 90%. This is an area that we will continue to report to our commissioners in our monthly performance report.

Measure 9: This measure shows the average waiting time for wheelchair assessment in HCH, and is important as it ensures we provide a more effective service to a vulnerable group of service users. The service has seen an increased volume of referrals to the service during the last year which has impacted upon our ability to sustain previous year’s improvement within the commissioned budget for the service. We will continue to work with commissioners to improve our waiting times with the increase in demand within available resources next year and this will be reported to our commissioners through the performance reporting system.

Measure 10: This measure looks at how many HCH patients use our ambulatory wound management service, to help service users get better quality of care closer to their homes. The service is now fully established and running every day with high numbers of referrals. As the service is now fully embedded with local GPs and receiving the optimum referrals, we do not plan to report on this area in future reports.

Service user experience

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>2011/12</th>
<th>2010/11</th>
<th>2009/10</th>
<th>Benchmark (where available)</th>
</tr>
</thead>
</table>
| 1. Delayed transfers of care | On average, what percentage of hospital beds are being used by service users who should have been discharged? | JADE scan | <7.5% | 3.1% | 2.8% | 4.4% | 3.15%*
| 2. CPA 12 month review | What percentage of our service users who are on CPA received a full CPA review within the last 12 months where appropriate?* | JADE scan | 95% | 95.6% | 95% | 99% (Jan-Mar 2010 audit) | Not available |
| 3. Copy of care plan | What percentage of our service users have been offered a copy of their care plan? (inpatients & community) | Internal audit | 95% | 88% | 88% | 90% | 64%*
| 4. Access for people with a learning disability | Self-certification against compliance with requirements regarding access for people with a learning disability | Internal database | 7/7 | 7/7 | 6/6 | Not measured | Not available |
| 5. Understanding what is in care plan | The % of community service on CPA who say they definitely understand what is in their care plan** | Community patient telephone survey | 75% | 48% | 63% | Not measured | Not available |
| 6. Referral to treatment | "The referral to treatment waiting times: non-admitted (HCH only)" | RIO scan | 95% | 99.9% | 100% | 99.8% | Not available |
| 7. HCH service users know how to provide feedback | Percentage of service users who knew how to compliment or complain about a service** | Annual HCH patient survey | 60% | 56% | 62% | TBC | Not available |
| 8. HCH phlebotomy service | Number of patients accessing the community phlebotomy service** | RIO scan | Target not set for 11/12 | 3310 | 3233 | Not measured | Not available |

* This was a QP for 2009/10. ** This was a QP for 2010/11. 3Source: CQC National Priorities Indicator Benchmarking 2009/10 (Regional average) 4Source: CQC National Community Service User Survey 2011
**Measure 1:** This indicator assesses what percentage of hospital beds are being used by those who should have been discharged. This is an important measure to monitor because inpatient beds should be kept free for those who need them most and also because service users should be treated in the most appropriate setting. Working in conjunction with our local authority partners we are pleased that once again we have seen very good performance in this area.

**Measure 2:** This indicator assesses whether those who are managed on CPA have a documented review of their care plan every 12 months. Reviewing service users’ care plans every 12 months enables us to update them inline with the service users’ current needs. We are pleased to report that we are achieving our target in this area.

**Measure 3:** This indicator checks whether or not we are recording giving our service users a copy of their care plan. We also measure whether our service users report being offered a copy of their care plan. We will continue to highlight the importance of this with our staff as part of the on-going focus on recovery and collaborative care planning as we performed slightly below our target.

**Measure 4:** This measure is about ensuring that those patients with a learning disability have the same access rights to services as those who don’t, to ensure that their mental health needs are being met. The assessment is against seven questions, based on the recommendations set out in *Healthcare for all* (2008) - the Independent Inquiry into Access to Healthcare for People with Learning Disabilities. We are pleased to report that the Trust achieved the maximum score for all questions at quarter four, hence the performance of seven out of seven (7/7) as shown.

**Measure 5:** This indicator is about making sure that our service users on the Care Programme Approach definitely understand what the plans are for their care. The figure reported is for those who ‘definitely’ understand, and although does not achieve the target, does exceed the national benchmark. If we include those who said that ‘to some extent’ they understand what is in their care plan we have achieved 79%, which is encouraging.

**Measure 6:** This is a nationally set target for consultant led services to ensure that patients are seen within an agreed timeframe from point of referral. This important national indicator is closely monitored across our services and we are pleased to report that we continue to meet and sustain performance against the 95% target.

**Measure 7:** This looks at whether HCH service users know how they can make a compliment or complaint about an HCH service. This is important as this feedback helps to inform future service delivery and developing. Considerable work has taken place to raise awareness of this issue and we are disappointed that this has not been reflected in our year end performance. We will therefore continue to focus on this during 2012 to attempt to increase patient awareness of this important area.

