Central and North West London NHS Foundation Trust

Annual Report and Accounts
2012/13

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) of the National Health Service Act 2006.
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Chairman and Chief Executive’s statement

We were delighted that our strength in this field was further recognised with the achievement of securing the community health services contract in Milton Keynes in December 2012. Central and North West London NHS Foundation Trust is an established and high performing NHS Foundation Trust which already offers a wide range of community and mental health services across London and southern England. The core values and services in Milton Keynes have clear synergies with those of CNWL, making the two organisations ideal to come together.

On 1 April 2013 we welcomed our new Milton Keynes colleagues to the Trust. We are looking forward to the coming year as we begin to work closely together and start to explore the opportunities that can be gained through this union to strengthen the services CNWL provides. We are aware of the great responsibility, as well as the privilege, that it is to be entrusted with the future of Milton Keynes Community Health Services.

As a larger, stronger organisation we believe we are in a much more stable position to be able to continue providing high quality, innovative services. At a time when resources are so precious it is important, now more than ever, that we are managing our services and operating in the most efficient way, while still promoting a culture of high quality, personalised care. For this reason, the theme of this report for 2012/13 is growth, and how through our business development strategy we have been able to make improvements across the Trust.

Improvements to information, communication technologies (ICT) have been a key priority this year. The Board approved a vigorous three-year ICT strategy that will ensure we have strong infrastructure, systems and processes in place for the future as the organisation develops and transforms.

The principles of service line management are now fully embedded within our organisation and this report marks the end of the first year with all service lines operating as distinct business units. Many improvements to patient care have been made as a result of the implementation of service line management and this report illustrates a number of them. This includes progress on our estates rationalisation strategy, which is enhancing the use of the Trust’s buildings to improve efficiency and physical environments.

During a time of such change and growth, we were encouraged again by the results of the NHS Staff Survey 2012. While the results show we need to place a greater emphasis on getting some of the basics right internally in the coming year, we were encouraged to hear that staff are satisfied with the quality of patient care and they are able to contribute towards improvements. A more in-depth analysis of the results is included within this report.

Work is also well underway to embed the objectives of recovery that are established with mental health policy in England. This has been an exciting year for the CNWL Recovery College, which brings together service users and staff to deliver courses that will be helpful for other staff, service users and carers. The College has now completed its first year and is looking at how to expand and reach out further in 2013.

We would like to thank our staff, partners, commissioners, service users, carers, advocates, Associate Hospital Managers and members of our Foundation Trust for their support and contributions to our work during 2012/13. Special thanks go to our Governors, who, every year, generously give their time and expertise and whose contributions are invaluable.
Central and North West London NHS Foundation Trust (CNWL) specialises in caring for people with a wide range of physical and mental health needs.

Over the last few years our catchment area has grown significantly, making the Trust’s population more diverse than ever. The area spans the diverse communities of inner-city and outer-city London, as well as wider geographical locations such as Surrey, Kent and Hampshire. There are areas of great affluence as well as areas of much deprivation, and there are over 100 first languages spoken within these communities. We are constantly developing and working in innovative ways to provide modern, dependable services that meet the needs of the diverse communities we serve.

We were proud to be authorised as a Foundation Trust on 1 May 2007. In 2012 we celebrated the five year anniversary of this status and our achievements during this period were the celebratory theme of our Annual General Meeting (AGM) in September 2012.

With the achievement of the Hillingdon and Camden community health integrations in 2011, these services now account for approximately half of all the patients we provide care and support to.

In 2012/13 we provided the following clinical services:

- A wide range of community health services, including adult and child physical care services
- A comprehensive range of mental health services for adults, from early intervention and psychological therapies to inpatient treatment or long-term rehabilitation care
- Specialist mental health services for children and adolescents, including family therapy
- Dedicated mental health services for older people, from early diagnosis, memory services and ongoing treatment options
- Substance misuse services for drugs, alcohol and the new group of ‘dub drugs’, provided in the community and a medically managed inpatient detoxification service

Wellbeing for life

- Specialist addiction services, available nationally for problems with gambling and compulsive behaviours
- Inpatient, outpatient and day patient eating disorders services, available to clients nationally
- Inpatient and outpatient learning disability services, available to clients nationally
- Mental health, addictions and primary health care services in HM Prisons
- Sexual and reproductive health services and HIV services, including walk-in services, in central London and Hillingdon

An established provider of community health services

The year 2012/13 was our second as a provider of community physical health services and the transition to community health provider has been a key development for the organisation. We believe in high quality, joined-up community services that enable people to be treated in the environment where they are most comfortable, and only require admission to hospital when it is absolutely necessary.

Good progress has been made during the year to further integrate community health services within the organisation. We are now in a strong position to provide an holistic approach to the care we provide; considering an individual’s mental health needs alongside their physical health requirements and vice versa. There are clear synergies between the two areas and we are still working towards seeing how this combination of services can lead to the development of unique, but hugely beneficial services that really deliver the very best patient care.

In December 2012 we were delighted to be awarded a new contract to integrate with Milton Keynes Community Health Services (MKCHS). This development supports our plans to grow and branch out to new locations, outside of our core London area. MKCHS services transferred to CNWL on 1 April 2013.
Our services
(as provided on 1 April 2013)

Services in the south of England

Services across London

Directors’ Report
This year we have made significant progress in developing services to create a positive, caring experience for all those accessing treatment. We have also made improvements to create a supportive environment for staff.

Our vision and values shape the way we operate. We aim to continually improve our services, processes, and expertise to enable us to provide the best possible healthcare services for the populations we serve. We believe that a flexible and innovative approach will allow us to constantly evolve to respond to the internal and external pressures we face.

Our vision and values were re-launched in 2011 and were issued to all new employees in a staff charter booklet, provided at the Trust induction. Over the last year we have continued to embed the values into everyday practice.

In 2013/14 the values will be revisited again to ensure they continue to meet the future vision and strategic objectives of the new, larger organisation.

We will involve people in their care plan and treatment, working together and alongside carers and families to create practical solutions that meet individuals’ needs. We will give our staff the support and opportunities they need to grow and develop.

Our values

- **DEDICATION**
  - We empower people to improve their overall quality of life, live independently within their communities and understand how to manage any long-term health conditions.

- **EMPOWERMENT**
  - We will involve people in their care plan and treatment, working together and alongside carers and families to create practical solutions that meet individuals’ needs. We will give our staff the support and opportunities they need to grow and develop.

- **DIVERSITY**
  - We value the diversity of the people we support and our staff. To create a respectful and supportive working environment, we will take the time to communicate clearly, ensuring that everyone understands one another and feels included.

- **PARTNERSHIP**
  - We believe in working together, both within our organisation and externally with our partners. We listen to, communicate with and work effectively with our partners, for example GPs, NHS Clusters and voluntary organisations.

Strategic objectives

CNWL’s vision and values are underpinned by the Trust’s strategic objectives:

- Providing integrated, high quality, timely services based on the needs of the individual.
- Engaging meaningfully with service users, carers and the local community to improve and align our services to meet needs and to ensure effective local accountability to the population we serve.
- Improving and maintaining to a high standard the physical environments in which we are providing services.
- Recruiting, retaining and developing a skilled and motivated workforce that is proud to work for the Trust and that the Trust is proud to employ.
- Providing a financial base that is robust for the future development of the Trust and providing economic and efficient services.
- Improving Trust information systems to support improvement in patient care and performance management.
- Seeking and developing new business opportunities and partnerships consistent with our vision.

This directors’ report will describe progress on meeting these objectives and provide some examples of highlights and achievements from 2012/13.
1 Providing high quality services

In 2012/13 we achieved:

- Service line management has become fully embedded within the organisation.
- Cost Improvement Plan (CIP) savings of £17.3m.
- A financial risk rating at year end of four (where 5 is highest).
- A green governance risk rating.
- New contracts in prison healthcare, community learning disabilities, addictions and community health services.
- A major new contract to integrate with Milton Keynes Community Health Services (MKCHS).
- Principles of recovery are embedded throughout mental health and allied specialties services.

Improvements through service line management

The year 2012/13 saw the completion of the Trust’s three-year change programme, which involved the implementation of service line management, a service redesign programme, and an estates rationalisation programme. The programme saw the creation of 11 mental health and allied specialties service lines, which sit alongside the community physical health and sexual health service lines.

Service line management involves identifying specialist clinical areas and managing them as distinct operational units. Service lines are able to establish management structures that are appropriate for their needs, work to a service line budget and develop a number of their own performance targets.

Service line management brings clinicians to the forefront of services by having each service line jointly managed by a clinical director and a service director. This strong joint management style helps the directors oversee and understand the performance of the service line in its entirety. This means that, together, they are able to organise services in a way that benefits patients whilst also delivering efficiencies for the Trust.

Previously, the Trust was managed on a borough basis, where a service director was responsible for a portfolio of services based in one area. This meant the experience of the same type of service could differ depending on where a patient lived. Managing the same type of service across a wider area, allows managers to share information about what makes services efficient, while also sharing important lessons learnt.

The Trust now has 13 service lines in operation. Service lines continue to implement changes to improve the quality and efficiency of services. This includes sharing expertise and knowledge, and rationalising services where available.

Here we report on some of the notable improvements that have been achieved in each service line following the implementation of service line management:

Acute services

These services provide assessment and treatment for adults with severe mental illness. Treatment and therapies can be provided in an inpatient hospital when necessary or through intensive support by a home treatment team in the community.

Improvements in 2012/13:

- A triage model has been implemented across CNWL’s six inpatient units to manage admissions and reduce the length of stay in hospital where appropriate. Three triage wards have been established where service users are admitted for a period of up to 14 days and assessed daily, including weekends. Service users can then either be discharged to a home treatment team, a community recovery team or transferred to a ward to continue their recovery process. For many service users the amount of time in hospital has reduced considerably as a result of this process, and over the last year approximately half of the people admitted to triage wards were discharged home within two weeks.
- The Productive Mental Health Ward Framework is being implemented across our acute wards. The aim is to ensure nursing staff have more time to spend engaging with service users and their families. This has had a direct impact on the quality of care and the ward environment, with a reduction in incidents and an increase in staff morale.
- The Trust wants to support more people with mental illnesses within their local community setting, thereby reducing unnecessary hospital admissions. The service line reviewed services across the Trust, and identified that more people in Kensington and Chelsea and Westminster could be treated through community mental health services rather than in hospital. This was supported by analysis of other borough provisions. In 2012/13 a consultation was launched to propose reducing inpatient provision, to enable more resources to be invested in the community. The Trust will present an update on these plans in 2013.

Addictions and substance misuse

These services provide high quality community and inpatient addiction treatments, including treatment for dependence on alcohol and a range of drugs. The service line provides the only NHS clinics for problem gambling and a range of compulsive behavioural addictions such as gaming and pornography.

Improvements in 2012/13:

- In 2012/13 the service line employed a group of peer support workers who have personal experience of substance misuse who work alongside health professionals in drug and alcohol services. The peers have also received special training to run social and support services at weekends, when service users are vulnerable to relapse or loneliness.
- The Club Drug Clinic, which provides specialist treatment for users of drugs such as ketamine, GHB/GHB and mephedrone has expanded to open a second clinic at Mortimer Market, CNWL’s sexual health centre in Camden. The clinic has received over 700 referrals since opening in 2011.
- Principles of recovery are embedded throughout mental health and allied specialties services.

Above: CNWL employee at the Max Glatt Unit (inpatient detoxification service).
Assessment and brief treatment
This is a new service line which provides assessment and short-term interventions in the community for people with mild to moderate mental health needs, including Improved Access to Psychological Therapies (IAPT) services.

Improvements in 2012/13:
- Assessment and brief treatment teams have been established in all boroughs to provide a first point of contact into mental health services. The teams have been developing assessment skills, and developing brief intervention treatments, including attending cognitive behavioural therapy (CBT) training and bespoke customer service courses.
- Teams have been working closely with service users and carers to develop CNWL Recovery College courses, specifically to meet their needs.
- In October 2012 an Improving Access to Psychological Therapies (IAPT) service was established in Hillingdon. This service has filled an important gap, meaning IAPT is now available in all boroughs where the Trust provides mental health services, to provide services for people with common mental health problems.
- The service line became the lead contractor of the Primary Care Mental Health Service in Kensington and Chelsea. We will be looking at how to develop this service in future, including embedding employment services and implementing a self-referral process.

Child and adolescent mental health services (CAMHS)
CAMHS are provided mostly in the community, but CNWL also has a specialist inpatient service for 8 to 13 year olds. Family therapy plays an important role in CAMHS care and the Trust also provides perinatal services to new mothers experiencing mental health problems.

Improvements in 2012/13:
- CAMHS in Westminster completed a two-year funded programme to transform Children and Young People Improving Access to Psychological Therapies Services (CYP IAPT). The programme funded five staff trained in cognitive behavioural therapy and their supervision to deliver therapies to children, young people and families.
- In 2012 the service line won funding for a CYP IAPT service in Kensington and Chelsea. Clinicians have been training in new interventions, and are building on the successes already achieved in Westminster to improve care for children and young people in the borough.
- In January 2013 the service line launched the Multi-Systemic Therapy Service which is delivered across the boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster. This service model is supported by the Department for Education and involves working intensively with families in their homes who have children who may otherwise have to be in care or custody.

Community physical health
In Hillingdon and Camden, CNWL provides community physical health services including physiotherapy, speech and language therapy, podiatry and health visiting. Community physical health services span from birth to end of life and cover the full range of common physical healthcare problems.

Improvements in 2012/13:
- In 2012/13 community health services in Camden and Hillingdon moved to one management structure. This ensures that expertise, experience and economies can be shared across these two boroughs.
- In October 2012 the Child Development Centre in Hillingdon moved to a new family-friendly site, located at the Woodlands Centre within the Hillingdon Hospital. The demand for this service continues to increase and in the last 15 years the team has grown from 15 to 60 members of staff and now takes a record number of referrals.
- The Camden Integrated Primary Care Team was awarded £500k by its local Clinical Commissioning Group (CCG) to develop re-enablement services by offering more intensive support to early supported discharge patients and increased access to CareLink services. The team was also successful in a bid for winter pressures funding to expand the Rapid Response Team and offer extended hours from February 2013.
- The Camden Disease Management and Specialist Support Service has developed new services including a pilot for a Parkinson’s disease self management group and a successful bid to deliver the community learning disability service contract to provide physiotherapy to clients with complex learning disabilities.

“Although it has been hard work physically, the staff have always made the sessions fun. I have enjoyed attending and have noticed the improvement in my health.”
Patient from community physical health services

Above: Rehabilitation staff and a patient at St Pancras Hospital in Camden.


**Community recovery**

These services support people to live independently, whilst also promoting recovery principles. This may be through early intervention for people experiencing their first episode of psychosis, through an integrated health and social care recovery team for people who require ongoing support, or through day services and personalised care.

**Improvements in 2012/13:**

- The service line was successfully awarded the contract for both Brent and Harrow community learning disability services in 2012. These services provide essential community based care to people with a learning disability who are living in these boroughs. The primary focus of these services is the prevention and management of complex health issues, and to improve access to all healthcare for people with a learning disability. A review of processes used within the Brent team is underway using lean principles, a procedure that maximises value while minimising waste.

- A group of staff and service users have been working in partnership with the CNWL Recovery College to develop a pioneering new course to be piloted in spring 2013. ‘Journey to self discovery’ is a bespoke course that has been designed specifically for service users with a learning disability, their supporters and staff. This is a unique opportunity for students to become experts in their own self-care, developing the skills and confidence to manage their recovery journey.

- The Trust has a responsibility to ensure that all people with a learning disability have access to all health services and that they receive the best treatment available in line with good practice and legal frameworks. In 2012, a Trust-wide learning disability champion network was developed to provide support to service users and carers, as well as leadership and guidance to staff. Each service, site or ward in the Trust has a named learning disability champion, whose role is to promote best practice around the care and treatment of service users with a learning disability during their time within CNWL services.

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**Eating disorders**

Support for people with an eating disorder, such as anorexia or bulimia, is provided at the Vincent Square Eating Disorder Service in Westminster, and at Northwick Park Hospital in Harrow. Inpatient, outpatient, and day patient treatments are available to service users nationally.

**Improvements in 2012/13:**

- During 2012/13 the service revised and improved its marketing plans to increase national referrals. A new website was launched in October 2012 with online referral forms available for national referrals. A website tour of the inpatient facilities has been developed, which allows patients and clinicians to see the unit before they visit. The service has been actively promoted through printed literature, attendance at events, online advertising and social media.

- Following the relocation of the Vincent Square Eating Disorder Service to the South Kensington and Chelsea Mental Health Centre in 2011, the service has had an opportunity to review both its clinical and management practice. The management team has been restructured to allow for a broader range of senior clinical staff backgrounds. A full-time business support officer has also been appointed to support senior managers.

- A strong emphasis has been placed on maintaining and improving the quality of data held by the service. This has been achieved by implementing a monthly internal performance management framework, monitoring the service performance against its main contracts and issuing monthly data improvement reports to clinicians.

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**Learning disabilities**

Learning disability inpatient and day services are provided at the Kingswood Centre in Brent. The centre provides assessment and treatment for service users who have complex mental health needs and/or complex challenging behaviour. Inpatient services are also provided in Enfield.

**Improvements in 2012/13:**

- The service line was successfully awarded the contract for both Brent and Harrow community learning disability services in 2012. These services provide essential community based care to people with a learning disability who are living in these boroughs. The primary focus of these services is the prevention and management of complex health issues, and to improve access to all healthcare for people with a learning disability. A review of processes used within the Brent team is underway using lean principles, a procedure that maximises value while minimising waste.

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**Offender care**

Working in partnership with the Criminal Justice System and other agencies, these services provide responsive, dependable and high quality primary care, mental health and substance misuse services to existing offenders (and those at risk of offending) in the communities we serve, to improve their health and to encourage social inclusion.

**Improvements in 2012/13:**

- During 2012/13 the offender care service line expanded considerably and new CNWL healthcare services have commenced at 12 new Her Majesty’s Prison (HMP) and Her Majesty’s Young Offender Institution (HMYOI) sites across Surrey, Kent and Hampshire.

- In April 2012 the Hillingdon Community Offender Health Service was established to provide court diversion services in the borough.

- The service line continues to expand following the successful bid for services in Milton Keynes, Bedfordshire and work commenced at HMP Woodhill following the transfer of the contract to CNWL on 1 April 2013.

- In December 2012 services at HMYOI Feltham were inspected by the Care Quality Commission (CQC) and were found to be meeting all 16 of the essential standards.
Older people and healthy ageing
Mental health problems developing in later life are often of a different nature and require a different approach than those occurring earlier in life; this applies to a range of conditions including cognitive disorders, mood disorders and psychoses. These services also provide treatment for people of all ages who have dementia, as well as support with other physical, psychological and social difficulties associated with older age.

Improvements in 2012/13:
• The memory services in Kensington and Chelsea and Westminster, and the Admiral Nurses Service are now being managed as one team. The team have addressed lengthy waiting times for new service user assessments and as a result the number of new assessments completed each month has almost doubled averaging 62 a month.

From August to November 2012 a consultation was held in Hillingdon to propose closing one of the two inpatient wards so community assessment and early diagnosis of dementia could be improved. Following the completion of the staff consultation in March 2013, Cedar Ward was closed. The closure enabled the community service to be developed while also increasing staffing levels and a refurbishment of the remaining Oak Tree Ward.

The Westminster Older People and Healthy Ageing Team and the Intermediate Mental Health and Physical Care Team have moved to new refurbished premises on Vauxhall Bridge Road. The services join other Westminster mental health services to create a hub where services can work closely alongside each other.

In Brent, partnership working has progressed, with services having input to the social services re-enablement project for people with dementia. The service has also been working closely with social services to explore improved integration with the community mental health teams across Brent, Harrow and Hillingdon.

In Harrow, services have worked closely with the local Clinical Commissioning Group (CCG) to re-design mental health intermediate care services. This has resulted in a reduction in inpatient services, which has enabled the development of a service that provides intermediate care in the community. Both aspects of this service are aimed at facilitating and avoiding unnecessary admissions to the acute hospital and to support early discharge.

Psychological medicine
Support is provided at general hospitals through liaison psychiatry services and clinical health psychology. The liaison services provide assessment and treatment for people who present with mental health or psychological needs in A&E and on wards in general hospitals. Service users can then be referred onto the appropriate local service.

Improvements in 2012/13:
• As the newest service line to be established, over the last year the team have been embedding the service line, its structures, governance systems and processes.
• In 2012 the service line was commissioned by NHS North West London to develop expanded psychiatry services across three hospitals: Central Middlesex, Northwick Park and Hillingdon. The impact of these services was shown in improved response times in A&E and the general hospital wards for people with urgent mental health needs, improved identification and treatment of mental health problems, improvements in quality of care, patient outcomes and more support for staff in acute trusts.
• In 2012 funding was awarded by NHS London/London Deanery to develop and pilot a training package for managing mental health needs in the emergency departments. A training package was developed and piloted with Northwick Park Hospital and is being rolled out to other general hospital partners. The training package was awarded an Excellence in Education Innovation award.
• The service line was involved in the NHS North West London Integrated Care Pathway for service users with long-term conditions, providing psychological support and holistic care for service users identified as having mental health problems. As part of this the service line has successfully tendered for a number of innovation bids to develop services to specifically improve the treatment available for patients with diabetes.
• A CNWL innovation bid has been awarded to the service line to develop a business case and service for the treatment of medically unexplained symptoms.

Rehabilitation
Rehabilitation services provide long-term care and support to service users with ongoing mental health needs in 24 hour staffed placements; either in inpatient units or the community. Rehabilitation services provide intensive therapeutic treatments to help people develop independent living skills and improve their quality of life.

Improvements in 2012/13:
• During 2012/13 the rehabilitation service line continued with the development of a community rehabilitation service. Three teams are now established in Kensington and Chelsea and Westminster (joint team), Harrow and Hillingdon (joint team) and Brent. Recruitment to these teams is almost complete and they are taking on care co-ordination of service users in 24 hour supported accommodation.
• There is a one-year service improvement programme throughout 2013 to improve five wards at Horton, our inpatient facility in Epsom, Surrey. The programme includes increasing staffing recruitment and retention, estates improvements to the houses and cottages, embedding the recovery approach in practice, maintaining commissioner relationships and marketing the service both within the Trust and nationally.
• The recovery approach continues to be embedded within the service line and has been implemented through staff training, adopting the recovery approach in practice, maintaining commissioner relationships and marketing the service both within the Trust and nationally.
• The service line was involved in the NHS North West London Integrated Care Pathway for service users with long-term conditions, providing psychological support and holistic care for service users identified as having mental health problems. As part of this the service line has successfully tendered for a number of innovation bids to develop services to specifically improve the treatment available for patients with diabetes.
• A CNWL innovation bid has been awarded to the service line to develop a business case and service for the treatment of medically unexplained symptoms.
**Sexual health**

Sexual health services offer confidential advice and information on contraception, sexually transmitted infections, pregnancy choices and planning a pregnancy. A comprehensive range of HIV services and treatment are also provided.

**Improvements in 2012/13:**
- The service line has increased the number of integrated clinics offering both sexual health and contraception. There are more specialist clinics for fitting long-acting forms of contraception and also for rapid HIV walk-in testing. Earlier appointments for fast-track genitourinary medicine (GUM) at Mortimer Market have proven popular with service users, and as a result the service is now looking to roll this out in the Archway Centre.
- In 2012/13 the service line refurbished some of its clinic facilities in Camden. The Central London Action on Sexual Health (CLASH) building had suffered from little investment in the past ten years and was refurbished. Upgrades to the Bloomsbury Clinic for HIV services included the development of larger and more accessible pharmacy and phlebotomy areas, additional clinical rooms and more welcoming, comfortable patient waiting areas. Plans are also underway to move the Margaret Pylke Centre to a new location in 2013.
- There have been a number of exciting developments for the service line with the introduction of clinics based in St Mungo’s homeless hostels, increasing outreach for young people both in Camden and Islington.
- The expansion of a satellite CNWL Club Drug Clinic at the Mortimer Market Centre, demonstrates the benefits of sexual health and addictions services being able to work closely together.

**Our performance**

**Care Quality Commission (CQC) registration**

From 1 April 2013 the Trust’s registration with the Care Quality Commission was extended without any conditions.

**Performance against Monitor targets**

The Trust’s performance is monitored against national targets set by Monitor, to identify potential and actual problems. We declare on a quarterly basis whether we are meeting the targets using a scoring metric of one to five for financial risk (where five is excellent), and red, amber, green status for governance risk and mandatory services.

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* The Trust’s governance risk rating was reduced to amber/red in quarter four of 2010/11, in line with the Monitor Compliance Framework. This was as a result of an outstanding compliance action at one of our sites in quarter four of 2010/11. An action plan to address the issues raised by the CQC was implemented and the concerns were lifted in quarter one 2011/12.

**Quality reporting targets**

In last year’s Quality Account, the Trust had a total of 17 quality priority measures for 2012/13. Eight of these originated from our mental health and allied specialty services, five from community health services in Hillingdon, and four from community health and sexual health services in Camden.

These 17 measures were tracked throughout the year and action plans developed where improvements were required. The chart below indicates our achievement against these 17 quality priority measures for 2012/13. Eight of these measures were also part of the Commissioning for Quality and Innovation (CQIN) payment framework, which allows commissioners to reward excellence by linking payment to local quality improvement goals.

This year we achieved 88% of our quality priorities, representing an increase in our achievement from 69% last year. In areas where the Trust did not meet quality priorities targets, actions have been formulated to further address these going forward. Please see pages 71-138 of this Annual Report to view the full Quality Account for 2012/13.
Risk management and quality governance

In recognising the need to develop risk awareness throughout the organisation, a range of training courses has been developed to ensure staff are trained in the identification and management of clinical risks. The development of local risk registers has served to promote awareness and understanding of the identification of risks and their management across the organisation.

The Trust’s Risk Management Policy sets out CNWL’s approach to risk. It defines structures for the management and ownership of risk, and explains the Trust’s risk management processes.

Key to the effectiveness of risk management in the organisation is the Executive Board, comprising all the Executive Directors. This membership recognises the importance and high profile of risk management in the organisation and facilitates senior ownership of the identification and management of risks on a continuing basis. This is important in ensuring that the Trust takes an integrated approach to governance and risk management issues.

Issues that are identified as constituting a significant risk are reported to the Executive Board, with progress being reported to the Board of Directors every six months. Lower graded risks are managed by the relevant service line or directorate. The Board of Directors receives a report at every meeting on the top risks facing the Trust. Work has taken place across the Trust to identify local risks and this has resulted in the development of the Trustwide risk register. The risk register contains details of risks under the headings of clinical, organisational, health and safety and financial.

The Board has a Quality and Performance Committee chaired by a Non-Executive Director, with Board Executive and Non-Executive Director membership. A range of groups, with responsibility for monitoring areas of work relating to clinical quality and governance, report to this committee.

It is a priority for the Trust to ensure that service users and their carers are provided with opportunities to be actively involved in the development of their own care and treatment, and to express their views about the services they receive from the Trust. We actively involve these important stakeholders in determining quality priorities for services, and in monitoring the implementation of those quality indicators.

Service user and carer engagement

We have continued to engage and involve service users and carers in a number of activities during the year, which include:

- Encouraging participation within national inpatient and community service user and carer surveys
- Performing service user telephone surveys each quarter (conducted by a team of trained service users) to provide data on quality priorities performance in community and inpatient mental health and addictions services
- Conducting a detailed service user telephone survey to provide qualitative data on service user expectations and perceived preferences
- Introducing a telephone survey to service users who have used the CNWL User Employment Programme (UEP) to gather feedback
- Engaging service users and carers through quality and governance forums to gain feedback for service lines
- Undertaking focus groups with service users and carers to gather specific feedback on chosen topics
- Involving service users in the recruitment and selection of staff, designing training sessions and training materials for staff
- Engaging service users in the design of information leaflets and clinical policy reviews
- Seeking the views of service users and carers in determining quality priorities for 2013/14

Capturing feedback

We have a number of mechanisms in place to ensure we capture feedback from our service users and carers to make ongoing improvements to the quality of care provided across CNWL services. The Trust regards dialogue and listening to our communities as integral to the ongoing improvement of our services, ensuring we deliver services appropriately and sensitively across the diverse communities we serve.

All services operate a variety of processes for gathering feedback from their service users and carers, which can include:

- Care reviews
- Questionnaires
- Liaison meetings
- Focus groups
- Public consultation events
- Internal quality and governance forums with user and carer representation
- Attendance at community events.

In response to the feedback received in 2012/13, a number of actions have been taken, for example:

- Crisis cards for mental health service users have been developed and distributed to relevant adult services
- Service users are now involved in the recruitment and training of staff
- Forums have been developed to provide an opportunity for service users and senior managers to meet and address local issues
Improving crisis care

The Trust has worked hard over the last couple of years to improve access to emergency out-of-hours mental health support for service users and carers. Previously the Trust had a different telephone number for each of the five boroughs where we provide mental health and learning disability services, with calls going through to overnight staff on wards. Feedback from service user surveys, and mystery shopping exercises showed that service users and carers were not satisfied with the level of support available under this arrangement.

Therefore, during 2012/13 we worked with service users and carers to identify ways in which this service could be improved. Overwhelmingly, responses indicated the requirement for a single number and a telephone line being answered by someone whose sole job it is to provide support and advice. As a result of this feedback, the new Out-of-Hours Urgent Advice Line went live for users of CNWL’s mental health and learning disabilities services on 25 February 2013.

The advice line will also be the first point of contact for GPs out-of-hours, providing access to information about CNWL service user’s treatment and history.

Between 25 February 2013, when the urgent advice line was launched, and 31 March 2013 the line has already received 521 calls.

Embedding recovery principles

CNWL was proud to open its CNWL Recovery College in April 2012, the third college of its kind to be developed in the UK. The college follows an adult education model and delivers a responsive, peer-led learning and development curriculum of recovery focused courses. The college promotes opportunities for the recovery and social inclusion of people with experience of mental illness. All courses are designed to re-skill and assist students to grow in the way they want to, to have a say in what works for them, to have a voice, to be heard, to have choices and to have control in their recovery journey.

The CNWL Recovery College is run by CNWL staff, and people with personal experience of mental health problems, who co-produce and co-deliver all the courses, in recognition of the value of both types of expertise. It is open to people who use services, their friends and family, and CNWL staff. This joint learning environment helps to break down the barriers between ‘them’ and ‘us’ that can perpetuate stigma and exclusion.

During 2012/13 the college successfully completed three terms with a curriculum of 37 courses. The courses were run 122 times and were attended by 600 individual students, 454 of whom were people who use services, 31 carers and 115 staff. In total, there were 1,496 attendances and 17,500 prospectuses were distributed during the first year. The college is looking to expand the range of courses and continues to work with service lines to develop tailor-made courses for service users.

Above: The CNWL Recovery College provides a range of courses for service users, their supporters and CNWL staff.

Student feedback has included:

“Meeting others who have shared similar experiences has made me realise that there might be a way out.”

“It was quite unique to be amongst so many service users who have crossed into recovery, I’ve never experienced that before.”

“I now don’t feel ashamed about my mental illness.”

“My perception of how I carry out my work and my approach towards the people I work with has improved.”

“The course has given me food for thought... It’s OK for me to know what I would like in terms of my recovery and to be more assertive or resourceful about achieving this.”
Communications
During 2012/13 the Trust further developed its communications function in order to reflect the changing needs of the organisation. The Communications Team now provides a fully integrated service providing both corporate and service line support to the whole organisation. The CNWL brand and reputation has been reinforced to ensure a consistent approach and message to our wide stakeholder group.

The team has increased support for service lines during 2012/13, focusing on the delivery of specific marketing and communications requirements. This includes the preparation of new information for referrers, recognising that health professionals require detailed information that carefully explains treatments and outcomes.

In November 2012, the Communications Team implemented a new reporting and monitoring system to manage media enquiries, interview requests, press releases, crisis communications and any associated coverage. This system is being used to effectively plan and manage the team’s activities, whilst also measuring the impact of any output.

In September 2012, the Trust launched a new website to improve online access to information about CNWL and the Trust’s services. The project involved a complete overhaul of the services directory, which now helps users find services by location and/or by clinical speciality. Changes to the website were made following extensive research with audiences such as service users, carers, members, governors, the public, staff and referring health professionals. Feedback was gathered through a series of focus groups, surveys and telephone interviews.

The feedback indicated that our audiences wanted to be engaged visually through a bright and welcoming design as well as through clear and concise information. We have received excellent feedback on the site so far and will continue to develop the site to further develop its content, particularly following our integration with community physical health services.

The launch of this new website has increased focus within the Trust on using the internet as an efficient and cost-effective method to engage with new and existing audiences. We have invested in improved search engine optimisation (SEO) methods, which help people looking for information about CNWL to find us, and are looking at other ways to improve how we communicate with our online audiences. Continued engagement with audiences is shaping the future provision of the Trust’s digital presence.

In November 2012 a new CNWL blog, called InConversation, was launched. The blog provides a channel where CNWL staff can speak directly to users and peers about their views on topical discussions and invite comments and feedback in return.

Patient Advice and Liaison Service (PALS)
The Patient Advice and Liaison Service (PALS) aims to make the Trust’s services as welcoming and responsive as possible, for as many people as possible. Our intention is to respond to enquiries and concerns immediately and to learn from feedback from those using CNWL services on an ongoing basis.

PALS help available includes:
• Provide information about local health services – especially the Trust’s services
• Help solve problems with services quickly and informally
• Advise how to make a formal complaint
• Pass on any suggestions for service improvement, and any comments or compliments.

There are three PALS departments that deal with enquiries for the organisation:
• Mental health and allied specialities: the PALS department received 690 enquiries. Of these, 43% were requests for advice, 38% were concerning problems that people were looking to be resolved and 1% were compliments.
• Community health and sexual health in Camden: the Patient Support Service (PSS) received 265 enquiries. Of these, 66% were compliments and 28% were concerns.
• Community health in Hillingdon: the PALS department received 320 enquiries. Of these, 41% were compliments.

Complaints
Complaints are a vital source of feedback from service users, their carers and relatives. This information continues to be used to inform the organisation and to develop priorities for the Trust. The 2012/13 Annual Report on complaints will look at themes and learning arising from complaints during the year.

In 2012/13, 331 formal complaints were received. Of these, 13 were escalated to the Parliamentary and Health Service Ombudsman, one of which was accepted for reinvestigation.

The Trust’s complaints, PALS and claims review group met three times during the year to consider collective learning from the complaints received across CNWL’s services. The Trust continued to monitor the timelines of responses, working in line with the policy to provide a response within 25 working days. Plans are ongoing for more robust monitoring in this area, including feeding back to service line directors on a monthly basis on the performance within their areas of responsibility.

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Membership

Foundation Trusts have greater freedom to develop services that meet the specific needs of local communities. Local people are invited to become members of CNWL, where they can help ensure the Trust is providing the most suitable services when and where they are needed. Members’ views are represented at the Council of Governors by 40 governors who are elected and appointed for specific groups of members, known as constituencies. Constituencies cover service users, carers, staff, partner organisations and public members.

Managing our membership

In early 2013, a new database was implemented to manage the Trust’s membership. Since becoming a Foundation Trust in 2007, the membership has grown to reach over 14,000 members, and it was identified that to increase value it could be managed more efficiently. As a result of the implementation we were able to update and cleanse the data against information held by Royal Mail for records that were no longer valid. While the Trust is now in a better position to communicate and engage with members, this has resulted in a slight reduction in the recorded membership.

Building our membership

A number of membership recruitment activities took place throughout the year, with special focus applied to recruiting young members, as this was identified as a group that was under represented. In October 2012, as part of World Mental Health Day celebrations, we worked in partnership with a number of universities across the Trust’s catchment area to run joint events. This resulted in new members from the student body, and due to the success of the campaign we will be looking to hold similar events in future.

A recruitment campaign in Milton Keynes started in March 2013 to recruit an initial 500 members from the local communities ahead of the integration with Milton Keynes Community Health Services on 1 April 2013. Further recruitment campaigns will be conducted in 2013 to attract service user and carer members.

We have also utilised social media channels, such as Facebook and Twitter, to recruit members and promote the benefits of joining the CNWL membership.

Membership figures 2012/13

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of members 2012/13</th>
<th>Number of members 2011/12</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service user</td>
<td>1,897</td>
<td>1,923</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Carer</td>
<td>533</td>
<td>538</td>
<td>-0.9%</td>
</tr>
<tr>
<td>Public</td>
<td>6,665</td>
<td>6,258</td>
<td>6.5%</td>
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<tr>
<td>Staff</td>
<td>5,198*</td>
<td>5,466</td>
<td>-4.9%</td>
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<tr>
<td>TOTAL</td>
<td>14,293</td>
<td>14,185</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

*Staff membership figures for social care staff who are not directly employed by the Trust have been omitted for 2012/13.

Membership engagement

The new member database, implemented in January 2013 was required for a number of reasons: to access information about members in a quick and easy way, to provide reports for internal and external reporting, and to improve engagement and communication with members.

The database provides a secure storage space for holding personal information and has a number of engagement features that include:

- Members’ electoral constituency allocated by post code
- Socio-demographic analysis
- Automatic accuracy checks and time saving data-entry tools
- One-click Monitor reporting
- Coordination with Electoral Reform Services to manage elections
- Quarterly data cleansing and bereavement checks.

The system provides tools to plan the Trust’s engagement strategy, such as the ability to communicate with members directly via email from the system, compose and dispatch postal mailing directly from the database, record members’ preferences, interests and attendance at events, as well as keep track of governors’ data, such as term dates and meeting attendance.

Following the implementation of the new database, the membership team plans to increase the number of email addresses held for members on the system. This will help the Trust keep in touch with members in the way they most prefer (via post or email) and will also improve the effectiveness and cost efficiency of communicating with members. Typical communications and engagement with members includes the distribution of a member magazine that includes news from the Trust, invitations to exclusive member events, invitations to the quarterly Council of Governors meetings and the Annual General Meeting.

Members can contact governors and directors via the CNWL website: www.cnwl.nhs.uk

Involvement

The Trust has an agreed protocol for involving and engaging with Local Involvement Networks (LINks), which has been developed collaboratively with Harrow LINk and shared with the other LINks.

LINks have been involved during the year in reviewing the performance of the Quality Account. They have been invited, and participated in focus groups taking a more in-depth look at user definitions of quality measures, and they have been involved in the consultation process to decide the Quality Account priorities for 2013/14.

From April 2013, local Healthwatch organisations replaced LINks in each area. Healthwatch will build on the knowledge and experiences of LINks and are independent consumer champions for health and social care services in their area. Local Healthwatch organisations can be identified at: http://www.healthwatch.co.uk and we look forward to extending our relationship with our local Healthwatch organisations in the forthcoming year.
Equality and diversity

CNWL covers a wide and culturally diverse area, with over 100 first languages spoken. We passionately believe that everyone has the right to receive the same level of care, regardless of who they are or where they live.

The year 2012/13 has seen a number of equality initiatives within the Trust designed to support service users and carers, which include:

- The Trust came fifth out of 32 healthcare organisations in the Stonewall Healthcare Equality Index. The Healthcare Equality Index is a new tool for health providers to benchmark and track their progress on equality for their lesbian, gay and bisexual patients and communities.
- The Trust published its annual equality monitoring reports and, for the first time, has been able to extend reporting across six equality characteristics: race/ethnicity, disability, gender, age, religion/belief and sexual orientation.
- A lesbian, gay, bisexual and transgender (LGBT) health conference was held in Camden in December 2012, bringing together local stakeholders with CNWL staff to develop a fuller understanding of the LGBT community’s health needs.
- Events were held to mark World Mental Health Day within local university campuses in order to reach out to the culturally diverse student group that attends them.
- Following the Trust’s integration with community health services in Camden, the Trust now has its own interpreting service which we are excited to be able to develop for the future, both for all CNWL services to access, and also to provide interpreting services to external organisations.

- The third faith and spirituality conference for staff, chaplains and representatives from faith communities was held in November 2012.
- A spirituality and wellbeing module has been developed and is included within the CNWL Recovery College programme.
- The Trust’s Equality, Diversity and Human Rights Policy (Service Delivery), Disability Policy (Service Delivery), Interpreting Policy, and Faith and Spiritual Support Policy have been reviewed and updated.
- The Health Visitor team in Hillingdon continue to run a community engagement programme across the borough, incorporating the health needs of homeless people and other marginalised communities, including travellers and gypsies.
- In April 2012 the Trust published five four-year equality objectives, which had been agreed following in-depth discussion at the Board of Directors. They cover a range of important areas and represent important themes for addressing equality and diversity.

They are:

- Improving the recording of demographic information for service users, in particular disability, religion or belief and sexual orientation and thereby creating opportunity for openness and dialogue.
- More community engagement events to facilitate understanding both of community needs and the services we offer.
- Increasing the number of learning and development opportunities for our staff to help and support them in responding to the diverse needs and backgrounds of service users.
- Reducing the level of violence, discrimination, harassment, bullying and abuse our staff experience at work from patients/service users, their relatives or other members of the public towards staff.
- Improving our staff’s experience and perception of the Trust as being a fair employer.

In January 2013 we published our second Equality Act Compliance Report, highlighting the actions and evidence of how the Trust is complying with the requirements of the Equality Act. Bringing information together into a single document helps us to provide a cohesive overview of Trust commitment to equality, diversity and inclusion.
3 Improving our buildings and environments

Work continued throughout 2012/13 to improve and rationalise the estate and facilities of the Trust. This has included improving the environments of our inpatient facilities and community services, while also ensuring that these buildings are fit for purpose and are operating efficiently.

Existing estate

The current estate comprises 113 buildings within a total of 88 separate sites (52 freehold sites, 51 leasehold sites and ten buildings that we occupy on an informal basis), with a total net internal floor area of 100,245m².

Estate and facility improvements

Work has continued to maintain and improve our inpatient environment, with a number of projects completed in 2012/13. These include:

- The completion of the final phase of the Northwick Park development. This brings to a conclusion two major projects to improve adult and older people's accommodation.
- The relocation of the Max Glatt Unit from Ealing into more appropriate, safe and upgraded accommodation in Kensington and Chelsea.
- Enhancements to the internal environment at a number of our main inpatient sites including Kingswood, Hillingdon Hospital, Gordon Hospital, St Charles Hospital and St Pancras Hospital.
- Refurbishment of Seacole Ward at Park Royal Centre for Mental Health to modernise the ward and create all en-suite bedrooms.

Upon moving to our new headquarters’ offices in October 2011, there have been a number of adjustments during 2012/13 to make the space fully meet the requirements of the business. These include an improved reception area, hospitality services, shared desks for agile workers and a new office management contract to manage the reception, hospitality service and cleaning service.

Estate rationalisation

In line with our strategy to improve the efficiency and quality of the Trust’s estate, a number of development schemes have been completed:

- Introducing a more flexible approach to how our buildings are utilised means we have been able to consolidate a number of existing community sites into purpose designed, efficient and modern adult community service hubs in Westminster and Brent. This has enabled the Trust to vacate a number of inefficient, poor quality buildings.
- Existing space at St Charles Hospital has been reconfigured and rationalised to create a purpose designed community services hub for Kensington and Chelsea.
- The Hillingdon Child Development Centre has relocated from unsuitable accommodation on the Hillingdon Hospital site, into new purpose designed facilities within surplus CNWL space at the Woodlands Centre.
- New occupational health, psychological medicine and Improving Access to Psychological Therapies (IAPT) services accommodation has been developed at Northwick Park Mental Health Centre. This facilitated the expansion of the Trust’s occupational health service (see page 38) and the relocation of the Brent IAPT team into more appropriate accommodation.

Patient Led Assessment of the Care Environment (PLACE)

Every year the Trust undertakes a self assessment of physical environments where our service users receive treatment, which is now overseen by the Health and Social Care Information Centre.

In early 2012 the Government announced that the previous system, Patient Environment Action Teams (PEAT), would be replaced in April 2013 with a new patient-led inspection regime covering privacy and dignity, food, and cleanliness in hospitals. The key feature is the involvement of patients or their representatives at all stages, including development of the system, the inspection process and validation of inspections.

This has meant that although patient environment assessments were conducted in early 2012 and will continue during spring 2013, none were completed during the 2012/13 financial year.

The Trust has played an active role in the design and implementation process for the new PLACE assessments. Park Royal Centre for Mental Health and the Gordon Hospital have both been involved in the pilot of the new programme.

Sustainability

CNWL continues to ensure that our business targets and activities reflect the Trust’s ambition to become a leading sustainable and low carbon organisation.

Progress during 2012/13 includes:

- In January 2013, new legislation was introduced to increase the amount of sites where we are required to display an energy certificate in a prominent position. We are currently in the process of including any buildings with a floor area between 500-1000m², which will be updated every three years.
- Continued membership of the London Travel Network hosted by Transport for London (TfL). This contact group meets quarterly to discuss a wide range of travel initiatives which will have an impact on London NHS organisations.
- Funded through our ongoing backlog maintenance and capital investment plan, we have invested in replacing old and inefficient building infrastructure.

New initiatives undertaken during 2012/13 include:

- The Trust submitted a bid against the Department of Health’s ‘Improving energy efficiency in the NHS’ initiative. The bid includes funding to undertake various lighting improvements and the installation of solar Photovoltaic (PV) to reduce energy consumption.
- In conjunction with specialist external consultants and the Sustainable Development Unit we are developing a Carbon Reduction Strategy that will set out the Trust’s strategy to meet national carbon reduction targets. This will replace our current Sustainability Strategy that was approved by the Board of Directors in 2008.
- CNWL is an active member of the NHS London sustainability forum. This group has been formed to share best practice in building efficiency and operational issues.
- A specialist Utility Bureau Service has been developed in partnership within the Trust’s Finance Department, to manage energy consumption and cost more efficiently. This has not only reduced the time spent by both the estates and finance teams processing utility invoices but also minimised the risk of inaccurate billing errors.

This includes:
- A continued programme of replacing old and inefficient boilers with boilers that are more efficient.
- Replacing air conditioning systems with obsolete refrigerant with a more environmentally friendly system.
- Ensuring that all current refurbishment projects utilise high efficiency/low maintenance light fittings and controls.
- Continuing to replace old and inefficient windows with modern high efficiency double glazed windows to lower our carbon footprint by using less energy to heat the building.

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Our workforce

CNWL prides itself on having a people-focused approach. The Trust places a strong emphasis on engagement with our staff through a range of channels that enable teams and individuals to have a voice in the future development of the organisation.

The development and engagement of the Trust’s workforce has been a key priority again this year. The workforce has grown during 2012/13 following the integration of a number of new contracts, in particular in prison healthcare, and community learning disabilities.

Recruitment

In 2012/13 the Trust’s Recruitment Team developed a number of targeted recruitment campaigns for posts that required additional promotion to increase the number of applicants. For example, this included specialist nursing posts, including health visitors, district nurses and school nurses. The recruitment team have also improved the process for disclosure checks, by bringing Atlantic Data Disclosure and Barring Service (DBS) (formerly Criminal Records Bureau (CRB)) contract in-house. As a result, we have been able to roll out the use of the online DBS checks across the entire Trust, which has improved the average time taken to complete a check from four weeks to just three days.

Integrating community services

With the Trust now recruiting for roles in community physical and mental health, the team had to refine a number of processes to ensure job seekers were applying for the correct roles. This included better signposting, references and profiling.

Payment for staff on post registration courses, such as health visitors and district nurses, has now been harmonised across the Trust. These rates were previously different between staff in Camden and Hillingdon community health services.

Board to ward

A series of 32 visits by both executive and non-executive directors have taken place over the past year to help Board members understand the issues that affect services and service users on a daily basis and to take effective action. Board to ward is one of a number of initiatives to help frontline staff communicate with the Board of Directors and share best practices with other colleagues.

Occupational health

Throughout 2012 an internal Occupational health (OH) service was rolled out across the Trust. CNWL previously had a number of contracts in place to deliver OH services to staff. Following the integration with Camden Provider Services, the Trust expanded the in-house OH service that was provided to Camden staff. This presented an opportunity to manage all the OH contracts centrally and provide OH services to all staff from our own Trustwide in-house team.

Training developments

Learning and Development Zone

In March 2013 the Trust launched a new Learning and Development Zone. This web based system enables staff to browse the training directory and directly book themselves onto the full range of clinical, managerial and administrative courses and programmes. The new system also improves managerial access to information about staff training records and appraisal information. The zone’s functionality will continue to be developed over the forthcoming year.

Mandatory training

Improving the uptake of mandatory training for mental health and allied specialty staff was a particular focus for 2012/13. The introduction of the three year block refresher programmes, tailored in length and content for different clinical roles, coupled with improved reporting processes, has enabled significant improvements to be made. The overall compliance rate by April 2013 was 90% with an additional 4% of staff booked onto training.

Directory of courses

We continue to develop our training directory and during the year the Learning and Development Team started to work more closely with the service lines to better understand the skill development needs of our staff. An external review took place in August 2012, which showed a need to separate out the mandatory training from our other development and training packages, as a way of balancing the demands. The review suggested the creation of a learning and development consultancy service, which will support service lines in the commissioning of education and training. This will be a focus for our work during the next year.

Celebrating staff

Celebrating achievements in education

The Learning and Development Team held an awards ceremony in July 2012 to celebrate the achievement of staff who completed one of our externally accredited courses:

- Diploma in Management and Leadership
- PRINCE2 Foundation and Practitioner certificate
- Award/Certificate in Medical Administration.

We also have a number of senior staff qualifying in executive coaching and they will be invited to next year’s event.

Celebrating commitment to quality

We continue to celebrate our ‘Hidden Gem’ employee of the month awards for staff who go the extra mile in their daily work. During 2012/13 we received over 100 nominations for the award and 12 winners were presented with a certificate and voucher prize.

Annual Gems

The last award to be presented on the evening was the team of the year award, nominated by colleagues across the Trust. The Hillingdon Safeguarding Children Team was given this prestigious award in 2012. The team were recognised for the important role they play in ensuring that all levels of community based staff have the training and support they need to safeguard children and young people in Hillingdon.

In addition to the Annual Gem Awards, the Trust’s Chair, Dame Ruth Runciman, presented over 100 staff with long service awards. Staff eligible are those with 20, 30 and 40 years of NHS service. Jointly these members of staff had accumulated over 2,440 years of service.
Launch of the performance management framework
Recognising the importance of our staff, that each person can make a real difference to the quality of service we provide, we introduced a new performance management framework during the year. As an organisation we want to retain and attract the highest quality of staff and to invest in their continued development. Such an approach is central to ensuring the very best patient experience, safety and quality of care. The performance management framework was aimed at strengthening the appraisal and supervisory process so that high performers, those that perform well, and those that under-perform all receive the support and development they need.

Equality and diversity
The Trust’s employment policies encourage the recruitment of people with experience of mental health problems and people with disabilities. We have implemented a range of policies to encourage equal opportunities for all and also offer training sessions for managers to encourage a more flexible approach to staff with disabilities.

- The Trust entered the Stonewall Workplace Equality Index for the first time in September 2012 and only narrowly missed coming into the top 100 employers in Britain for lesbian, gay and bisexual people to work for. We plan to build on and improve our ranking during 2013/14.
- Diversity celebrations during Black History Month took place at various locations across the Trust with food, presentations, music and quizzes to help promote understanding.
- A Trustwide e-learning learning disability (LD) awareness package is being developed to complement staff awareness of LD issues, relevant to the level of contact with LD service users. Further enhanced training is being provided via a workshop approach relative to the knowledge of staff.
- The Equality, Diversity and Human Rights Policy (Employment) and Disability Policy (Employment) have been reviewed and updated.
- Work is currently underway in developing further training modules for staff addressing: lesbian, gay, bisexual and transgender (LGBT), faith and spirituality awareness.

Communications and engagement
The Trust’s Joint Negotiating and Consultative Committee (JNCC) is the primary way for CNWL to formally engage with the trade unions. It meets every six weeks and provides a forum for discussion and debate. The committee includes representatives for each service area in the Trust. We continue to encourage local discussions within services with staff representatives and hold formal consultations with staff and representatives in relation to organisational change proposals.

The Trust’s quarterly Inbrief magazine and Weekly News e-bulletin are other well-established mechanisms through which we communicate with our large staff group. Trustnet, CNWL’s intranet, supports these channels and holds a large store of reference documents and news. Each service line and professional group within the Trust has a dedicated page on the intranet for staff to visit for information. Community health staff in both Camden and Hillingdon now also use Trustnet to store relevant reference materials, such as local policies and procedures.

The Trust’s senior staff brief was re-launched in 2012 to provide strategic briefings to senior managers every two months. A write-up of the brief is circulated to the staff group after the briefing, which managers are encouraged to use to cascade information to staff through team meetings.

In February 2013 the Trust launched ‘The Conversation’ at the CNWL annual nursing conference and it was rolled out across all professions in March. The Conversation is a Trustwide discussion about the values that should be at the core of everything we do. All staff members were invited to submit their top four values that they believe reflect the high quality, compassionate care the Trust delivers. The ideas received are being used to shape the values of the organisation, and will be reflected in the Annual Plan, incorporated into the Staff Charter, and will also be used as a measure of performance in appraisals.

Staff survey 2012
The 2012 NHS staff survey was carried out in October 2012, with 47% of CNWL staff responding, compared to a national average of 50%. We were disappointed with this low response rate, which is a reduction on the previous year, despite a prize draw for five randomly chosen respondents to each win a Kindle Fire. We will be looking at new initiatives to improve this rate in the following year.

Overall, there were many positive outcomes from the 2012 results. We were delighted to be placed in the top 20% of Trust’s nationwide across many categories, including staff engagement. The last year has not been without challenges, and it is during these times that staff engagement is really important to support the organisation. Staff remain as highly engaged as last year with an overall score of 76%, placing CNWL in the top 20th percentile. Results show that staff felt they were able to contribute towards improvements at work, are highly motivated and would recommend CNWL as a place to work or receive treatment.

 NHS Staff Survey 2012 – response rate

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2011/12</th>
<th>Trust improvement / deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>47%</td>
<td>50%</td>
<td>Decrease of 6%</td>
</tr>
<tr>
<td>National average</td>
<td>53%</td>
<td>54%</td>
<td></td>
</tr>
</tbody>
</table>

 NHS Staff Survey 2012 – top four ranking scores

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2011/12</th>
<th>Trust improvement / deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>97%</td>
<td>93%</td>
<td>0%</td>
</tr>
<tr>
<td>Percentage of staff having well structured appraisals in last 12 months</td>
<td>52%</td>
<td>42%</td>
<td>Increase of 10%</td>
</tr>
<tr>
<td>Staff recommendation of the Trust as a place to work or receive treatment</td>
<td>75%</td>
<td>71%</td>
<td>Increase of 4%</td>
</tr>
<tr>
<td>Percentage of staff agreeing that their role makes a difference to patients</td>
<td>92%</td>
<td>90%</td>
<td>Decrease of 2%</td>
</tr>
</tbody>
</table>
Staff sickness data

The graph below outlines the staff sickness rates for this year 2012/13 and the previous year 2011/12. Sickness levels are calculated by dividing the whole time equivalent (WTE) of days lost, by the whole time equivalent (WTE) of the days available. The NHS target for sickness is 4%, and the Trust is below this target. The Trust average is lower for the period 2012/13 than the previous year.

Counter fraud

The Trust is committed to providing and maintaining an absolute standard of honesty and integrity in dealing with our assets. We are committed to the elimination of fraud and illegal acts within the Trust. We ensure rigorous investigation and criminal prosecution (or other sanctions) as appropriate. The Trust adopts best practice procedures to tackle fraud, as recommended by NHS Protect.

Over the last year we have widely publicised our policies and procedures for staff to report any concern about potential fraud. Support for counter fraud has been reinforced with fraud and bribery awareness roadshows which were supported by a message from the Director of Finance inviting staff to attend. Any concerns are investigated by our Local Counter Fraud Specialist (LCFS) or NHS Protect, as appropriate. All investigations are reported to the Audit Committee.

NHS Staff Survey 2012 – bottom four ranking scores

<table>
<thead>
<tr>
<th>Bottom 4 ranking scores</th>
<th>2012/13</th>
<th>2011/12</th>
<th>Trust improvement / deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell</td>
<td>27% 22%</td>
<td>19% 20%</td>
<td>Increase of 8%</td>
</tr>
<tr>
<td>Percentage of staff receiving job-relevant training, learning or development in last 12 months</td>
<td>78% 82%</td>
<td>83% 80%</td>
<td>Decrease of 5%</td>
</tr>
<tr>
<td>Percentage of staff believing the trust provides equal opportunities for career progression or promotion</td>
<td>81% 90%</td>
<td>85% 90%</td>
<td>Decrease of 4%</td>
</tr>
<tr>
<td>Percentage of staff experiencing discrimination at work in last 12 months</td>
<td>18% 13%</td>
<td>17% 14%</td>
<td>Increase of 1%</td>
</tr>
</tbody>
</table>

Health and safety

Within CNWL, health and safety is managed by an in-house team comprising the Head of Safety, who oversees the work undertaken by three health and safety managers. The team assumes the role of the competent person and supports local managers in ensuring that health and safety is managed effectively across the organisation and in accordance with Trust policy.

Local managers have responsibility for health and safety in their area and receive a bespoke two-day training package. This provides them with the knowledge and skills to take on the role and the associated responsibilities. The model promotes a positive safety culture across the organisation with additional support and monitoring arrangements via a robust programme of audit. The Health and Safety Team provides an extended office hours service, providing advice and support to staff on a range of issues. They also work closely with other corporate services to ensure that the health and safety of our staff, service users, and other partners is at the forefront of the work we undertake.

A range of training courses are provided to staff, including face-to-face training, workbooks and bespoke e-learning packages designed by the CNWL Health and Safety Team. Incident reporting remains a priority for the Trust as it provides a system for ensuring that the Trust is able to monitor its arrangements and support learning via investigation and analysis. Since 2011, the Trust has been utilising web-based incident reporting software: a system that enables central oversight of reported incidents, whilst providing operational services with the best tools available to manage the clinical environment.

Staff ethnicity, age and disability statistics

<table>
<thead>
<tr>
<th>Age</th>
<th>Staff 31 Mar 2013</th>
<th>%</th>
<th>Staff membership 2012/13</th>
<th>%</th>
<th>Staff 31 Mar 2012</th>
<th>%</th>
<th>Staff membership 2011/12</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-16</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td></td>
<td>0.0</td>
</tr>
<tr>
<td>17-21</td>
<td>5</td>
<td>0.1</td>
<td>5</td>
<td>0.1</td>
<td>10</td>
<td>0.2</td>
<td></td>
<td>0.2</td>
</tr>
<tr>
<td>22+</td>
<td>5,304</td>
<td>99.9</td>
<td>5,193*</td>
<td>99.9</td>
<td>5,264</td>
<td>99.8</td>
<td>5,483</td>
<td>99.8</td>
</tr>
</tbody>
</table>

Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2012/13</th>
<th>2011/12</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>2,859</td>
<td>2,872</td>
<td>2,892</td>
</tr>
<tr>
<td>Mixed</td>
<td>1,162</td>
<td>1,162</td>
<td>1,192</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>1,632</td>
<td>1,632</td>
<td>1,632</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>1,243</td>
<td>1,243</td>
<td>1,243</td>
</tr>
<tr>
<td>Other</td>
<td>303</td>
<td>303</td>
<td>303</td>
</tr>
<tr>
<td>Not stated</td>
<td>219</td>
<td>219</td>
<td>219</td>
</tr>
</tbody>
</table>

Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>2012/13</th>
<th>2011/12</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1,435</td>
<td>1,459</td>
<td>1,520</td>
</tr>
<tr>
<td>Female</td>
<td>3,763</td>
<td>3,815</td>
<td>3,973</td>
</tr>
</tbody>
</table>

Disability

<table>
<thead>
<tr>
<th>Recorded disability</th>
<th>135</th>
<th>121</th>
<th>121</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff members not on CNWL payroll</td>
<td>219</td>
<td>219</td>
<td>219</td>
</tr>
</tbody>
</table>

*Staff membership figures for social care staff who are not directly employed by the Trust have been omitted for 2012/13.
Financial overview

The 2012/13 financial year was our sixth year as a Foundation Trust, and we have continued to build upon our strong track record of financial performance. We have once again achieved our target financial risk rating, as well as delivering the majority of efficiencies set out in our cost improvement programme (76%).

The Trust has reported a surplus of £4.34m. The non-recurrent items are the net impairment on fixed assets (that is, a reduction in the value of our asset base), and restructuring costs, both of which are detailed below. This excellent result is due to a combination of factors, including the delivery of the Trust’s efficiency targets, higher than planned income, and good financial discipline and cost control.

Financial overview

The Trust’s Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) for the year ending 31 March 2013 was £19.56m (5.2% of income), with total capital and reserves standing at £202.9m.

The Trust delivered an underlying surplus of £4.34m, £5.4m lower than set out in the Annual Plan, which can be explained by the net reduction in the value of our land and buildings asset base of £5.4m. This is explained in more detail below.

This result represents a strong performance from the Trust, especially given the challenging financial environment in which the Trust is operating, as the impact of the Health and Social Care Act 2012 has led to significant staff movements from the ‘old’ to ‘new’ commissioning organisations, including Clinical Commissioning Groups, NHS England and local authorities, in advance of 1st April 2013. In the midst of the reconfiguration commissioners have been trying to negotiate challenging efficiency targets. The healthy underlying performance is borne out by Monitor’s financial risk rating, in which the Trust scored four (with five the highest score possible).

At the year end, the Trust had cash of £58.9m. The underlying cash position is closer to £55.1m, as at year end the Trust was holding £3.8m cash as receipts on account. The Trust’s strong cash position is demonstrated by the Trust consistently scoring a four from Monitor on its liquidity ratio. Much of this cash is required to meet existing financial commitments and funding future service developments.

The classification of income was as follows:

Classification of income 2012/13 (%)

Income

The Trust recorded operating income of £376.2m (2011/12 £375.7m), which came from the following sources:

Sources of income 2012/13 (£m)

Pay expenditure by staff category

Pay expenditure 2012/13 (£254.7m)

Expenditure

Total operating expenditure was £367.5m (2011/12 £358.1m), of which £254.7m related to pay and £113m related to non-pay expenditure.
Monitor risk rating

Over the full year, the Trust has consistently maintained a financial risk rating of four (where five is the best and one the worst). This means that the Trust is considered by Monitor, the independent regulator of NHS Foundation Trusts, to be low risk in financial terms.

The table below sets out the Trust’s performance against each of the financial indicators:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Mth 12</th>
<th>Rating</th>
<th>Weight</th>
<th>Weight score</th>
<th>Higher score</th>
<th>Lower score</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDA margin</td>
<td>Target</td>
<td>5.4%</td>
<td>3</td>
<td>25%</td>
<td>0.75</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>5.2%</td>
<td>3</td>
<td>25%</td>
<td>0.75</td>
<td>&gt;5%</td>
</tr>
<tr>
<td>EBITDA achieved</td>
<td>Target</td>
<td>104.5%</td>
<td>5</td>
<td>10%</td>
<td>0.50</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>98.4%</td>
<td>4</td>
<td>10%</td>
<td>0.40</td>
<td>&gt;100%</td>
</tr>
<tr>
<td>Return on assets</td>
<td>Target</td>
<td>6.2%</td>
<td>5</td>
<td>20%</td>
<td>1.00</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>5.8%</td>
<td>5</td>
<td>20%</td>
<td>1.00</td>
<td>N/A</td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>Target</td>
<td>3.11%</td>
<td>5</td>
<td>20%</td>
<td>1.00</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>3.02%</td>
<td>5</td>
<td>20%</td>
<td>1.00</td>
<td>N/A</td>
</tr>
<tr>
<td>Liquidity ratio (days)</td>
<td>Target</td>
<td>42.1</td>
<td>4</td>
<td>25%</td>
<td>1.00</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>39.6</td>
<td>4</td>
<td>25%</td>
<td>1.00</td>
<td>&gt;60</td>
</tr>
</tbody>
</table>

Cost improvement programme

In 2012/13 CNWL achieved a recurrent cost improvement programme of £14.7m, and these recurrent savings deliver a full year effect of £17.3m, the equivalent of 5% of its baseline expenditure budget. A further £5.8m of non-recurrent savings were made in year in order to support achievement of the Trust’s plan. This provides the Trust with a sound financial base for the following financial year.

The savings programme did not result in a reduction of either safety or quality of patient services, and was delivered through a variety of schemes. There were significant savings achieved through service redesign, and these schemes included:

- Reduction of the bed base across several boroughs and service lines, in line with the desire to shift to community settings of care.
- Estates rationalisation including the creation of treatment hubs.
- Community service redesign in line with the requirements of GP commissioners.
- Tighter contract management through better procurement controls leading to a reduction in non-pay spend.
- Increased income through more targeted marketing and better activity recording.

In addition to its own internal cost improvement programme, the Trust has once again contributed to the wider commissioning Quality, Improvement, Productivity and Productivity (QIPP) programmes. For example, the Trust’s Placement Efficiency Team has delivered recurrent savings of £4.0m in 2012/13 on commissioners’ behalf, rising to a full year effect of £7.28m in 2013/14 and the cumulative to date is £10.7m, full year effect £16.9m.

The Trust has been working with local commissioners to improve quality and productivity. The Trust is committed to continuing to deliver quality, value for money services whilst still maintaining the optimum Monitor risk rating that is both reflective of the Trust’s commitment to finance and to safety and quality.

Tariffs and the threat of competition

The majority of the Trust’s income continues to be from block contracts for services provided within the boroughs it serves as shown above. The expected move to more tariff based services has not happened in 2012/13, however, it is likely that some areas will move to tariff payments in 2013/14 or 2014/15, thus creating much more uncertainty around parts of the Trust’s income base. The Trust is implementing a Patient Level Costing (PLICS) in 2013/14 in recognition of the need for greater understanding of its cost base.

The Department of Health has indicated that there will be no move to a National Payment by Results (PbR) tariff for adults and older adults mental health before 2014/15 at the earliest, although they have published indicative prices for 2013/14 and have indicated that they expect local tariffs to be in place in 2013/14. The Trust continues to work with local commissioners and London-wide groups to implement the packages of care required for the move to PbR, and is heavily involved in both local and national implementation groups for adult and older adult mental health, child and adolescent mental health, IAPT and learning disability services currencies and tariffs. A Memorandum of Understanding across London is currently under discussion in order to provide financial stability for providers and commissioners in 2013/14.

The transfer of commissioning responsibilities from Primary Care Trusts (PCTs) to Clinical Commissioning Groups (CCGs), NHS England and local authorities has led to an uncertain and confused contracting environment. Department of Health guidance has indicated that it expects new commissioners to continue in a steady state in 2013/14 in order to allow new commissioning relationships to form, however, this is guidance only and cannot be enforced. The Health and Social Care Act 2012 puts increased obligation on commissioners to tender services and so will pose a significant competitive threat to the Trust in future. Fortunately the Trust has a

“The group was a great help, especially discussing problems with other patients.”

Patient from mental health services
strong history of success in the competitive tendering process over the past few years, and so has an excellent foundation on which to build its growth strategy.

Financial risks

As part of the preparation of the Trust’s Annual Plan which is submitted to Monitor each year, the Trust completes a detailed three year financial plan incorporating revenue, capital, cash and cost improvement (including income generation) plans. The assumptions behind this plan are risk assessed, and all high rated risks successfully mitigated against as part of the planning process. The Trust subsequently monitors the possibility of those risks occurring during the year, in addition to any new risks which may have been identified during the year.

Transfer of commissioning responsibilities

The change in commissioning responsibilities as described above has made it very difficult for the Trust to engage in constructive long-term planning discussions with its commissioners. There is a substantial increase in the number of contracts that need to be agreed with commissioning support units (on behalf of CCGs), local authorities and different sections of NHS England, each requiring significant management resource during the negotiation process.

Cost improvement programme

The cost improvement programme of £23m outlined above is the highest the Trust has ever faced. This should be seen in the context of the squeeze on public finances and the size of the QIPP programme across London. The Trust is committed to maintaining its sound financial base and will continue to provide safe, high quality patient services whilst striving to identify the necessary efficiencies.

Health and Social Care Act 2012

- increased competition

The Trust is likely to be subject to increased levels of competition as commissioners are obliged to put increased numbers of services out to tender. The complexity of contractual relationships is likely to increase as the Trust may have to bid in partnership with other organisations in order to provide pathways of care.

General economic climate

The outlook for public sector finances continues to look bleak for the medium to long term, as despite likely increases in demand from the aging population there will be no real increases in NHS funding. The expectation from commissioning bodies is that NHS providers will absorb any increases through service redesign and increased productivity.
The Directors present their report and audited financial statements for the year to 31 March 2013.

Principal activities
The Trust’s principal activity is the provision of mental health, community, substance misuse, and learning disability services to patients.

Business review
The NHS Foundation Trust’s activities are reviewed in:
1. The Chairman’s and Chief Executives statement on page 8
2. The Directors’ Report on progress against our strategic objectives on pages 13-54
3. The Annual Accounts on pages 139-198. In addition to this, other information relevant to the Trust’s activities is set out in the other sections of this document.

Code of Governance
The Board of Directors uses the NHS Foundation Trust Code of Governance published by Monitor as best practice advice to improve governance practices in the Trust. The Trust complies with the code in all aspects but one; the one exception is that the Executive Directors of the Trust are all on standard employment contracts and they are not entitled to performance related pay. The Remuneration Committee has general oversight of the Trust’s pay policies but determines the reward package for the Directors only. All other staff remuneration is either covered by the NHS Agenda for Change pay structure or other nationally agreed pay rates (for example for medical staff).

Subsequent events
Milton Keynes Community Health Services
The Trust has entered into a contract with Milton Keynes PCT to deliver Milton Keynes Community Health Services (MKCHS) from 1 April 2013. The transaction involved a nominal consideration of £1 for the net assets of MKCHS. No other assets were transferred and no other consideration was paid. There has been no impact on the 2012/13 financial statements other than this disclosure note.

Transfer of PCT assets from 1 April
On 1 April 2013 the Trust took over assets previously owned by Camden PCT and Hillingdon PCT used for the provision of community services. These consist of freehold estates and IT assets. The assets transferring from Camden PCT were last valued in September 2012 and the value of assets transferring was £15,672k. The estates transferring from Hillingdon PCT were last valued in July 2010 and had a value of £13,511k.

The transaction is being funded by a receipt of Public Dividend Capital and therefore a cash payment was not required by the Trust for the acquisition of the assets.

Political and charitable donations
The Trust has not made any political or charitable donations this year.

Public sector payment policy
The Non NHS Trade Creditor Payment Policy of the NHS is to comply with both the CBI Prompt Payment Code and the Government Accounting Rules. The Government Accounting Rules state: “The timing of payment should normally be stated in the contract. When there is no contractual provision, departments should pay within 30 days of receipt of goods and services or on the presentation of a valid invoice, whichever is the later.” During the 2012/13 financial year, the Trust achieved an average of 78% (prior year 68%) by number of invoices and 90% (prior year 88%) by value of all NHS invoices.

For non-NHS, the Trust achieved an average of 83% (prior year 76%) by number of invoices and 81% (prior year 77%) by value. The Trust continues to endeavour to pay all of its small businesses within 10 working days.

Auditors
The Trust’s appointed external auditors are KPMG. The auditors carry out the statutory audit of the Trust’s Annual Accounts including a review of Whole Government Accounts and the Quality Accounts. The cost of this audit service in 2012/13 was £110,000 (2011/12: £113,000). All of the above amounts include VAT at the prevailing rate as the Trust is unable to reclaim this VAT.

Per the terms of engagement, KPMG have a maximum financial liability in relation to these accounts of £1,000,000.

The fee for services relating to corporate finance transactions was for a due diligence review to analyse Milton Keynes Community Health Services prior to integration. Other assurance services provided were for assurance on the IT strategy and procurement of new IT systems.

As well as those fees disclosed above members of the CNWL management team attended a conference organised by KPMG to advise on managing pensions. The expense for individual personal advice was payable by the individuals attending, however payment was made initially by the Trust. The total value of payments made for the conference were £37,000. As this was not an expense to the Trust it has not been included in the above analysis or the Statement of Comprehensive Income.”

Going concern
The Trust’s accounts have been prepared on the basis that the Trust is a “going concern”. This means that the Trust’s assets and liabilities reflect the ongoing nature of the Trust’s activities. After making enquiries, the Directors have a reasonable expectation that Central and North West London NHS Foundation Trust has adequate resources to continue in operational existence in the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Costing information returns
The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

“I have a very caring and friendly matron and always look forward to her visits.”
Patient from Community Physical Health Services
Our aspiration is to become a national organisation and the past year has seen some exciting steps towards achieving this ambition with contracts having been won in both Surrey, Kent and Hampshire for the provision of prison healthcare and, of course, this latest move out of London into Milton Keynes.

During the 2012/13 year, the Trust expressed an interest in new services through a total of 47 tender opportunities, an increase in tendering activity of 88% compared to the previous year. This reflects the drive by Government to increase the amount of competition in the healthcare market. There has also been a marked increase in the number of bids from which the Trust has withdrawn – largely as a result of services not proving to be financially viable. This is most likely to reflect the national trend of driving down costs in an effort to achieve significant savings across the NHS. This trend will only continue as even more downward pressure is placed on contract values to achieve the year on year savings from the national healthcare budget.

### 7 Improving our information systems

**IM&T supporting the delivery of healthcare**

During 2012/13 the Trust began to deliver the Information Management and Technology (IM&T) strategy, with the launch of two ambitious programmes of work covering the Trust’s infrastructure and clinical systems.

Four further programmes will be launched over the next two years, with a view to radically improving the Trust’s systems and technology, enabling new ways of working and helping CNWL to achieve excellence in clinical care.

During the last year, preparation has been underway for the launch of the strategy, including introducing specialist skills to our Information and Communication Technology (ICT) Team, alongside rigorous governance, structure and controls. An Informatics Committee was established in May 2012, which is chaired by Non-Executive Director, Mandie Campbell. A Portfolio Management Office (PMO) monitors progress on all projects and programmes, giving the full picture of how we are progressing, and early warning of any potential issues we may need to address.

**Information and communications technology (ICT) strategic infrastructure**

Work began in 2012/13 to establish the new infrastructure or ‘foundations’ for improved ICT, which will result in faster and more reliable computer networks, more advanced desktop and laptop computers, advanced remote and mobile working capabilities, flexible phone systems, enhanced email systems, and improved printing and scanning facilities.

An important part of this work has been engaging with clinicians and allied health professionals and their administrative teams to help ensure that the ICT solutions selected not only meet their current needs, but will also support changes in how healthcare might be delivered in the future.

In February 2013, a notice was issued in the Official Journal of the European Union (OJEU), inviting suppliers to tender for infrastructure and associated information technology (IT) services. The Trust expects to appoint a supplier in 2013, and begin the transition to new services during 2014.

**Strategic clinical systems**

The Trust also started work on the clinical systems programme, led by Andy Mattin, Director of Operations and Nursing. This work focuses on improved service user clinical records, from contact details through to appointments, assessments, admissions, discharges and medication.

Staff need clinical systems that are easy to use, accessible and mobile and that help the Trust to achieve excellence in patient care. The ICT team has been focusing on working closely with clinicians and other stakeholders to support new ways of working including:

- Making sure that clinical systems provide clinical staff with the right information at the right time about their service users, wherever they need it to support effective clinical decision making, risk management and promote safety.
- Improving communications both within the Trust and across partner organisations, enabling information sharing between the relevant services and agencies, and co-ordinated care for service users.
- Exploring innovative ways to use IT to empower service users to be more involved in their own care. For example, by providing appropriate access to their records, tools to tell them about CNWL services or ways to signpost service users to other sources of support.
- Providing service managers and administrators with the information they need to more efficiently manage the Trust’s resources.