**Measure 8:** This measure looks at the number of patients that access HCH domiciliary phlebotomy service. This new service is now fully embedded with referrals from GP practices levelling off at around 3,300 following promotion of the new service. As such, we do not plan to report on this area in future reports of the Quality Account.
Borough breakdown – review of performance against national priorities and historical quality priorities

### Clinical Safety

<table>
<thead>
<tr>
<th>Ref</th>
<th>Quality priorities 2011/12</th>
<th>Adult Service</th>
<th>Older Adult Service</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon and Chelsea</th>
<th>Westminster</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon and Chelsea</th>
<th>Westminster</th>
<th>HCH</th>
<th>CPS</th>
<th>Overall Trust Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>CPA 7-day follow-up</td>
<td></td>
<td></td>
<td>95%</td>
<td>95.3%</td>
<td>98.1%</td>
<td>95.7%</td>
<td>96.1%</td>
<td>95%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>2.</td>
<td>Risk assessment and</td>
<td></td>
<td></td>
<td>95%</td>
<td>90%</td>
<td>80%</td>
<td>100%</td>
<td>100%</td>
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<td></td>
<td>management</td>
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<tr>
<td>3.</td>
<td>Infection control</td>
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<td></td>
<td>a. The number of cases</td>
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<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
<td></td>
<td>of MRSA (MRSA infection)</td>
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<td>b. The number of cases</td>
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<tr>
<td></td>
<td>of MRSA (MRSA bacteraemia)</td>
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<td></td>
<td>c. The number of cases</td>
<td></td>
<td></td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>3</td>
<td>4</td>
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<tr>
<td></td>
<td>of Clostridium Difficile</td>
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<td>annually (YTD)</td>
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</tr>
<tr>
<td>4.</td>
<td>Crisis/contingency plans</td>
<td></td>
<td></td>
<td>90%</td>
<td>95%</td>
<td>55%</td>
<td>75%</td>
<td>100%</td>
<td>85%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Key**
- **Not applicable**
- **Data not available by directorate/data not collected in the quarter**
### Clinical Effectiveness

<table>
<thead>
<tr>
<th>Ref</th>
<th>Quality priorities 2011/12</th>
<th>Adult Service</th>
<th>Older Adult Service</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon</th>
<th>Kensington and Chelsea</th>
<th>Westminster</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon</th>
<th>Kensington and Chelsea</th>
<th>Westminster</th>
<th>HCH</th>
<th>CPS</th>
<th>Overall/Trust Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Re-admission rates</td>
<td>What percentage of service users were re-admitted to hospital within 28 days of leaving? (YTD)</td>
<td>&lt;11%</td>
<td>2%</td>
<td>0%</td>
<td>3%</td>
<td>3%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2.</td>
<td>Outcome measures –</td>
<td>Patients (community &amp; inpatient; adult/older adult only) who have been assessed using HoNOS, who have had at least two events which require scoring whose scores have been paired (YTD)</td>
<td>60%</td>
<td>90%</td>
<td>89%</td>
<td>88%</td>
<td>96%</td>
<td>82%</td>
<td>84%</td>
<td>80%</td>
<td>93%</td>
<td>60%</td>
<td>74%</td>
<td></td>
<td></td>
<td>87%</td>
</tr>
<tr>
<td>3.</td>
<td>Crisis resolution team gate keeping</td>
<td>The percentage of service users admitted to acute adult inpatient beds who were assessed as to their eligibility for home treatment prior to admission? (YTD)</td>
<td>90%</td>
<td>98%</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Crisis resolution home treatment episodes</td>
<td>Did we achieve the commitments (set by commissioners) to deliver new crisis resolution home treatment episodes? (YTD)</td>
<td>5</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5.</td>
<td>Early intervention teams</td>
<td>Did our Early Intervention Teams meet the commitments (set by commissioners) to serve new psychosis cases? (YTD)</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key**
- Not applicable
- Data not available by directorate/data not collected in the quarter
6. Mental Health Minimum Data Set (data completeness)

<table>
<thead>
<tr>
<th>Ref</th>
<th>Quality priorities 2011/12</th>
<th>Adult Service</th>
<th>Older Adult Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Brent</td>
<td>Harrow</td>
</tr>
<tr>
<td>a. Identifiers (YTD)</td>
<td>99%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Outcomes (YTD)</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Physical health checks

<table>
<thead>
<tr>
<th>Ref</th>
<th>Quality priorities 2011/12</th>
<th>Adult Service</th>
<th>Older Adult Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Brent</td>
<td>Harrow</td>
</tr>
<tr>
<td>a. Inpatient service users with physical health assessment after admission (either nursing or medical) (quarter four)</td>
<td>95%</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>b. Inpatient service users with physical health assessment after admission (Nursing) (quarter four)</td>
<td>95%</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>c. Inpatient service users with physical health assessment after admission (Medical) (quarter four)</td>
<td>95%</td>
<td>30%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Key

Not applicable
Data not available by directorate/data not collected in the quarter
### Service user experience

<table>
<thead>
<tr>
<th>Ref</th>
<th>Quality priorities 2011/12</th>
<th>Adult Service</th>
<th>Older Adult Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Brent</td>
<td>Harrow</td>
</tr>
<tr>
<td>1.</td>
<td>Delayed transfers of care</td>
<td>&lt;7.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>2.</td>
<td>CPA 12 month review</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>3.</td>
<td>Copy of care plan</td>
<td>95%</td>
<td>77%</td>
</tr>
<tr>
<td>4.</td>
<td>Understanding what is in care plan</td>
<td>75%</td>
<td>53%</td>
</tr>
</tbody>
</table>

**Key**
- Not applicable
- Data not available by directorate/data not collected in the quarter
Gardens at Kingswood Centre.
Other indicators of quality

Staff satisfaction

We know that in order to deliver the best quality of services to our service users, our staff must have the right skills and attributes, and importantly feel supported and satisfied in their work.