### 8 New opportunities and partnerships

The past year has seen a considerable amount of activity in relation to securing new business and in driving forward our bold three year corporate business and marketing strategy, which sets an ambitious path for CNWL to become a national leader in community and mental health service provision.

One of the biggest and proudest achievements of the year, as part of this strategy, is winning the contract to provide community health and mental health services in Milton Keynes. This is under the last of the ‘Transforming Community Services’ contracts whereby all Primary Care Trusts (PCTs) were required to divest themselves of their provider arms. The Trust had already won two other community health service contracts under this programme in 2011 (in Camden and Hillingdon) and felt well placed to put a strong proposal together for Milton Keynes Community Health Services (MKCHS).

We were therefore delighted to hear just before Christmas that CNWL had been chosen - out of five other contenders - to become the new home for MKCHS from 1 April 2013. There are many similarities between the two organisations, not just in the services provided, but in the values that we share and bringing the organisations together forms a very natural fit which we are confident will bring real benefits to people in Milton Keynes.

Winning this contract, worth £170m over its three year term, now means CNWL is one of the largest community service trusts in the UK, caring for people with a wide range of physical and mental health needs. We have approximately 7,000 staff with an annual turnover in the region of £420m, which puts the Trust in a strong position to achieve the challenging efficiency savings required across the NHS.

Our aspiration is to become a national organisation and the past year has seen some exciting steps towards achieving this ambition with contracts having been won in both Surrey, Kent and Hampshire for the provision of prison healthcare and, of course, this latest move out of London into Milton Keynes.

During the 2012/13 year, the Trust expressed an interest in new services through a total of 47 tender opportunities, an increase in tendering activity of 88% compared to the previous year. This reflects the drive by Government to increase the amount of competition in the healthcare market. There has also been a marked increase in the number of bids from which the Trust has withdrawn – largely as a result of services not proving to be financially viable. This is most likely to reflect the national trend of driving down costs in an effort to achieve significant savings across the NHS. This trend will only continue as even more downward pressure is placed on contract values to achieve the year on year savings from the national healthcare budget.

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2011/12</th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reached final stage and awarded contract</td>
<td>12</td>
<td>4</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Tenders undertaken but not awarded contract</td>
<td>13</td>
<td>9</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Application withdrawn/ process suspended</td>
<td>16</td>
<td>2</td>
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<td>Current tenders in progress at year end</td>
<td>6</td>
<td>10</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

**TOTAL** 47 25 23 12
The Trust has also made significant progress against our three year business and marketing strategy with detailed work having been achieved against the majority of strategy recommendations. For example, we have undertaken a detailed market analysis and assessment in relation to growing our community services, developing the private patient market and exploring acquisition opportunities. We have also taken very early steps in positioning ourselves as a Trust interested in working with the Government in the international arena and were delighted to welcome a Chinese delegation of healthcare officials on a visited hosted by NHS Global, working in partnership with the UK Trade and Investment Department.

The coming year will be increasingly challenging as we rigorously defend our current position in an environment where we will see even more competition for both our existing business and new opportunities for growth as the market is opened further to competition. With the reorganisation of the NHS and the new Clinical Commissioning Groups taking up the commissioning reins from 1 April 2013, the landscape is likely to change significantly. We are determined to have a strong position in the healthcare market and progress to the next level, our aspiration of becoming a national provider of high quality, innovative and integrated healthcare services.

**Innovation scheme**

Since January 2009 when the innovation scheme was first launched, the Trust has funded a total of 16 projects, representing an overall investment of £1.49m. This year has focused mainly on seeing the completion of a number of projects rather than approving any new ones, which means that there will be more ‘new’ money available in the overall innovation pot for new schemes during 2013/14.

**Innovation scheme projects that have been completed this year include:**

- **CNWL Recovery College:** Launched in April 2012, the college offers a pioneering approach aimed at empowering people with mental health problems to be experts in their own recovery, live well and make the most of their skills and talents. It is one of just a handful of mental health recovery study and training facilities across the country, providing a range of courses and resources for service users, families, friends, carers and staff. Initial funding was awarded to establish and launch the college in its first year of operation.

- **CNWL’s Club Drug Clinic:** This has been a resounding success, providing assessment and treatment to patients with problem use of a group of substances known as ‘club drugs’ – a new audience who do not tend to present to traditional drug treatment services which are primarily tailored towards heroin and crack drug users. The project is now self funding and has received a significant amount of publicity and media attention both here in the UK and overseas.

- **Communication and Assessment Skills Training (CAST):** This project has set up structured multidisciplinary communication and assessment skills training programmes across a number of the Trust’s services. It has produced very encouraging results with overall results of training showing a subjective improvement in both participants’ confidence and skills, and also in patient satisfaction levels with staff communication with them.

In the coming year, we will again be reviewing the criteria for applications to make the innovation fund accessible to an even wider range of projects that will support the delivery of the Trust’s business and marketing strategy. We are also looking forward to welcoming applications from our new colleagues in Milton Keynes. All those wishing to be considered for innovation funding will continue to receive support from the Business Development Team.
How we are organised
Board of Directors

The Board of Directors is chaired by Dame Ruth Runciman. Meetings are held every two months and are open to the public. A quorum of two thirds is needed for the meeting to take place.

Decisions taken by the Board

The directors run the Trust’s services and develop strategies and plans for the future. Directors are accountable for meeting national standards, performance targets, and financial requirements.

Decisions delegated to management

The executive directors are responsible for the day-to-day running of the organisation and implementing decisions taken at a strategic level by the Board.

Board of Directors’ balance

The Board has carefully considered its composition and currently has seven executive directors including the Chief Executive, and eight non-executives directors including the Chairman. The Board will review its composition regularly and believes that this current composition reflects the skills and competencies required for the Trust to fulfil its obligations.

Performance evaluation of the Board of Directors

The Board of Directors has a systematic approach to assessing its collective performance including annual away days to consider its own performance and to set strategic objectives for the Board throughout the coming year. The Board also carries out self-evaluations at the conclusion of each Board meeting, when it decides how to structure its future agenda and ensure the most important items are given the time they deserve.

The Chairman is appraised annually through a process approved by the Council of Governors. The process requires independent input from each director, which is then considered by the governors. The process does not require non-executive directors to meet separately without the Chairman.

Process for appointment of Chairman and non-executive directors

The Nominations Committee of the Board meets to discuss potential vacancies and to determine the skills and experience most valuable to the Board. The Appointments Committee of the Council of Governors receives these considerations and decides on the job description, recruitment and appointment process.

Code of Governance

The Board of Directors uses the NHS Foundation Trust Code of Governance as best practice advice to improve governance practices across the Trust. The Trust complies with the code in all aspects but one; the exception is that the executive directors of the Trust are all on standard employment contracts and they are not entitled to performance-related pay. There is provision for non-pensionable bonus for exceptional performance; however no bonuses were awarded in 2012/13.

Members of the public can gain access to the register of directors’ interests by contacting the Trust Secretary, Christine Baldwinson on tel. 020 3214 5776 or email christine.baldwinson@nhs.net

Conditions of service for non-executive directors

The length of appointments of the non-executive directors is three years. Appointments beyond two terms can be agreed by the Council of Governors where it is in the best interests of the efficient and effective management of the Trust. Terms of office may be ended by resolution of the Council of Governors following a procedure laid down in the Foundation Trust’s constitution.

Non-executive directors

Dame Ruth Runciman
Chairman
BA WITS, BA (Hons) (Cantab)
Term of office: 30/11/2013

Ian Holder
Non-Executive Director
ACA, BSc (Hons), Snr Accred MBACP
Term of office: 30/09/2014

Bhavana Desai
Non-Executive Director
BA (Hons), JP
Term of office: 30/11/2013

Helen Edwards
Non-Executive Director
MA, CBE, CB
Term of office: 01/04/2015

Dame Ruth Runciman is also Deputy Chairman of the Prison Reform Trust. She was Chairman of the UK Drug Policy Commission until its work ended in 2012. She is a former Chairman of the National AIDS Trust and was Chairman of the Mental Health Act Commission from 1994-1998. She is a former Chairman of the Joseph Rowntree Foundation Drug and Alcohol Research Committee and from 1974-1995 was a member of the Advisory Council on the Misuse of Drugs. Dame Ruth was an advice worker in the Citizens Advice Bureau Service for 30 years to 2001.

Ian Holder is Director of 3C Partners Limited, an organisational consultancy, business and executive coaching and counselling practice. He was formerly Finance Director of Chez Gerrard plc, Managing Director of Castle Communications GmbH and Group Finance Director of Castle Communications plc. Ian combines international experience in business, finance, counselling and organisational disciplines to help organisations and individuals address their development needs.

Bhavana Desai has over 25 years of business experience in the private sector. She was the Group Retail Finance Director of BAA Plc and prior to this held various senior management positions within The London Stock Exchange, NCR and BOC Plc. She also has around 20 years’ active involvement in the voluntary sector including RBG Kew, AgeLink and Ealing Social Club for the Blind.

Helen Edwards is a member of the Department for Communities and Local Government Corporate Management Board. Her previous experience includes Director General for Justice Policy in Ministry of Justice, Chief Executive of the National Offender Management Service, Director General of the Home Office Communities Group and Director of the Active Communities Directorate in the Home Office. Before joining the Civil Service, Helen worked at NACRO, the national crime reduction charity for 38 years, where she spent the last five years as Chief Executive. She originally trained as a social worker for East Sussex County Council and has also worked for Save the Children.
Executive directors

Professor Dorothy Griffiths
Senior Independent Director
BSc, MSc, OBE, FCGI
Term of office: 10/05/2014

Dorothy Griffiths is Dean of the Imperial College Business School and Professor of Human Resource Management. She also has significant private sector experience having worked as a consultant to a number of large and small companies. She has also worked on healthcare reform in a number of countries and worked on management development in the NHS.

David Walker
Non-Executive Director
BSc, MSc, OBE, FCGI
Term of office: 1/05/2014

Laks Khangura has extensive commercial experience across a range of sectors including healthcare, telecoms, consultancy and aviation. He has a strong blend of public and private sector experience and is currently Strategy and Commercial Director of DMC Healthcare. His previous roles include Non-Executive Director of NHS Hillingdon Primary Care Trust, Chair of Hillingdon Community Health Services Provider Board, Non Co-opted Governor Thames Valley University, Divisional Finance Controller for Speedwing International (British Airways) and Group Finance Director of the Affini Group. He originally trained as an accountant with Southern Electric PLC.

David Walker is a communications professional, with extensive experience in journalism, research, public affairs and marketing. Up to 2010 he was Managing Director, Communications and Public Reporting at the Audit Commission and is now contributing editor at the Guardian Public Leaders Network. He is a Council Member of the Economic and Social Research Council, visiting professor at King’s College, London, and was formerly a trustee of the Nuffield Trust for health services research. David lives in Camden.

Professor Laks Khangura
Non-Executive Director
FCCA, MBA, MIOD
Term of office: 1/05/2014

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Mandie Campbell
Non-Executive Director
BSc, MSc, OBE, FCGI
Term of office: 1/05/2014

Mandie Campbell has over 25 years public sector experience in a range of operational, policy, corporate services and change management roles. She is currently the Chief Operating Officer for Border Force, responsible for operational border security at all of the UK’s ports of entry. Mandie was formerly Director of Drugs, Alcohol and Community Safety at the Home Office, responsible for the UK drug and alcohol strategies, drug intervention and integrated offender management programmes. Previous roles include Head of UK Visas and Director of Leadership and Learning in the Home Office.

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John Vaughan
Director of Strategic Development and Community Services
Registered Mental Health Nurse, Registered General Nurse, MA in Leadership

John Vaughan joined the Trust in 2006 having previously been Head of Mental Health at North West London Strategic Health Authority. He has held a number of management posts in voluntary sector mental health organisations as well as general management in the NHS, including commissioning and nurse management.

Claire Murdoch
Chief Executive
Registered Mental Health Nurse, Hons degree in Social Policy

Claire is a registered nurse and is in her 30th year of working in the NHS. She qualified as a mental health nurse in 1983 and worked in various clinical settings including as a ward sister in an acute inpatient ward. She gained a first class honours degree in social policy in 1991. Before becoming Chief Executive of CNWL in 2007, she was the Director of Nursing and Operations. In recent years she has held many other positions such as being a Trustee of the Foundation Trust Network, a director of the Imperial Partnership and membership of the CQC Stakeholder group.

Dr Alex Lewis
Director of Quality and Medical Director
BSc (Hons), MB, BS, MRCpsych

Dr Alex Lewis was appointed in 2003. He has extensive experience in the delivery of care in mental health settings and, over the past 22 years, of working within the NHS. He has been involved in the management of research projects including links with the commercial sector.

Trevor Shipman
Director of Finance
Fellow of Chartered Association of Certified Accountants, BSc (Hons)

Trevor joined the Trust in 2004 having previously been Deputy Director of Finance at University College London Hospitals (UCLH). He was the former lead on Finance and Private Finance Initiative for the re-building of UCL Hospitals and has over 30 years NHS experience, mainly in finance.

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The purpose of the Nominations Committee is to:
- Review the structure of the Board of Directors and make recommendations for change where appropriate
- Prepare a description of the role and capabilities required for a particular appointment in the event of a vacancy
- Agree with the Appointments Committee of the Council of Governors a clear process for the nomination of a chair or non-executive director
- Make recommendations to the Board on the appointment of executive directors.

Independence of external auditor

We have considered the independence principles set out by the Auditing Practices Board in relation to the work of our external auditor undertaking non-audit work. We did not identify any risks in this respect, particularly in relation to self-review and familiarity. Our auditors will not be relying on any of the work undertaken when forming their opinion. We will continually assess and address any risks to independence as appropriate.

There have been two meetings of the nominations committee during 2012/13. The first considered whether the current Board with its mix of executive and non-executive directors had the required skills and capabilities required to lead the organisation over the next 18 months. The second meeting considered the skills and experience required of a new Chairman.

The members of the Nominations Committee are:
- Dame Ruth Runciman - Chairman
- Ian Holder - Deputy Chair
- Claire Murdoch - Chief Executive
- Bhavana Desai - Non-Executive Director
- Helen Edwards - Non-Executive Director
- Professor Dorothy Griffiths - Non-Executive Director
- Laks Khandura - Non-Executive Director
- David Walker - Non-Executive Director
- Mandie Campbell - Non-Executive Director
Wider committees

There are two more formal sub-committees, which non-executive directors are involved in to ensure the Trust achieves its objectives and adhere to all regulatory frameworks. The groups include the Business and Finance Committee, and a Quality and Performance Management Committee. In addition an Investment Committee, chaired by a non-executive director, oversees any major investments or acquisitions.

Number of meetings and attendance at the Board of Directors and Audit Committee:

Board of Directors  Total Meetings = 7
Dame Ruth Runciman (Chairman)  7
Claire Murdoch  7
David Brettle  7
Helen Edwards  5
Bhavana Desai  6
Dot Griffiths  5
Ian Holder  6
Alex Lewis  5
Andy Mattin  7
Ian McIntyre  6
Trevor Shipman  7
John Vaughan  7
David Walker  7
Mandie Campbell  7
Laks Khangura  7

Audit Committee  Total Meetings = 4
Ian Holder (Chairman)  4
David Walker  3
Laks Khangura  4

The Council of Governors plays an essential role in the governance of the Trust, with its main duties being to:

- Appoint or remove the Chairman and other non-executive directors.
- Approve the appointment of the Chief Executive.
- Decide the remuneration and allowances of the Chairman and non-executive directors.
- Appoint or remove the auditor.
- Be consulted in setting the forward business plans of the Trust.
- Review annually the Trust’s objective of delivering high quality services.

Prior to December 2012, the Trust’s Council of Governors was known as the Council of Members. The council changed its name in accordance with the requirements of the Health and Social Care Act.

The make-up of the Council of Governors

CNWL’s Council of Governors is made up of elected governors across four constituencies, plus appointed governors from our partner organisations. The four constituencies are listed below:

- Service user – this is open to people over 16 years of age. There are two sub-categories based on a geographical split of the boroughs served by the Trust.
- Carer – this is open to people over 16 years of age who care for a service user of this Trust.
- Public – this is open to residents in England and Wales.
- Staff – all staff are automatically members unless they choose to opt-out. Membership is also open to employees of our partner organisations where they are managed within our services and have been in post for more than 12 months.

Meetings of the Council of Governors

The Council of Governors meets quarterly and meetings are open to the public. Individual attendance by Governors is shown in the table on page 64.

The Register of Interests of the Council of Governors is available any time through the Trust Secretary, Christine Baldwinson Tel. 020 3214 5776 or email christine.baldwinson@nhs.net.

Communication

The Council of Governors has a good working relationship with the Board of Directors and directors regularly attend Council of Governor meetings to be available to answer questions and participate in discussions. There is regular communication with individual governors and questions regarding the performance of any individual Directors would be channelled through the Chief Executive or Chairman, as appropriate. There are active governor working groups looking in detail at annual planning, quality, social inclusion, recovery and member engagement.
Performance evaluation of the Council of Governors

The Council of Governors regularly reviews its operation to ensure its effectiveness. The governors have concentrated this year on ensuring that they are fully equipped to understand the changing health landscape and have the skills and confidence to constructively challenge the Trust. For example, they have made sure that they understand the requirements of the Health and Social Care Act, undertaken professional communication skills training, attended workshops explaining finance reports and performance scorecards, and participated in training on effective questioning.

Lead Governor

Ketan Sheth was appointed Lead Governor in September 2011 for two years until September 2013.

Conditions of service for governors

The length of appointments of governors is three years. Terms of office may be ended by resolution of the Council of Governors following a procedure laid down in the Foundation Trust’s constitution.

Terms of office and summary attendance by individual governors at meetings of Council of Governors 2012/13. Total number of Council of Governors meetings in 2012/13 was four.

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<th>Meetings attended</th>
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<td></td>
<td>Cathy Wield</td>
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<td>Angela Hook**</td>
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<tr>
<td></td>
<td>John Clark</td>
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<td>May 2015</td>
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<td></td>
<td>Timothy Seale</td>
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<tr>
<td></td>
<td>Elvira De Souza</td>
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<td>Lina Christopoulou</td>
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<td>Sean Bell-Briggs</td>
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<td></td>
<td>Ezzat Jalili</td>
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<td></td>
<td>Sara Balabanoff*</td>
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<td>Lina Calderwood*</td>
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<td>Carer</td>
<td>Molly Bandah</td>
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<td></td>
<td>Monique Klang-Voves</td>
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</tr>
<tr>
<td></td>
<td>Janet Seale</td>
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</table>

<table>
<thead>
<tr>
<th>Constituency</th>
<th>Name</th>
<th>Meetings attended</th>
<th>End of appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Governors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brent</td>
<td>Stephen Chamberlain</td>
<td>3</td>
<td>May 2015</td>
</tr>
<tr>
<td>Harrow</td>
<td>Irene Leeman</td>
<td>4</td>
<td>May 2013</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>Samuel Whiteside</td>
<td>4</td>
<td>May 2015</td>
</tr>
<tr>
<td>Kensington and Chelsea</td>
<td>Kevin O’Brien</td>
<td>0</td>
<td>May 2015</td>
</tr>
<tr>
<td>Westminster</td>
<td>Beryl Birchnell*</td>
<td>0</td>
<td>May 2015</td>
</tr>
<tr>
<td>Westminster</td>
<td>Cheryl Prax</td>
<td>1</td>
<td>May 2015</td>
</tr>
<tr>
<td>Enfield, Hounslow, Hammersmith and Fulham</td>
<td>Barry Colin Gibbins</td>
<td>0</td>
<td>May 2015</td>
</tr>
<tr>
<td>Camden</td>
<td>John Kerstake Dunne</td>
<td>0</td>
<td>May 2013</td>
</tr>
<tr>
<td>Rest of England and Wales</td>
<td>Henry Arthurs</td>
<td>3</td>
<td>May 2015</td>
</tr>
</tbody>
</table>

| Staff Governors       |                             |                   |                    |
| Medical               | Karim Dar                   | 4                 | May 2015           |
| Nursing               | Paul Byrne                  | 4                 | May 2013           |
| Nursing               | Bridget Clarence Smith      | 3                 | May 2015           |
| Allied Health Professionals | Charlotte Green            | 3                 | May 2015           |
| Other – non-clinical  | Laura Chatterton*           | 0                 | December 2012      |

| Appointed Governors   |                             |                   |                    |
| Brent Local Authority | Ketan Sheth                 | 3                 |                    |
| Harrow Local Authority| Margaret Davine             | 2                 |                    |
| Hillingdon Local Authority | Peter Kemp         | 3                 |                    |
| Kensington and Chelsea Local Authority | Cllr. Robert Freeman* | 1 |                    |
| Kensington and Chelsea Local Authority | Cllr Charles Williams** | 3 |                    |
| Westminster Local Authority | Vacant                  |                   |                    |
| Camden Local Authority | Vacant                     |                   |                    |
| PCT (inner north west London) | Sandra Mounier Jack | 2 |                    |
| PCT                   | Vacant                      |                   |                    |
| Partnership organisations | Beverley Dawkins         | 1                 |                    |
| Partnership organisations | Vacant                  |                   |                    |
| Partnership organisations | Jill Patel               | 0                 |                    |
| Imperial College      | Mike Crawford               | 2                 |                    |

* Left Council of Members before end of term of office
** Elected part way through year
Remuneration Committee

The Remuneration Committee determines the salaries of the Chief Executive and Executive Directors by considering market rates. All Executive Directors are appointed on permanent contracts with the Chief Executive having a six month notice period and Executive Directors three months. There is no performance-related pay and no compensation for early termination is provided.

The Non-Executive Directors who sit on the Remuneration Committee are:
- Dame Ruth Runciman - Chairman
- Professor Dorothy Griffiths - Non-Executive Director
- Bhavana Desai - Non-Executive Director
- Helen Edwards - Non-Executive Director
- Laks Khangura - Non-Executive Director
- David Walker - Non-Executive Director
- Mandie Campbell - Non-Executive Director

Between 1 April 2012 and 31 March 2013 there was one meeting of the Remuneration Committee on 11 July 2012. Six members were present.

The remuneration for Non-Executive Directors is set by the Council of Governors. This was considered by the Council of Governors in 2010/11 and it was decided that the remuneration remain unchanged. No ‘golden hellos’, compensation for loss of office or other remuneration from the Trust was received by any of the above during 2010/11. All benefits in kind payments relate solely to the provision of cars. Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Claire Murdoch
Chief Executive
28 May 2013

Remuneration Report 2012/13

Salary and allowances of executive and non-executive directors for the year ended 31 March 2013

<table>
<thead>
<tr>
<th>Name and title</th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary</td>
<td>Other allowances</td>
</tr>
<tr>
<td></td>
<td>(£000)</td>
<td>(£000)</td>
</tr>
<tr>
<td>Chairman</td>
<td>£90 - 95</td>
<td>0</td>
</tr>
<tr>
<td>Claire Murdoch</td>
<td>£105 - 110</td>
<td>0</td>
</tr>
<tr>
<td>Executive Directors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>David Bettle - Director of HR</td>
<td>£100 - 105</td>
<td>0</td>
</tr>
<tr>
<td>Dr Alex Lewis - Medical Director</td>
<td>£85 - 90</td>
<td>0</td>
</tr>
<tr>
<td>Trevor Shipman - Director of Finance</td>
<td>£125-130</td>
<td>0</td>
</tr>
<tr>
<td>John Vaughan - Director of Partnerships and Commercial Development</td>
<td>£95 - 100</td>
<td>0</td>
</tr>
<tr>
<td>Ian McIntyre - Director of Estates and Facilities</td>
<td>£90 - 95</td>
<td>0</td>
</tr>
<tr>
<td>Robyn Doran - Director of Operations</td>
<td>£100 - 105</td>
<td>0</td>
</tr>
<tr>
<td>Andrew Maltin - Director of Operations and Nursing</td>
<td>£105 - 110</td>
<td>0</td>
</tr>
<tr>
<td>Non-Executive Directors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professor Dorothy Griffiths</td>
<td>£10 - 15</td>
<td>0</td>
</tr>
<tr>
<td>Ian Holder</td>
<td>£15 - 20</td>
<td>0</td>
</tr>
<tr>
<td>Bhavana Desai</td>
<td>£10 - 15</td>
<td>0</td>
</tr>
<tr>
<td>Helen Edwards</td>
<td>£10 - 15</td>
<td>0</td>
</tr>
<tr>
<td>Laks Khangura</td>
<td>£10 - 15</td>
<td>0</td>
</tr>
<tr>
<td>David Walker</td>
<td>£10 - 15</td>
<td>0</td>
</tr>
<tr>
<td>Mandie Campbell</td>
<td>£10 - 15</td>
<td>0</td>
</tr>
</tbody>
</table>

*Helen Edwards salary is met by the Ministry of Justice.

No ‘golden hellos’, compensation for loss of office or other remuneration from the Trust was received by any of the above directors during 2012/13. All benefits in kind payments relate solely to the provision of cars.
### Pension entitlements of executive directors for the year ended 31 March 2013

<table>
<thead>
<tr>
<th>Name and title</th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Real increase in pension at age 60</td>
<td>Lump sum at age 60</td>
</tr>
<tr>
<td>Chairmen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dame Ruth Runciman</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Executive Directors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claire Murdoch</td>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>David Brettle - Director of HR</td>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>John Vaughan - Director of Finance</td>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>John Vaughan - Director of Finance</td>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>Ian McIntyre - Director of Estates and Facilities</td>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>Robyn Doran - Director of Operations</td>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>Andrew Mattin - Director of Operations and Nursing</td>
<td>0.25</td>
<td>0.25</td>
</tr>
</tbody>
</table>

#### Real increase in pension at age 60
- £000
- £000
- £000
- £000
- £000
- £000
- £000

#### Lump sum at age 60
- £000
- £000
- £000
- £000
- £000
- £000
- £000

#### Cash Equivalent Transfer Value at 31 March 2013
- £000
- £000
- £000
- £000
- £000
- £000
- £000

*In addition to the Remuneration Report, the Companies Act 2006 requires disclosure, in a note to the accounts, of the aggregate of remuneration and other benefits receivable by directors during the financial year. This information is required even where entities prepare a Remuneration Report, although in such cases the disclosure requirements in the accounts are correspondingly fewer. The requirements for disclosing directors’ remuneration are set out in section 412 of the Act and in Regulation 8 and Schedule 5 to the Large and Medium-Sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410).*

In summary, the disclosures comprise the aggregate amounts of each of the following:
- Total remuneration paid to directors for the year ended 31/03/2013 (in their capacity as directors) totalled £1.1 million (2011/12 £1.23 million);
- Employer contributions to the NHS Pension Scheme for Executive Directors for the year ended 31/03/2013 totalled £127,032 (2011/12 £124,511);
- The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was eight.
- No other remuneration was paid to Directors in their capacity as directors and there were no advances or guarantees entered into on behalf of directors by the Trust.

The highest paid director earns approximately 7.8 times the median staff salary figure of £28,319 per annum (2011/12 re-calculated 8.4 times the median salary of £27,182 per annum).

For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012:

<table>
<thead>
<tr>
<th>Name of Director</th>
<th>Number in place on 31 January 2012</th>
<th>Number of new engagements</th>
<th>Number that have come to an end</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman</td>
<td>5</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Chief Executive</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Executive Directors</td>
<td></td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>
Pension costs

NHS Pension Scheme

The NHS pension scheme is subject to a full valuation every four years by the Government Actuary. The latest published valuation relates to the period 1 April 1999 to 31 March 2004 which was published in December 2007 and is available on the Pensions Agency website:


The notional deficit of the scheme was £3.3billion as per the latest scheme valuation by the Government Actuary for the period 1 April 1999 to 31 March 2004. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis.

Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation, it was recommended that employer contribution rates should continue at 14% of pensionable pay. From 1 April 2008, employees’ contributions have been on a tiered scale from 5% to 8.5% of their pensionable pay.

Above right: Paralympic double gold medallist, Natasha Baker, (with Claire Murdoch) opened the new Child Development Centre in Hillingdon
Quality Account
Chief Executive’s statement

The purpose of this Quality Account is to hold our organisation to account for the quality of the NHS funded healthcare services we deliver. We do this by presenting our achievements against the quality priorities previously set for 2012/13, alongside national priorities and the wider quality and service improvement work we have completed. We also demonstrate how we will continue to enhance the quality of services we provide, and what our focus is going to be this coming year. Our quality priorities for 2013/14 are shared in this report, and have been developed in conjunction with our staff, patients, carers and external stakeholders.

CNWL is the provider of a wide range of healthcare services across London and the surrounding area. These include mental health, sexual health, community physical health (Hillingdon and Camden), addictions, eating disorders, offender care and learning disability services.

For a detailed description of the services we offer, please refer to page 103.

I am pleased that we have met 14 of our 17 quality priority measures for 2012/13. This is an improvement in our performance compared to last year, and in part two of the Quality Account we explain these measures in further detail. We were disappointed however that we did not meet three measures relating to involvement in care planning, patient experience of call bells at an inpatient unit, and a measure relating to the control of the HIV virus once patients with HIV have begun treatment.

Service user safety, effective treatments, compassion and inclusivity are at the heart of all CNWL services, and we are proud that these values are reflected at all levels with the organisation. Our national patient survey results for 2012 tell us that more of our patients’ say we provide ‘excellent’ or ‘very good’ care compared to last year. Moreover we are proud to report that an increasing number of our staff recommend the Trust as a place to work or receive treatment; this places us above the national average when compared to other NHS trusts nationally.

We are aware that delivering world-class healthcare services can only be achieved if we work in partnership with all our stakeholders. We proactively seek to facilitate engagement with our internal and external stakeholders, for feedback and shared decision-making which help to shape how our services are run, developed and monitored. It is not only about listening to views, but facilitating open and continuous dialogue between all our stakeholders, and from the Board to the ward. Dialogue underpins the Trust’s core values of dedication, empowerment, partnership and diversity. To emphasise this approach, CNWL’s brand icons reflects our four key values as a series of speech bubbles.

Our focus on effective partnerships and communication is demonstrated by the development of our quality priorities and the production of this Quality Account each year, which is achieved through wide and ongoing consultation with our key stakeholders including our staff, Council of Governors, service users, carers, Local Involvement Networks (LINks)/Healthwatch, commissioners, GPs and local authorities.

This year we have developed a new integrated quality and performance reporting dashboard that allows us to look at our quality indicators alongside those of performance, finance and staffing. This helps us to build up an overall and informed picture of quality. We share this information on a quarterly basis with our Council of Governors and our specific quality information with our LINks. In the coming year we will look to develop this approach with the local Healthwatch and other external stakeholders.

The purpose of this Quality Account is to hold our organisation to account for the quality of the NHS funded healthcare services we deliver. We do this by presenting our achievements against the quality priorities previously set for 2012/13, alongside national priorities and the wider quality and service improvement work we have completed. We also demonstrate how we will continue to enhance the quality of services we provide, and what our focus is going to be this coming year. Our quality priorities for 2013/14 are shared in this report, and have been developed in conjunction with our staff, patients, carers and external stakeholders.

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For a detailed description of the services we offer, please refer to page 103.

I am also pleased to tell you that on 1 April 2013, CNWL integrated with Milton Keynes Community Health Services (MKCHS). This is an exciting time for both organisations to pool strengths and share learning and resources to enhance all aspects of healthcare services we deliver. I warmly welcome our MKCHS colleagues.

Welcome to Central and North West London NHS Foundation Trust’s (CNWL) annual Quality Account for 2012/13.

I am proud to present this report, which demonstrates many of the Trust’s achievements and innovations that have taken place over the last year, driving quality improvements at every level within the organisation. Our ongoing focus on quality also enables the Trust to identify where our services are to be further improved. These intentions are also outlined in the document.

Following an extensive programme of consultation, our quality priority areas for 2013/14 will be:
- Care planning
- Carer involvement
- Satisfaction with services.

Milton Keynes Community Health Services undertook an independent consultation exercise with their key stakeholders, prior to the integration with CNWL in April 2013. For 2013/14, these services will retain separate quality priority areas, building on their previous performance and identified priority areas, which include:
- Transfer of care and discharge
- The Safety Thermometer and avoidable pressure ulcers
- Satisfaction with services.

Across all CNWL services, we uphold a commitment to work in partnership with our stakeholders over the coming year, to work towards a common goal: the delivery of safe and effective care to our patients and their families and friends. My thanks go to everyone who has continued to support, engage and feedback their views in the shaping of our service developments, our innovations and how we monitor the quality of our services.

The Quality Account is also produced in an easy read format, and is available on the NHS Choices website.

Claire Murdoch
Chief Executive
28 May 2013
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 Board of Governors of Central and North West London NHS Foundation Trust to perform an independent assurance engagement in respect of Central and North West London NHS Foundation Trust’s Quality Report for the year ended 31 March 2013 (the “Quality Report”) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- CPA 7 day follow up; and
- Access to crisis resolution home treatment teams.

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 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 criteria set out in 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 consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2012 to May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
- Feedback from the commissioners dated 6 May 2013;
- Feedback from local Healthwatch organisations dated 6 May 2013;
- The Trust’s Complaints Report 2012/13 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The latest national patient survey for 2012;
- The latest national staff survey for 2012;
- Care Quality Commission quality and risk profiles dated 31/03/2013; and
- The Head of Internal Audit’s annual opinion over the Trust’s control environment dated 13/05/2013.

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

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 of assurance practitioners and relevant subject matter experts.

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 2013:

- 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 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.
- The indicators in the Quality Report subject to limited assurance 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 2013:

- 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.

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.
- 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.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.
Part 2 Priorities for improvement

A review of our performance in 2012/13 against last year’s quality priorities

CNWL takes great pride in the healthcare services it delivers to local communities with the aim of being the best at what we do. We strive to continually innovate and improve our services through closely monitoring and proactively reacting to our performance against a wide variety of measures and information streams; benchmarking ourselves nationally; and developing and maintaining an open dialogue between our staff, governors, service users, carers, and communities at large. These are the stakeholders who help shape our service developments.

This section outlines CNWL’s performance against our quality priorities set in partnership with our stakeholders last year. It also explains how we developed and agreed our quality priorities for 2013/14. This will include a description of our consultation process, the reasons for choosing the indicators we have, and how we will measure, monitor and report on these throughout the coming year.

Summary of performance against our 2012/13 quality priorities

For 2012/13 CNWL had a total of 17 quality priority measures. Eight of these originated from our mental health and allied specialty services (MHAS), five from Hillingdon Community Health (HCH), and four from Camden Provider Services (CPS). These 17 measures were tracked throughout the year and action plans were developed where improvements were highlighted. It is important to note that depending on the methodology used to collect the data against each measure, our year end reporting figures are either ‘year-to-date’ or at ‘quarter four’. This will be made clear throughout the Quality Account.

We have also included a section in Part 3 ‘Other indicators of quality’ which reviews performance in our staff survey, patient experience measures, and details of our complaints and equalities and diversity developments. We feel it is important to provide a well rounded view of our performance over the last year.

This year we achieved 82% of our quality priorities, representing an increase in our achievement from last year of 69%.

An ‘at a glance’ overview of how we performed against these 17 quality priorities is provided in a summary table overlay. The details of how we performed against each of our quality priorities, how we achieved them, and the Trust’s actions in these areas, are presented to you over the subsequent pages.

We have also included a section in Part 3 ‘Other indicators of quality’ which reviews performance in our staff survey, patient experience measures, and details of our complaints and equalities and diversity developments. We feel it is important to provide a well rounded view of our performance over the last year.

At a glance: Performance of CNWL’s quality priorities 2012/13

<table>
<thead>
<tr>
<th>Quality priority area</th>
<th>Target achieved</th>
<th>2012/13</th>
<th>2011/12</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL HEALTH AND ALLIED SPECIALTIES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>At least 65% of community patients report that they were ‘definitely’ involved as much as they wanted to be in decisions about their care plan (Q4)</td>
<td>65%</td>
<td>57%</td>
<td>41%</td>
</tr>
<tr>
<td>2</td>
<td>At least 50% of service users on CPA whose care plans contain at least one personal recovery goal (Q4)</td>
<td>50%</td>
<td>83%</td>
<td>n/a</td>
</tr>
<tr>
<td>3</td>
<td>At least 95% of service users with dementia prescribed anti-psychotic medication have three-monthly reviews, and output sent to GPs and families/patients within two weeks (Q4)</td>
<td>95%</td>
<td>100%</td>
<td>n/a</td>
</tr>
<tr>
<td>4</td>
<td>At least 65% of community service users on CPA that they got enough advice and support for their physical health (Q4)</td>
<td>65%</td>
<td>75%</td>
<td>66%</td>
</tr>
<tr>
<td>HILLINGDON COMMUNITY HEALTH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>At least 75% of end of life care patients on a district nursing caseload with an advanced care plan (YTD)</td>
<td>75%</td>
<td>81%</td>
<td>n/a</td>
</tr>
<tr>
<td>10</td>
<td>At least 25% of patients with learning disability conditions using HCH services have personalised care plans (YTD)</td>
<td>25%</td>
<td>37%</td>
<td>n/a</td>
</tr>
<tr>
<td>11</td>
<td>Reducing the number of avoidable pressure ulcers</td>
<td>&lt;62</td>
<td>19</td>
<td>n/a</td>
</tr>
<tr>
<td>12</td>
<td>Develop localised guidelines for all HCH staff to enable more effective support for carers which will include development and delivery of a training package for staff in conjunction with third sector partners</td>
<td>Developed guidelines and training</td>
<td>Achieved</td>
<td>n/a</td>
</tr>
<tr>
<td>13</td>
<td>Ensure at least 80% of all new referrals to the wheelchair service are given specific information for their carers about using a wheelchair and, where requested, provide additional training (YTD)</td>
<td>80%</td>
<td>100%</td>
<td>n/a</td>
</tr>
<tr>
<td>CAMDEN PROVIDER SERVICES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>At least 95% of HIV patients whose immune systems are maintained at a CD4 count greater than 200 (YTD)</td>
<td>95%</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>15</td>
<td>At least 95% of patients with a viral load less than 50 copies/ml within one year of treatment commencing (YTD)</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
</tr>
<tr>
<td>16</td>
<td>At least 80% of patients with an appointment with sexual health services, who arrive on time, are seen within thirty minutes of the appointment time (YTD)</td>
<td>80%</td>
<td>91%</td>
<td>n/a</td>
</tr>
<tr>
<td>17</td>
<td>Number of responses stating poor responsiveness to call bells on the inpatient wing of St Pancras Hospital (YTD)</td>
<td>0</td>
<td>10</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Our mental health and allied specialty services

This year we have been more innovative with our approach to measuring and monitoring our quality priorities. We believe that a more varied approach to collecting data will provide us with a richer understanding of the quality of our services and where improvements are needed. So this year we collected both quantitative and qualitative data through clinical audit, patient surveys, and focus groups. We have also introduced new policies and protocols for implementation to improve areas of our service.