The staff survey is very useful in helping us to measure our staff satisfaction levels and we are pleased to report that our staff satisfaction levels have improved on the good performance from last year, and once again are in the highest (best) 20% when compared with Trusts of a similar type.

We also recorded strong performances (compared to national average) for: percentage of staff feeling there are good opportunities to develop their potential, quality of job design (clear job content, feedback and staff involvement), percentage of staff that agreed that their role made a difference to patients, and level of staff motivation at work.

Whilst it is good to know what we do well at, it is important to look at where we can improve and implement action plans to address any findings. This year’s staff survey highlighted that we were below the national average for the following areas: percentage of staff saying hand washing materials are always available, percentage of staff believing that the trust provides equal opportunities for career progression or promotion, and percentage of staff experiencing discrimination at work in the last 12 months. With reference to equal opportunities for career progression, we launched our mentoring and coaching scheme in 2011. This is promoted to all staff but with a particular focus for staff from BME backgrounds. The BME Network took the lead in developing this scheme. Further analysis was taken to understand the report that staff experienced discrimination at work, and this showed that staff faced discrimination from patients and not other staff.

Our HR department collect data on, and report against, a range of indicators and as in last year’s quality account we have included two indicators that we believe provide a high-level indication of staff well-being.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>2011/12</th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff turnover (including CNWL, HCH, CPS)</td>
<td>Year on year improvement</td>
<td>14.50%</td>
<td>*12.6%</td>
<td>*11.1%</td>
</tr>
<tr>
<td>Average sickness per employee (CNWL and HCH)</td>
<td>Year on year improvement</td>
<td>3.8%</td>
<td>3.8%</td>
<td>*3.6%</td>
</tr>
<tr>
<td>Average sickness per employee (CPS)</td>
<td>Year on year improvement</td>
<td>2.7%</td>
<td>2.7%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* CNWL only
Complaints

We treat any formal complaints received as valuable feedback from our service users and their carers. We make sure we take the time to investigate those complaints, meet with complainants and take action where required.

303 formal complaints were made to CNWL. Most were graded as moderate or low and six were related to a serious incident. At the end of April 2012 we had responded to 246, 16% of which were fully upheld. The remainder have a response which is being finalised, or remains under investigation. A review group to consider learning from complaints, PALS and claims issues has been convened, the first meeting of which took place in January 2012.

Equalities and diversity

The Trust’s Equality Act Compliance Report 2012, published in January 2012, includes an action plan specifically addressing data recording and reporting, involvement of staff and service users and communities, staff development and incident reporting. The Trust believes these to be priority areas to provide a firmer information base upon which to further develop services for the future, as well as to support staff in terms of their career progression and in relation to incidents of harassment and bullying. Progress will be reported on in the Trust’s next Equality Act Compliance Report, due to be published by the end of January 2013.

Patient experience

CNWL undertake various user experience surveys including the National Surveys of Mental Health Patients conducted for 2010 (inpatients) and 2011 (community). These are useful in providing a baseline from which to measure our performance in locally conducted surveys throughout 2011/12.

CNWL also runs quarterly service user-led telephone surveys of people who have been seen within the inpatient and community adult and older adult services.

The Service User Survey Team has also conducted a six-monthly face-to-face survey of current inpatients in the adult and older adult acute admission wards across the Trust, including PICU’s.

From the results of the local CNWL telephone surveys the inpatient services have shown a steady improvement in most areas against the baseline of the national survey results. In community services the local telephone surveys have shown a mixed response in comparison with the national survey results, showing some better scores some worse and some the same.

The results from all surveys are reviewed at service level and Board level, and are used to inform decisions regarding improvement plans, and in deciding the quality priorities.
In addition, the Trust has more recently published five four-year equality objectives and the Trust is keen to ensure that equalities and diversity features within the Trust’s quality agenda. We have therefore identified the following areas to report on within the Quality Accounts during the course of 2012/13, each of which are taken from the four-year equality objectives that the Trust has published under the requirements of the Equality Act 2010.

1. **A minimum of one community engagement event with service users, carers and local communities takes place within each service line or borough served by the Trust each year, focusing on the top identified under-represented groups accessing services.**

   We will report on events and initiatives undertaken during the year which will contribute to our understanding of community needs and promote understanding within communities of the services that we provide, both of which we believe will contribute to both increased access to services and improvements in the patient experience.

2. **Improve the recording rates for new service users for religion or belief, sexual orientation and disability.**

   In order to understand who is (and who is not) accessing our services, we need to improve our recording rates, in particular in relation to service user religion or belief, disability and sexual orientation. This will better enable us to identify where there is a need for further, specific community engagement to encourage access to services from particular diverse groups, and to identify where there may be a need for specific training and awareness raising amongst staff.

3. **Achieve a reduction in the level of violence, discrimination and harassment, bullying and abuse at work from patients/service users, their relatives or other members of the public towards staff.**

   The CNWL Staff Survey 2011 indicates that CNWL staff are reporting unacceptable levels of violence, bullying and harassment, and discrimination, from service users, particularly though not exclusively related to ethnicity. The Trust will undertake a survey of staff during 2012 to obtain a more detailed qualitative understanding of what staff are experiencing, and what action can be productively taken. The findings will then be circulated to service user groups so that actions taken can encompass both staff and service user views.
Annex 1: any statements provided by our commissioners, OSCs or LINks

Commissioning

The Commissioning Collaborative PCTs have reviewed Central North West London NHS Foundation Trust’s (“the Trust”) Quality Account (QA) report for 2011-12. The Trust presented its proposed QA report and improvement areas for 2012-13 to representatives of the Commissioning Collaborative PCTs at the beginning of April 2012, with earlier involvement via the Trust’s Quality Priorities Setting meeting with its key stakeholders in March 2012. The Trust’s QA was reviewed by the lead commissioners Inner North West London PCTs Executive Management Team, which includes Clinical Commissioning Group representation, Outer North West London PCTs Contract Meeting with Hillingdon Community Health, Brent and Harrow Contract and Quality Teams, and North Central London PCTs Contract Manager.