As set out in last year’s Quality Account, we measured our performance in four main quality priority areas for our mental health and allied specialty services:

- Recovery and involvement
- Physical health
- Carer involvement
- Service pathway/access to services in a crisis.

Here we will present our performance, explain what we did to achieve this performance, or what we will be doing to ensure improvement. Our ‘service user reported’ measures were collected via a telephone survey run by trained group of service users.

Recovery and involvement

CNWL strives towards a recovery focused model of care. Although there is no single definition of the concept of recovery, for many people recovery means staying in control of their life despite experiencing a mental health problem, with the guiding principle being one of hope. Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms.

We know that one of the key factors highlighted by people when supporting them on their journey towards recovery is being believed in, listened to and understood. A good measure to understand this is whether or not service users felt involved in the decisions made about their care. This is important in ensuring that our service users feel empowered, and that we continue to work in partnership with them to best plan their care.

MEASURE A: At least 65% of community patients report that they were ‘definitely’ involved as much as they wanted to be in decisions about their care plan

This year we continued to measure this priority for both service users on Care Programme Approach (CPA) and Lead Professional Care (LPC). We achieved 57% in our quarter four survey. Although we missed the 65% target, we showed a good improvement from last year and also performed better than the national average for this measure.

To gain a fuller understanding of how many of our service users feel this way, we also consider those who felt involved ‘to some extent’. We have improved by 10% on last year, reporting 84% at the end of quarter four.

Whilst we are pleased to see improvement and are reporting better than the national average, we are not complacent. Work to improve service user involvement continues to take place across a number fronts. This includes the development and dissemination of a briefing to staff about the importance of involving service users in care planning, presentation and review of data at local managers meetings, and the involvement of service users in the standardisation of the initial assessment process and in the development of care packages. Central to this has also been the introduction of service user reported measures to ensure service users are involved in decisions about their care.

We have also designed and disseminated staff and service user posters: one to encourage staff to involve service users, and another to encourage service users to follow up with their lead professional/care co-ordinator if they didn’t feel as involved as they wanted to be in developing their care plan.

We want to continue to focus on driving up improvement in this important measure, as it is fundamental to achieving a true recovery approach to care. Involvement in care planning was a continued theme in our consultations with our stakeholders and so will be carried forward as a quality priority for next year.

MEASURE B: At least 50% of service users on CPA whose care plans contain at least one personal recovery goal

We wanted to measure the extent to which our service users’ care plans included at least one personal recovery goal. This is a goal set by the service user to encourage and empower them to take a degree of responsibility in their journey towards wellbeing with the support of the healthcare services. For example, this may include going swimming once a week, or going on a short course. This is a CQUIN measure for 2012/13.

This year we continued to measure this priority for both service users on Care Programme Approach (CPA) and Lead Professional Care (LPC). We achieved 56% in our quarter four survey. Although we missed the 50% target, we showed a good improvement from last year and also performed better than the national average for this measure.

To gain a fuller understanding of how many of our service users feel this way, we also consider those who felt involved ‘to some extent’. We have improved by 10% on last year, reporting 65% at the end of quarter four.

We are pleased to report that we exceeded our baseline target of 50% for this measure, achieving 63% at quarter four.

This achievement follows an increased focus on driving forward recovery focused practice across the organisation, underpinned by our engagement with the national Implementing Recovery through Organisational Change (InROCe) Project, the rollout of the Trust’s health and wellbeing plan and work undertaken as part of our CQUIN measures of recovery. This work included 69 services from across CNWL completing team recovery implementation plans, benchmarking recovery practice in their service, and agreeing action plans. Many of these were driven by the need to co-produce care plans with the service users, and to ensure they reflect personal recovery as well as clinical goals. Information about personal recovery goals was produced, local presentations were given to teams and auditors were trained. However, the development of the CNWL Recovery College has offered the most influential input: Service users, their carers and staff now have access to a range of recovery related training which impacts on the wider organisational culture. Together this brings about a sustainable shift to practice, and the significant improvement in recovery focused care plans is evidence of this.

Physical health

CNWL recognises the importance of assessing and supporting the physical health care needs of its mental health service users. This is underlined by the Government’s strategy ‘No Health Without Mental Health’ which aims to improve the physical health of those with mental health conditions. This is of utmost importance as there is increasing evidence which suggests that the life expectancy of those with serious mental health conditions is up to 15 years lower than the average UK resident.
MEASURE A: At least 95% of service users with dementia prescribed anti-psychotic medication have three-monthly reviews, and output is sent to GPs and families/patients within two weeks

Each year in England, approximately 180,000 people with dementia receive antipsychotics. Of these, around 1,650 result in cerebrovascular adverse events (such as a stroke). The National Institute of Clinical Excellence (NICE) recommends that this treatment is only prescribed for this frail population if non-cognitive symptoms (like psychosis and/or agitation) develop and the patient is severely distressed or at immediate risk of harm to themselves or others. It is therefore essential that our dementia patients who are prescribed antipsychotics in these circumstances are monitored very closely. We wanted to ensure that the treatment our older adult service users were receiving was safe, effective and well aligned with support they may receive from primary care practitioners. This was also a CQUIN measure for this year.

Carer involvement

Carers provide a vital role in the safety, safeguarding and wellbeing of service users. It is therefore important that we provide carers with the support and information they need to effectively cope with the needs of the person they are supporting.

We wanted to understand how we could better support our carers, and what support they felt they needed. We also wanted to assess what information carers wanted, and if they had the information to access services in a crisis. Focus groups were held with different carer groups, such as young carers, carers from black and minority ethnic (BME) communities, carers of older people and people with learning disabilities, and carers supporting someone accessing community recovery services. This was also a CQUIN measure for 2012/13.

Focus group outcomes

The following key themes emerged from the Trust’s focus groups:

- Carers told us that they wanted more general information about our services and how to access them, including better sign-posting. As a result, our service lines are developing general information leaflets about the services, team or ward, to be given to service users and carers.
- Carers told us that it wasn’t always clear who to contact when out-of-hours advice was needed. This year we launched a single contact number for the Out of Hours Urgent Advice Line for our service users. Concurrently, we developed, in partnership with carers, carer contact cards for carers supporting someone accessing adult mental health services. (See In Focus, page 96).
- Carers also told us that services needed to recognise their role in supporting service users and patients accessing our services. We will continue to develop ‘family inclusive practice’ across all services, which includes improved performance in identifying carers; improved recording of carer involvement in care and discharge planning; and for each service line to run two annual focus groups, to hear feedback from carers about their experience of services, and discuss service improvements.

Together with our stakeholders, we are keen to focus on developing and embedding this work further, therefore carer involvement has been rolled forward as a quality priority area for next year.

Service pathway and access to services when in a crisis

Our service pathway quality priority focused on taking the first step to developing a more robust process when discharging service users to their community and care to their GP. This is to ensure that service users remain well during this transition, have their needs effectively met and supported, and that there is open communication between our specialist services and the GP. We also wanted to ensure that, if once discharged to primary care, service users need our help again, that they could access it quickly.

MEASURE B: At least 65% of service users on CPA report that they got enough advice and support for their physical health

We also wanted to ensure that our service users on CPA were satisfied with the advice and support given for any physical health conditions they had. We are pleased to report that we exceeded our set target in this area, achieving 75% in quarter four. This figure is the result of steady improvement since last year’s figure, and is 10% better than the national average for this measure.

This target was achieved through the roll out of our care and support plans which highlight the importance of physical health, and prompts discussion on service users’ physical health needs and the support required. We also monitor and feedback results from our surveys throughout the year to our services, to inform action plans and raise awareness with our staff through local care quality meetings.

We will continue to work hard to maintain and improve this good result and will monitor and report on it in our next Quality Account.
We consistently achieved this target in 2012/13, showing a good improvement from our result last year. We achieved 67% in the quarter four telephone survey. We are heartened that this is 17% better than the national average.

To gain further understanding of this result we also considered those who also felt they got the help they wanted ‘to some extent’. We reported 85% for these responses, which is a great improvement from last year where we achieved 64%.

We made many changes and put much effort into improving our crisis line this year. This included, based on feedback from our service users and carers, the introduction of a new Out-of-Hours Urgent Advice Line for CNWL. We will continue to measure feedback in this area next year, to demonstrate if the changes undertaken have resulted in improvements for our service users.

In focus

New crisis cards and single out-of-hours crisis number

A new Out-of-Hours Urgent Advice Line was launched on 25 February 2013 for users of CNWL’s mental health and learning disability services. This service replaces all previous out-of-hours borough crisis line arrangements, providing a single point of support across CNWL. It was set up in response to feedback from service users and carers, who said that they did not feel that they were getting adequate response from the individual borough crisis lines.

The Out-of-Hours Urgent Advice Line is a standalone dedicated telephone service, which provides advice and signposting for CNWL service users and their families, outside of normal service hours. It is open Monday to Friday from 5pm to 8am, with a 24 hour service available at weekends and bank holidays.

The line has been developed in consultation with both service users and carers. They have been involved in the development of a leaflet about the line, and also in the planning of the ongoing evaluation of the new service.

New crisis cards have been distributed to services, which contain the single point of access out-of-hours telephone number.

A borough breakdown - Our mental health and allied specialties 2012/13 quality priority performance

A borough breakdown view is provided for our commissioners and other user and involvement groups to track progress for their local constituencies.

<table>
<thead>
<tr>
<th>Quality priority 2012/13</th>
<th>Period</th>
<th>Brent*</th>
<th>Harrow*</th>
<th>Hillingdon*</th>
<th>Kensington and Chelsea*</th>
<th>Camden*</th>
<th>Learning disabilities</th>
<th>Eating disorders</th>
<th>Addictions</th>
<th>Offender care</th>
<th>Psychological medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery and Involvement</td>
<td>1</td>
<td>At least 65% of community patients report that they were ‘definitely’ involved as much as they wanted to be in decisions about their care plan</td>
<td>Q4</td>
<td>65%</td>
<td>53%</td>
<td>58%</td>
<td>53%</td>
<td>64%</td>
<td>55%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>At least 50% of service users on CPA who were care plans contain at least one personal goal</td>
<td>Q4</td>
<td>50%</td>
<td>86%</td>
<td>88%</td>
<td>84%</td>
<td>73%</td>
<td>86%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Physical Health</td>
<td>3</td>
<td>At least 85% of service users with dementia prescribed anti-psychotic medication have three-monthly reviews, and output sent to GPs and families/patients within two weeks</td>
<td>Q4</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>At least 65% of community service users on CPA report that they got enough advice and support for their physical health</td>
<td>Q4</td>
<td>65%</td>
<td>90%</td>
<td>50%</td>
<td>63%</td>
<td>73%</td>
<td>80%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Carer Involvement</td>
<td>5</td>
<td>Thematic review of responses via focus groups asking if carers felt supported by CNWL, and why</td>
<td>Q4</td>
<td>N/A</td>
<td>Qualitative measure</td>
<td>Achieved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Thematic review of responses via focus groups asking if carers had the information they needed to access services in crisis</td>
<td>Q4</td>
<td>N/A</td>
<td>Qualitative measure</td>
<td>Achieved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service pathway and access in crisis</td>
<td>7</td>
<td>To establish supported discharge processes and protocols to support service users who have been discharged to primary care</td>
<td>Q4</td>
<td>N/A</td>
<td>Qualitative measure</td>
<td>Achieved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>At least 65% of patients reporting that they ‘definitely’ received the help they wanted from CNWL when they contacted them in a crisis</td>
<td>Q4</td>
<td>N/A</td>
<td>83%</td>
<td>67%</td>
<td>60%</td>
<td>100%</td>
<td>57%</td>
<td>-</td>
<td>-</td>
<td>50%</td>
</tr>
</tbody>
</table>

*Borough data includes results from the following service lines: Acute, older people and healthy aging, recovery, rehabilitation, and assessment and brief treatment.

* This represents those who responded ‘definitely’ and ‘to some extent’.

**Source: CQC National Community Service User Survey 2012.
We aimed to reduce the incidence of avoidable grade 2/3/4 pressure ulcers by 10% this year. These grades indicate the seriousness of the pressure ulcer, with grade 4 being the most serious.

MEASURE A: Reducing the number of avoidable grade 2/3/4 pressure ulcers

Patients with learning disabilities (LD) sometimes have complex healthcare needs. We have done a lot of work to develop our services to more effectively meet the needs of people with learning disabilities, including better systems to identify and record patients, the roll out of a training package for staff and the evolution of specific care planning. This quality priority is about measuring our ongoing work to ensure that learning disability patients have a personalised care plan. This is a national priority and is also a CQUIN measure this year.

Our on-going focus and work in this area is improving, and we exceeded our target.

This indicator was achieved through a variety of complex actions which included:

- The development of a standard operating procedure to ensure all staff accurately record whether a patient has a personalised care plan on our electronic patient records
- Placing a flag on our clinical systems for all patients with a learning disability, to ensure their needs are identified
- Undertaking monthly audits to ascertain whether LD patients have a personalised care plan.

We want to continue to improve in this area and so we will continue this work and closely monitor this measure internally.

MEASURE B: At least 25% of patients with learning disability conditions using HCH services have personalised care plans

A pressure ulcer is commonly known as a bedsore. It is a type of localised injury to the skin and underlying tissue, usually caused by unrelieved pressure, like sitting in the same position for too long. Reducing the number of avoidable pressure ulcers is an important area of our work, especially in the community where their incidence is higher. This is also a national priority area, as identified in the operating framework for 2012/13, and is a CQUIN target. Patient Safety First defines “avoidable” as meaning that the patient receiving care developed a pressure ulcer and the provider did not a) evaluate the patient’s clinical condition and pressure ulcer risk factors, b) plan and implement interventions consistent with the patient’s needs and recognised standards of practice, or c) monitor and evaluate the impact of the interventions.

We are pleased that our focus in this area brought the number of these avoidable pressure ulcers down to 19 by year end, well below our target.

We successfully achieved this reduction by developing a register of all patients who had or were at risk of developing a pressure ulcer within each of our district nursing teams. Following this, we:

- Ensured that patients reaching the end of their lives are appropriately identified and supported by an advanced care plan
- Advanced care plans are put in place or recorded via ‘Coordinate my care’, and monthly audits undertaken.
- Completed root cause analysis investigations for all reported grade 3/4 pressure ulcers to identify actions and learning, for sharing at team meetings
- Undertook pressure ulcer training for our district nursing teams.

We worked hard to achieve this good result and will continue to monitor this internally throughout 2013/14.
We achieved a good result of 97%, 14% better than the national average. This is due to the close on-going engagement with, and education of our patients in treatment compliance through our service user workshops and leaflets, supported by our committed teams of doctors, health advisors and patient representatives. We also monitor our electronic system which filters all patient results and flags when an individual has a low CD4 count.

**In focus**

**CWL’s Complex Wound Treatment Centre (CWC)**

The CWC aims to provide care closer to home for patients with chronic wounds. This prevents unnecessary hospital admissions, and ensures that regular in-house training is provided to staff in Hillingdon in the management of complex wounds. In June 2012 the team developed an outreach clinic in Oak Farm Clinic, Uxbridge, offering complex wound care on a weekly basis by a designated ‘issue viability nurse’ (IVN). The clinic allows patients living in the local area, easier access to specialist services. Patients are seen for assessment and a care plan is outlined together with the patient and GP. The service has improved communication and education, providing a seamless service for patients with complex wounds and improving outcomes for patients.

**Improving staff awareness in relation to carers**

This is a similar theme to our focus on carers’ needs in our mental health and allied specialty services. Our aims in HCH were two-fold: firstly, to develop guidelines and train staff to more effectively support the needs of carers, and secondly to focus specifically on our wheelchair service, to ensure carers are given the information and training they need to safely operate a wheelchair.

Our first target (measure A) was achieved, and we developed localised guidelines and protocols for our staff to more effectively support carers. We also developed a training package for HCH staff delivered in conjunction with Hillingdon carers, as well as an information leaflet for carers.

As a result of our consultations, the theme of carers, their involvement and support will be carried forward as part of our quality priorities for next year.

MEASURE B: Ensure at least 80% of all new referrals to the wheelchair service are given specific information for their carers about using a wheelchair and, where requested, provide additional training

We set a high target for ourselves of 80%, and we are proud to report that this was achieved and exceeded: 100% of our carers were given information on the safe use of their wheelchair, and were provided with training where they required it.

Our actions to achieve this included:

- Sourcing and obtaining appropriate wheelchair information for carers
- Staff training on recording the provision of information leaflets, and the offer for further training to carers
- Undertaking an audit of new referrals to the service who received carer information
- The development of a user training programme for carers to be tailored for individual training sessions with patients and carers.

In summary, all our Hillingdon Community Health quality priorities were achieved for 2012/13. These measures will not be reported on in next year’s Quality Account, however they will continue to be measured, monitored and reported on within the relevant internal forums over 2013/14.

**Camden Provider Services (CPS)**

In Camden Provider Services we focused our quality priorities around two main areas: clinical quality in our HIV services, and patient experience.

**Clinical quality in our HIV services**

The two quality priorities measured within the Trust’s HIV services are aimed at ensuring our clinical practices are effective and that our patients remain safe and healthy. Given how important this is, high targets were set.

MEASURE A: At least 95% of HIV patients whose immune systems are maintained at a CD4 count greater than 200

CD4 cells (cluster of differentiation 4) are a type of white blood cell that fights infection, and their ‘count’ represents their number per cubic millimetre of blood. Maintaining this at a level greater than 200 is vital to ensuring the patient’s immune system is healthy.

This measure is one which reflects that many other good practice points have taken place in maintaining our patients’ immune systems; including that we correctly monitored and identified those patients in need of treatment, started them on treatment in good time, used effective treatments, monitored those treatments, and supported patients in their adherence to the treatments.

We achieved a good result of 97%, 14% better than the national average. This is due to the close on-going engagement with, and education of our patients in treatment compliance through our service user workshops and leaflets, supported by our committed teams of doctors, health advisors and patient representatives. We also monitor our electronic system which filters all patient results and flags when an individual has a low CD4 count. This allows for early identification, management and follow-up.

MEASURE B: At least 95% of patients with a viral load less than 50 copies/ml within one year of treatment commencing

This measure indicates how well the infection is monitored and controlled once treatment has begun. The viral load reflects the amount or number of copies of virus per millilitre (ml) of blood. Less than 50 copies/ml, is deemed ‘undetectable’, and ensures that the damage the infection can have to the immune system and other organs is kept to a minimum, and that the patient is much less infectious. We therefore monitor this very closely.

Our year-to-date performance achieved 94%, and although this narrowly missed the target, it out-performed the national average of 87%. Our performance throughout the year has been maintained around our 95% target with only slight fluctuations. This has been due to our electronic filtering system which automatically flags to clinicians when a patients’ viral load...
is no longer undetectable while on treatment. This can then be appropriately managed as soon as possible. As we have consistently performed well against these two measures for the past two years, as well as out-performing the national average, we will monitor this internally and not report it in next year’s report.

**Patient experience**

**MEASURE A: At least 80% of patients with an appointment with sexual health services, who arrive on time, are seen within 30 minutes of their appointment time**

In order to ensure the Trust continues to meet this target we are:

- Monitoring clinic start times to avoid the knock-on effect of late starts and taking appropriate action
- Looking at the anticipated mix of emergency walk-ins and booked appointments for each clinic
- Changing the staff skill mix according to the patient case mix to ensure best care and speed of patient pathway
- Ensuring all our computer systems are ready to use as soon as the clinic opens.

CNWL would like to improve its performance further in this area, and will continue to monitor this on a monthly basis throughout next year. Our year end performance will be reported in next year’s report.

**MEASURE B: Number of responses stating poor responsiveness to call bells on the inpatient wing of St Pancras Hospital**

Last year a patient survey indicated some concern regarding the responsiveness to the call bells on the inpatient wing. This year we set ourselves the challenge that by quarter four we would have no responses stating that responsiveness was ‘poor’ in subsequent surveys. Unfortunately we received ten ‘poor’ responses, and therefore did not meet this target. However, for context, the graph below shows that the overall results are encouraging, given a notable improvement from the previous year.

The graph shows that this year, 95% of patients (175/185) rated the response to call bells as satisfactory or better. This represents a significant improvement when compared with 2011/12 where this figure was 82% (204/248). Call bell response was measured as part of the inpatient exit questionnaire on a quarterly basis. Following comments from patients regarding delayed response to patient hand-held call bells, an electronic system was put in place in June 2012. A snapshot audit of response times was undertaken in October, covering response times over a 24 hour period. Results indicate that the electronic system encourages a prompt response from staff. In tandem with this work, a questionnaire on patient perception regarding call bell response times was planned for March 2013 in order to compare the empirical data that is collected via the electronic system with patient experience.

This target will continue to be measured and reported on next year. However, the target is being reviewed by service managers and will take into account the benchmark set by our quarter four results. The new target will reference the percentage of patient’s rating response to call bells as satisfactory or above, and will continue to be measured internally.

![Above: A patient is supported by CNWL staff at St Pancras Hospital.](image)
Quality priorities for 2013/14

In this section, we will outline our quality priorities for 2013/14. We will describe the journey we have taken to arrive at these quality priorities, explain the rationale for them, and how we will measure, monitor and report on them.

For each quality priority, we have identified specific indicators and targets. Data will be collected throughout the year against these indicators, to help us measure how we are performing in these areas. This is so that we can put things right for service users throughout the year, as well as put action plans in place to drive up the quality of services.

It is important to note that these are not the only indicators of quality we monitor, and our work is not limited to delivering against these. To this end, we have included ‘in focus’ good news stories to give you further understanding of the varied and innovative work we are doing to enhance the quality of CNWL services.

We will also demonstrate whether each measure aligned to a CQUIN, is a new measure or an extension of a measure from the previous year.

Consultation with stakeholders

We value the views of our stakeholders, and proactively facilitate engagement and partnership with them. This year, we aimed to strengthen our working relationships further with these stakeholders.

Throughout December 2012 and January 2013, the Trust hosted a further programme of quality priority consultation workshops with staff, service users, carers and the Council of Governors. These forums also facilitated two-way communication relating to CNWL’s forthcoming quality priorities for the next year.

These forums also facilitated two-way communication relating to CNWL’s forthcoming quality priorities for the next year.

How we agreed our quality priorities for 2013/14

Our approach to developing our quality priorities for 2013/14 built on and expanded on the methodology from last year and the positive reviews it received: We held more consultation events throughout the year, and consulted with more people.

We considered a wide range of information when identifying our quality priorities for 2013/14. This included:

- Performance against our current quality priorities and other quality indicators throughout the year
- Organisational learning themes
- Feedback from consultation with our stakeholders

Our quality data

In reviewing and analysing our quality data, we identified areas which indicated that further improvement and embedding of actions were required. These, along with our organisational learning themes, directly informed discussions with our stakeholders for what our next year’s quality priorities should be.

Organisational learning themes

Our organisational learning themes are an important source for identifying areas for improvement within the Trust. These are identified through analysing and ‘triangulating’ data from complaints, claims, PALS (Patient Advice and Liaison Service), incidents, and staff, patient surveys, and clinical audit results.

Our organisational learning themes from 2011/12 were:

<table>
<thead>
<tr>
<th>Mental health and allied specialties</th>
<th>Community physical health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement, communication and information sharing with users, carers and professionals</td>
<td>Reduction in falls</td>
</tr>
<tr>
<td>Managing transitions in care pathways</td>
<td>Reduction in transfer and discharge issues with outside organisations</td>
</tr>
<tr>
<td>Physical health in a mental health context</td>
<td>Reduction in avoidable pressure ulcers</td>
</tr>
<tr>
<td>Better understanding and compliance of policies and procedures</td>
<td>Reduction in medication administration issues</td>
</tr>
<tr>
<td>Protecting staff from violence</td>
<td>Reduction in waiting times for district nurse visits (HCH)</td>
</tr>
<tr>
<td></td>
<td>Reduction in complaints about wheelchair supplier (CPS)</td>
</tr>
</tbody>
</table>

These themes form part of our annual Organisational Learning Report 2011/12, which is overseen by the Organisational Learning Group (chaired by a clinical director). Each theme is assigned a particular lead, or designated committee to develop and monitor the implementation of action plans to address issues, and updates are reported twice a year.

Our performance against our quality data and identified organisational learning themes served as the starting point for discussions when we consulted with our stakeholders on the quality priorities for 2013/14.

Key messages

The following section shows the consistent themes we heard from our discussions with our internal and external stakeholders.

Stakeholders felt that CNWL should reduce and consolidate our current quality priorities to enable further focus, and the embedding and improvement of current quality priorities, rather than developing a new set of priorities. It was also felt that measures should span the whole organisation, rather than being relevant to a particular service: this would allow for consistency in service provision around the quality priorities, and benchmarking between services to occur. We will not lose sight of those indicators that are specific to individual services. These will continue to be monitored and reported on internally and externally via the integrated dashboard but not necessarily in the annual Quality Account.

Consistently, feedback suggested that the Trust’s quality priorities should be developed around three key areas: care planning, carer involvement and support, and service satisfaction.

Our discussions throughout the year culminated in the all stakeholder consultation event which was held on 7 March 2013. Here our draft quality priorities for 2013/14 were presented for further feedback and refinement.

It was attended by over 50 delegates and was held for representatives from LINks, service users, carers, Council of Governors, commissioners, GPs, overview and scrutiny members, staff and the Chair of our Board. Each stakeholder group was given the opportunity to feed back their views, share personal insights, and experiences and network. The event received very positive reviews with one anonymous service user requesting more similar events as “they have given service users more hope and reminded the staff members why they work here and what it is all for.”
Key themes from our discussions on the day included:

- Stakeholders valued CNWL’s ambitions for culture change towards one of ‘partnership’, ‘personalisation’ and ‘hope’; where both service users and carers are part of the on-going care planning process; however, that this does not solely focus on their needs/wants and ignores the full spectrum of need, risk and safeguarding.

- Access to information and resources: knowing what services are available to service users and carers, and how these can be accessed, with one stakeholder stating “I have a problem seven days a week, not nine to five”.

- To assess service satisfaction through eliciting the qualitative feedback – the understanding of the rationale for responses, as well as the context of the responder, for example, how long ago they were discharged, provides far richer and more useful feedback for service development.

- That our quality priorities utilise a universal language which is used and understood by all services, service users and carers.

The feedback from this event helped to inform the final quality priorities for 2013/14.

Quality priorities 2013/14

This year CNWL’s quality priorities apply across all the Trust’s services, to ensure that there is a consistent approach and measure of quality across the organisation. Given the integration with Milton Keynes Community Health Services took place on 1 April 2013, these services will continue to work towards separate quality priorities during 2013/14, which can be seen on page 99.

Priority 1: Helping our patients to recover by involving them in decisions about their care

CNWL has a clear recovery approach to care, which continues as a key theme in this year’s quality priorities. This priority builds on our focus of recovery and involvement in previous years, with the aim to make continued improvements in this area, in order to improve the health and wellbeing of our local population.

It is vital that we involve our patients and service users in decisions about their care. Key to achieving our recovery goals is the involvement of our service users in the creation of their care plan, thereby developing shared ownership of their goals and treatment. Through this partnership approach we can ensure that issues important to individuals form part of their care plan, working in the knowledge that patients who know, understand and shape the actions they can take to aid their recovery, are more likely to follow their treatment and therefore recover.

We want to make sure that all our patients are offered a copy of their care plan, and report feeling involved in decisions about their care. This is a priority for the Trust in terms of improving the overall quality of our services; keeping patients’ safe and providing effective care.

We have three ways of measuring this priority for the year, as follows.

In focus

The CNWL Recovery College

CNWL’s Recovery College was launched in April 2012. The third college of its kind to be developed in the UK, the college follows an adult education model and delivers a series of recovery focused courses. The college promotes opportunities for the recovery and social inclusion of people with experience of mental health illness. All courses are designed to develop and assist students to grow in the way they want to, to have a say in what works for them, to have a voice, to be heard, to have choices, and to have control in their recovery journey.

CNWL’s Recovery College is run by staff with lived experience of mental health problems and mental health practitioners, co-producing and co-delivering all the courses in recognition of the value of both types of expertise. It is open to people who use services, their carers and CNWL staff. This joint learning environment helps to break down the barriers between ‘them’ and ‘us’ that can perpetuate stigma and exclusion.

So far the college has successfully completed three terms. 554 individual students have attended, 415 of whom were people who use services, 21 carers and 118 staff. In total there were 2,020 attendees. Courses are currently offered across five London boroughs that the Trust provides services in and is developing CNWL Recovery College ‘spokes’ or local development leads across all service lines.

Syena Skinner, Manager CNWL Recovery College

It’s OK for me to know what I would like in terms of my recovery and to be more assertive or resourceful about achieving this.

CNWL Recovery College student

Above: A community physical health patient from Camden.
Why have we set these priorities?

As outlined above, we believe in working in partnership with our patients and service users to ensure that they are involved in their care. The Trust first introduced measures in this area in 2010/11, and whilst we are pleased to note improvements in this area, we are aware that we still have a lot of work to do to make this integral to the way our teams work on a daily basis.

Last year we aimed to achieve 65% of our patients reporting to ‘definitely’ being involved as much as they want to be in decisions about their care plan. This year we have extended our focus to 95% of patients reporting to ‘definitely’ being involved as much as they want to be in decisions about their care plan.

How are we going to achieve and monitor them?

This priority will be measured using a combination of quantitative data, obtained from spot check audits of patient records, alongside information on patient experiences that demonstrate real life outcomes for our patients and service users.

This data will be reported via our integrated dashboard, fed back to the Trust’s clinical service lines for action planning, and reviewed and scrutinised by our internal committees, as detailed on page 102.

We aim to build quality on a patient by patient basis. Each supporting individuals accessing the various community health services we provide, as we continue to introduce carer-inclusive practice across all service lines. This year CNWL has launched a Carers Council, chaired by a carer governor, to oversee carer developments across the Trust. The Carers Council have identified key priorities which are aligned with the Trust’s quality priorities outlined below, to monitor and oversee the implementation of these workstreams.

Our measures for this year

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2013/14</th>
<th>Target 2012/13</th>
<th>Achievement 2012/13 or new measure this year</th>
<th>Measure same as last year but sample extended</th>
<th>Is a CQUIN for 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A. Patients reporting ‘definitely’ involved as much as they want to be in decisions about their care plan</td>
<td>65%</td>
<td>65%</td>
<td>57%</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>1B. Inpatients and community (mental health) patients have been offered or given a copy of their care plan</td>
<td>95%</td>
<td>95%</td>
<td>71%</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>1C. Community health (HCH/CPS) patients have an agreed care plan</td>
<td>95%</td>
<td>-</td>
<td>New measure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why have we set these priorities?

Early identification of carers, providing carers with information and signposting to additional support is a key part of carer involvement for CNWL. Carers are family members or friends providing support to a patient/service user accessing our services, and by identifying whether a patient has a carer or not, and establishing the ‘carer status’, we can involve them as partners in care and continue to recognise the invaluable role they provide.

The Trust has developed its knowledge and understanding of the carer role over the last few years and this has historically been a key area within our quality priorities. We intend to build on these developments over the forthcoming years. We aim to prioritise learning to carers, to ensure that we directly hear about their concerns and experiences, so that we can build on this learning and improve carer experiences of our services, staff and support.

A strategic collaboration has been established between CNWL and Lancaster University’s Spectrum Centre, which will provide the Trust with a unique opportunity to review and research carer involvement in mental health care. This collaboration will involve a review of current practice, interviewing carers, service users and staff on issues relating to carer involvement. Through this project we expect to receive better knowledge and understanding of how to gather information on carer experience, improved access to and knowledge of services for carers during a crisis, further development of CNWL Recovery College courses to benefit carers and improved carer inclusive practice.

This is a new measure for our community physical health services and we will share the learning from applying this in the mental health setting with them.

How are we going to achieve and monitor them?

Measure 2A will be collected quarterly via a clinical audit of our computer systems for a sample of patients from across our services. This information will then be fed back to the Trust’s clinical service lines for action planning, and reviewed and scrutinised by our internal committees, as detailed on page 102.

2B. Do carers feel supported by CNWL and do they know how to access support in a crisis?

Why have we set these priorities?

Many of our patients and service users are cared for by people outside of the healthcare setting, namely by their family and friends who act as a key part of the support network an individual has in place during their journey to recovery. It is important for the Trust to identify whether an individual has a carer or not, as we can then actively involve carers in care plans, and ensure that everyone is working together to reach a collective, shared goal.

Carers also have needs and requirements of their own, and often we have identified that a caring relationship is in place, we can help carers to access wider support networks and ensure that their own health and wellbeing needs are being met.

CNWL works in partnership with a range of carer organisations including local government, to further develop our knowledge and understanding of the various roles that carers provide when supporting service users who access our services. With the provision of community health services in Camden and Hillingdon, we need to better understand the needs of carers supporting individuals accessing the various community health services we provide, as we continue to introduce carer-inclusive practice across all service lines. This year CNWL has launched a Carers Council, chaired by a carer governor, to oversee carer developments across the Trust. The Carers Council have identified key priorities which are aligned with the Trust’s quality priorities outlined below, to monitor and oversee the implementation of these workstreams.
Why have we set these priorities?

A quality healthcare service is one which understands and delivers beyond the expectations of its service users. We want to understand how satisfied our service users are with the services they receive, and specifically why they have responded in the way that they have.

Through understanding patients’ satisfaction with our services, we will be able to share and develop good practice across the Trust where things are working well, as well as to make changes and innovate in areas which are not working as well. These may be service-wide or team-specific recommendations.

The priorities outlined above make use of a measure which has been nationally recognised and tested for validity: The Department of Health’s Friends and Family test, which will be used for our community physical health surveys in Hillingdon and Camden, and also reflects one of Milton Keynes Community Health Services’ quality priorities. Measure 3B, also featuring in the national patient survey, will be applied to our mental health and allied specialty services.

In focus

Carer contact cards

We heard from our carer focus groups that carers wanted the contact numbers of whom to contact if their family member or friend was in crisis. As a result, and with the development of the new Out-of-Hours Urgent Advice Line, we have designed and produced new carer contact cards. These were created in partnership with carers and rolled out across our services in April 2013.

In focus

Northwood and Pinner Community Unit

Thank you all so much for your kindness and thoughtful care given to my mother while she has been on your ward. During my visits I have observed how very hard you all work to tend to patients’ needs and to try to make everyone as comfortable as possible. You are a very special and splendid group of people. You should be very proud of your efforts and you are most certainly in our debt.
Introducing Milton Keynes Community Health Services (MKCHS)

In December 2012 it was announced that CNWL was successful in its bid to integrate with Milton Keynes Community Health Services (MKCHS). CNWL formally welcomed colleagues from MKCHS on 3 April 2013. This integration represents a great opportunity for both organisations to pool their strengths and share learning and resources to enhance the quality, safety and effectiveness of healthcare services.

MKCHS provides a wide range of NHS community physical and mental health services, including intermediate care, community equipment and learning disability services.

In summary MKCHS:
- Provides more than 50 different community health care services to residents of Milton Keynes, as well as services at Her Majesty's Prison Woodhill and specialist dental services across Milton Keynes and Buckinghamshire.
- Services are delivered from 25 sites, but mostly provided within people’s own homes.
- Employs 1,100 staff.

MKCHS quality priorities 2013/14

MKCHS followed their own programme of consultation with their stakeholders to develop their quality priorities for 2013/14. Next year the Trust intends to merge our consultation processes and quality priorities.

MKCHS stakeholder engagement developed throughout the year via key meetings and committees. Specifically, for 2013/14, consultation with the following groups took place:
- LINks Patient Participation Group
- LINks Quality Account presentation
- Commissioner Quality Review Group meeting
- MKCHS senior managers workshop
- Patient Experience Strategy Working Group
- Campaigns
- Sign off meeting

Our priorities for this year

MKCHS will work in partnership with other local health and social care providers to reduce the number of transfer of care incidents over the next 12 months therefore reducing the potential for preventable ‘harm’. This target will be measured as follows:

- Measure 1a) MKCHS will forward 100% of transfer of care incidents reported by our staff to the relevant organisation for investigation within one week.
- Measure 1b) The proportion of transfer of care incidents that are reported regularly by our services; most relate to the transfer into our services, and many have resulted in harm. We have undertaken trend analyses to understand the impact on service users and their carers, and have shared the findings with relevant partner organisations. Incidents relating to poor transfer of care between services are reported regularly by our services; most relate to the transfer into our services, and many have resulted in harm. We have undertaken trend analyses to understand the impact on service users and their carers, and have shared the findings with relevant partner organisations.

Priority 1: Transfer of care

When people transfer from one clinical setting to another, we need to have effective systems in place to ensure that they are transferred safely. This is of particular importance for some of our most vulnerable service users who need complex arrangements to be put in place, involving many different health and social care professionals.

Incidents relating to poor transfer of care between services are reported regularly by our services; most relate to the transfer into our services, and many have resulted in harm. We have undertaken trend analyses to understand the impact on service users and their carers, and have shared the findings with relevant partner organisations.