The Commissioning Collaborative PCTs can confirm that, in our view, the QA complies with the guidelines. To the best of our knowledge through contract management meetings and other commissioning communications, the Trust has made reasonable interpretations of data and has not made any significant omissions.

It is good to see significant improvements in the identification of carers and the offering of carers’ assessments, as well as the improvements seen with in-patients having their medications cross-checked against more than one source within 72 hours of admission. Where the Trust has not achieved their targets, there are clear plans to ensure their future delivery, through projects and schemes such as the out of hours project and the recovery college. The Commissioning Collaborative PCTs support these plans. The PCTs also endorse the continued monitoring of quality priorities already achieved.

The move to look into methods of addressing the “survey fatigue” that service users says they are experiencing is welcomed. Patient involvement in service improvements is a key element to this change process, so any moves to make this area more meaningful and make a positive affect on service redesign is encouraged.

The report has mentioned the huge task of transferring data between clinical systems within 2011-12 and that plans have been formulated to mitigate against the risks to patient safety and patient confidentiality. However, the report does not indicate how successfully the mitigating actions have been implemented.

The Commissioning Collaborative PCTs support the areas chosen as quality priorities and believe they are locally meaningful and reflect local priorities.

Specifically for mental health and allied specialties and considering the size of the organisation in terms of geographical coverage, multiple sites and complex service delivery requirements, the PCTs would prefer a target per borough approach. This would allow for a more considered and appropriate stretch within each borough, rather than a blanket target which may be an easy target for one borough, a reasonable stretch for some boroughs, but an unrealistic stretch for another borough. However, the PCTs understand that the Trust would like all boroughs to reach a certain standard.
Within the section on Mental Health, an achievement of 74% is shown for the number of service users who responded ‘definitely’ or ‘to some extent’ when asked if they were involved as much as they wanted to be in decisions about their care plan. We assume that this relates only to the number of service users surveyed, as this is not explicitly clear.

A target of 58% is shown for the number of women who maintain breastfeeding at 6-8 weeks post-delivery. This was agreed after a query last year about whether this was sufficiently stretching, and commissioners are pleased to note that it has been exceeded in reaching 60%.

The report states 98% of respondents to a questionnaire on diabetes training (the DESMOND programme) reported a greater understanding of their condition and said they had more confidence to manage it better – against a target of 65%. Although there is reference to the response rate as having been “excellent”, inclusion of the response rate itself would ensure clarity on whether the results are truly representative of service user feedback.

As for priorities for the year ahead and the End of Life Care target concerning advanced care plans, commissioners had queried whether the 65% target was sufficiently stretching (since the 11/12 CQUIN target has achieved 64%) and have agreed the increase to 75% now shown.

There are also some specific numbers shown as baselines for targets within identified priorities – for example in the planned reduction in pressure ulcers. Even if Hillingdon commissioners were to already know and understand the context, there is no supporting detail on caseload size to help understand whether a 10% reduction is actually meaningful as a rolling target for reduction.

Overall, the quality priorities for 2012-13 are representative, balanced and consider local users, which is commendable.

**Brent OSC**

Brent Council’s Health Partnerships Overview and Scrutiny Committee has been invited to comment on Central and North West London NHS Foundation Trust’s Quality Account. We welcome this opportunity to comment on the document and give our perspective on the services provided by the trust, based on experiences in 2011/12.

This is a major time of change in the NHS, both nationally and locally. The scrutiny committee’s agendas have focussed primarily on developments in the primary and acute care sectors in Brent, at the expense of scrutinising the work of CNWL and mental health services in the borough. Mental health is extremely important and it is a regret of ours that we haven’t been able to devote more time to this issue.

There was one issue that the committee spent time looking at in 2011/12 relating to CNWL – the decision to close Fairfield House and move patients to alternative provision. Whilst councillors understood the need to improve patient care, there were concerns about costs that potentially would be picked up by the local authority after Fairfield had closed. Members also stressed that there needed to be thorough consultation with patients, many of whom would be vulnerable people, on the plans for their ongoing care.
Due to restrictions on the committee’s time, members were unable to follow up this issue as they would have liked with a visit to Fairfield House and Rosedale Court, to see for themselves the difference in service provision.

There are two other issues from the Quality Account that the committee has concerns about. The first relates to the percentage of community service users that report they had been given (or offered) a written or printed copy of their care plan. Performance for this indicator was 50% against a target of 80%. The importance of helping patients to make decisions about their care and manage their condition cannot be overstated. If only 50% of patients are being given or offered their care plan, this is likely to have an impact on the ability of patients to take more responsibility for their care. We would hope that in 2012/13 steps are taken by CNWL to improve performance in this area. It is something that the committee would like to monitor through the coming year.

The second area of concern relates to the performance indicator “Community service users who call the crisis number report that they definitely got the help they wanted”. In Brent only 20% of adults and 25% of older adults received the help they wanted, compared to a target of 65% and, in adult services, this result was significantly lower than the other boroughs. Again, this is an area where we would expect to see improvement. Ensuring patients have access to appropriate advice and help in a crisis is crucial, and could potentially prevent that crisis from escalating causing more harm for the patient and a higher level of intervention and care from CNWL.

Once again, we thank you for the opportunity to comment on the CNWL Quality Account and hope that we can spend more time looking at mental health services in Brent in the coming 12 months.

**Westminster and Kensington & Chelsea OSC**

We welcome the opportunity to comment on Central and North West London NHS Foundation Trust’s Quality Account 2011/2012. Our respective Councils both have a good working relationship with Central and North West London NHS Foundation Trust (CNWL FT).

It is difficult to analyse these Quality Accounts as much information is not included: Data comparisons over a longer timeframe would better show the ups and downs of performance. Benchmarked data would help us to see how CNWL FT’s performance compares to comparable trusts.

We are disappointed to note:

- The trust underperforms on the numbers of users with a crisis card (Access to service in a crisis - Measure B) and their care plan (Respect and Involvement – Measure B);
- only 33% of K&C community service users who called the crisis number reported they definitely got the help they wanted;
- only 50% of Westminster inpatient service users report they got enough advice or support for their physical health.

We are pleased that the Trust plans to include both care plans and physical health in its Quality Priorities for 2012/13.
We are concerned about any serious medication error. There were three in Hillingdon Community Healthcare in 2011/12.

We are concerned about the financial outlook for CNWL FT. There is less money both in the NHS and local government. We are also concerned because the impact of competition on the Trust’s finances is uncertain. We hope cash pressures will not translate into cuts to patient care. We would support the Trust in its efforts to make efficiency savings without loss of service.

We encourage the CNWL FT to be fully involved in local health promoting strategies. More could be said in the Quality Account on how the proposed actions of the Trust align with major public health campaigns.

We would be pleased if the local OSCs were invited to future stakeholder Quality Account events. Input from overview and scrutiny committees should be sought as early as possible.

Overall, our OSCs welcome the progress the Trust has made over the last year and look forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2012/13.

**Kensington & Chelsea LINk**

Kensington and Chelsea Local Involvement Network (K&C LINk) welcomes the opportunity to comment on the Central and North West London NHS Foundation Trust (CNWL) Quality Accounts (QAs) 2011/12.

The LINk is pleased to have had the opportunity to engage with the Trust on a number of issues over the last year including:

- Further to local concern, the K&C LINk raised the quality and implementation of the crisis card with CNWL. We are pleased that the Trust agreed, adopted our proposals and re-developed the card. The LINk is keen to monitor the quality of staffing provision for the planned trust-wide crisis phone line going forward;
- the mini quality account workshops and the larger stakeholder consultation, we are grateful for this opportunity and played an active part in identifying emerging themes;
- attendance at the launch event for the service line re-configuration;
- The launch of the recovery college;
- we supported the planning group of the borough wide ‘mental health seminars’ informing local people about service developments and financed by CNWL;
- we also took part in Patient Environment Action Team inspection visits;
- the pilot closure of one of our local community acute treatment wards. We will continue to monitor the impact of this closure, how service users are engaged with and how efficiencies are being implemented locally. We also intend to work with commissioners and CNWL in deciding how our secondary care mental health budget is allocated and spent, the identification of priorities and the introduction of innovative new services.

However, K&C LINk would like to highlight the following on the draft QA for 2011/12:

**Chief Executive’s statement**

We would like to echo the Chief Executive’s statement that ‘this has been a year of major change for the trust’ and also its service
users and carers. We are pleased to see that throughout these changes to the organisation ‘staff satisfaction levels have remained high’. We would welcome further data on how service user and carer satisfaction levels compare also. We also repeat our request for the inclusion of local data in the Quality Account.

Quality priority area 1 – Recovery and Involvement
The K&C LINk is concerned that local service users appear to have low awareness of which cluster(s) they have been assigned to, how this then leads to a care package pathway, and how this fits in with recovery focussed service delivery. Patient choice and control over the shape of support received and choice of treatment options is essential during this process as emphasised by the underpinning principles of the Health and Social Care Act. We are pleased to see the introduction of the new recovery CQUIN. However the K&C LINk suggests a six monthly review target for the Care Programme Approach (CPA) would be more ‘ambitious’ and in line with current practice than an annual review as suggested.

Quality priority area 2 – Physical Health
We are pleased to see this area retained as there is room for improvement and the ‘holistic’ approach was strongly flagged up at the QA stakeholder consultation event. We hope patient representatives will be included in the physical health strategy group and are happy to assist with recruitment if required.

The LINk suggests reporting on anti-psychotic prescribing should be across the age range and not only limited to the CQUIN focus on dementia patients

Quality priority area 3 – Carer Involvement
The possible introduction of a CQUIN around carers’ assessments and the support they require is a welcome development. Further to our work on the re-development of the crisis card in the past year, we now welcome the development of a carers’ crisis card also. We would welcome greater integration of carer support between CNWL and the Royal Borough of Kensington and Chelsea.

Quality priority area 4 - Service pathway and access in a crisis
Developing protocols to support safe discharge from secondary care to primary care and simplified access into secondary care is an important development. The LINk believes the introduction of a CQUIN will help facilitate these pathways. All service users should soon have crisis cards. Relapse prevention and access in a crisis should also be addressed in care plans.