Whilst there have been some positive developments in care pathways for people with complex needs, progress has fluctuated because of the difficulties in working across organisational boundaries, and to date there has been no measurable improvement in the frequency or severity of the incidents. It is important therefore to maintain our focus on this serious patient safety issue in 2013/14.

Why have we set these priorities?

The nature of transfer of care incidents, and their impact on service-users and carers in Milton Keynes is well understood through rigorous analyses of incident trends and complaints. Poor transfer of care affects:

- The safety and wellbeing of service users
- Access to appropriate and timely treatment, care and rehabilitation
- Relationships between service users and health care professionals and between staff in different settings.

Although this is not a national or local CQUIN target, it is of high importance to our service users, and we want to ensure that people who use our services are reassured that their safety and wellbeing is our top priority.

How are we going to achieve and monitor them?

Through the Milton Keynes Safeguarding Adults Board, we will ensure the adoption and implementation of the multi-agency ‘Transfer of Care Strategy’. This will ensure that there is a ‘Board to ward’ approach to transfer of care with strong leadership, accountability and engagement by all staff.

We will continually monitor adverse events (through complaints, safeguarding referrals and incidents) and carry out regular audits to highlight areas for improvement. Quarterly reports will be produced, and presented to the Milton Keynes Adults Safeguarding Board, and this will...
be a standing agenda item at the Milton Keynes Quality Committee. Progress will also be discussed via the Quality Assurance Report which is presented to the Board on a bi-monthly basis.

**Priority 2: Responsiveness to patient needs and improving patient experience**

An organisation’s responsiveness to a patient’s needs is key to the quality of patient experience. Annually a score is given to each NHS health organisation based on the answers to five questions within the Care Quality Commission (CQC) national inpatient survey. For MKCHS this survey is only relevant to our mental health units, as community care at present is not included.

During the last 12 months we have not only been working to improve overall scores for our mental health units but gathering baseline information on the five questions for all services across MKCHS.

A further measure of patient experience is gathered via the ‘Friends and Family Test’, discussed on page 100 of this Quality Account. This asks all patients who have been discharged from an inpatient setting if they would recommend the service to their friends and family.

In 2012/13 our commissioners set a quality (CQUIN) target using this tool which solely focused on discharged inpatients. However, MKCHS have committed to progress this agenda, knowing that in 2014/15 it will become a requirement.

**Why have we set these priorities?**

At the heart of the NHS Constitution putting the patient first is a priority. Over the years, we have built on this overarching value and principle and are seeing real and positive changes in the way we deliver services. This has increased not only patient satisfaction, but the satisfaction and pride of our staff in the services and care they deliver. We understand that improvements should be continuous and this agenda is still evolving.

**How are we going to achieve and monitor them?**

We will continually monitor patient experience feedback through a variety of methods; patient stories, complaints, locally agreed patient experience campaigns, focus groups, family and friends test, and the national patient and staff surveys.

This information will be reviewed, acted on, and fed back to staff and service users. Monitoring will take place via our Patient Experience Strategy Working Group, our Quality Committee as a standing agenda item and through the Quality Assurance report that is presented to the Board bi-monthly.

**Priority 3: NHS Safety Thermometer - organisational ambition of zero ‘avoidable’ pressure ulcers**

The NHS Safety Thermometer is a national tool that was developed for acute hospital settings.

This tool has now been included in the national CQUIN targets for all NHS organisations (apart from ambulance services) and is used to monitor falls, urinary infections in patients with catheters, pressure ulcers, and venous thromboembolism (blood clots).

Using the data that is collected on a monthly basis, a percentage of ‘harm-free care’ can be calculated for each organisation. On the basis of national data, it is likely that most organisations will find that the majority of their harm is represented by pressure ulcers.

MKCHS have been actively working towards zero avoidable pressure ulcers for a number of years. However, a whole system pressure ulcer peer review coupled with the SHA pressure ulcer ambition work has enabled a more targeted approach to this ambition.

**Why have we set these priorities?**

We know from the information collected through serious incident reporting, and the collection of monthly data via the NHS Safety Thermometer that pressure ulcers are a problem for patients in Milton Keynes. Pressure ulcers cause considerable distress and pain to patients so if they can be avoided it must be a priority that this is achieved. It has taken us over the last year to ensure an accurate system of identifying avoidable and unavoidable pressure ulcers, however this is now achieved.

**How are we going to achieve and monitor them?**

Working from six months worth of data, we will now be able to monitor and target effective pressure ulcer education, avoidance, and care. Monthly service level monitoring will be overseen by the Clinical Quality Manager via the Zero Pressure Ulcer Ambition Group. Results will be reported via the Quality Assurance Report on a bi-monthly basis for further scrutiny and assurance by the Quality Committee and the Board.

Finally, progress against all MKCHS quality priorities will be reported to the CNWL Quality and Performance Committee throughout the year for review, scrutiny and support to ensure measures are achieved as set out. These results will then be reported to CNWL’s Operations Board (on a by exception basis) and to the CNWL Board.
Monitoring and sharing how we perform

Measuring and monitoring our performance

The measuring and monitoring of safety, effectiveness and service user/carer experience of CNWL’s services is a top priority. This is done in a variety of ways to provide the broadest and most accurate, in-depth picture of the quality of services delivered.

We monitor our performance against our national indicators and current and previous quality priority measures on a monthly and quarterly basis. Data against these measures is collected in a variety of ways, including both quantitative and qualitative methods, outcomes/patient reported and process information, to provide us with the most rich and informed picture of quality.

We run clinical audits (spot checks on our documentation and processes), service user surveys (run by a trained group of service users), focus groups with carers, and participate in national audits and service user and staff surveys. We have also improved our computer systems so that it is possible to more efficiently capture information and report on performance from these systems. Where necessary, actions are developed and this information is reported throughout the year to both central committee and local service line review groups.

We also compare or ‘triangulate’ the messages from our incidents, complaints, claims, PALS and audits to produce organisational learning themes. These themes, as described in the previous section, are used to inform action plans with executive leads to ensure improvement in the area identified, and used to inform quality priorities in the coming year.

Finally, we monitor and review our quality of care against the Care Quality Commissioner’s (CQC) essential standards for quality and safety. In November 2012, we implemented an electronic system to support our monitoring, reviewing and reporting of compliance against these standards in a far more efficient, robust way. The system also allows us to more easily analyse and action plan against third party information the CQC holds within CNWL’s quality and risk profile.

Bench marking

CNWL is a member of the NHS Benchmarking Network. The network carries out national benchmarking across all mental health and community trusts across a variety of performance measures, such as ‘length of stay’ or ‘re-admission rates’ for example.

We are also a member of the Prescribing Observatory for Mental Health (POMH-UK). CNWL undertakes clinical audits as part of a national programme relating to medicine prescribing and side effect monitoring, in order to benchmark ourselves against other trusts providing mental health services. Where areas for improvement are identified, the actions are agreed with our services and performance is monitored via the appropriate committee or service to ensure that improvement is made.

Reporting our performance

Data that we find from the various methods outlined above is shared with each of our service lines, who in turn discuss, scrutinise and action plan against areas for improvement. Service lines monitor their quality and performance data via their service line quarterly review meetings (attended by one of two directors of operations, service line heads and other senior staff), as well as at local monthly care quality management groups with the service line. It is at this level that issues can be acted upon to ensure improvement and commitment to providing high quality services.

On a monthly basis, the data and associated actions for improvement are reported to and overseen by our Quality and Performance Committee (chaired by a non-executive director and made up of executive and other non-executive directors) and Operations Board (chaired by the Director of Operations). Here, quality and performance data is triangulated with other information streams such as performance against national and other indicators, CQUIN targets, incidents, and key human resource and financial measures for an all encompassing view of the organisation’s services and early identification of risk. This is facilitated by an integrated dashboard. The Quality and Performance Committee who have the key responsibility for this work provide the Board of Directors with assurance.

Results are also reported quarterly to our Council of Governors and to our public engagement meetings attended by our Local Involvement Networks (LINks) to share with their communities.

Statements relating to quality of NHS services provided

Our regulators need to understand how we review and are working to improve quality. The following pages include specific messages they have asked us to provide.

Services

During 2012/13 CNWL provided and/or sub-contracted seven relevant health services.

These include:

- Mental health (including adult, older adult and CAMHS)
- Eating disorders
- Learning disabilities
- Addictions
- Offender care
- Sexual health/HIV services
- Community physical health services (Camden and Hillingdon).

CNWL has reviewed all the data available to them on the quality of care in seven of these relevant health services. The income generated by the relevant health services reviewed in 2012/13 represents 100% of the total income generated from the provision of relevant health services by CNWL for 2012/13.

Where we provide our seven NHS services:

<table>
<thead>
<tr>
<th>Mental health services</th>
<th>Other services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>Older people</td>
</tr>
<tr>
<td>Brant</td>
<td>Y</td>
</tr>
<tr>
<td>Harrow</td>
<td>Y</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>Y</td>
</tr>
<tr>
<td>Kensington and Chelsea</td>
<td>Y</td>
</tr>
<tr>
<td>Westminster</td>
<td>Y</td>
</tr>
<tr>
<td>Camden and Islington</td>
<td>Y</td>
</tr>
<tr>
<td>Enfield</td>
<td>-</td>
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<tr>
<td>Hounslow</td>
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<td>Ealing</td>
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<tr>
<td>Hammersmith and Fulham</td>
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<tr>
<td>City of London</td>
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<tr>
<td>Surrey</td>
<td>Y</td>
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<tr>
<td>Kent</td>
<td>-</td>
</tr>
<tr>
<td>Barnet</td>
<td>-</td>
</tr>
<tr>
<td>Hampshire</td>
<td>-</td>
</tr>
</tbody>
</table>

*In partnership
**Referrals accepted nationwide and includes offender, diversion and treatment services
The reports of five national clinical audits were reviewed by the provider in 2012/13, and CNWL intends to take the following actions to improve the quality of healthcare provided:

- **National Schizophrenia Audit**: The audit results have been discussed at the Trust’s NICE Group, and Medicines Management Group. The NICE Group have asked that the Physical Health Steering Group consider the report with regard to the standards relating to physical health monitoring. The results have also been disseminated to the recovery service line and older people and healthy ageing service line, as well as presented through the academic programme.

- **POMH-UK Audit Topic 12a**: Prescribing for people with a personality disorder: This is a baseline audit, aimed at addressing prescribing for people with a personality disorder. The audit results have been circulated through local care quality meetings and the Trust’s Medicines Management Group. Teams are required to respond to the audit and formulate an action plan to address any gaps in service provision.

- **POMH-UK Audit Topic 2f**: Screening for metabolic side effects: Compared with the national sample, the trust performed well in screening of obesity/BMI, high blood pressure and offering help with smoking cessation. Action needs to be taken to ensure all aspects of the metabolic syndrome are measured. The results have also been discussed at local care quality meetings. The audit results were also discussed at a Medicines Management Group in November 2012. Teams are required to respond to the audit and formulate an action plan to address any gaps in service provision.

- **POMH-UK Audit Topic 31b**: Prescribing antipsychotic medication for people with dementia audit. This is a follow up audit to the baseline audit undertaken in 2009. The audit results show that 5% (nationally, 13%) of patients were prescribed antipsychotics for dementia without co-morbid psychotic illness. The audit report has been circulated to the older people and healthy ageing service, and an action plan is being drawn up by the service line to address gaps identified and ensure continued good practice in areas where standards have improved.

- **National Parkinson’s Audit Report 2011** (published May 2012). Camden Provider Services submitted data for this audit. There were only seven eligible cases in the service and the audit took a snapshot of clinical practice rather than comparing practice to standards. The audit did not identify any cause for concern or urgent improvement required, however the results of the audit will be used in the future to assist in shaping services.

The reports of approximately 270 local clinical audits were reviewed by the provider in 2012/13, 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 monitor, 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 below:

### Sexual health and HIV services

- **Audit title**: Gento-Urinary Medicine Audit - BASHH Guidelines for Gonorrhoea Management

#### Actions:

- Undertake a Gonorrhoea Test of Cure Audit - to be presented in 2013
- Record that written patient information is given via a new domain in the Health Advisor eProforma
- To produce a new clinic leaflet informing patients of the importance of taking gonorrhoea cultures and returning for test of cure
- To review the National Standards for Gonorrhoea, to ensure that our local guidelines for first line antibiotic treatment are fully compliant.

#### Camden Provider Services Audit title: Catheter Care Audit

#### Actions:

- Introduce a community catheter care booklet. This is designed to be personalised to the patient and provide details of management, education provision, a catheter diary and problem solving
- Improve documentation to prompt staff to record whether alternatives to indwelling catheters have been considered.
• Ensure an on-going review of need for catheter documentation, trial without catheter and staff competency.
• Audit the use of the catheter care booklet during 2013/14.

Audit title: Wheelchair Service Non-attendance Audit

Actions taken prior to the audit period which resulted in improvements to the non-attendance rate:
• Meeting held to review the reliability of transport and identify actions that could be taken by both parties to reduce the number and impact of issues.
• Clients are sent a letter to provide them with details of their appointment, they then receive a phone call 24 hours before the appointment to confirm attendance, and should a client be too ill to attend, attempts are made to book another client into that appointment slot.

Further actions:
• On-going monitoring of the non-attendance rate through performance reporting to ensure that the non-attendance rate remains below target.

Hillingdon Community Health

Audit title: Cold Chain Monitoring Audit 2012

Actions:
• Information has been sent to all clinics and GP practices that vaccine fridges must not have anything other than vaccines in situ as this is a breach of the cold chain.
• A reminder has been sent to clinics’ supervisors to ensure that the minimum/maximum temperature is recorded daily.
• Information has been sent to all staff reminding them about disposing of vaccines and sharps safely.

Audit title: District Nursing Deaths at Home and in Preferred Place of Care

Actions:
• The service plans to undertake another audit in 2013/2014, to capture how many patients were known to the service but were not identified on the end of life register. This will enable identification of educational gaps.
• To continue to capture how many patients with a non-malignant diagnosis are identified by teams and placed on the End of Life register.

Mental health and allied specialties

Audit title: Liaison Psychiatry Services, Northwick Park Hospital: An Audit of the Standard of Medical and Psychosocial Care for Inpatients with Alcohol Dependence in an Acute Hospital

Actions:
• Review treatment guidelines, and develop new pathways for the treatment of alcohol use disorders and these findings will serve as a baseline for future service evaluation, including pick-up rates from referrals to community alcohol services.
• Introduce a process of reviewing chlordiazepoxide during detoxification to reduce the numbers of patients experiencing delirium tremens.
• Routinely review dose of chlordiazepoxide from evening to noon to allow same day discharge.

Audit title: Community Rehabilitation Services: An Evaluation of Self Administration in Supported Accommodation

Actions:
• To develop a training package for both staff and service users around self administration.
• To review equipment and facilities to support with the implementation of the self administration policy.

Audit title: Acute Inpatient Service (Mental Health) Admissions Audit

Action:
• Implementation of a project considering the referral pathways into the acute service line for known patients as a joint project with acute bed management and psychiatric liaison to try and reduce re-admission by known patients.

Audit title: Mixed Dose and Prescription Chart Audit – HMPYOI Feltham

The audit results show that there has been overall improvement from the previous audit, particularly in the following areas:
• Documentation of allergy status has improved since the last audit.
• Banks on administration recording have improved.
• Missing photo ID has improved.
• Better documentation of the immunisation section on the charts.

Research

The number of patients receiving relevant health services provided or sub-contracted by CNWL in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 191.

Throughout the year, the Trust has been involved in 66 studies 56 were funded of which three were commercial trials and 10 unfunded.

Over the past year researchers associated with the Trust have published 130 articles in peer reviewed journals.

Goals agreed with commissioners

A proportion of CNWL income in 2012/13 was conditional upon 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 relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2012/13, and for the following 12 month period are available online at: www.cnwl.nhs.uk

Last year (2011/12) CNWL achieved 96% of its CQUIN goals, securing the total CQUIN income of £5.8million. For 2012/13, CNWL’s CQUIN income equates to approximately £6.2million. Achievement against this was unconfirmed at the time of printing and will be reported next year.

What others say about CNWL

CNWL is required to register with the Care Quality Commission (CQC) and its current registration status is: unconditional registration. CNWL has no conditions on its registration. The CQC has not taken enforcement action against CNWL during 2012/13.

CNWL has participated in special reviews or investigations by the CQC relating to the following areas during 2012/13:

• In focus

Introduction of CNWL Pharmacy Clinical Trials

The Trust has an ambitious research and development plan for the future.

Until recently, the Pharmacy Department had not been able to support pharmaceutical trials due to lack of suitable facilities and therefore these types of trials could not be hosted by CNWL.

As a result of investment and planning approval, a new unit for hosting trials has now opened at the Trust’s pharmacy site at St Charles Hospital. For the first time in CNWL’s history, clinicians will be able to enrol patients into key medicine related trials supported by the Trust’s Pharmacy Team.

Anne Tyrrell, Chief Pharmacist
CNWL will be taking the following actions to improve data quality:

- Continue to review our information systems to ensure we are able to report by service line, including our community services
- Continue with the distribution of weekly data quality reports with patient level data to identify any breach areas and ensure that plans are in place to capture and record information in a timely way
- Continue to expand the provision of weekly QIS (the Trust’s business intelligence system) reports, to provide services with key performance data and enable monitoring of data quality
- Develop audits in line with the standards set out in the Data Quality Policy and ensure 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
- Monitor progress against data quality, for all key indicators across all service lines via the internal integrated dashboard
- Internal audits to measure compliance of KPI reporting against clinical notes
- Review and develop more efficient data collection methods for manually collected data to support data quality improvement.

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

CQC reviews of compliance

<table>
<thead>
<tr>
<th>Location</th>
<th>Outcome of review</th>
<th>Progress with actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Kensington and Chelsea Mental Health Centre</td>
<td>Fully compliant with CQC essential standards assessed</td>
<td>None required</td>
</tr>
<tr>
<td>Woodfield Road</td>
<td>Fully compliant with CQC essential standards assessed</td>
<td>None required</td>
</tr>
<tr>
<td>Rosedale Court</td>
<td>Fully compliant with CQC essential standards assessed</td>
<td>None required</td>
</tr>
<tr>
<td>South Wing, St. Pancras Hospital</td>
<td>Fully compliant with CQC essential standards assessed</td>
<td>None required</td>
</tr>
</tbody>
</table>
| Max Glatt Unit, South Kensington and Chelsea Mental Health Unit | Not compliant with outcome 13: Staffing | An action plan has been devised and a report on progress with the actions has been submitted to the CQC. Actions included:
- Fast-track recruitment of two members of staff
- A full-time modern matron and ward manager in post from January 2013
- The development of a list of high quality, preferred bank staff with whom the ward manager is in regular contact to ensure they have the requisite skills and competencies. |
| HMP Young Offenders Institute Feltham | Fully compliant with CQC essential standards assessed | None required |
| North Westminster Recovery Team | Fully compliant with CQC essential standards assessed | None required |

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 is taken to address any concerns raised by the CQC. Robust action plans are in place where required, and the Trust reports back progress to the CQC.

CNWL has made the following progress by 31st March 2013 in taking such action: see table above for details of the Trust’s response to CQC inspections and update on action plans.

Data quality

NHS Number and General Medical Practice Code Validity

CNWL submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, these 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 2012/13 was:

- 94.9% for admitted patient care
- 99.5% for outpatient care
- N/A for accident and emergency care.

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

- 100% for admitted patient care
- 100% for outpatient care
- N/A for accident and emergency care.

Information Governance Toolkit attainment levels

CNWL Information Governance Assessment Report overall score for 2012/13 was 85% and was graded satisfactory (green).

Clinical coding error rate

CNWL was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission.
### Part 3 Other information

**Our performance against national priorities and historical quality priorities**

The following section describes how we have performed against indicators required by Monitor (our regulator), the Operating Framework for the NHS in England, and our previous years’ quality priorities which we continue to monitor.

**Service user safety**

The indicators are grouped by the quality dimensions of Service user safety, clinical effectiveness and service user experience as per Lord Darzi’s High Quality Care for All report.

In some instances quality priorities measured in previous years were not measured for 2012/13. Where this is the case an explanation and assurance is given that quality in this area will not slip even though it is no longer reported in the Quality Account.

### Service user safety

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data source</th>
<th>2012/13</th>
<th>2011/12</th>
<th>2010/11</th>
<th>2009/10</th>
<th>Benchmark (where available) national average and lowest scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CPA seven day follow-up</td>
<td>JADE scan</td>
<td>95%</td>
<td>97%</td>
<td>95.2%</td>
<td>96%</td>
<td>97% National avg 97.4% National max 100.0%; Min 93.4%</td>
</tr>
<tr>
<td>2. Risk assessment and management</td>
<td>Internal audit</td>
<td>95%</td>
<td>92%</td>
<td>96%</td>
<td>92%</td>
<td>95% Not available</td>
</tr>
<tr>
<td>3. Infection control</td>
<td>a. The number of cases of MRSA (MRSA infection) annually (YTD)</td>
<td>Internal database</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>b. The number of cases of MRSA (MRSA bacteraemia) annually (YTD)</td>
<td>Internal database</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>c. MHAS: The number of cases of Clostridium Difficile annually (YTD)</td>
<td>Internal database</td>
<td>&lt;7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>d. HCH: The number of cases of Clostridium Difficile annually (YTD)</td>
<td>Internal database</td>
<td>&lt;7</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>e. CPS: The number of cases of Clostridium Difficile annually (YTD)</td>
<td>Internal database</td>
<td>&lt;7</td>
<td>0</td>
<td>4</td>
<td>Not available</td>
</tr>
<tr>
<td>4. Service user safety</td>
<td>Service users reported that they felt safe during their most recent inpatient stay (Q4)</td>
<td>Telephone survey</td>
<td>75%</td>
<td>79%</td>
<td>75%</td>
<td>Not available</td>
</tr>
</tbody>
</table>

**Key:**

* This was a quality priority for 2009/10
** This was a quality priority for 2010/11
# This was a quality priority for 2011/12
*** This figure is for CNWL mental health and allied specialties services only
1 Source: Health and Social Care Information Centre
^ Source: CQC National Community Service User Survey 2012
^^ Population data taken from ONS 2011 Census for the main six boroughs we serve
MEASURE 1: CPA seven day follow up: This measure is in place to ensure our service users remain safe and have their needs cared for after discharge from hospital to community care. We are pleased to report that, year-to-date, 97% of CPA cases received a follow-up contact within seven days of discharge, achieving the target. CNWL considers that this percentage is as described for the following reasons: performance is monitored locally each week via the Trust’s business intelligence system (QIS) which identifies discharges and follow-ups, and enables our business managers to alert clinicians and take focused, informed action. There is a CPA Policy to support this operationally, and the business rules are published and shared across the Trust to ensure we are acting on and recording this information correctly. This indicator is also tracked monthly via an integrated dashboard which is reported to the Quality and Performance Committee. CNWL has taken these actions to improve this percentage, and so the quality of its services, and will continue to do so through the coming year.

MEASURE 2: Risk assessment and management: This measure aims to ensure that a risk assessment has been completed, and that any issues highlighted are directly addressed in the service user’s care plan. This is to ensure the service user’s ongoing safety and management of any risk issues. This was achieved in 92% of cases for quarter four. Our service lines have received this data and are working on action plans to ensure this is improved for quarter four.

MEASURE 3: Infection control: We have a duty to ensure that our service users do not get any healthcare acquired infections whilst in contact with our services. At year end we are pleased to report that we achieved our targets with no MRSA or Clostridium Difficile cases reported this year.

MEASURE 4: Service user safety: It is important to understand our service users’ sense of safety on the ward. This impacts on their care experience and satisfaction of our services. Where we identify wards where inpatients are not feeling safe we take action to further investigate this and make changes to improve patients’ sense of security during their stay. We have consistently achieved this target throughout this year. While we are proud of our performance in this area, we will continue to focus on this measure to drive it up further.

MEASURE 5: Medication reconciliation: It is important, that when a patient is admitted to our services, we check against two other sources to be certain of what medication the patient is currently on, to prescribe safely and appropriately while under our care. This year we increased our target from 75% to 90%, and achieved a quarter four position of 97%. This has been due to the hard and on-going work by our pharmacy teams throughout the Trust. As we have performed consistently well with this measure over the past two years, it will not be reported on next year.

MEASURE 6: Access in a crisis: We want to monitor that our community services users have a phone number to call in a crisis to ensure they get help when they need it most. We exceeded our target at quarter four, with 75% of service users reporting that they have a crisis access number. This had been due to our drive in developing and distributing our crisis cards to all our patients. For 2013/14 we have developed a single crisis line, and new crisis contact cards are being distributed to both service users and carers. As such we will continue to monitor and report on this measure next year.

MEASURE 7: HIV services: These two measures are in place to ensure patients are receiving the safest possible care for their HIV. It aims to ensure open communication and information sharing with the patient’s GP, so all practitioners involved are aware of the patient’s condition(s) and current medications. We are pleased to report that we have achieved both our targets for these measures. The importance of involving GPs is raised by the clinician at each consultation, and there is great focus on this at patient workshops, especially around drug interactions with HIV and other medications. While the service will continue to report on both of these measures locally, next year we will only report on 7b which has a focus on, where patient GP’s have been disclosed to the service, that they are updated at least once a year on the patient’s progress.

MEASURE 8: HCH falls: This indicator monitors the number of falls at our Northwood and Pinner Community Unit and aims to achieve a 10% reduction for each year it is measured. We are pleased to report that we achieved this target for the last two years and will continue to focus on reducing this figure internally, but not report this in future Quality Accounts.

MEASURE 9: HCH medication errors: This measure relates to our community services in Hillingdon. Serious medication errors can harm our service users and so it is vital that none occur. Strict systems, processes and staff training are in place to ensure medicines are stored, prescribed and administered correctly. We are pleased to report that no serious/red medication incidents occurred in the last two years. While this will continue to be monitored closely internally, this will not be reported next year.

MEASURE 10: Incidents: We take reported incidents very seriously at CNWL. We have an electronic reporting system to support this and over the last few years have developed a positive reporting culture within the organisation. Incidents are graded, analysed and, where required, undergo a root cause analysis investigation to inform actions, recommendations and learning.

Incident data is reported on a quarterly basis to the Trust’s Incidents and Serious Incidents Group. Serious incidents are also reviewed at our service line quarterly review meetings. Analysis of this data is considered by our Organisational Learning Group to inform our organisational learning themes which are reported to the Board.

This measure indicates the total number of safety incidents reported during 2012/13 and, of these, what number and proportion resulted in severe harm or death. CNWL considers that this number is as described for the following reasons: the Trust provides a broad range of services, and supports the reporting of all incidents whether related to service users, staff or other parties. As such, the Trust has a positive reporting culture which supports a culture of learning. The data included within the report relates to all safety incidents and includes incidents which have been graded as resulting in no harm, low harm, moderate harm, severe harm and death.

CNWL has taken the following actions to improve this number, and thus the quality of its services. It has strengthened its arrangements for ensuring learning is shared across the Trust and developed its systems for monitoring the implementation of actions following root cause analysis investigations. Further to this, the Trust is looking to optimise its use of technology to strengthen the initial reporting of serious incidents during the 2013/14 reporting period. An additional action that the Trust has recently approved is the provision of a central root cause analysis investigation team. This central resource will not only strengthen the current arrangements for investigation, but support wider learning through the close links they will establish with our operational services.

The following is a list of those service user safety indicators which were retired from last year. The reason for this, is that the indicators either reflected a discreet piece of work which had reached completion, or where CNWL was found to be performing consistently well against the target:

- Number of medication errors by Health Care Professionals (HCH/ staff (10% reduction per annum)
- 90% of patients happy with their HCP’s attention to hand hygiene
- CPS syringe drivers: to have completed all actions required in response to the safety alert before 16/12/11; to identify a preferred new model ambulatory syringe driver to be used in CPS; and to revise the syringe driver policy, training programme and competency assessments for safe operation.
### Clinical Effectiveness

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Benchmark (where available)</th>
<th>Best and worst scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Readmission rates</td>
<td>JADE scan</td>
<td>5.3%</td>
<td>4.3%</td>
<td>5%</td>
<td>5.7%</td>
<td>Not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. For patients aged 0-14</td>
<td>a. 0; b. 5.3%</td>
<td>Not measured</td>
<td>Not measured</td>
<td>Not available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. For patients aged 15 or over</td>
<td>a. 0; b. 4.1%</td>
<td>Not measured</td>
<td>Not measured</td>
<td>Not available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Crisis Resolution Team gate-keeping</td>
<td>JADE scan</td>
<td>90%</td>
<td>99.4%</td>
<td>98%</td>
<td>95%</td>
<td>94.5%</td>
<td>National avg: 80.2%</td>
<td>National max: 100.0% Min = 89.4%</td>
</tr>
<tr>
<td>3. Crisis resolution home treatment episodes</td>
<td>JADE scan</td>
<td>5</td>
<td>5/5</td>
<td>5/5</td>
<td>5/5</td>
<td>Not measured</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>4. Early Intervention Teams</td>
<td>JADE scan</td>
<td>95%</td>
<td>100%</td>
<td>99.5%</td>
<td>100%</td>
<td>Not measured</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>a. Identifiers (YTD)</td>
<td>JADE scan</td>
<td>99%</td>
<td>99.1%</td>
<td>99.1%</td>
<td>99%</td>
<td>99.6%</td>
<td>99.1%</td>
<td></td>
</tr>
<tr>
<td>b. Outcomes (YTD)</td>
<td>JADE scan</td>
<td>50%</td>
<td>97.6%</td>
<td>97.2%</td>
<td>87.5%</td>
<td>59.6%</td>
<td>55.1%</td>
<td></td>
</tr>
<tr>
<td>5. Mental Health Minimum Data Set (data completeness)</td>
<td>JADE scan</td>
<td>Internal audit</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
<td>Not measured</td>
<td></td>
</tr>
<tr>
<td>a. Inpatient service users with physical health assessment after admission (nursing)**</td>
<td>Internal audit</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
<td>89%</td>
<td>Not measured</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Inpatient service users with physical health assessment after admission (medical)**</td>
<td>Internal audit</td>
<td>95%</td>
<td>89%</td>
<td>80%</td>
<td>89%</td>
<td>Not measured</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Physical health checks</td>
<td>RIO scan</td>
<td>90%</td>
<td>90%</td>
<td>92%</td>
<td>90%</td>
<td>78%</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>7. HCH Edinburgh Post Natal Mood Assessment</td>
<td>RIO scan</td>
<td>13 weeks</td>
<td>8</td>
<td>24</td>
<td>11</td>
<td>Not measured</td>
<td>Not available</td>
<td></td>
</tr>
</tbody>
</table>

**Measure 1:** Readmission rates: Readmission rates describe how many service users get readmitted to hospital post discharge within a given timescale. It is important for us to monitor this, as it may warrant investigation into whether our service users are being discharged before they are ready, or not given the appropriate support in the community. We are pleased to report that our readmission rates within 28 days of discharge are below 1% target at 5.3%.

CNWL considers that these percentages are as described for the following reasons: performance is monitored locally each week via the Trust’s business intelligence system (QIS) which identifies patients that were readmitted. There are published and shared business rules across the Trust to ensure we are acting on and recording this information correctly. This indicator is also tracked monthly via an integrated dashboard which is reported to the Quality and Performance Committee and the associated service line care quality meetings.

CNWL has taken the following actions to improve this number, and so the quality of its services, by the development and introduction of a supported discharge protocol and process for service users who have been discharged to primary care. Also, CNWL has introduced a new triage model of care which is supported by proactive discharge planning, and this measure is monitored closely by our acute service line to ensure our care pathway is working.

**Measure 2:** Crisis resolution gate-keeping: Our crisis resolution teams assess service users when they are in crisis to quickly determine if they are suitable for home treatment prior to admission. It is important to treat our service users in the most appropriate settings to ensure their safety and that they receive the most effective treatment. We are proud that we have done well on this measure for two years running, achieving 99.4% against our 90% target. CNWL considers that these percentages are as described for the following reasons: Performance is monitored locally each week via the Trust’s business intelligence system (QIS) which identifies admissions and gate-keeping, which informs actions as required. The Crisis Resolution Team policy and business rules are published and shared with all staff via our intranet to ensure we are acting on and recording this information correctly. This indicator is also tracked monthly via an integrated dashboard which is reported to the Quality and Performance Committees.

CNWL has taken the following actions to improve this number, and so the quality of its services, by reviewing, updating and distributing the Crisis Resolution Team Policy this year, as well as providing weekly reports to local business managers for action planning. This is also reviewed at local care quality management groups or senior management team meetings within the appropriate service line.

**MEASURE 3:** Crisis resolution home treatment episodes: This indicator is a way in which we measure that we can offer 24 hour services to people in crisis. Our local crisis resolution teams are assessed as to their eligibility for home treatment prior to admission. The percentage of service users admitted to acute adult inpatient beds who were assessed as to their eligibility for home treatment prior to admission is reported to the Quality and Performance Committee and the associated service line care quality meetings.

CNWL has taken the following actions to improve this number, and so the quality of its services, by the development and introduction of a supported discharge protocol and process for service users who have been discharged to primary care. Also, CNWL has introduced a new triage model of care which is supported by proactive discharge planning, and this measure is monitored closely by our acute service line to ensure our care pathway is working.

**MEASURE 4:** Early intervention teams: This indicator assesses whether we have met our commitments, set by our commissioners, to serve new cases of first episode psychosis. We are pleased to report that we achieved 100% against a 95% target.

**MEASURE 5:** Mental health minimum data set: This information is important for us to collect as it helps ensure that we are delivering services that meet the needs of our service users. It is important to treat our service users in the most appropriate settings to ensure their safety and that they receive the most effective treatment. We are proud that we have done well on this measure for two years running, achieving 99.4% against our 90% target. CNWL considers that these percentages are as described for the following reasons: Performance is monitored locally each week via the Trust’s business intelligence system (QIS) which identifies admissions and gate-keeping, which informs actions as required. The Crisis Resolution Team policy and business rules are published and shared with all staff via our intranet to ensure we are acting on and recording this information correctly. This indicator is also tracked monthly via an integrated dashboard which is reported to the Quality and Performance Committees.

CNWL has taken the following actions to improve this number, and so the quality of its services, by reviewing, updating and distributing the Crisis Resolution Team Policy this year, as well as providing weekly reports to local business managers for action planning. This is also reviewed at local care quality management groups or senior management team meetings within the appropriate service line.

**MEASURE 6:** Physical health checks: Measure 6a and b indicate the percent of service users who have received nursing and medical physical assessments respectively after their admission. The percentage of service users admitted to acute adult inpatient beds who were assessed as to their eligibility for home treatment prior to admission is reported to the Quality and Performance Committee and the associated service line care quality meetings.

CNWL has taken the following actions to improve this number, and so the quality of its services, by the development and introduction of a supported discharge protocol and process for service users who have been discharged to primary care. Also, CNWL has introduced a new triage model of care which is supported by proactive discharge planning, and this measure is monitored closely by our acute service line to ensure our care pathway is working.

**Key:**
- * This was a quality priority for 2009/10
- ** This was a quality priority for 2010/11

1. Source: Health and Social Care Information Centre
2. Source: Mental Health Minimum Data Set Q4 2012/13

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# This was a quality priority for 2011/12
**MEASURE 7:** HCH Edinburgh Post Natal Mood Assessment: We monitor the percentage of new mothers who are screened with this mood assessment tool aimed at identifying postnatal depression which can have unfortunate consequences on the lives of new born babies and families if undiagnosed. We are pleased to report that our year-to-date position is 90%. We have consistently achieved this target since 2010, and so although we will continue to monitor this internally, it will not be reported in future Quality Accounts.

**MEASURE 8:** HCH wheelchair initial assessment waiting time: This measure shows the average waiting time, in weeks, for a wheelchair assessment. We are pleased that through monitoring demand and continued work with commissioners, we have greatly improved upon our performance last year, achieving the target year-to-date. This indicator will continue to be monitored internally only.

The following is a list of those clinical effectiveness indicators which were retired from last year. The reason for this is that the indicators either reflected a discreet piece of work which had reached completion, or where CNWL was found to be performing consistently well against the target:

- 58% of women sustaining breast feeding at six to eight weeks post delivery
- 65% of service users who have undergone DESMOND training report that they are better able to understand and manage their condition
- CPS Stroke Network targets for a community non-acute care unit. For an update on work which has continued through 2012/13, and our Stroke REDS (Rapid Early Supported Discharge Service) Care Integration Award (July 2012) see In focus below.

**In focus**

**Stroke REDS** Last year, the Stroke REDS (Rapid Early Supported Discharge Service) in Camden worked with the Stroke Network to set targets for a community non-acute care unit, this work has continued through 2012/13. This on-going work has informed Stroke Network standards. As a result, over 2012/13, measures have changed and the service currently reports a number of measures both internally, and to the Stroke Network which are now more in line with commissioned service provision. Long term monitoring of these has indicated stable results.

**Care Integration Awards** The Care Integration Awards celebrate partnership working across agencies to improve patient care and are presented by the Health Service Journal (HSJ) and Nursing Times. From a pool of 60 nominations, the Stroke REDS was awarded a Care Integration Award in July 2012. This team is part of the newly formed integrated Stroke and Neurology Service. The team won this award not only for their joined up working with acute hospitals, community teams and social services but also the efficiency and cost saving to the NHS that having an integrated early supported discharge team can make. Early supported discharge helps to prevent unnecessary hospital admission or long-stay in inpatient facilities. The team based at St Pancras Hospital work with patients in their homes to ensure they receive the specialist care and support that they would have received on a stroke unit. This involves rehabilitation and aftercare for approximately six weeks after returning home. The service is integrated with acute hospital stroke units across London, and is a conduit between acute and community health, social and preventative services to ensure those patients and carers, receive the best care and support possible. Following the success of the service, this early supported discharge framework has been expanded to other neurological conditions.

### Service user and carer experience

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data source</th>
<th>Target</th>
<th>2012/13</th>
<th>2011/12</th>
<th>2010/11</th>
<th>2009/10</th>
<th>Benchmark: mean average and highest and lowest scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Delayed transfers of care</td>
<td>JADE scan</td>
<td>-7.5%</td>
<td>6.3%</td>
<td>3.1%</td>
<td>2.8%</td>
<td>4.4%</td>
<td>Not available</td>
</tr>
<tr>
<td>2. CPA 12 months review</td>
<td>JADE scan</td>
<td>95%</td>
<td>95.9%</td>
<td>95.6%</td>
<td>95%</td>
<td>99% (Jan-Mar 2010 audit)</td>
<td>National avg: 80.2%; National max: 90.0%; Min: 15.2%</td>
</tr>
<tr>
<td>3. Care plans a. What percentage of our service users have been offered a copy of their care plan? (inpatients and community) (Q4)</td>
<td>Internal audit</td>
<td>95%</td>
<td>71%</td>
<td>88%</td>
<td>88%</td>
<td>90%</td>
<td>Not available</td>
</tr>
<tr>
<td>b. Community service users report that they had been given offered a copy of their care plan (Q4)</td>
<td>Telephone survey</td>
<td>80%</td>
<td>56%</td>
<td>51%</td>
<td>Not measured</td>
<td>Not measured</td>
<td>Not measured</td>
</tr>
<tr>
<td>4. Access for people with a learning disability</td>
<td>Internal database</td>
<td>77%</td>
<td>77%</td>
<td>77%</td>
<td>6%</td>
<td>Not measured</td>
<td>Not available</td>
</tr>
<tr>
<td>5. Carer identification and assessments a. Percentage of service users who have their carer status identified (Q4)</td>
<td>Internal audit</td>
<td>55%</td>
<td>75%</td>
<td>78%</td>
<td>Not measured</td>
<td>Not measured</td>
<td>Not measured</td>
</tr>
<tr>
<td>b. Percentage of carers recorded as having been offered a carers assessment (Q4)</td>
<td>Internal audit</td>
<td>40%</td>
<td>75%</td>
<td>98%</td>
<td>Not measured</td>
<td>Not measured</td>
<td>Not measured</td>
</tr>
<tr>
<td>6. CPS telephone responsiveness</td>
<td>Mystery shopping</td>
<td>80%</td>
<td>75%</td>
<td>94%</td>
<td>Not measured</td>
<td>Not measured</td>
<td>Not measured</td>
</tr>
<tr>
<td>7. HCH referral to treatment</td>
<td>RIO scan</td>
<td>95%</td>
<td>100%</td>
<td>99.9%</td>
<td>100%</td>
<td>99.1%</td>
<td>Not available</td>
</tr>
<tr>
<td>8. HCH service users feedback</td>
<td>Annual HCH patient survey</td>
<td>60%</td>
<td>63%</td>
<td>56%</td>
<td>62%</td>
<td>TBC</td>
<td>Not available</td>
</tr>
</tbody>
</table>

**Key:**
- * This was a quality priority for 2009/10
- ** This was a quality priority for 2010/11
- # This was a quality priority for 2011/12
- 1 Source: Health and Social Care Information Centre
- ^ Source: CQC National Community Service User Survey 2012
The following three tables reflect the data relevant to mental health and allied specialties from pages 110-117 broken down by borough.

**Service user safety**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon</th>
<th>Kensington and Chelsea</th>
<th>Westminster</th>
<th>CAINHS</th>
<th>Learning Disabilities</th>
<th>Eating Disorders</th>
<th>Addictions</th>
<th>Offender Care</th>
<th>Trust-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CPA seven day follow-up</td>
<td>What percentage of our service users who are on Care Programme Approach did we contact within seven days of them leaving the hospital (YTD)?</td>
<td>95%</td>
<td>98%</td>
<td>95.3%</td>
<td>98.7%</td>
<td>97.6%</td>
<td>91.2%</td>
<td>87.5%</td>
<td>92.3%</td>
<td>n/a</td>
<td>n/a</td>
<td>97%</td>
</tr>
<tr>
<td>2. Risk assessment and management</td>
<td>What percentage of inpatient service users have had a risk assessment completed and linked to their care plans (Q4)?</td>
<td>95%</td>
<td>93%</td>
<td>85%</td>
<td>88%</td>
<td>97%</td>
<td>88%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>-</td>
</tr>
<tr>
<td>3. Service user safety</td>
<td>Service users reported that they felt safe during their most recent inpatient stay (Q4)</td>
<td>75%</td>
<td>63%</td>
<td>73%</td>
<td>86%</td>
<td>75%</td>
<td>83%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>4. Medication reconciliation</td>
<td>Inpatients who have had their medication cross-checked by more than one source within 72 hours of admission (Q4)</td>
<td>90%</td>
<td>92%</td>
<td>97%</td>
<td>100%</td>
<td>94%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>-</td>
<td>97%</td>
</tr>
<tr>
<td>5. Access in a crisis</td>
<td>Community service users reported that they have a phone number to call in a crisis (Q4)</td>
<td>65%</td>
<td>77%</td>
<td>75%</td>
<td>77%</td>
<td>78%</td>
<td>77%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>57%</td>
</tr>
</tbody>
</table>
## Clinical effectiveness

<table>
<thead>
<tr>
<th>Measure</th>
<th>Trust-wide</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon</th>
<th>Kensington and Chelsea</th>
<th>Westminster</th>
<th>CAMHS</th>
<th>Learning disabilities</th>
<th>Eating disorders</th>
<th>Addictions</th>
<th>Offender care</th>
<th>Offender care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Readmission rates</td>
<td>What percentage of service users were re-admitted to hospital within 28 days of leaving? (YTD)</td>
<td>&gt;11% 8.5% 8.2% 1.7% 5% 5.3% n/a n/a n/a n/a n/a 5.3%</td>
<td></td>
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</tr>
<tr>
<td>2. 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% 99.5% 98.7% 100% 99.6% 99% n/a n/a n/a n/a n/a 99.4%</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3. 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>5/5 yes yes yes yes yes n/a n/a n/a n/a n/a 5/5</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4. 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% 100% 100% 100% 100% 100% n/a n/a n/a n/a n/a 100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Physical health checks</td>
<td>a. Inpatient service users with physical health assessment after admission (Nursing) (Q4)</td>
<td>95% 100% 95% 96% 95% 100% 100% 100% 100% - 95%</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>b. Inpatient service users with physical health assessment after admission (Medical) (Q4)</td>
<td>95% 93% 90% 70% 97% 88% 100% 100% 100% - 89%</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

## Service user and carer experience

<table>
<thead>
<tr>
<th>Measure</th>
<th>Trust-wide</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon</th>
<th>Kensington and Chelsea</th>
<th>Westminster</th>
<th>CAMHS</th>
<th>Learning disabilities</th>
<th>Eating disorders</th>
<th>Addictions</th>
<th>Offender care</th>
<th>Offender care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Delayed Transfers of Care</td>
<td>On average, what percentage of hospital beds are being used by service users who should have been discharged? (YTD)</td>
<td>&lt;7.5% 7.1% 6.2% 13.5% 4.7% 7.4% n/a 26.2% n/a n/a n/a 6.3%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CPA 12 month review</td>
<td>What percentage of our service users who are on CPA received a full CPA review within the last 12 months where appropriate? (YTD)</td>
<td>95% 96.8% 95.6% 97.1% 97.9% 96% 97.3% 100% 74.4% n/a n/a 95.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Care plans</td>
<td>What percentage of our service users have been offered a copy of their care plan? (Inpatients and community) (Q4)</td>
<td>95% 85% 61% 68% 53% 74% 100% 86% 80% 100% n/a 72%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community service users report that they had been given/offered a copy of their care plan (Q4)</td>
<td>80% 72% 38% 58% 54% 58% - - - 44% n/a 56%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Carer Identification and Assessments</td>
<td>Percentage of service users who have their carer status identified (Q4)</td>
<td>55% 76% 86% 87% 48% 64% n/a 92% 80% 90% - 75%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of carers recorded as having been offered a carer assessment (Q4)</td>
<td>40% 73% 100% 70% 100% 65% n/a - - - 75%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Other indicators of quality

Staff satisfaction

We believe that in order to deliver high quality, safe and effective services, we need a high quality workforce which is committed, engaged, trained and supported. The evidence shows that high staff engagement ratings in the NHS result in better quality services, higher patient satisfaction and less absenteeism. This is supported by the White Paper ‘Equity and Excellence’ which stated that “staff who are empowered, engaged, and well supported provide better patient care”.

One of our key measures of workforce feedback is via the annual national staff survey. We are pleased to report that in the 2012 survey overall staff engagement at CNWL was within the highest (best) 20% when compared with Trusts of a similar type.

The table below demonstrates further top scoring staff responses, benchmarked against national averages of similar Trusts:

<table>
<thead>
<tr>
<th>Measure</th>
<th>CNWL performance 2012</th>
<th>National average for similar Trusts</th>
<th>Top performing Trust score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff recommendation of the Trust as a place to work or receive treatment*</td>
<td>3.75 / 5</td>
<td>3.54 / 5</td>
<td>4.06 / 5</td>
</tr>
<tr>
<td>Staff motivation at work</td>
<td>3.88 / 5</td>
<td>3.84 / 5</td>
<td>4.03 / 5</td>
</tr>
<tr>
<td>Staff feeling satisfied with the quality of work and patient care that they were able to deliver</td>
<td>81%</td>
<td>78%</td>
<td>86%</td>
</tr>
<tr>
<td>Staff ability to contribute towards improvement at work</td>
<td>72%</td>
<td>71%</td>
<td>79%</td>
</tr>
</tbody>
</table>

* With regards to staff recommending the place to work or receive treatment, CNWL considers that this percentage is as described for the following reasons:

- There is emphasis on good management and leadership at every level of the organisation: this begins at induction for new staff where they are welcomed by the Chief Executive and our expectations and values are made clear. This is followed through with leadership, mentoring and coaching programmes for all staff and annual conferences for key professional groups. The focus is on how we continue to keep patients and their families at the centre of all we do.

CNWL has taken, and will continue to take, the following actions to improve this indicator score, and so the quality of its services:

- We have started ‘The Conversation’ on our values within the Trust: this means that we will continue to build our value base in partnership with our staff, and test these with our patients and public. We are continuing to build a culture of care that permeates every level of our organisation;
- We ensure our service users are involved in recruiting to key posts within the Trust, and are rolling out Band five Nursing Assessment Centres where we ‘test’ for compassion;
- As a diverse workforce serving the needs of a diverse population, we want to ensure all of our staff feel equally able to contribute to the work of our organisation. We launched the posts of Race awareness advisors and have trained thirteen staff so far. Whilst it is good to understand where staff needs are being met, it is important to consider where they are not, in order to implement targeted action plans to improve staff experiences of the workplace.

The following table demonstrates where CNWL has performed below the national average (for similar trusts) and where improvements need to be made:

This information became available in February 2013, and at the time of printing the data was being further broken down by service and analysed to identify areas in need of improvement. Based on this analysis action plans will be developed, implemented and monitored by the relevant internal committees.

We also collect and report on further data internally on an ongoing basis and, as with last year’s Quality Account, we have included two indicators which we believe provide a valuable indication of staff well-being and engagement.

In future, these measures will be reported as combined figures as the Trust further completes its integrations with community services HCH and CPS.

<table>
<thead>
<tr>
<th>Measure</th>
<th>CNWL performance 2012</th>
<th>CNWL performance 2011</th>
<th>National average for similar Trusts</th>
<th>Top performing Trust score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff receiving job relevant training, learning or development in the last 12 months</td>
<td>78%</td>
<td>82%</td>
<td>82%</td>
<td>87%</td>
</tr>
<tr>
<td>Staff receiving health and safety training in the last 12 months</td>
<td>63%</td>
<td>74%</td>
<td>73%</td>
<td>90%</td>
</tr>
<tr>
<td>Staff reporting that hand washing materials are always available</td>
<td>51%</td>
<td>47%</td>
<td>55%</td>
<td>64%</td>
</tr>
<tr>
<td>Staff feeling pressure in the last three months to attend work when feeling unwell</td>
<td>27%</td>
<td>18%</td>
<td>22%</td>
<td>9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>2012/13</th>
<th>2011/12</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff turnover (including CNWL, HCH and CPS)</td>
<td>Year on year improvement</td>
<td>14.6%</td>
<td>14.5%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Average sickness per employee (including CNWL, HCH and CPS)</td>
<td>Year on year improvement</td>
<td>3.6%</td>
<td>See breakdown below</td>
<td>See breakdown below</td>
</tr>
<tr>
<td>Average sickness per employee (including CNWL and HCH)</td>
<td>Year on year improvement</td>
<td>See combined figure above</td>
<td>3.8%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Average sickness per employee (including CPIs only)</td>
<td>Year on year improvement</td>
<td>See combined figure above</td>
<td>2.7%</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

* CNWL only
CNWL considers that these indicators are as described for the following reasons:

The results for CNWL improved between 2011 and 2012, primarily because of the attention that was given to ensuring that the care programme approach is conducted with a patient-centred focus. Training on CPA was conducted across all staff groups with service user and carer input, promoting more positive experiences for patients of involvement, and addressing care plans to the patients’ identified needs. Linked with this is the development of the Recovery College which has encouraged a dialogue between service users and staff about experiences of mental health care, and the importance of personalised care and support packages.

CNWL is taking the following actions to improve these percentages, and the quality of services, by:

- Conducting regular Trust-wide surveys using a team of trained service users to address issues of involvement and the overall level of satisfaction with services
- Conducting bespoke surveys within services using real-time feedback methodology to finely tune intelligence about user experiences
- Continuing to ensure that CPA is conducted to the highest standards through refresher training
- Establishing service user participation at management level within service lines to scrutinize and monitor the results of service user and carer feedback, with feedback to the Trust Board
- Further developing the Recovery College
- Reinforcing service user involvement as a clear priority for the Trust with an overarching strategy and local implementation targets.

Whilst participation in a national patient survey is not mandatory for community healthcare services, our Hillingdon service conducts an annual patient survey which highlights very positive results. Finally, our quality priorities 2013/14 of ‘care planning’, ‘carer involvement’ and ‘service satisfaction’ strongly reflect CNWL’s continued commitment to understanding and acting upon what we hear from our service users and carers.

### Patient experience

We value our patients’ feedback so we can better understand how we are performing against their expectations, and can focus improvement efforts. Apart from our quarterly and annual internal surveys, we also benchmark ourselves against the results from national surveys.

The table below presents the results for patient experience measures for CNWL and associated national benchmarks (national averages) from the National Community Mental Health Patient Survey for 2011 and 2012. The data relates to the NHS healthcare worker or social care worker the patients had seen most recently:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2012* CNWL</th>
<th>2011* CNWL</th>
<th>2012^ national average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did this person listen carefully to you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes definitely</td>
<td>81%</td>
<td>76%</td>
<td>79%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>16%</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>No</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Did this person take your views into account?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes definitely</td>
<td>73%</td>
<td>72%</td>
<td>73%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>23%</td>
<td>23%</td>
<td>22%</td>
</tr>
<tr>
<td>No</td>
<td>3%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Did you have trust and confidence in this person?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes definitely</td>
<td>70%</td>
<td>70%</td>
<td>72%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>25%</td>
<td>26%</td>
<td>21%</td>
</tr>
<tr>
<td>No</td>
<td>4%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Did this person treat you with respect and dignity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes definitely</td>
<td>88%</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>10%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>No</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Were you given enough time to discuss your care and treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes definitely</td>
<td>76%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>20%</td>
<td>22%</td>
<td>20%</td>
</tr>
<tr>
<td>No</td>
<td>3%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Overall how would you rate the care you have received from mental health services in the last 12 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>30%</td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>Very Good</td>
<td>29%</td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>Good</td>
<td>21%</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td>Fair</td>
<td>12%</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>Poor</td>
<td>5%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Very Poor</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
</tr>
</tbody>
</table>

*CNWL results supplied for 2011 and 2012 surveys by Quality Health Ltd
^ National averages as supplied by the CQC’s National Community Service User Surveys
2. Improve the recording rates for new service users for religion or belief, sexual orientation and disability.¹

<table>
<thead>
<tr>
<th></th>
<th>Recording rate for new service users</th>
<th>Recording rate for new service users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>January to March 2012</td>
<td>October to December 2012</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>73.2%</td>
<td>75.4%</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>51.6%</td>
<td>58.6%</td>
</tr>
<tr>
<td>(includes ‘do not wish to disclose’)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>5.7%</td>
<td>6.45%</td>
</tr>
</tbody>
</table>

We are encouraged to see progress in all of the above areas, however, we note the continued low recording rate of service user disability. We believe this is in part due to the current recording format, which does not allow for the entry into the Trust’s electronic service user records of multiple disabilities. We have been advised that this will be updated during the Spring of 2013, and we anticipate improved recording during the year.

¹The data here does not include community health and prison services. Data collection is being targeted in these areas as historically much of this data has not been routinely collected. Progress will be reported on in the Trust’s Equalities Monitoring Report (Service Delivery) 2012/13 to be published later in the year.

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 indicated that CNWL staff are reporting unacceptable levels of violence, bullying and harassment, and discrimination, from patients/service users, their relatives or other members of the public towards staff, particularly, though not exclusively related to ethnicity. The Trust is alarmed that staff experience of violence, harassment, bullying and abuse has increased according to the 2012 staff survey. There has been a slight drop in discrimination.

Whilst there were some changes in the way the questions were asked between the two surveys, this cannot be taken as a cause of the increases.

As promised in last year’s report, the Trust has undertaken a survey of staff specifically addressing these experiences and the results are currently being analysed.

Equities and diversity
In January 2013 the Trust published its second Equality Act Compliance Report. This report included references to progress against the areas identified for actions in the previous year’s report, as well as further evidence from the 12 month reporting period of how the Trust is meeting the requirements of the Equality Act 2010.

In addition, the Trust published five four-year equality objectives in April 2012, three of which were highlighted within last year’s Quality Account: a commitment to community engagement events with service users, carers and local communities, improving recording rates of disability, religion or belief and sexual orientation for service users, and reducing 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.

We report on our progress below:

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.

Given that this year saw much organisational change with the implementation of a service line structure, undertaking community engagement events was a particular challenge. However, a number of events and initiatives took place and we highlight some of these below:

- A programme of carer events including: carers focus group involving: Family members from various BME communities including, East Asian, Chinese, Kenyan Asian, Ghanaian Asian, Jamaican, Irish, British Asian; young carers events in Harrow and Brent involving carers from a range of communities; engagement events throughout the year for carers of people who have a learning disability
- Arabic speaking women’s group includes Moroccan, Lebanese, Egyptian, Iraqi and Somali women in Westminster to raise awareness of mental health services for children and adults
- Mental health first aid training, targeting members of BME communities in Westminster (Bangladeshi, Arabic and South American communities)
- Extensive programme of community engagement by sexual health services including: Outreach to members of African communities to raise awareness of HIV and access to health care; young people’s sessions at The Archway Clinic and Mortimer Market – services have been awarded the “You’re Welcome” accreditation by young ambassadors from the local council which recognises how the service has tailored itself toward the needs of young people
- Engagement events at London University campuses to meet with foreign students to raise awareness of mental health problems and services. This initiative was undertaken as part of the Trust’s recognition of World Mental Health Day
- Following on from a Tamil Well-being Conference held in partnership with West London Mental Health Trust, engagement is taking place with representatives from the Tamil community to discuss how CNWL can facilitate access to services and develop information resources for the community
- Participation in borough-wide events in Kensington and Chelsea, bringing together service users and service providers from a range of communities, providing opportunities for information sharing, signposting to services and encouragement to services users in recovery
- A new LGBT Forum is being developed in partnership with the local authority, and the voluntary sector in Harrow following on from a half-day workshop ‘Getting to know you’, which involved stakeholders from the LGBT community; a similar event has also been held in Camden helping to foster stronger links with LGBT support services and networks.

We report on our progress below:

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

|                        | Recording rate for new service users |
|                        | January to March 2012               |
| Religion or belief     | 73.2%                               |
| Sexual orientation     | 51.6%                               |
| (includes ‘do not wish to disclose’) |                                  |
| Disability             | 5.7%                                |

I think that everything is as good as it could be, I feel as though I’m on holiday and at the day centre they are all lovely people and the staff there are too, they’re my friends.

Mental health service user
CNWL thanks those organisations who have submitted responses to our Quality Account 2012/13. We were pleased to be able to present and discuss performance with the commissioners, however, to remain compliant with Quality Account guidance and regulation, some changes could unfortunately not be made.

North West London Commissioning Support Unit

The points below reflect ongoing dialogue with CNWL. Commissioners actively support CNWL’s commitment to improving quality, and appreciate CNWL’s efforts working in partnership with CCGs to improve and sustain service quality and patient experience. CNWL is to be congratulated upon its clear and open approach in its Quality Account 2012/13 and its proposals to continue to improve. The document as laid out does well in reflecting upon quality across a number of complex pieces of work and disparate service lines, and distils a number of themes into clear key findings. This is very positive.

We’d recommend greater emphasis on the following in the final document with respect to 2012/13 performance:

- More focus and attention on the jointly agreed strategic approach with CCG clinical leads to improve the shift of settings of care to be as close as possible to the patient’s home, with more care transferring to primary care setting
- Narrative on ways in which partners are working together to make sure that quality is firmly incorporated into all integration initiatives
- Greater emphasis on outcomes and impact arising from good process. Commissioners request that CNWL uses its quality accounts to share more findings on the outcomes of some quality initiatives such as CQIUNs, and how those developmental outcomes will be sustained over time. For example, CNWL reports on having held focus groups with carers. Commissioners would like more specific detail on what happened after the themes were identified at focus groups, and what has changed as a result

- Greater attention to detail on how variance is being tackled. For instance table 2.1.2 at p.100 helpfully sets out borough mental health service performance against priority targets. Commissioners would welcome more content and narrative on what is being done to address factors to redress the situation in boroughs which are not meeting CNWL targets. For CCG commissioners responsible for CCG populations, this is essential. As you would expect, commissioners have concerns where there are shortfalls for their CCG catchment areas, and would welcome assurance on how variance is identified and addressed.

Commissioners request reports on quarterly achievement, rather than quarterly four achievements, with commentary indicating performance has improved over the year. To demonstrate how and where performance has improved commissioners would welcome this, for example, graphs with quarterly performance over each quarter in 2012/13 would be helpful. Alongside content on quarterly performance, commissioners would like to know the numbers of reviews carried out each quarter. This would give a sense of relative impact and proportionality.

It would also be very useful to have commentary on how benchmarking across CNWL’s catchment area – or even more widely, perhaps across London – is being used to drive forward quality improvement.

Commissioners welcome CNWL’s efforts to show how action will be taken forward in 2013/14, so long as the overall focus remains on 2012/13 as the year under scrutiny. Commissioners recommend CNWL revisits the document and reviews commentary to ensure that focus on future plans does not eclipse actual achievement in 2012/13. For 2013/14 CCG commissioners look forward to working in partnership with CNWL to continue to make progress on this important agenda.

Submitted by: Fiona Butler, mental health lead commissioner for NHS West London CCG/Chair North West London Mental Health Programme Board, and Elizabeth Youard, Account Director for Mental Health North West London CSU

Annex 1: Statements provided by our commissioners, Overview and Scrutiny Committees (OSC) or Healthwatch

Camden Clinical Commissioning Group

Although the CNWL Quality Account has detail of various services it delivers, there is no Quality Account in relation to the Camden Provider Services, for the community nursing element of this service (sexual health services and community care are the only elements covered in this Quality Account). Patients and users in Camden who look at services provided by you via http://www.camdenproviderservices.nhs.uk/our-services would find a gap in your existing report, and we have concerns about this omission. This is in contrast to the detail you have put for the Hillingdon Community Services provision.

Your involvement in our integrated care services has not been mentioned, nor is there any information provided on your performance related to it. It is good to acknowledge the achievement of Camden Stroke REDs service’s award in June 2012. There have been a number of challenges in the past 12 months in relation to blockages at the rehabilitation unit that has impacted on the local health system, and there is no mention of this.

We recognise your achievements in your GUM/HIV services. The report mentions an 11% increase in activity levels and it would be useful to know and understand the reason for this increase.

In terms of your focus for the coming year, it needs to be linked to targeted improvements/failures in the previous year, so the link to improving avoidable pressure ulcers, discharge etc. should be in this account explaining why. There have been considerable challenges with your community provision for Camden, and this report fails to mention these challenges, or some of the recent improvements.

Westminster, Kensington and Chelsea OSC

Introduction

We welcome the opportunity to comment on the Central and North West London NHS Foundation Trust’s Quality Account 2012/13. Our respective Councils have a good working relationship with CNWL.

Performance

We recognise the improvements that have taken place in many areas however issues in some areas still need to be addressed.

We are disappointed to note some of the performance against the quality priorities 2012/13:

- The Trust scored only 57% (Kensington and Chelsea 64% and Westminster 55%) for “At least 65% of community patients report that they were ‘definitely’ involved as much as they wanted to be in decisions about their care plan.
- The Trust scored only 57% in Westminster for “At least 65% of patients reporting that they ‘definitely’ received the help they wanted from CNWL crisis contact points when they contacted them in a crisis.”
- The percentage of inpatient service users who have had a risk assessment completed and linked to their care plans has fallen from 96% (2011/12) to 92% (2012/13)
- The measure ‘inpatient service users with physical health assessment after admission (Medical)’ scored 89% (target 95%).
- On care plans: 71% (target 95%) of service users were offered a copy of their care plan. 56% (target 80%) of community service users reported that they had been given/56% (target 80%) of community service users reported that they had been given/offered a copy of their care plan. We support the trust in their decision to make this a quality priority for 2012/13.
- Only 75% (target 80%) of calls to the key contact points are picked up within one minute (a drop from 94% in 2011/12). We are pleased action plans are being developed.

2Taken from “Quality Priority 2012/13 - A borough breakdown: Mental Health and allied specialties” page 83
3Taken from “Quality Priority 2012/13 - A borough breakdown: Mental Health and allied specialties” page 83
We are disappointed to note on the performance against the national priorities and historical quality priorities in 2012/13:

- In Westminster, 88% (target 95%) of inpatient service users have had a risk assessment completed and linked to their care plans.
- In Westminster, (a) 90% (target 95%) inpatient service users with physical health assessment after admission (Nursing); (b) 88% (target 95%) inpatient service users with physical health assessment after admission (Medical).
- On care plans: The target for the percentage of service users that have been offered a copy of their care plan (inpatients and community) was 95%. The score in Kensington and Chelsea was 53%, in Westminster 74%. The target for community service users that report that they had been given/offered a copy of their care plan was 80%. The score in Kensington and Chelsea was 54%, in Westminster 58%.
- Percentage of service users who have their carer status identified in Kensington and Chelsea was 48% (target 55%).

We are pleased to note:

- The Trust is a high performing organisation.
- CNWL met 14 of the 17 quality priority measures for 2012/13 (seven of the eight “mental health and allied specialties” quality priorities).
- The long list of actions the Trust has carried out to improve overall quality: safety, clinical effectiveness and patient experience in 2012/13.

- The launch of the recovery college.
- CNWL score 3.7% compared to Central London Community Healthcare NHS Trust at 3.66 and West London Mental Health Trust at 3.46 for “staff recommendation of the trust as a place to work or receive treatment” (Key finding 24 from NHS staff survey 2012).
- The Trust’s Board was singled out as amongst the best in England by the NHS Confederation. We believe this worth a mention in your report.

**Longer-term plans**

The financial outlook for NHS provider trusts in London is considered to be a matter of concern. The cash pressure could lead to cuts to patient care. It is a concern that the impact of competition on the Trust’s finances is uncertain. We hope that any concentration on promoting the most profitable services does not have any negative impact on the NHS clinical services provided.

We note CNWL is looking to expand its private mental health services and has been selected as the preferred acquirer for Milton Keynes Community Health Services.

We are concerned that these developments might be a distraction from the Trust’s core work and would like reassurance that this is not likely to be case.

**Public health**

Public health is now a statutory local authority function but all partners need to take on their responsibility. We encourage the Trust to be fully involved in major public health campaigns and local health promoting strategies.

**Quality Account**

We would like to acknowledge CNWL’s commitment to improve their Quality Account through a continuous learning process. This is evident by the way in which CNWL have responded to the recommendations made by Hillingdon LInK in last year’s Quality Account.

We welcome the actions they have taken, especially their adoption of a methodological approach of data collection and their use of qualitative methods for obtaining feedback, such as focus groups.

This learning approach is further evidenced by the improvement made in the presentation of this year’s quality account; the reporting format being much better, with clear explanations under each measure of how it was delivered and how the data was collected.

We would however ask, that the information presented under “Reducing the number of avoidable pressure ulcers” (page 85) is made clearer, as it makes an assumption that the readers understand the clinical grades/types of pressure ulcers. It will be useful to have some basic information about this for the clinical information to be understood by the lay person.

As we have previously stated, we commend CNWL on their commitment to make their Quality Account more accessible to the public, by making the document easier to read and by continuing to produce an easy read version. We still however feel that an 80 page document in this format will have a limited audience and to be truly titled “an annual report produced for the public”, more efforts are needed by all Trusts to make Quality Accounts more concise and understandable. It could be argued that pages 103 to 127 are actually not required for the purpose of the Quality Account, and would ask the Trust to reflect on this.

**Quality priorities**

Healthwatch Hillingdon congratulates CNWL on achieving 88% of their quality priorities set for 2012/2013 and on improving the 2011/2012 scores across all measures.

LInK had always expressed a concern that the target for Measure B (page 79) was set too low at only 50%, as they saw it as crucial to the individual’s recovery that they have at least one recovery goal. We are therefore pleased to see the improvements CNWL have made, where 83% of users on CPA have a care plan which contains at least one personal recovery goal. We look forward to this figure increasing, especially with the emphasis now being put on the recovery model and the inception of the Recovery College.

Healthwatch Hillingdon welcomes the steps taken by CNWL to understand the needs of carers of mental health service users and the plans to implement some of the outcomes from the focus groups e.g. carer contact cards. It commends the work carried out within community health to improve staff awareness of carers, and that the development of guidelines and staff protocols has been completed.

We look forward to this work continuing as a
Trust-wide priority in 2013, and would recommend that carer’s stories are captured for recording in next year’s Quality Account, as a measure of the success of the implementation of these initiatives.

In last year’s response, UNiK highlighted that it would like to see some enhancements to the way in which borough specific quality targets were reported, and where quality did not meet the required standard, how this would be addressed in the specific borough. Healthwatch Hillingdon would suggest that there is still some work to be done by the Trust in this area. When looking at the borough breakdown on page 119, there is a large disparity between Hillingdon which failed to meet the set target for priorities four and eight, and Brent who excelled. The reporting of cumulative trust wide results does not give a true reflection of the quality in each area, and we would recommend that CNWL looks at how it will approach Quality Accounts reporting in the future.

We would like to see good practice in these measures, like that of Brent, emphasised, as much as seeing the plans to bring Hillingdon up to Brent’s standard published in the account. As it expands its operations into other parts of the country, CNWL may also need to consider producing two accounts, one for community health and one for mental health.

Hillingdon Community Health should be congratulated for exceeding all the targets set for their 2012/13 priorities. Especially the work around carers, end of life and mental health. We note the various measures being introduced to support carers and will monitor this area going forward.

**CNWL priorities 2013/14**

Healthwatch Hillingdon supports CNWL in simplifying its choice of priorities, for setting Trust wide initiatives and would commend CNWL for not including measures which are QUns. This does not however detract from the fact that as indicated in our response, we would like to see a concise document which outlines how the Trust has performed against it priorities across each area, acknowledging best practice and highlighting poor performance, with improvement measures.

We have acknowledged the relationship CNWL have had with UNiK, which has seen a joint commitment to monitor and improve services. Healthwatch Hillingdon looks forward to continuing this relationship and working with CNWL.

**Healthwatch Central West London**

Healthwatch Central West London (Healthwatch CWL) welcomes the opportunity to comment on the Central and North West London NHS Foundation Trust (CNWL) Quality Accounts (QAs) 2012/13. Under the provisions of the Health and Social Care Act, Healthwatch CWL replaced the Local Involvement Network on April 1 2013. The work of the UNiK has therefore informed the majority of this submission.

The Kensington and Chelsea UNiK was pleased to have had the opportunity to engage with the Foundation Trust on a number of issues over the last year including:

- Quarterly QA meetings and the stakeholder event on 7 March
- Local mental health partnership meetings, chaired by our mental health lead with our CNWL Borough Director, local CNWL service line managers, voluntary sector staff, service user representatives and carers
- The Foundation Trust has regularly attended our sub-group meetings updating local users and workers on services and service changes.

Healthwatch CWL has noticed major changes dictated by the ‘Shifting Settings of Care’ strategy. Whilst we are very much supportive of the vision, the strategy has led to the fragmentation of services in to separate ‘service lines’ with their own financial budgets, and the introduction of ‘Payment by Results’ (PbR) linked to 20 needs based clusters. It is not yet apparent how separate service lines are an advantage for users in our borough. Local anecdotal evidence suggests that people have yet to be told which cluster they have been assigned to.

It would have been helpful to include a broad overview of all of these significant cultural changes including joint working with other agencies and the voluntary sector, before focusing on priorities for improvement in the QAs.

In general terms the format, language and graphs in the QAs seem to be geared for an audience of health professionals, rather than explaining services, performance and priorities in accessible language, for its intended public audience.

The recent ‘Building Better Mental Health Care’ consultation in Kensington and Chelsea and in Westminster, resulted in a significant reduction in inpatient acute and psychiatric intensive care beds (PICU) and reduced finance to our boroughs rehabilitation service line, including the loss of further beds.

Our boroughs are braced for further significant financial shrinkage in the Kensington and Chelsea CNWL community mental health service lines in 2013/14. We will continue to be in close contact with our commissioners in the Royal Borough, Westminster, NHS West and Central London Clinical Commissioning Groups, as well as the Trust, to ensure services are building better healthcare. Priority areas for our members include physical health, effective discharge, care plans, access to primary care, support in a crisis and support for carers11.

**Physical health:**

This measure details the monitoring of prescribed anti-psychotic medication ‘three monthly reviews’ for dementia patients. Healthwatch CWL recommends similar monitoring across the age range, including early intervention, to monitor the effectiveness of anti-psychotics, adverse effects of anti-psychotics, risk benefit ratios, informed choice and collaborative decisions.

**Discharge:**

Effective discharge processes and protocols to support service users who have been discharged back to primary care appear to be patchy. As the bed rate in the London Borough of Hillingdon was used as a benchmark for the reduction in acute beds under “Building Better Mental Health Care,” we are concerned that the Kensington and Chelsea and Westminster hospital re-admission rate is three times that of the outer borough.

Annex 2: Quality Account glossary of terms

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CAMHS</td>
<td>child and adolescent mental health service</td>
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<tr>
<td>CPA</td>
<td>Care programme approach</td>
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<tr>
<td>CPS</td>
<td>Camden Provider Services</td>
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<tr>
<td>CQMG</td>
<td>Care Quality Management Group</td>
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<tr>
<td>CRHT</td>
<td>Crisis resolution home treatment</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<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>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
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<tr>
<td>HCH</td>
<td>Hillingdon Community Health</td>
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<tr>
<td>HoNOS</td>
<td>Health of the Nation Outcomes Scales</td>
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<tr>
<td>LINks</td>
<td>Local Involvement Networks</td>
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<tr>
<td>LPC</td>
<td>Lead professional care</td>
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<tr>
<td>MKCHS</td>
<td>Milton Keynes Community Health Services</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NHSLA</td>
<td>NHS Litigation Authority</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<tr>
<td>OSC</td>
<td>Overview and Scrutiny Committee</td>
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<tr>
<td>PALS</td>
<td>Patient advice and liaison service</td>
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<tr>
<td>PCT</td>
<td>Primary care trust</td>
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<tr>
<td>POAMH</td>
<td>Prescribing Observatory for Mental Health</td>
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<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
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</table>

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.

Cluster of differentiation 4 (CD4)
Known as CD4’s, these are the ‘helper’ white blood cells that are an essential part of the human immune system. Their main role is to send signals to other types of immune cells, e.g. CD8 killer cells, to destroy infections. When the number of CD4s or ‘CD4 count’ is low, due to untreated HIV infection or immune suppressant prior to organ transplant, the body is vulnerable to a wide range of infections.

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, they 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.
There is also clinical judgement in the classification of an incident as “severe harm” as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change, so the figure reported could change from that shown here due to this review process.

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

By order of the Board

Claire Murdoch
Chief Executive
28 May 2013

Dame Ruth Runciman
Chairman
28 May 2013

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Annex 3: 2012/13 Statement of director’s responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (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 Account, directors are required to take steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 to 24 May 2013;
  - Papers relating to quality reported to the Board over the period April 2012 to 24 May 2013;
  - Feedback from the commissioners dated 6 May 2013 (closing date of the Quality Account 30-day consultation);
  - Feedback from governors dated 6 May 2013 (closing date of the Quality Account 30-day consultation);
  - Feedback from local Healthwatch organisations dated 6 May 2013 (closing date of the Quality Account 30-day consultation);
  - The Trust’s Annual Complaints Report (2012/13) published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
  - The national patient survey dated 2012;
  - The national staff survey dated 2012;
  - The Head of Internal Audit’s annual opinion over the Trust’s control environment dated 28 May 2013;
  - Care Quality Commission quality and risk profiles dated to March 2013;
  - The Quality Account presents a balanced picture of the NHS foundation Trust’s performance over the period covered;
  - The performance information reported in the Quality Account is reliable and accurate;
  - There are proper internal controls over the collection, and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account 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 Account (available at www.monitor-nhsft.gov.uk/sites/all/modules/ckeditor/plugins/ktbrowser/_openTKFile.php?id=3275).

We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other Trusts.