Outlook going forward
Recovery focussed service delivery and the personalisation agenda are the main drivers for change going forward. The K&C LINk would welcome further information on how this change will be implemented practice. For example, how are staff now engaging with service users? Whilst welcome, we would suggest that the shift from the medical to recovery model of service delivery needs to be measured and monitored closely. Personalisation, patient control and choice need to be embedded into CNWL service lines.

Eligibility criteria for services and personal budgets, inter-cluster working, the relationship between CPA and lead professional care and
back to primary care are issues concerning service users this year.

As mentioned in previous years, the accessibility of the document continues to be a concern due to small font and CNWL ought to tailor this information appropriately for the intended audience. A summary of the document including local data would be very helpful.

The limited data included on the service user experience is most disappointing. In the continued absence of local data, we would support the development of a CNWL wide engagement strategy prompted by an organisational AND local change register. We look forward to receiving regular local updates on the progress of service lines, service changes, the recovery college and priority targets. We welcome the opportunity to strategically engage with the Trust via a coordinated and planned strategy in the near future to help improve standards of care across the borough.

Westminster LINk
The Westminster LINk welcomes the opportunity to have been involved in the CNWL’s Quality Accounts consultation process.

Overall, the LINk feels that the QA reflects a broad range of priorities and the results and analysis are presented in sufficient depth. However, the report would benefit from further detail explaining why the criterion for certain measures has been altered from previous years.

Service quality is discussed in depth but actions to go forward are vague and lack tangibility.

A broad attempt is made to reflect PPI but the quotes included are not substantiated and add little to the overall impression of quality.

Greater relevance could be added to the PPI feedback if more information on the individual’s condition or position were made available.

The presentation is clear and accessible but could benefit from an Executive Summary.

Westminster LINk look forward to further developing our work with CNWL in the coming year.

Harrow LINk
The LINk appreciates that the shape and content of the Account is in many ways dictated to the Trust but our response while commenting on the Account content also indicates the content an Account should contain to inform patients and the public.

The LINk is presented with a QA that is peppered with a plethora of platitudes, percentages, and non sequiturs. The only nodding reference to statistics is to say “the sample size for this measure is relatively small” in the section on responses to using the crisis telephone number. The use of percentages is meaningless without providing the sample size from which the percentage is calculated. What tests have been applied to determine the construct validity of “definitely” and “to some extent” as response measures. Is “as much as they wanted to be” a measurable construct? You tell us who did the mystery shopping but give no indication of the protocol they used and then report the outcomes using the phrases “excellent response times” and “direct access to a MH professional” without any supporting statement to indicate what they mean.

The report on Crisis Cards causes great concern. You report that just over 50% of patients have a crisis card which are being given out “when
we see them” which is a strategy that has failed. Your response to this failure is “...we will continue to roll these out...” How complacent can you get? In the section on care plans you respond to the 50% who are offered or given a care plan by saying “we need to focus on ensuring that service users on LPC (what about those on CPA?) are aware of their care plan.” The solution “focusing on” is inadequate ~ action is required.

The “feel safe” section causes us to wonder about how you conduct surveys and what tools you use. This raises the question of what audits were carried out, other than those which are mandatory and listed later in the document, and how they led to changes in practice, and where we can find details of them.

It is proper that you are increasingly attending to the physical health of your patients but how often are checks carried out by physical healthcare nurses on in-patients and what is meant by “advice and support” being available subsequently? What do these nurses actually measure and what protocols are in place for the follow-up? What is the role of the Care Coordinator when dealing with your patients living in the community concerning physical health checks? Do they record the frequency and adequacy of the checks? To whom do they report this data?

To establish some baseline measures for services for carers will be useful but surely you already have substantial data on their involvement in care planning. We wonder how many were asked about their involvement in care planning, how they were asked and what did you do about those who were not involved? (The full report of the 2009 Carer Survey has still not been published!) The word “involved” is pretty meaningless.

It is good to see some new priorities emerging but there is only one passing reference to PROMS and PREMS early in the document. We had hoped to see some indication of how you intend to develop these measures and when you expect them to become operational.

The statement “that Service Line Management will ensure consistency of care across the whole patient pathway” conveys almost no information. An unequivocal statement about the advantages to the patient of SLM would have been welcome. We have concerns that there is only one reference to Integrated Care (and the current pilots) which talks of “conversations” surely by now the conversations should have ceased and the work begun.

The information on Audit and Research is encouraging in some ways. The Trust is very big and should be initiating more original research, particularly in the domain of integrated care, which could bring it into closer contact with Primary Care and Social Care providers.

The statement on Data Quality is very welcome but the to use JADE for anything other than clinical information should be reported.

It would have been helpful to have some elaboration of issues surrounding CQUINs and how they impact on your negotiations with Commissioners. There should have been some report on the quality of services that the Trust commissions from third sector providers.
Hillingdon LINk

Hillingdon LINk thanks Central and North West London NHS Foundation Trust (CNWL) and welcomes the opportunity to comment on the Trust’s Quality Accounts (QA) for the year 2011-2012.

The account is a comprehensive and detailed assessment of the provider’s approach to quality and highlights on-going commitment to delivering safe effective patient care. The report this year is an improvement from last year’s report in terms of its overall format, presentation and general accessibility. However, we feel that the report is very lengthy and somewhat wordy. It contains an excessive amount of information for the public to use an indicator of quality. LINk would suggest that by making the document more concise that there is more likelihood that the public may read it. We commend CNWL for producing an easy read version of the report last year. Our research shows that this was well received by the public and we would recommend that this is repeated this year.

In terms of reporting the overall performance of the Trust we feel that the figures presented which show the overall position of the Trust could lead to the reader being misinformed of the quality standards reached. The targets are compared with the overall Trust position and not that of the individual boroughs. This does not give a true indication of the Trust’s quality performance. For example, “Community service users definitely involved in decisions about care plan” has an overall score of 41% yet the lowest borough score is 12% and the highest 83%. To ensure that quality performance is represented accurately each borough should be shown separately.

We would like to see the report provide an explanation of the reasons for the many discrepancies in performance targets achieved across the boroughs. We acknowledge that funding has an impact on the services provided and that the budgets vary across the boroughs, but this is not sufficient to justify such dramatic differences in performance.

To verify accuracy we would also like to see sample sizes included in the borough wide data presented and would recommend that graphs and charts are given clear consistent, referencing for the reader to understand the source of data and the context. Overall, we generally believe that the performance results need to be linked to harder evidence of achievement and specific plans for improvement.

We understand that CNWL work closely with their stakeholders to meet their priorities and we applaud this. The QA could be enhanced by involving these stakeholders in the examination of evidence to verify data and performance. The stakeholder could then provide a qualification statement, which could be included in the QA to add to the credibility of the information presented in it.
Specific comments:

CNWL

Respect and Involvement Measure C: “percentage of community service users who called the crisis number report that they definitely received the help they wanted”.

When viewing this target graphically the reporting is very misleading as it appears that the target has been achieved. This is clearly not the case as incorrect data has been used to form the graph. The target was to measure those who ‘definitely’ received help and not those who received help ‘to some extent’. This is not the only incident of this occurring in the QA. Although CNWL have explained that they have represented the two figures together, picturing it graphically in this way could lead to the reader believing targets have been reached, and therefore this is a misrepresentation that CNWL should look to change.

Carer involvement: Whilst we appreciate the efforts made by CNWL to involve carers, we would like information for the reasons for failing to provide carer assessments. We would also like to ask for further detail on the steps being taken to improve this area for next year.

Hillingdon Community Healthcare (HCH)

LINk is pleased to see the performance by HCH in the different priority areas. We believe they should be complimented for meeting the majority of their targets.

It is pleasing to see the collaborative approach taken by HCH in meeting certain targets and the successful outcomes of joint working.

We would also like to compliment HCH on their performance in supporting service users with diabetes through their DESMOND training initiative.

We have concerns about the priority area concerning the provision of interpreting support to service users. LINk would welcome the opportunity to work with HCH to improve patient involvement over all, and in particular those users who may need interpreting support.

2012-2013 Priorities

The information about the selection of priorities is useful in understanding the process of how these were determined. We would like to suggest that this section is moved to the beginning of the report in order for the reader to gain an understanding of the process at the outset. Any future changes that are put in place in the subsequent year to the selection process can be explained briefly in the section discussing future performance.

We would like to see more emphasis on user involvement in the next year. We also think that surveys (quantitative methods) are not the most appropriate ways to understand patient feedback and experiences for some of the service users. Surveys can provide a snapshot of views, but do not provide the qualitative depth of the patient’s views and experience.

We are concerned about the low targets set for certain measures. For example, “percentage of service users on CPA whose care plans contain at least one personal goal” is 50%. Does that mean that the remaining 50% of users have no goals set in their care plan? Furthermore, we think that having one goal is very minimal in contributing to their recovery. It seems counter-
productive to have a recovery plan without any goals. It doesn’t inspire confidence in the care and treatment approach.

With the additional priorities that are being introduced, some of the targets are only indicated as “baseline”. It would be helpful to have an explanation for the public on what this baseline figure will be and how it is arrived at.

**Brent LINk**

Does the quality account provide a balanced report on quality of services?

Part 2 of the Quality Accounts starts with a Trust wide summary chart of performance against 2011/12 quality priorities which is generally positive. However, an analysis of the data for Brent (shown later in the section) points to a less encouraging position.

Of particular concern are:

- **Quarter 4 measure 1C (Adult Services)** percentage of community service users who called the crisis number report that they definitely received the help they wanted. This measure had a target of 65% but recorded only 20%.

- **Quarter 4 measure 3B (Adult Services)** percentage of inpatient service users report that they got enough advice and support for their physical health. This measure had a target of 65% but only recorded 25%.

- **Quarter 4 measure 2A (Older Adult)**: percentage of community service users report that they were definitely involved as much as they wanted to be in decisions about their care plan. This measure had a target of 65% but performance of 12%.

**Are there any important issues missed in the quality account?**

Brent LINk is concerned at the low patient satisfaction levels and the absence of details of how patient data is collected. We also feel that the report could benefit from more detail on target setting. However, we note CNWL’s commitment to innovation in the way that it measures patient experience and captures patient feedback. We feel this is a good starting point for our two organisations to work together to analyse the reasons behind low patient satisfaction levels and to explore the possible service improvements needed to improve the patient experience in Brent.