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There is also clinical judgement in the classification of an incident as “severe harm” as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change, so the figure reported could change from that shown here due to this review process.

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

By order of the Board

Claire Murdoch
Chief Executive
28 May 2013

Dame Ruth Runciman
Chairman
28 May 2013
“Excellent service and I was given confidence to move again after a fracture in my spine.”

Community physical health patient

Above: A CNWL staff member from the Paediatric Physiotherapy and Occupational Therapy Team in Hillingdon.
Annual Accounts
Statement of Accounting Officer’s Responsibilities

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor’s NHS Foundation Trust Accounting Officer Memorandum.

Signed:

Claire Murdoch
Chief Executive
29 May 2013
Statement of directors’ responsibilities in respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. Monitor, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period. In preparing those accounts, the directors are required to:

- Apply on a consistent basis accounting policies laid down by Monitor with the approval of the Treasury
- Make judgments and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

By order of the Board of Directors

Claire Murdoch                              Trevor Shipman
Chief Executive                            Director of Finance
29 May 2013                                 29 May 2013

Annual Governance Statement 2013

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust’s policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Central and North West London NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Central and North West London NHS Foundation Trust for the year ended 31 March 2013 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

As Chief Executive I have overall responsibility for risk management within the Trust, for meeting all statutory requirements and adhering to the guidance issued by the Department of Health in respect of governance. The Executive Board, which I chair, has the remit to ensure the adequacy of the structures, processes and responsibilities for identifying and managing key risks facing the organisation, prior to discussion at the Board.

Recognising the need to develop risk awareness throughout the organisation, a range of training courses have been developed incorporating aspects of risk management and large numbers of staff have been trained in the identification and management of clinical risk. The development of local risk registers has also served to promote awareness and understanding of the identification of risks and their management across the organisation.

The risk and control framework

The Risk Management Policy sets out the organisation’s attitude to risk, defines the structures for the management and ownership of risk and for the management of situations in which control failure leads to material realisation of risks and explains risk management processes.

Key to the effectiveness of risk management in the organisation is the Executive Board, comprising all the executive directors. This membership recognises the importance and high profile of risk management in the organisation and facilitates ownership at that level of the identification and management of risks on a continuing basis. This is important in ensuring that the Trust takes an integrated approach to governance and risk management issues.

Risks that are identified as constituting a significant risk are monitored by the Executive Board and progress in addressing them reported to the Board of Directors every six months. Lower graded risks are managed by the local service/directorate.
Work has taken place across the Trust to identify local risks and this has resulted in the further development of the Trust wide risk register. The risk register contains details of risks including those relating to clinical, financial, health and safety and organisational risks. Each meeting of the Executive Board and Board of Directors receives a report on the top risks facing the Trust.

Top risks are identified by executive directors. They have been graded, in accordance with the process set out in the Risk Management Policy, and an action plan developed to address them.

Awareness of the top risks facing the organisation enables the Board to review the operation of the Trust and potential business opportunities in a way that helps them determine the level of risk appetite they have at any time.

During 2012/13, the top risks facing the Trust included a range of business and financial risks, all of which were considered monthly by the Executive Board, Business and Finance Committee and at the Board’s bi-monthly meetings. These were longer term risks in their nature and were managed by a range of actions including improved monitoring of financial performance, ongoing communication and negotiations with local Primary Care Trusts (PCTs), and the setting of challenging savings targets within the Trust.

Where necessary contingency reserves were established, along with a range of alternative and extensive savings plans. The changes to the structures within the NHS have exacerbated the commissioning challenge and this has remained a high risk for the Trust. The Trust has committed significant senior management time to working with the evolving commissioning partners. The Trust is engaged in a significant investment in our Information and Communication Technology (ICT) infrastructure and the need to enhance both our infrastructure and our informatics capacity has been a feature of both local and the top risk registers. The Trust has established an Informatics Committee of the Board to have direct oversight of this programme. We also placed statutory and mandatory training on our top risk register and have made it a top priority to ensure that all our staff have regular training on key policies and procedures.

Other risks included recruiting qualified nurses with adequate basic skills and a compassionate caring attitude. The Trust has established its own assessment centres which test all of these elements. All services are looking at varying the skill mixes in their teams to best provide optimum service delivery.

Bed management has been a recognised risk during the year. The Trust has reduced its number of acute beds as it moves treatment to community settings. There is also an increased pressure through delayed transfers of care to social services community settings. Whilst managing its beds has been a continued challenge, the Trust has managed to significantly reduce its use of extra contractual referrals (ECRs).

The Trust faces an ever-present risk of the potential loss of services and/or funding reductions. Whilst some services have been reduced over the time period the Trust as a whole has continued to grow. The Trust has managed disruption to staff through service changes and there have been very few redundancies.

Many of the risks in the service line risk registers also appear on the top risk register, reflecting that these issues local services are facing are being recognised and captured corporately, and concurrently that local services are recognising the main difficulties being discussed corporately. All services review their risks regularly in their management meetings which are jointly led by a service director and a clinical director. Services have quarterly reviews of their performance and assessment of their ongoing risks is an integral part of these reviews.

Each year the Board of Directors reviews its key objectives in the coming years in the context of its appetite for risk and these will be included in the next Annual Plan. The Trust has an assurance framework, which provides it with a simple but comprehensive method for the effective and focused management of the principal risks to meeting its objectives. This simplifies Board reporting and the prioritisation of action plans, which in turn allow for more effective performance management.

The Trust has the following strategic priorities:

- Provide integrated, high quality, timely services based on the need of the individual.
- Engage meaningfully with service users, carers and the local community to improve and align our services to meet needs, and to ensure effective local accountability to the population we serve.
- Improve and maintain high standards of the physical environments in which we provide services.
- Recruit, retain and develop a skilled and motivated workforce that is proud to work for the Trust and that the Trust is proud to employ.
- Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.
- Improve Trust information systems to support Improvement in patient care and performance management.
- Seek and develop new business opportunities and partnerships consistent with our vision.

The assurance framework reflects the work streams involved in achieving the above objectives. Implementation of the Trust’s objectives is a dynamic process and that means that there will always be a number of gaps in control mechanisms and in the assurance process. As a result, such gaps are present across most of the objectives and services in the assurance framework (including corporate and operational services and risk management) and action plans exist to identify means of addressing them. Importantly, however, there are no significant gaps in controls and assurance, a position confirmed through independent assessment by internal auditors. The Executive Board and the Foundation Trust’s Board of Directors monitor progress against the action plans, which provides assurance on each of the strategic priorities.

During 2012/13, for each risk in the assurance framework a lead person was identified and responsible for the action necessary to address it and progress was reported to the Board of Directors at regular intervals.

Public stakeholders are involved in managing risks which impact on them through a range of different means. These include the involvement of service user foundation trust members in local clinical governance / quality management groups. The Trust had a User Experience Forum but has recognised that this body, being focused on mental health, is no longer suitable for a Trust where almost half of our activity is the delivery of physical health care in the community. Work is ongoing to establish a new provider user forum. The regular service user surveys produce a large amount of data that illustrate service user experiences, which contribute to the formation of actions to drive up quality and ultimately reduce risk. The Board of Directors receive a report on service user experience at each meeting held in public. A Carer’s Council, chaired by a carer governor, has also been established.

Service users and carers have been involved in monitoring key quality indicators as part of the Quality Account through involvement in local care quality groups. The Trust holds quarterly reviews of its performance and assessment of its ongoing risks is an integral part of these reviews.

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The Trust has an Information Governance Programme Board, chaired by the Director of Strategic Planning and Community Services, which is the principle body overseeing the management of information risks. This group has a reporting line into the Executive Board. It oversees the Trust’s information governance toolkit action plan. Exception reports and information management serious untoward incidents are reported to the Information Governance Programme Board.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The Trust Board has reviewed the findings of the Francis Report on Mid Staffordshire NHS Foundation Trust. The Board reaffirmed its commitment to maintain an open culture where there is clinical leadership and engagement. The Board recognised the critical role for staff, recruited through the Trust’s assessment centres for compassion, treating patients with dignity and respect. The Board also reviewed its processes for evaluating the quality impact of service redesign and budget reductions. The Council of Governors also discussed the report and focused not only on the governor’s role in challenging the Board, especially in relation to the quality of services, but on the opportunities available throughout the Trust to listen to patients and listen to staff. A full detailed action plan addressing the Francis recommendations is being prepared.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with. The Foundation Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation’s obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

In conjunction with our own specialist external consultants and the NHS Sustainable Development Unit we are currently developing a sustainable development management plan that will refresh our strategy to meet national carbon reduction targets.

The Trust agreed an annual audit programme and a range of ad-hoc, individual audits, carried out by the internal auditors. These audit reports are aimed at evaluating our effectiveness in operating in an efficient and effective manner and are focused on reviewing our operational arrangements for securing economy in respect of the services we provide.

**Review of economy, efficiency and effectiveness of the use of resources**

The Trust has a range of processes that ensure that resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff, the role of performance management and the development of key performance indicators, a committee dedicated to performance management issues and regular reporting on performance management to the Board of Directors.

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**Annual Quality Account**

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) 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 Account which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The following steps have been put in place to assure the Board that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data:

- The Board has a Quality and Performance Committee chaired by a non-executive director with Board director membership. The annual Quality Account was considered by the Quality and Performance Committee and included input from a wide range of internal and external stakeholders in order to ensure that it presented a balanced view.

- The Quality and Performance Committee continue to review their performance against the Monitor Quality Governance Framework.

- The Trust employs a range of staff that possess the skills, experience and ability to deliver the quality priorities.

- Quality priorities are identified both externally and within the Trust. They are reported to and monitored by the Quality and Performance Committee. The joint quality and performance report is published quarterly, considered by the Council of Governors and made public via the Trust website.

**Review of effectiveness**

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.
The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by internal and external audit reports, the core standards self-assessment declaration and a review of the risk management arrangements conducted on behalf of the NHS Litigation Authority. This is in addition to the work of executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

The assurance framework has been reviewed by the Trust’s internal auditors. They have confirmed that an assurance framework has been established which is designed and operating to meet the requirements of the 2012/13 Annual Governance Statement and provides substantial assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The Board of Directors meets every other month, with all of the meetings being open to the public. It has as a standing item on the agenda reports on the areas of financial management, risk management and performance management. It regularly receives the minutes of meetings or reports of its committees and an update on progress against its strategic objectives.

The committee structure continues to include an Audit Committee, which has specific responsibilities for overseeing matters relating to internal control and risk management respectively. Responsibility for risk management rests with the Executive Board. The Audit Committee regularly receives reports on internal control and risk management matters from the internal and external auditors.

None of the internal or external auditors’ reports considered by the Audit Committee during 2012/13 raised significant internal control issues.

The Trust was subject to a risk management assessment in June 2011 and achieved level one. The Trust has set itself a growth strategy and once new services are acquired policies and procedures need to be safely aligned. While the Trust continues to work to ensure that policies and procedures are embedded and practiced in accordance with levels two and three of the standard in each year where there is a major acquisition the requirement for single policies across the Trust is likely to result in level one compliance.

2012/13 was a year of continued growth and consolidation of good practice for the Trust. There were no significant internal control issues identified during 2012/13. It remains clear from this statement that we generally have effective systems of internal control and I am satisfied that the systems outlined in this statement reflect an organisation that continues to operate with effective and sound systems of internal control.

Signed:

Claire Murdoch
Chief Executive
29 May 2013
Independent auditor’s report to the Board of Governors of Central and North West London NHS Foundation Trust

We have audited the financial statements of Central and North West London NHS Foundation Trust for the year ended 31 March 2013 on pages 152 to 198. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2012/13.

This report is made solely to the Board of Governors of Central and North West London NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accounting Officer and the auditor

As described more fully in the Statement of Accounting Officer’s Responsibilities on page 141, the Accounting Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice’s Board’s Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust’s circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the Accounting Officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:
- Give a true and fair view of the state of Central and North West London NHS Foundation Trust’s affairs as at 31 March 2013 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors’ Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Central and North West London NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Neil Thomas
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square, London, E14 5GL
29 May 2013
Financial statements

Foreword to the accounts
Central and North West London NHS Foundation Trust
These accounts for the period 1 April 2012 to 31 March 2013 have been prepared by the Central and North West London NHS Foundation Trust, under the direction of Monitor, in accordance with paragraphs 24 and 25 of Schedule 7 to the 2006 National Health Service Act.

Claire Murdoch
Chief Executive
28 May 2013

Statement of comprehensive income for year ended 31 March 2013

<table>
<thead>
<tr>
<th>Note</th>
<th>2012/13</th>
<th>2011/12</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
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<tr>
<td>Operating income from continuing operations</td>
<td>2</td>
<td>376,240</td>
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<tr>
<td>Operating expenses of continuing operations</td>
<td>3</td>
<td>(367,537)</td>
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<tr>
<td>Operating surplus / (deficit)</td>
<td></td>
<td>8,703</td>
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<tr>
<td>Finance costs</td>
<td></td>
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<tr>
<td>Finance income</td>
<td>6</td>
<td>545</td>
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<tr>
<td>Finance expense - financial liabilities</td>
<td>7</td>
<td>(74)</td>
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<tr>
<td>Finance expense - unwinding of discount on provisions</td>
<td></td>
<td>(234)</td>
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<tr>
<td>PDC dividends payable</td>
<td></td>
<td>(4,596)</td>
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<tr>
<td>Net finance costs</td>
<td></td>
<td>(4,359)</td>
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<tr>
<td>Surplus/(deficit) from continuing operations</td>
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<td>4,344</td>
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<tr>
<td>Surplus/(deficit) for the year</td>
<td></td>
<td>4,344</td>
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<tr>
<td>Other comprehensive income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revaluations</td>
<td></td>
<td>21,582</td>
</tr>
<tr>
<td>Other recognised gains and losses</td>
<td></td>
<td>(10)</td>
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<tr>
<td>Other reserve movements</td>
<td></td>
<td>0</td>
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<tr>
<td>TOTAL comprehensive income / (expense) for the year</td>
<td></td>
<td>25,916</td>
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### Statement of financial position as at 31 March 2013

<table>
<thead>
<tr>
<th>Non-current assets</th>
<th>Note</th>
<th>31/03/13</th>
<th>31/03/12</th>
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<tbody>
<tr>
<td>Intangible assets</td>
<td>9</td>
<td>9,327</td>
<td>4,562</td>
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<tr>
<td>Property, plant and equipment</td>
<td>10</td>
<td>174,102</td>
<td>153,765</td>
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<tr>
<td>Trade and other receivables</td>
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<tr>
<td>Total non-current assets</td>
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<td>162,297</td>
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<table>
<thead>
<tr>
<th>Current assets</th>
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<tbody>
<tr>
<td>Inventories</td>
<td>13</td>
<td>172</td>
<td>158</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>14</td>
<td>27,437</td>
<td>23,019</td>
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<tr>
<td>Cash and cash equivalents</td>
<td>16</td>
<td>58,023</td>
<td>58,967</td>
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<tr>
<td>Total current assets</td>
<td></td>
<td>85,631</td>
<td>82,144</td>
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</table>

<table>
<thead>
<tr>
<th>Current liabilities</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables</td>
<td>17</td>
<td>(52,810)</td>
<td>(42,087)</td>
</tr>
<tr>
<td>Provisions</td>
<td>21</td>
<td>(3,581)</td>
<td>(4,867)</td>
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<tr>
<td>Other liabilities</td>
<td>20</td>
<td>(6,499)</td>
<td>(11,402)</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td></td>
<td>(62,890)</td>
<td>(58,356)</td>
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<tr>
<td>TOTAL assets less current liabilities</td>
<td></td>
<td>206,171</td>
<td>186,184</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-current liabilities</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables</td>
<td>17</td>
<td>(499)</td>
<td>(369)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>18</td>
<td>(775)</td>
<td>(1,080)</td>
</tr>
<tr>
<td>Provisions</td>
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<td>(1,956)</td>
<td>(7,848)</td>
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<tr>
<td>Total non-current liabilities</td>
<td></td>
<td>(3,230)</td>
<td>(9,297)</td>
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<tr>
<td>TOTAL assets employed</td>
<td></td>
<td>202,941</td>
<td>176,888</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financed by (taxpayers’ equity)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public dividend capital</td>
<td></td>
<td>134,594</td>
<td>134,457</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>23</td>
<td>43,696</td>
<td>22,114</td>
</tr>
<tr>
<td>Income and expenditure reserve</td>
<td></td>
<td>24,651</td>
<td>20,317</td>
</tr>
<tr>
<td>Total taxpayers’ equity</td>
<td></td>
<td>202,941</td>
<td>176,888</td>
</tr>
</tbody>
</table>

### Statement of changes in taxpayers’ equity (2012-2013)

<table>
<thead>
<tr>
<th>Statement of changes in taxpayers’ equity</th>
<th>Total</th>
<th>Public Dividend Capital</th>
<th>Revaluation Reserve</th>
<th>Income and Expenditure Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taxpayers’ equity at 1 April 2012</td>
<td>176,888</td>
<td>134,457</td>
<td>22,114</td>
<td>20,317</td>
</tr>
<tr>
<td>Surplus/(deficit) for the year</td>
<td>4,344</td>
<td>0</td>
<td>0</td>
<td>4,344</td>
</tr>
<tr>
<td>Revaluations</td>
<td>21,582</td>
<td>0</td>
<td>21,582</td>
<td>0</td>
</tr>
<tr>
<td>Other recognised gains and losses</td>
<td>(10)</td>
<td>0</td>
<td>0</td>
<td>(10)</td>
</tr>
<tr>
<td>Public dividend capital received</td>
<td>137</td>
<td>137</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Taxpayers’ equity at 31 March 2013</td>
<td>202,941</td>
<td>134,594</td>
<td>43,696</td>
<td>24,651</td>
</tr>
</tbody>
</table>

### Statement of changes in taxpayers’ equity (2011-2012)

<table>
<thead>
<tr>
<th>Statement of changes in taxpayers’ equity</th>
<th>Total</th>
<th>Public Dividend Capital</th>
<th>Revaluation Reserve</th>
<th>Income and Expenditure Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taxpayers’ equity at 1 April 2011</td>
<td>163,184</td>
<td>134,457</td>
<td>23,572</td>
<td>5,155</td>
</tr>
<tr>
<td>Surplus/(deficit) for the year</td>
<td>13,704</td>
<td>0</td>
<td>0</td>
<td>13,704</td>
</tr>
<tr>
<td>Other reserve movements</td>
<td>0</td>
<td>0</td>
<td>(1,458)</td>
<td>1,458</td>
</tr>
<tr>
<td>Taxpayers’ equity at 31 March 2012</td>
<td>176,888</td>
<td>134,457</td>
<td>22,114</td>
<td>20,317</td>
</tr>
</tbody>
</table>
1. Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012/13 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury’s Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Consolidation

For the year to 31 March 2013, NHS foundation trusts are not required to consolidate the results of charities in which they hold a controlling interest. The Trust is the corporate trustee of ‘The Central and North West London NHS Foundation Trust Charitable Funds’ as well as the ‘North Central London Charitable Fund’. The results of both these charities have therefore not been consolidated into the results of the Trust.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Notes to the accounts

1.3 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

NHS Pension Scheme

The NHS Pension Scheme is subject to a full valuation every four years by the Government Actuary. The latest published valuation relates to the period 1 April 1999 to 31 March 2004 which was published in December 2007 and is available on the Pensions Agency website http://www.nhspa.gov.uk/nhspa_site/foi/foi/Scheme_Valuation_Report/NHSPS_Valuation_report.pdf.

The notional deficit of the scheme was £3.3 billion as per the latest scheme valuation by the Government Actuary for the period 1 April 1999 to 31 March 2004. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis.

Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation, it was recommended that employer contribution rates should continue at 14% of pensionable pay. From 1 April 2008, employees’ contributions have been on a tiered scale from 5% to 8.5% of their pensionable pay.
1.4 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Pooled budgets
The Trust has entered into pooled budget agreements with the London Borough of Harrow and Westminster City Council. Under the arrangements, funds are pooled under section 75 of the National Health Service Act 2006 for joint activities. Each of the pools is hosted by the Trust. Payments for services provided by the Trust are accounted for as income from local authorities. The Trust accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:
- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably
- The item individually has a cost of at least £5,000
- The items form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent; they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Measurement
- Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
All land and buildings are revalued using professional valuations in accordance with IAS 16. Valuations are carried out by professional qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The most recent asset valuation was undertaken by external valuers Deloitte LLP as at 31 March 2013.

The method of valuation used was as follows:
- Specialised assets:
  For specialised assets, the depreciated replacement cost (DRC) method was used to arrive at a fair value.
  The International Valuation Standards definition of ‘specialised property’ is; “certain types of properties which are rarely, if ever, sold in the open market...due to uniqueness arising from its specialised nature and design, configuration, size, location, or otherwise.”

  The cost of the modern equivalent reflects two elements - land and buildings. The land is based on the least price that a prudent purchaser would pay for the land and is based on open market values. This is based on open market transaction evidence. The cost of providing a modern equivalent building is based on market prices that are directly observed. All assumptions follow the RICS Valuation Information Paper 10.

  From the gross replacement cost for the building, a valuation judgement is made regarding the physical, functional, and external obsolescence factors which can be applied to the assumed new gross replacement value of the building. These three factors are then combined and weighted according to how much influence each depreciation type is likely to have according to the type of operation that is run from the property concerned. The depreciated building value is then added to the land value.

- Non-specialised assets
Assets valued on an existing use basis are non-specialised property which are occupied solely by the Trust for its own purposes. This includes property assets such as office accommodation. The fair values of these assets were arrived at by comparison to transactions of similar property in the market place. A market capital value per square foot was then applied to the net internal area provided to arrive at a total capital value. It is evidence therefore that the existing use values were determined directly by reference to observable market transactions.

- Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset’s carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its useful economic life then the expenditure is charged to operating expenses.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the Foundation Trust Annual Reporting Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

The Trust considered whether the Trust’s property, plant and equipment had become impaired during the year to 31 March 2013 and concluded that it had not become impaired.
De-recognition
Assets intended for disposals are reclassified as ‘held for sale’ once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- The sale must be highly probable i.e.: - Management are committed to a plan to sell the asset - An active programme has begun to find a buyer and complete the sale - The asset is being actively marketed at a reasonable price - The sale is expected to be completed within 12 months of the date of classification as ‘held for sale’ - The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the ‘fair value less costs to sell’ falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.6 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust’s business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Software
Software which is integral to the operation of hardware for example, an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware for example, application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the Foundation Trust Annual Reporting Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve in the balance sheet attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

1.7 Inventories

Inventories are valued at the lower of cost and net realisable value applying the FIFO (first in, first out) method of valuation for costing of inventories.

1.8 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust’s normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as ‘fair value through income and expenditure’, loans and receivables or ‘available-for-sale financial assets’. Financial liabilities are classified as ‘fair value through income and expenditure’ or as ‘other financial liabilities’.

Loans and receivables
The Trust’s loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and ‘other debtors’. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.
Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date. Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’. When items classified as ‘available-for-sale’ are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in ‘finance costs’ in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices/independent appraisals/discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at ‘fair value through income and expenditure’ are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision. Provision for bad debts is taken when the Trust judges that there is significant risk regarding the recovery of the debt; only when all avenues to recover the debt have been pursued does the Trust write off the debt.

1.9 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the expected life of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.10 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date based on the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury’s discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury’s pension discount rate of 2.9% in real terms.

The Trust commissioned an independent firm of professional actuaries to carry out a valuation of the pension liability relating to injury benefits on the Trust’s Statement of Financial Position. This related to costs arising as a result of staff taking early retirement upon the closure of two of the Trust’s hospitals in the late 1990s. This valuation was carried out as at 31 March 2013 by Barrett Waddingham LLP.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 23.2.

Non-clinical risk pooling

The Trust participates in the property expenses scheme and the liabilities to third parties scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any ‘excesses’ payable in respect of particular claims are charged to operating expenses when the liability arises.

Above: A rehabilitation patient is supported at St Pancras Hospital in Camden
1.11 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 32, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.12 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) net cash held with the Government Banking Service (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.13 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.14 Corporation Tax

Section 148 of the Finance Act 2004 amended S59A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year.

In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- Is the activity an authorised activity related to the provision of core healthcare? The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
- Is the activity actually or potentially in competition with the private sector? Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax;
- Are the annual profits significant? Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trust’s activities are related to core healthcare and are not subject to tax. Where trading activities are undertaken that are commercial in nature they are considered insignificant with profits per activity below the £50,000 tax threshold.
1.15 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s Financial Reporting Manual.

1.16 Segmental reporting
In accordance with IFRS 8 these accounts set out the operating results which are reviewed regularly by the Trust’s chief operating decision maker to make decisions regarding resources.

1.17 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

2.1 Operating income (by classification)

<table>
<thead>
<tr>
<th>Income from activities</th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental health trusts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost and volume contract income</td>
<td>30,410</td>
<td>29,682</td>
</tr>
<tr>
<td>Block contract income</td>
<td>177,884</td>
<td>168,917</td>
</tr>
<tr>
<td>Clinical Partnerships providing mandatory services (including S31 agreements)</td>
<td>15,394</td>
<td>15,915</td>
</tr>
<tr>
<td>Clinical income for the secondary commissioning of mandatory services</td>
<td>3,034</td>
<td>3,081</td>
</tr>
<tr>
<td>Other clinical income from mandatory services</td>
<td>15,394</td>
<td>15,915</td>
</tr>
<tr>
<td>Community services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income from PCTs</td>
<td>105,581</td>
<td>116,295</td>
</tr>
<tr>
<td>Income not from PCTs</td>
<td>3,785</td>
<td>5,901</td>
</tr>
<tr>
<td>All trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private patient income</td>
<td>264</td>
<td>113</td>
</tr>
<tr>
<td>Other non-protected clinical income</td>
<td>1,147</td>
<td>861</td>
</tr>
<tr>
<td>Other operating income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research and development</td>
<td>4,879</td>
<td>4,547</td>
</tr>
<tr>
<td>Education and training</td>
<td>13,812</td>
<td>12,602</td>
</tr>
<tr>
<td>Other (See Note 2,4)</td>
<td>9,479</td>
<td>10,063</td>
</tr>
<tr>
<td>Gain on disposal of assets held for sale</td>
<td>0</td>
<td>1,009</td>
</tr>
<tr>
<td><strong>Total other operating income</strong></td>
<td>28,170</td>
<td>28,221</td>
</tr>
<tr>
<td><strong>TOTAL operating income</strong></td>
<td>376,240</td>
<td>375,768</td>
</tr>
</tbody>
</table>

The income from the provision of goods and services for the purposes of the health service in England at 92.5% of total income has exceeded the income from the provision of goods and services for any other purposes. The other operating income has been mainly from activities related to education, training, research and development which have positive benefits on the provision of services in the NHS.
2.2 Private patient income

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

2.3 Operating income (by type)

<table>
<thead>
<tr>
<th>Income from activities</th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Foundation trusts</td>
<td>4,856</td>
<td>4,523</td>
</tr>
<tr>
<td>NHS trusts</td>
<td>5,231</td>
<td>2,602</td>
</tr>
<tr>
<td>Strategic health authorities</td>
<td>352</td>
<td>291</td>
</tr>
<tr>
<td>Primary care trusts</td>
<td>314,145</td>
<td>322,955</td>
</tr>
<tr>
<td>Local authorities</td>
<td>18,243</td>
<td>16,388</td>
</tr>
<tr>
<td>Department of Health - grants</td>
<td>21</td>
<td>83</td>
</tr>
<tr>
<td>Non nhs / private patients</td>
<td>264</td>
<td>113</td>
</tr>
<tr>
<td>NHS other</td>
<td>9,958</td>
<td>592</td>
</tr>
<tr>
<td><strong>Total income from activities</strong></td>
<td>348,070</td>
<td>347,547</td>
</tr>
</tbody>
</table>

Other operating income:

| Research and development                | 4,879   | 4,547   |
| Education and training                  | 13,812  | 12,602  |
| Other *                                 | 9,479   | 10,063  |
| **Profit on disposal of assets held for sale** | | |
| **Total other operating income**        | 28,170  | 28,221  |
| **TOTAL operating income**              | 376,240 | 375,768 |

*Other income of £9,479k includes condom income of £1,700k, non activity income from Hillingdon PCT of £1,600k, interpreting income of £194k, £34k from Clinical Excellence Awards and other miscellaneous items none of which are individually material. (For 2011/12 - other income of £10,043k included £500k for income relating to Clinical Excellence Awards and income relating to Camden Provider Services consisting of £3,009k for condom income, £1,400k interpreting income and £700k occupational health income).

2.4 Segmental reporting

<table>
<thead>
<tr>
<th>Adult and older adult mental health services</th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>37,379</td>
<td>42,013</td>
</tr>
<tr>
<td>Older people and healthy ageing</td>
<td>22,284</td>
<td>22,627</td>
</tr>
<tr>
<td>Assessment and brief treatment</td>
<td>12,034</td>
<td>13,525</td>
</tr>
<tr>
<td>Community recovery</td>
<td>23,761</td>
<td>26,706</td>
</tr>
<tr>
<td>Psychological medicines</td>
<td>3,553</td>
<td>3,994</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>8,306</td>
<td>9,336</td>
</tr>
<tr>
<td>Harrow Section 75</td>
<td>4,362</td>
<td>4,903</td>
</tr>
<tr>
<td>Continuing care</td>
<td>0</td>
<td>(222)</td>
</tr>
<tr>
<td>Unallocated</td>
<td>958</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>112,637</td>
<td>122,862</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions directorate</td>
<td>9,980</td>
<td>12,941</td>
</tr>
<tr>
<td>Child and family</td>
<td>10,438</td>
<td>10,481</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>2,550</td>
<td>3,087</td>
</tr>
<tr>
<td>Offender care directorate</td>
<td>17,857</td>
<td>10,849</td>
</tr>
<tr>
<td>Vincent Square Clinic</td>
<td>1,379</td>
<td>1,366</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>42,184</td>
<td>38,724</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CPS - GP and hospital support</td>
<td>18,636</td>
<td>19,937</td>
</tr>
<tr>
<td>CPS - sexual health</td>
<td>39,763</td>
<td>38,637</td>
</tr>
<tr>
<td>CPS - income and other</td>
<td>5,780</td>
<td>0</td>
</tr>
<tr>
<td>HCH</td>
<td>(5,704)</td>
<td>(5,620)</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>58,475</td>
<td>52,954</td>
</tr>
</tbody>
</table>

HQ services

| Income                                      | (293,337)| (283,280) |
| Business and estates                        | 34,436   | 29,373   |
| Corporate                                  | 41,272   | 25,643   |
| **Sub-total**                               | (217,629)| (228,264)|

**TOTAL TRUST (surplus)/deficit**

| (217,629)                                  | (228,264) |

The Board reviews financial performance on a service by service basis. The table shows the actual net expenditure charged to each of the services over 2011/12 and 2012/13. Net expenditure consists of income credited to each of the services less the expenditure charged to each of the services.

Some categories of income are not uniformly credited to individual services, for example some cost per case activity is credited to ‘income’ and other cost per case activity is credited to the individual service. The same is true of some expenditure categories, for example some rental expenses are charged to ‘corporate’ whereas other rental expenses are charged to the individual service.

Therefore net expenditure is not an accurate reflection of the direct cost of delivering an individual service, and net expenditure is not comparable across the different services. However, on a Trust level, the total net income of £4.3m is the same as the Trust’s reported surplus.
The fee for services relating to corporate finance transactions was for a due diligence review to analyse Milton Keynes Community Services prior to integration. Other assurance services provided were for assurance on the IT strategy and procurement of new IT systems.

As well as those fees disclosed above members of the CNWL management team attended a conference organised by KPMG to advise on managing pensions. The expense for this conference was payable by the individuals attending, however payment was made initially by the Trust. The total value of payments made for the conference was £17,000. As this was not an expense to the Trust it has not been included in the above analysis or the Statement of Comprehensive Income.

### 4.1 Employee expenses

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and wages</td>
<td>200,336</td>
<td>196,414</td>
</tr>
<tr>
<td>Social security costs</td>
<td>18,483</td>
<td>17,330</td>
</tr>
<tr>
<td>Employers contributions to NHS Pensions</td>
<td>22,392</td>
<td>21,363</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>334</td>
<td>1,103</td>
</tr>
<tr>
<td>Agency/contract staff</td>
<td>16,810</td>
<td>14,280</td>
</tr>
<tr>
<td><strong>TOTAL staff costs</strong></td>
<td><strong>258,355</strong></td>
<td><strong>250,490</strong></td>
</tr>
<tr>
<td>of which costs capitalised as part of assets</td>
<td>(3,800)</td>
<td>(272)</td>
</tr>
<tr>
<td><strong>Total employee benefits excl. capitalised costs</strong></td>
<td>254,555</td>
<td>250,218</td>
</tr>
</tbody>
</table>
4.2 Average number of employees (Whole time equivalent (WTE) basis)

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th></th>
<th>2011/12</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>428</td>
<td>395</td>
<td>33</td>
<td>412</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>1,306</td>
<td>1,159</td>
<td>147</td>
<td>1,269</td>
</tr>
<tr>
<td>Healthcare assistants and other support staff</td>
<td>783</td>
<td>777</td>
<td>6</td>
<td>681</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>1,767</td>
<td>1,608</td>
<td>159</td>
<td>1,843</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting learners</td>
<td>8</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>799</td>
<td>749</td>
<td>50</td>
<td>765</td>
</tr>
<tr>
<td>Social care staff</td>
<td>68</td>
<td>64</td>
<td>4</td>
<td>155</td>
</tr>
<tr>
<td>TOTAL average numbers</td>
<td>5,159</td>
<td>4,760</td>
<td>399</td>
<td>5,125</td>
</tr>
</tbody>
</table>

4.3 Employee benefits

There are no staff benefits that fall within the definition requiring disclosure during the year ending 31 March 2013. (Year ending 31 March 2012 - nil).

4.4 Early retirements due to ill health

During the year ended 31 March 2013 there were eight early retirements from the Trust on the grounds of ill-health (year ending 31 March 2012 - three cases). The estimated additional pension liability of this ill-health retirement is £670k (year ending 31 March 2012 £290k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority Pensions Division.

4.5 Redundancy costs

<table>
<thead>
<tr>
<th>Redundancy costs 2012/13</th>
<th>Number of compulsory redundancies</th>
<th>Total number of exit packages by cost band</th>
</tr>
</thead>
<tbody>
<tr>
<td>£&lt;10,000</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>£10,000 - £25,000</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>£25,001 - £50,000</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>£50,001 – £100,000</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>£100,000 - £150,000</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL number of exit packages by type</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL resource expended (£'000)</td>
<td>334</td>
<td>334</td>
</tr>
</tbody>
</table>

Redundancy costs 2011/12

<table>
<thead>
<tr>
<th>Redundancy costs 2011/12</th>
<th>Number of compulsory redundancies</th>
<th>Total number of exit packages by cost band</th>
</tr>
</thead>
<tbody>
<tr>
<td>£&lt;10,000</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>£10,000 - £25,000</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>£25,001 - £50,000</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>£50,001 – £100,000</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>£100,000 - £150,000</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL number of exit packages by type</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>TOTAL resource expended (£'000)</td>
<td>1,103</td>
<td>1,103</td>
</tr>
</tbody>
</table>

Note that the tables above represent the specific exit packages agreed by the Trust on a person-by-person basis.
5. Operating leases

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>£8,595</td>
<td>£8,706</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£8,595</td>
<td>£8,706</td>
</tr>
</tbody>
</table>

6. Finance income

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest on loans and receivables</td>
<td>£323</td>
<td>£267</td>
</tr>
<tr>
<td>Other</td>
<td>£222</td>
<td>£199</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£545</td>
<td>£546</td>
</tr>
</tbody>
</table>

7. Finance costs - interest expense

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance leases</td>
<td>£74</td>
<td>£104</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£74</td>
<td>£104</td>
</tr>
</tbody>
</table>

8. Impairment of assets

Impairment of assets was considered under the requirements of the Annual Reporting Manual and IAS16. There was an impairment of £5.4m due to a change in market price.

9.1 Intangible assets - 2012/13

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Software licences (purchased)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuation/Gross cost at 1 April 2012</td>
<td>£11,966</td>
<td>£11,966</td>
</tr>
<tr>
<td>Additions - purchased</td>
<td>£5,620</td>
<td>£5,620</td>
</tr>
<tr>
<td>Reclassifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross cost at 31 March 2013</td>
<td>£17,586</td>
<td>£17,586</td>
</tr>
<tr>
<td>Amortisation at 1 April 2012</td>
<td>£7,804</td>
<td>£7,804</td>
</tr>
<tr>
<td>Provided during the year</td>
<td>£455</td>
<td>£455</td>
</tr>
<tr>
<td>Amortisation at 31 March 2013</td>
<td>£8,259</td>
<td>£8,259</td>
</tr>
<tr>
<td>Net Book Value (NBV) TOTAL at 1 April 2013</td>
<td>£9,327</td>
<td>£9,327</td>
</tr>
</tbody>
</table>

The minimum economic life of software is eight years and the maximum life is 10 years.