**Do the priorities of the provider reflect the priorities of the local population?**

In September 2011, Brent LINk and Fanon co hosted “The Journey Forward Looking Ahead at Mental Health & Wellbeing in Brent”. This conference aimed to allow local communities to voice their Mental Health concerns and to raise awareness of Mental Health services in Brent. The event identified four key recommendations relating to mental health service provision in Brent:

1. Regular mental health community forum to give local people a voice in shaping and scrutinising mental health service provision;

2. Develop Mental Health awareness training for GPs (with service user involvement);

3. Undertake pilot project: faith groups engaging with health care professionals around mental health issues;
4. Provision of an up to date list of local mental health services in Brent.

Brent LINk welcomes the continued inclusion of recovery and involvement as a 2012/13 quality priority. In particular, we agree that the Recovery College Model is an innovative way for staff and service users to work and learn together. The opportunity for service users to train to become peer support workers and work in CNWL multi-disciplinary teams is a particularly welcome and service user oriented approach.

Given the low numbers of inpatient service users (Adult Service) reporting that they got enough advice and support for their physical health, Brent LINk welcomes the Trust’s continued inclusion of Physical Health as a 2012/13 quality priority.

Is the quality account clearly presented for patients and the public?

We welcome CNWL’s decision to produce an “easy read “ version. As Brent LINk highlighted in last year’s Quality Account, an “easy read“ version improves accessibility and consequently, raises awareness of the Trust’s efforts to achieve better outcomes for service users and carers.

Brent LINk feels that breaking down the report by borough would greatly improve readability.
Medicines administration on an inpatient ward.
Annex 2: Quality Account glossary of terms

### Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
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<td>CPA</td>
<td>Care Programme Approach</td>
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<td>CPS</td>
<td>Camden Provider Services</td>
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<td>CQMG</td>
<td>Care Quality Management Group</td>
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<td>CRHT</td>
<td>Crisis Resolution Home Treatment</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
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<tr>
<td>DESMOND</td>
<td>Diabetes Education and Self Management for Ongoing and Newly Diagnosed</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HCH</td>
<td>Hillingdon Community Health</td>
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<td>HoNOS</td>
<td>Health of the Nation Outcome Scales</td>
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<td>LINks</td>
<td>Local Involvement Networks</td>
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<td>LPC</td>
<td>Lead Professional Care</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NHSLA</td>
<td>NHS Litigation Authority</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>OSC</td>
<td>Overview and Scrutiny Committee</td>
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<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<tr>
<td>POMH</td>
<td>Prescribing Observatory for Mental Health</td>
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### Explanation of terms used

#### Care Programme Approach (CPA)

CPA is the framework for care and support provided by mental health services. There are two types of support, CPA and Lead Professional Care. CPA is for people with complex characteristics, who are at higher risk, and need support from multiple agencies. The Trust uses the term ‘Lead Professional Care’ for people with more straightforward support needs.

#### CPA assessment

All those being seen by the mental health service will receive a holistic assessment of their health and social care needs.

#### CPA care co-ordinator

A CPA care co-ordinator is the person responsible for overseeing the care plan of someone on CPA. See also Lead Professional.

#### CPA care plan

A written statement of the care, treatment and/or support that will be provided. In mental health services, people on CPA have a formal CPA care plan and people on LPC have a less formal LPC care plan in the form of a standard letter.

#### Clinical/specialist care plans

Clinical/specialist care plans give the detailed procedure for each service identified as being appropriate to support the service user within their overall CPA care plan.
Crisis plan
A crisis plan is included within the CPA care plan. It sets out the action to be taken if the service user becomes ill or their mental health deteriorates.

Contingency plan
A contingency plan is included within the CPA care plan to outline the arrangements to be used to prevent a crisis from developing. Contingency planning is the process of considering what might go wrong and pre-planning to minimise adverse or harmful outcomes.

CPA review
Care plans are reviewed at least once a year, in partnership with service users and carers wherever possible.

Carer
A carer is someone who provides regular and substantial assistance/support to a service user. Carers are not paid to provide this support and are entitled to have an assessment of their own caring needs.

Lead professional
The professional, in mental health services, who provides care or treatment for someone who needs support from secondary mental health services, but has more straightforward needs than someone on CPA and usually only needs support from one professional.

Local Involvement Networks (LINks)
Local Involvement Networks (LINks) are made up of individuals and community groups, such as faith groups and residents’ associations, working together to improve health and social care services and provide a community ‘voice’ in determining local health and social care priorities.

Patient Advice and Liaison Service (PALS)
PALS offers help, support, advice and information to service users, carers, family or friends.

Service user
The term “service user” refers to those people receiving treatment and care.
Annex 3: Statement of Directors’ responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Services (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor 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 Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

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

• The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
• 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 2011 to June 2012;
  - Papers relating to quality reported to the Board over the period April 2011 to June 2012;
  - Feedback from the commissioners dated 5 May 2012 (closing date of the Quality Account 30-day consultation)
  - Feedback from Governors dated 5 May 2012 (closing date of the Quality Account 30-day consultation)
  - Feedback from LINks dated 5 May 2012 (closing date of the Quality Account 30-day consultation)
• The trust’s Annual Complaints Report (2011-12) published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
• The latest national patient survey (2011)
• The latest national staff survey (2011)
• The Head of Internal Audit’s annual opinion over the trust’s control environment dated 24 May 2012
• Care Quality Commission quality and risk profiles dated to March 2011
• 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 specific data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).
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

Claire Murdoch  
Chief Executive  
31 May 2012

Dame Ruth Runciman  
Chairman  
31 May 2012

Identifying certain infections while the patient waits.