9.2 Intangible assets - 2011/12

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Software licences (purchased)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuation/Gross cost at 1 April 2011</td>
<td>£9,357</td>
<td>£9,357</td>
</tr>
<tr>
<td>Additions - purchased</td>
<td>£2,609</td>
<td>£2,609</td>
</tr>
<tr>
<td>Valuation/Gross cost at 31 March 2012</td>
<td>£11,966</td>
<td>£11,966</td>
</tr>
<tr>
<td>Amortisation at 1 April 2011</td>
<td>£7,629</td>
<td>£7,629</td>
</tr>
<tr>
<td>Provided during the year</td>
<td>£175</td>
<td>£175</td>
</tr>
<tr>
<td>Amortisation at 31 March 2012</td>
<td>£7,804</td>
<td>£7,804</td>
</tr>
<tr>
<td>NBV TOTAL at 1 April 2012</td>
<td>£4,162</td>
<td>£4,162</td>
</tr>
</tbody>
</table>
### 9.3 Intangible assets financing

<table>
<thead>
<tr>
<th>Net book value (NBV)</th>
<th>Total £000</th>
<th>Software licences (purchased) £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NBV - Purchased at 31 March 2013</td>
<td>9,327</td>
<td>9,327</td>
</tr>
<tr>
<td><strong>NBV TOTAL at 31 March 2013</strong></td>
<td><strong>9,327</strong></td>
<td><strong>9,327</strong></td>
</tr>
<tr>
<td>Net book value (NBV)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NBV - Purchased at 31 March 2012</td>
<td>3,972</td>
<td>3,972</td>
</tr>
<tr>
<td>NBV - Donated at 31 March 2012</td>
<td>190</td>
<td>190</td>
</tr>
<tr>
<td><strong>NBV total at 31 March 2012</strong></td>
<td><strong>4,162</strong></td>
<td><strong>4,162</strong></td>
</tr>
</tbody>
</table>

### 10.1 Property, plant and equipment - 2012/13

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Assets under construction and payments on account £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture and fittings £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuation/gross cost at 1 April 2012</td>
<td>163,208</td>
<td>43,116</td>
<td>100,239</td>
<td>10,086</td>
<td>2,759</td>
<td>278</td>
<td>5,972</td>
<td>759</td>
</tr>
<tr>
<td>Additions - purchased</td>
<td>10,115</td>
<td>0</td>
<td>9,070</td>
<td>0</td>
<td>109</td>
<td>0</td>
<td>805</td>
<td>131</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
<td>10,086</td>
<td>(10,086)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluations</td>
<td>21,582</td>
<td>18,355</td>
<td>3,226</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals</td>
<td>(295)</td>
<td>(295)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Valuation/gross cost at 31 March 2013</td>
<td>194,610</td>
<td>61,471</td>
<td>122,326</td>
<td>0</td>
<td>2,868</td>
<td>278</td>
<td>6,777</td>
<td>890</td>
</tr>
<tr>
<td>Accumulated depreciation at 1 April 2012</td>
<td>11,443</td>
<td>0</td>
<td>5,406</td>
<td>0</td>
<td>2,056</td>
<td>273</td>
<td>3,380</td>
<td>328</td>
</tr>
<tr>
<td>Provided during the year</td>
<td>3,695</td>
<td>0</td>
<td>2,844</td>
<td>0</td>
<td>82</td>
<td>3</td>
<td>714</td>
<td>52</td>
</tr>
<tr>
<td>Impairments</td>
<td>5,370</td>
<td>771</td>
<td>4,599</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accumulated depreciation at 31 March 2013</td>
<td>20,508</td>
<td>771</td>
<td>12,849</td>
<td>0</td>
<td>2,138</td>
<td>276</td>
<td>4,094</td>
<td>380</td>
</tr>
<tr>
<td>NBV TOTAL at 1 April 2013</td>
<td>174,102</td>
<td>60,700</td>
<td>109,477</td>
<td>0</td>
<td>730</td>
<td>2</td>
<td>2,683</td>
<td>510</td>
</tr>
</tbody>
</table>

Above right: A health visitor meets with a new mother.
### 10.2 Property, plant and equipment - 2011/12

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Assets under construction and payments on account £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture and fittings £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuation/gross cost at 1 April 2011</td>
<td>153,788</td>
<td>43,116</td>
<td>95,489</td>
<td>6,512</td>
<td>2,735</td>
<td>278</td>
<td>4,995</td>
<td>663</td>
</tr>
<tr>
<td>Additions - purchased</td>
<td>9,420</td>
<td>0</td>
<td>4,750</td>
<td>3,574</td>
<td>24</td>
<td>0</td>
<td>977</td>
<td>96</td>
</tr>
<tr>
<td>Valuation/gross cost at 31 March 2012</td>
<td>163,208</td>
<td>43,116</td>
<td>100,239</td>
<td>10,086</td>
<td>2,759</td>
<td>278</td>
<td>5,972</td>
<td>759</td>
</tr>
<tr>
<td>Accumulated depreciation at 1 April 2011</td>
<td>8,149</td>
<td>0</td>
<td>2,689</td>
<td>2,043</td>
<td>270</td>
<td>2,862</td>
<td>285</td>
<td></td>
</tr>
<tr>
<td>Provided during the year</td>
<td>3,294</td>
<td>0</td>
<td>2,717</td>
<td>13</td>
<td>3</td>
<td>518</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Accumulated depreciation at 31 March 2012</td>
<td>11,443</td>
<td>0</td>
<td>5,406</td>
<td>2,056</td>
<td>273</td>
<td>3,380</td>
<td>328</td>
<td></td>
</tr>
<tr>
<td>NBV total at 1 April 2012</td>
<td>151,765</td>
<td>43,116</td>
<td>94,833</td>
<td>10,086</td>
<td>703</td>
<td>5</td>
<td>2,592</td>
<td>431</td>
</tr>
</tbody>
</table>

### 10.3 Property, plant and equipment financing

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Assets under construction and payments on account £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture and fittings £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net book value at 31 March 2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owned</td>
<td>172,878</td>
<td>60,700</td>
<td>108,253</td>
<td>730</td>
<td>2</td>
<td>2,683</td>
<td>510</td>
<td></td>
</tr>
<tr>
<td>Finance Lease</td>
<td>1,224</td>
<td>0</td>
<td>1,224</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Donated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>NBV TOTAL at 31 March 2013</td>
<td>174,102</td>
<td>60,700</td>
<td>119,477</td>
<td>730</td>
<td>2</td>
<td>2,683</td>
<td>510</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Assets under construction and payments on account £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture and fittings £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net book value at 31 March 2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owned</td>
<td>150,696</td>
<td>43,116</td>
<td>93,764</td>
<td>10,086</td>
<td>703</td>
<td>5</td>
<td>2,591</td>
<td>431</td>
</tr>
<tr>
<td>Finance lease</td>
<td>1,069</td>
<td>0</td>
<td>1,069</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NBV TOTAL at 31 March 2012</td>
<td>151,765</td>
<td>43,116</td>
<td>94,833</td>
<td>10,086</td>
<td>703</td>
<td>5</td>
<td>2,591</td>
<td>431</td>
</tr>
</tbody>
</table>

### 11 Economic life of property, plant and equipment

<table>
<thead>
<tr>
<th></th>
<th>Min Life</th>
<th>Max Life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Years</td>
<td>Years</td>
</tr>
<tr>
<td>Buildings excluding dwellings</td>
<td>51</td>
<td>99</td>
</tr>
<tr>
<td>Plant and machinery</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Transport equipment</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Information technology</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Furniture and fittings</td>
<td>7</td>
<td>10</td>
</tr>
</tbody>
</table>

Above: CNWL staff from the Hammersmith and Fulham Community Drug and Alcohol Service (CDAS)
### 12.1 Analysis of property, plant and equipment at 31 March 2013

<table>
<thead>
<tr>
<th>Net book value</th>
<th>Total £000</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Assets under construction and payments on account £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture and fitments £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protected assets</td>
<td>170,178</td>
<td>60,700</td>
<td>109,478</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unprotected assets</td>
<td>3,924</td>
<td>0</td>
<td>0</td>
<td>731</td>
<td>2</td>
<td>2,682</td>
<td>510</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>174,102</strong></td>
<td><strong>60,700</strong></td>
<td><strong>109,478</strong></td>
<td><strong>731</strong></td>
<td><strong>2,682</strong></td>
<td><strong>510</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

### 12.2 Analysis of property, plant and equipment 31 March 2012

<table>
<thead>
<tr>
<th>Net book value</th>
<th>Total £000</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Assets under construction and payments on account £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture and fitments £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protected assets</td>
<td>137,949</td>
<td>43,116</td>
<td>94,833</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unprotected assets</td>
<td>13,816</td>
<td>0</td>
<td>0</td>
<td>10,086</td>
<td>703</td>
<td>5</td>
<td>2,591</td>
<td>431</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>151,765</strong></td>
<td><strong>43,116</strong></td>
<td><strong>94,833</strong></td>
<td><strong>10,086</strong></td>
<td><strong>703</strong></td>
<td><strong>5</strong></td>
<td><strong>2,591</strong></td>
<td><strong>431</strong></td>
</tr>
</tbody>
</table>

### 12.3 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2013

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>As at 1 April 2012</td>
<td>22,114</td>
<td>8,118</td>
<td>13,996</td>
</tr>
<tr>
<td>movement in year</td>
<td>21,582</td>
<td>18,355</td>
<td>3,227</td>
</tr>
<tr>
<td>As at 31 March 2013</td>
<td>43,696</td>
<td>26,473</td>
<td>17,223</td>
</tr>
</tbody>
</table>

### 12.4 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2012

<table>
<thead>
<tr>
<th></th>
<th>Total £000</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>As at 1 April 2011</td>
<td>23,572</td>
<td>9,134</td>
<td>14,438</td>
</tr>
<tr>
<td>movement in year</td>
<td>(1,458)</td>
<td>(1,016)</td>
<td>(442)</td>
</tr>
<tr>
<td>As at 31 March 2012</td>
<td>22,114</td>
<td>8,118</td>
<td>13,996</td>
</tr>
</tbody>
</table>

### 13. Inventories

<table>
<thead>
<tr>
<th></th>
<th>31/03/13 £000</th>
<th>31/03/12 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials</td>
<td>172</td>
<td>158</td>
</tr>
</tbody>
</table>

**TOTAL inventories**

|                        | 172           | 158           |
### 14. Trade receivables and other receivables

<table>
<thead>
<tr>
<th></th>
<th>31/03/13</th>
<th>31/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS receivables - revenue</td>
<td>11,248</td>
<td>11,696</td>
</tr>
<tr>
<td>Provision for impaired receivables</td>
<td>(2,136)</td>
<td>(2,367)</td>
</tr>
<tr>
<td>Prepayments (non-PFI)</td>
<td>4,221</td>
<td>3,618</td>
</tr>
<tr>
<td>Accrued Income</td>
<td>8,416</td>
<td>7,781</td>
</tr>
<tr>
<td>PDC dividend receivable</td>
<td>0</td>
<td>265</td>
</tr>
<tr>
<td>VAT receivable</td>
<td>1,401</td>
<td>938</td>
</tr>
<tr>
<td>Other receivables*</td>
<td>4,287</td>
<td>888*</td>
</tr>
<tr>
<td><strong>TOTAL current trade and other receivables</strong></td>
<td>27,437</td>
<td>23,019</td>
</tr>
<tr>
<td><strong>Non-Current</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS receivables - revenue</td>
<td>0</td>
<td>7,448*</td>
</tr>
<tr>
<td>Provision for impaired receivables</td>
<td>0</td>
<td>(978)</td>
</tr>
<tr>
<td><strong>TOTAL non current trade and other receivables</strong></td>
<td>0</td>
<td>6,470</td>
</tr>
</tbody>
</table>

*Other receivables in prior year were shown net of a cash payment on account from North Central London Cluster of £3,900k – this treatment was applied as the receipt could not be assigned to specific receivable balances outstanding.

**Refer Note 2i: Provision for Liabilities and Charges

### 15.2 Analysis of impaired receivables

#### Ageing of impaired receivables

<table>
<thead>
<tr>
<th></th>
<th>31/03/13</th>
<th>31/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 30 days</td>
<td>3</td>
<td>164</td>
</tr>
<tr>
<td>30-60 days</td>
<td>920</td>
<td>122</td>
</tr>
<tr>
<td>60-90 days</td>
<td>8</td>
<td>106</td>
</tr>
<tr>
<td>90-180 days (was “In three to six months”)</td>
<td>628</td>
<td>261</td>
</tr>
<tr>
<td>over 180 days (was “Over six months”)</td>
<td>577</td>
<td>2,682</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>2,136</td>
<td>3,345</td>
</tr>
</tbody>
</table>

#### Ageing of non-impaired receivables past their due date

<table>
<thead>
<tr>
<th></th>
<th>31/03/13</th>
<th>31/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 30 days</td>
<td>7,636</td>
<td>2,498</td>
</tr>
<tr>
<td>30-60 days</td>
<td>4,057</td>
<td>1,509</td>
</tr>
<tr>
<td>60-90 days</td>
<td>973</td>
<td>333</td>
</tr>
<tr>
<td>90-180 days (was “In three to six months”)</td>
<td>348</td>
<td>574</td>
</tr>
<tr>
<td>over 180 days (was “Over six months”)</td>
<td>0</td>
<td>168</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>13,014</td>
<td>5,082</td>
</tr>
</tbody>
</table>

### 16. Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>31/03/13</th>
<th>31/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At 1 April</strong></td>
<td>58,967</td>
<td>43,209</td>
</tr>
<tr>
<td><strong>At 31 March</strong></td>
<td>58,023</td>
<td>58,967</td>
</tr>
</tbody>
</table>

#### Broken down into:

- Cash at commercial banks and in hand
  - 1,226 | 586
- Cash with the Government Banking Service
  - 56,797 | 58,381
- Cash and cash equivalents as in SoFP
  - 58,023 | 58,967
17. Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>31/03/13</th>
<th>31/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receipts in advance</td>
<td>3,838</td>
<td>4,256</td>
</tr>
<tr>
<td>NHS payables - revenue</td>
<td>3,106</td>
<td>5,332</td>
</tr>
<tr>
<td>Other trade payables - capital</td>
<td>530</td>
<td>504</td>
</tr>
<tr>
<td>Other trade payables - revenue</td>
<td>5,804</td>
<td>3,658</td>
</tr>
<tr>
<td>Other taxes payable</td>
<td>5,349</td>
<td>5,255</td>
</tr>
<tr>
<td>Other payables</td>
<td>3,480</td>
<td>3,093</td>
</tr>
<tr>
<td>Accruals</td>
<td>30,516</td>
<td>19,989</td>
</tr>
<tr>
<td>PDC dividend payable</td>
<td>196</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL current trade and other payables</strong></td>
<td><strong>52,810</strong></td>
<td><strong>42,087</strong></td>
</tr>
</tbody>
</table>

18. Borrowings

During the year ended 31 March 2013, the Trust had £775k of borrowings relating to finance leases (31 March 2012 - £1,080k).

19. Prudential borrowing limit (PBL)

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- The maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in the Prudential Borrowing Code for NHS foundation trusts. The financial risk rating set under Monitor’s Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and
- The amount of any working capital facility approved by Monitor.

Further information on the Prudential Borrowing Code for NHS foundation trusts and Compliance Framework can be found on Monitor’s website.

<table>
<thead>
<tr>
<th></th>
<th>31/03/13</th>
<th>31/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total long term borrowing limit set by Monitor</td>
<td>74,900</td>
<td>73,300</td>
</tr>
<tr>
<td>Working capital facility limit agreed by Monitor</td>
<td>15,200</td>
<td>15,200</td>
</tr>
<tr>
<td><strong>TOTAL prudential borrowing limit</strong></td>
<td><strong>90,100</strong></td>
<td><strong>88,500</strong></td>
</tr>
</tbody>
</table>

There was no actual use made of the borrowing facilities in either of the two financial years other than for the finance leases.

The trust has a prudential borrowing limit of £90.1m in 2012/13 (£88.5m in 2011/12). Other than the finance lease borrowing referred to above, the Trust has actually borrowed £ nil in 2012/13 (£ nil in 2011/12). The Trust has £15.2m of approved working capital facility (£15.2m in 2010/11). The Trust had drawn down £ nil of its working capital facility at 31 March 2013 (£ nil at 31 March 2012).

<table>
<thead>
<tr>
<th></th>
<th>Actual ratios 2012/13</th>
<th>Approved PBL ratios 2012/13</th>
<th>Actual ratios 2011/12</th>
<th>Approved PBL ratios 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum dividend cover</td>
<td>3.88</td>
<td>&gt;1x</td>
<td>4.72</td>
<td>&gt;1x</td>
</tr>
<tr>
<td>Minimum Interest cover</td>
<td>58.16</td>
<td>&gt;3x</td>
<td>52.55</td>
<td>&gt;3x</td>
</tr>
<tr>
<td>Minimum debt service cover</td>
<td>23.12</td>
<td>&gt;2x</td>
<td>18.33</td>
<td>&gt;2x</td>
</tr>
<tr>
<td>Maximum debt service cover</td>
<td>0.21%</td>
<td>&lt;2.5%</td>
<td>0.29%</td>
<td>&lt;2.5%</td>
</tr>
</tbody>
</table>
20. Other liabilities

<table>
<thead>
<tr>
<th></th>
<th>31/03/13</th>
<th>31/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deferred income</td>
<td>£11,402</td>
<td>£6,499</td>
</tr>
<tr>
<td>TOTAL other current liabilities</td>
<td>£11,402</td>
<td>£6,499</td>
</tr>
</tbody>
</table>

21.1 Provisions for liabilities and charges

<table>
<thead>
<tr>
<th></th>
<th>31/03/13</th>
<th>31/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Non-current</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Total</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Pensions relating to former directors</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pensions relating to other staff</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other legal claims</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Redundancy</td>
<td>550</td>
<td>1,320</td>
</tr>
<tr>
<td>Other ***</td>
<td>3,031</td>
<td>4,554</td>
</tr>
<tr>
<td>Total</td>
<td>3,581</td>
<td>4,987</td>
</tr>
</tbody>
</table>

21.2 Provisions for liabilities and charges analysis

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Pensions(former directors)</th>
<th>Pensions(other staff)</th>
<th>Redundancy</th>
<th>Other ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>At 1 April 2012</td>
<td>£12,715</td>
<td>£229</td>
<td>£6,613</td>
<td>£1,320</td>
<td>£4,554</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>£3,646</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3,646</td>
</tr>
<tr>
<td>Utilised during the year - accruals</td>
<td>(1,375)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(1,375)</td>
</tr>
<tr>
<td>Utilised during the year - cash</td>
<td>(7,974)</td>
<td>(235)</td>
<td>(6,797)</td>
<td>(635)</td>
<td>(308)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>(1,709)</td>
<td>0</td>
<td>0</td>
<td>(135)</td>
<td>(1,574)</td>
</tr>
<tr>
<td>Unwinding of discount</td>
<td>234</td>
<td>6</td>
<td>184</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>At 31 March 2013</td>
<td>5,537</td>
<td>0</td>
<td>0</td>
<td>550</td>
<td>4,987</td>
</tr>
</tbody>
</table>

Expected timing of cash flows:

- not later than one year; 3,581 0 0 550 3,031
- later than one year and not later than five years; 994 0 0 0 994
- later than five years; 962 0 0 0 962

TOTAL 5,537 0 0 550 4,987

Pensions - other staff: In line with Department of Health (DoH) guidance, the Trust bought out retirement benefits by a lump sum payment of £8,608k to the Pensions Agency thus eradicating the need for provisions relating to retirement benefits. This buy out has been funded by settling payment from all “back to back” debtors and thereby enabling “back to back” debtors (Note 14) materialising into cash receipts or as an unpaid invoice.

Other: A residual provision of £1,956k for injury allowances for former employees of CNWL remains on the Statement of Financial Position as risks remain with the Trust. This valuation is based on a recent actuarial valuation. Also included here is a provision for Hillingdon Loss Making Contract of £930k and an onerous lease at £1,588k.

£3,937k is included in provisions of the NHSLA at 31 March 2013 in respect of clinical negligence of the Trust (31 March 2012 - £3,620k).
## 22. Contingent (liabilities)/assets

<table>
<thead>
<tr>
<th></th>
<th>31/03/13</th>
<th>31/03/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross value of contingent liabilities</td>
<td>(89)</td>
<td>(52)</td>
</tr>
<tr>
<td>Net value of contingent liabilities*</td>
<td>(89)</td>
<td>(52)</td>
</tr>
</tbody>
</table>

* The contingent liabilities relate to the excess of liabilities under the NHS Litigation Authority

## 23.1 Revaluation reserve - 2012/13

<table>
<thead>
<tr>
<th></th>
<th>Total revaluation reserve</th>
<th>Revaluation reserve - property, plant and equipment</th>
<th>Revaluation reserve - assets held for sale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revaluation reserve at 1 April 2012 -</td>
<td>22,114</td>
<td>22,114</td>
<td>0</td>
</tr>
<tr>
<td>Asset disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluations</td>
<td>21,582</td>
<td>21,582</td>
<td>0</td>
</tr>
<tr>
<td>Other reserve movements</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluation reserve at 31 March 2013</td>
<td>43,696</td>
<td>43,696</td>
<td>0</td>
</tr>
</tbody>
</table>

## 23.2 Revaluation reserve - 2011/12

<table>
<thead>
<tr>
<th></th>
<th>Total revaluation reserve</th>
<th>Revaluation reserve - property, plant and equipment</th>
<th>Revaluation reserve - assets held for sale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revaluation reserve at 1 April 2011</td>
<td>23,572</td>
<td>22,114</td>
<td>1,458</td>
</tr>
<tr>
<td>Asset disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other reserve movements</td>
<td>(1,458)</td>
<td>0</td>
<td>(1,458)</td>
</tr>
<tr>
<td>Revaluation reserve at 31 March 2012</td>
<td>22,114</td>
<td>22,114</td>
<td>0</td>
</tr>
</tbody>
</table>

## 24.1 Related party transactions

<table>
<thead>
<tr>
<th></th>
<th>Income</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value of transactions with related parties in 2012/13</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Department of Health</td>
<td>1,259</td>
<td>4</td>
</tr>
<tr>
<td>Other NHS bodies</td>
<td>349,655</td>
<td>49,478</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>346,914</strong></td>
<td><strong>50,482</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Income</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value of transactions with related parties in 2011/12</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Department of Health</td>
<td>1,910</td>
<td>4</td>
</tr>
<tr>
<td>Other NHS bodies</td>
<td>353,735</td>
<td>56,045</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>355,645</strong></td>
<td><strong>56,049</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS body</th>
<th>Income</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westminster PCT</td>
<td>58,286</td>
<td>402</td>
</tr>
<tr>
<td>Hillingdon PCT</td>
<td>53,273</td>
<td>1,690</td>
</tr>
<tr>
<td>Brent Teaching PCT</td>
<td>40,475</td>
<td>575</td>
</tr>
<tr>
<td>Kensington and Chelsea PCT</td>
<td>36,246</td>
<td>652</td>
</tr>
<tr>
<td>Croydon PCT</td>
<td>30,817</td>
<td>0</td>
</tr>
<tr>
<td>Camden PCT</td>
<td>28,787</td>
<td>3,415</td>
</tr>
<tr>
<td>Harrow PCT</td>
<td>23,677</td>
<td>332</td>
</tr>
<tr>
<td>Islington PCT</td>
<td>16,838</td>
<td>116</td>
</tr>
<tr>
<td>London SHA</td>
<td>12,508</td>
<td>(26)</td>
</tr>
<tr>
<td>Central London Community Healthcare Trust</td>
<td>4,915</td>
<td>221</td>
</tr>
<tr>
<td>Hounslow PCT</td>
<td>4,674</td>
<td>(105)</td>
</tr>
<tr>
<td>Ealing PCT</td>
<td>4,423</td>
<td>261</td>
</tr>
</tbody>
</table>
The Trust works with Imperial College London on research projects. During the year it has paid £1,182k (2011/12 - £1,700k) to the College, mostly for the recharge of staff time working on research projects. Professor Dorothy Griffiths is a Non-Executive Director for the Trust and employed by the College, however is not involved with the joint projects undertaken. Recharge of staff time is determined based on salary rates and so is considered to be under market conditions. At 31 March 2013 the Trust had an outstanding balance of £106k (31 March 2012 - £66k) payable to Imperial College London.

Helen Edwards is a Non-Executive Director at CNWL and is also employed by the Ministry of Justice. The Trust works with the Ministry of Justice in providing services to Holloway prison. During the year it has incurred costs of £1,251k (2011/12 - 1,039k) for the recharge of staff time of prison officers. Recharge of staff time is determined based on salary rates and so is considered to be under market conditions. At 31 March 2013 the Trust had an outstanding balance of £243k (31 March 2012 - £153k) payable to the Ministry of Justice.

The Foundation Trust also provides administrative support to its charitable funds, in this function a total of £58k has been charged for the year ended 31 March 2013 (£54k for the year ended 31 March 2012).

### 24.2 Related party balances

<table>
<thead>
<tr>
<th>Value of balances with related parties at 31 March 2013</th>
<th>Income £000</th>
<th>Expenditure £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health</td>
<td>42</td>
<td>196</td>
</tr>
<tr>
<td>Other NHS bodies</td>
<td>18,778</td>
<td>13,574</td>
</tr>
<tr>
<td><strong>Total balances with related parties at 31 March 2013</strong></td>
<td><strong>18,860</strong></td>
<td><strong>13,770</strong></td>
</tr>
<tr>
<td>Value of balances (other than salary) with related parties in respect of doubtful debts written off in year at 31 March 2012</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Value of balances with related parties at 31 March 2012</td>
<td>265</td>
<td>148</td>
</tr>
<tr>
<td>Other NHS bodies</td>
<td>30,418</td>
<td>16,911</td>
</tr>
<tr>
<td><strong>Total balances with related parties at 31 March 2012</strong></td>
<td><strong>30,683</strong></td>
<td><strong>17,059</strong></td>
</tr>
</tbody>
</table>

### 25. Contractual capital commitments

<table>
<thead>
<tr>
<th>NHS body</th>
<th>Receivables £000</th>
<th>Payables £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westminster PCT</td>
<td>2,366</td>
<td>2,703</td>
</tr>
<tr>
<td>Brent Teaching PCT</td>
<td>2,326</td>
<td>464</td>
</tr>
<tr>
<td>Hertfordshire PCT</td>
<td>1,982</td>
<td>0</td>
</tr>
<tr>
<td>Islington PCT</td>
<td>1,674</td>
<td>1,300</td>
</tr>
<tr>
<td>Hillingdon PCT</td>
<td>1,301</td>
<td>441</td>
</tr>
<tr>
<td>Harrow PCT</td>
<td>1,323</td>
<td>297</td>
</tr>
<tr>
<td>Camden PCT</td>
<td>1,000</td>
<td>631</td>
</tr>
<tr>
<td>University College London NHS FT</td>
<td>566</td>
<td>3,387</td>
</tr>
<tr>
<td>Haringey Teaching PCT</td>
<td>513</td>
<td>0</td>
</tr>
<tr>
<td>Kensington and Chelsea PCT</td>
<td>448</td>
<td>25</td>
</tr>
<tr>
<td>Croydon PCT</td>
<td>489</td>
<td>0</td>
</tr>
<tr>
<td>Barnet PCT</td>
<td>395</td>
<td>0</td>
</tr>
</tbody>
</table>

### 26. Finance lease obligations

<table>
<thead>
<tr>
<th>Gross lease liabilities</th>
<th>31/03/13 £000</th>
<th>31/03/12 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>of which liabilities are due</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year</td>
<td>74</td>
<td>104</td>
</tr>
<tr>
<td>- later than one year and not later than five years</td>
<td>297</td>
<td>415</td>
</tr>
<tr>
<td>- later than five years</td>
<td>6,685</td>
<td>9,000</td>
</tr>
<tr>
<td>Finance charges allocated to future periods</td>
<td>(6,281)</td>
<td>(8,439)</td>
</tr>
<tr>
<td><strong>Net lease liabilities</strong></td>
<td>775</td>
<td>1,080</td>
</tr>
<tr>
<td>- not later than one year</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- later than one year and not later than five years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- later than five years</td>
<td>775</td>
<td>1,080</td>
</tr>
</tbody>
</table>
27. Subsequent events

27.1 Milton Keynes Community Services

The Trust has entered into a contract with Milton Keynes PCT to deliver Milton Keynes Community Services (MKCS) from 1 April 2013. The transaction involved a nominal consideration of £1 for the net assets of MKCS. No other assets were transferred and no other consideration was paid. There has been no impact on the 2012-13 financial statements other than this disclosure note.

This transaction represents a transfer of services between public sector bodies which are under common control and therefore is a 'machinery of government change'. This transaction meets the definition of a 'Group Reconstruction' under IFRS 3 'Business Combinations' and therefore falls outside the scope of that standard.

The FT ARM requires that this is accounted for using transfer by absorption methods. This does not require the restatement of transactions that occurred in 2012/13 or earlier periods. Using this method the book value of the net assets received will be recorded in the Statement of Financial Position and a corresponding amount will be recorded as income in the Statement of Comprehensive Income.

27.2 Transfer of PCT assets from 1st April

On 1 April 2013 the Trust took over assets previously owned by Camden PCT and Hillingdon PCT used for the provision of community services. These consist of freehold estates and IT assets. The assets transferring from Camden PCT were last valued in September 2012 and the value of assets transferring was £15,672k. The estates transferring from Hillingdon PCT were last valued in July 2010 and had a value of £13,511k.

The transaction is being funded by a receipt of public dividend capital and therefore a cash payment was not required by the Trust for the acquisition of the assets.

28. Financial assets (by category)

<table>
<thead>
<tr>
<th>Assets as per Statement of Financial Position (SoFP)</th>
<th>Total £000</th>
<th>Loans and receivables £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS trade and other receivables excluding non-financial assets (at 31 March 2013)</td>
<td>16,651</td>
<td>16,651</td>
</tr>
<tr>
<td>Non-NHS trade and other receivables excluding non-financial assets (at 31 March 2013)</td>
<td>10,786</td>
<td>10,786</td>
</tr>
<tr>
<td>Cash and cash equivalents at bank and in hand (at 31 March 2013)</td>
<td>58,023</td>
<td>58,023</td>
</tr>
<tr>
<td><strong>Total at 31 March 2013</strong></td>
<td><strong>85,460</strong></td>
<td><strong>85,460</strong></td>
</tr>
<tr>
<td>NHS trade and other receivables excluding non-financial assets (at 31 March 2012)</td>
<td>20,675</td>
<td>20,675</td>
</tr>
<tr>
<td>Non-NHS trade and other receivables excluding non-financial assets (at 31 March 2012)</td>
<td>8,813</td>
<td>8,813</td>
</tr>
<tr>
<td>Non current assets held for sale and assets held in disposal group excluding non-financial assets (at 31 March 2012)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash and cash equivalents (at bank and in hand) (at 31 March 2012)</td>
<td>58,968</td>
<td>58,968</td>
</tr>
<tr>
<td><strong>TOTAL at 31 March 2012</strong></td>
<td><strong>88,456</strong></td>
<td><strong>88,456</strong></td>
</tr>
</tbody>
</table>

28.2 Financial liabilities (by category)

<table>
<thead>
<tr>
<th>Liabilities as per SoFP</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obligations under finance leases (at 31 March 2013)</td>
<td>775</td>
</tr>
<tr>
<td>NHS trade and other payables excluding non-financial assets (at 31 March 2013)</td>
<td>16,301</td>
</tr>
<tr>
<td>Non-NHS trade and other payables excluding non-financial assets (at 31 March 2013)</td>
<td>37,009</td>
</tr>
<tr>
<td>Provisions under contract (at 31 March 2013)</td>
<td>5,537</td>
</tr>
<tr>
<td><strong>Total at 31 March 2013</strong></td>
<td><strong>59,622</strong></td>
</tr>
<tr>
<td>Obligations under finance leases (31 March 2012)</td>
<td>1,080</td>
</tr>
<tr>
<td>NHS trade and other payables excluding non-financial assets (31 March 2012)</td>
<td>25,321</td>
</tr>
<tr>
<td>Non-NHS trade and other payables excluding non-financial assets (31 March 2012)</td>
<td>17,135</td>
</tr>
<tr>
<td>Provisions under contract (at 31 March 2012)</td>
<td>12,715</td>
</tr>
<tr>
<td><strong>TOTAL at 31 March 2012</strong></td>
<td><strong>56,251</strong></td>
</tr>
</tbody>
</table>
Fair value of financial assets and liabilities
The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Financial risks are listed below:

• **Liquidity risk**
  The Trust’s net operating costs are incurred under three year contracts with local Clinical Commissioning Groups (CCGs), which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. All fixed assets have been purchased without the need for commercial borrowing. Central and North West London NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

• **Interest-rate risk**
  The majority of the Trust’s financial assets and financial liabilities carry nil or fixed rates of interest. Central and North West London NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

• **Credit risk**
  The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations.

30. Losses and special payments
There were 35 cases of losses and special payments totalling £117k during the period (31 March 2012 - 38 cases totalling £41k). These amounts are reported on accrual basis but excluding provisions for future losses.

29. Pension schemes on-Statement of Financial Position
The Trust has no on-Statement of Financial Position pension schemes.

31. Third party assets
31.1 Patient monies
The Trust held £1.02m cash at bank and in hand at 31 March 2013 (31 March 2012 - £1.1m) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

31.2 Integrated care pathway (ICP)
During 2012/13 the Trust commenced hosting the Outer North West London integrated care pathway (ICP). This is intended to encourage providers and commissioners to deliver a more integrated package of care to patients. The ICP is made up of the boroughs and CCGs in Brent, Ealing, Harrow and Hillingdon.

Under the arrangement the Trust receives payments for the ICP and makes payments on their behalf, however it is not able to decide who to make purchases from. During 2012/13 the Trust received £7.5m (2011/12 - 0) of income on behalf of the ICP and had expenditure to the value of £2.9m (2011/12 - 0). Of the £7.5m of income, £4.6m was deferred into 2013/14. These are not recorded in the Statement of Comprehensive Income.

32. Critical accounting estimates and judgement
In the application of the Trust’s accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The judgements and key sources of estimation uncertainty that have a significant effect on the material amounts recognised in the financial statements in the current or next financial year are detailed below:

• Assets valuations are provided by Deloitte LLP. Valuations are subject to general price changes in the property values across the UK. Asset values might vary from the real market value when assets are disposed.

• Determination of useful lives for property, plant and equipment - estimated useful lives for Trust’s assets are based on common, widely used assumptions for each asset type except where specialist information is available from professional bodies. The Trust reviews these lives on a regular basis as part of the process to assess whether assets have been impaired.

• Accruals are based on estimates and judgements of historical trends and anticipated outcomes. At the end of each accounting period, management review items that are outstanding and estimate the amount to be accrued in the closing financial statements of the foundation trust. Any variation between the estimate and the actual is recorded under the relevant heading within the accounts in the subsequent financial period.

• Provisions for pension and legal liabilities are based on the information provided from NHS Pension Agency, NHS Litigation Agency and the Trust’s own sources. Pension provision is based on the life expectancy of the individual pensioner as stated in the UK Actuarial Department most recent life tables which change annually. All provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made.
### Accounting standards that have been issued but not yet adopted

The following accounting standards have been issued but have not yet been adopted. NHS bodies cannot adopt new standards unless they have been adopted in the HM Treasury FReM. The HM Treasury FReM generally does not adopt an international standard until it has been endorsed by the European Union for use by listed companies.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Impact on CNWL accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>IFRS 7</td>
<td>This is a new standard to replace IAS 39 Financial Instruments: Recognition and measurement. Two elements of the standard have been issued so far: Financial assets and financial liabilities. The main changes are in respect of financial assets where the existing four categories will be reduced to two: Amortised cost and 'fair value through profit and loss'. At the present time it is not clear when this standard will be applied because the EU has delayed its endorsement.</td>
</tr>
<tr>
<td>IFRS 9</td>
<td>This is a new standard to replace IAS 39 Financial Instruments: Recognition and measurement. Two elements of the standard have been issued so far: Financial assets and financial liabilities. The main changes are in respect of financial assets where the existing four categories will be reduced to two: Amortised cost and 'fair value through profit and loss'. At the present time it is not clear when this standard will be applied because the EU has delayed its endorsement.</td>
</tr>
<tr>
<td>IFRS 10</td>
<td>The new standard establishes the principles for the presentation and preparation of consolidated financial statements when an entity controls one or more other entities. It is applicable from 2013/14 but not yet adopted by the EU. The principles of the standard have been applied in the current year accounts in accounting for the “transforming community services” for the mergers with Hillingdon Community Health (HCH), Camden Provider Services (CPS). The information disclosed has been on the basis of guidance issued by the HM Treasury and Monitor.</td>
</tr>
</tbody>
</table>
| IFRS 11 | The new standard establishes the principles for financial reporting by parties to a joint arrangement. A joint arrangement is an arrangement of which two or more parties, bound by a contractual agreement, have joint control. Joint arrangements are classified, dependent on the controlling parties’ rights and obligations, as either:  
  - Joint operations – joint arrangements whereby the parties that have joint control of the arrangement have rights to the assets and obligations for the liabilities relating to the arrangement.  
  - Joint ventures – joint arrangements whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement.  
It is applicable from 2013/14 but not yet adopted by the EU. At present there are no such arrangements in place and it is unlikely to have an impact on CNWL. |
| IFRS 12 | This is a new standard that combines, in a single standard, the disclosure requirements for subsidiaries, associates and joint arrangements, as well as unconsolidated structured entities. It was issued by the IASB on 12 May 2011 as part of its new suite of consolidation and related standards, replacing existing requirements for subsidiaries and joint ventures (now joint arrangements), and making limited amendments in relation to associates. During the financial crisis it was perceived that there was a lack of transparency about the risks to which a reporting entity is exposed due to its involvement with structured entities. We expect particular interest in the new disclosures in respect of structured entities, especially in the financial services sector. It is applicable from 2013/14 but not yet adopted by the EU. There are no anticipated impacts to the reporting of transactions for CNWL. |
| IFRS 13 | IFRS 13 establishes a single framework for all fair value measurements when fair value is required or permitted by IFRS. IFRS 13 does not change when an entity is required to use fair value, but rather, describes how to measure fair value under IFRS when it is required or permitted by IFRS. As a result of consequential amendments, much of the specific requirements for determining fair value in IAS 40 Investment Property will be deleted, and instead, fair value measurements will be made based on the requirements of the new standard. The principal impact of the standard will be on real estate entities, the adoption of IFRS 13 could result in significant changes to processes and procedures for determining fair value and providing the required disclosures. While the requirement to determine fair value by reference to market participants is not new, the definition of fair value in IFRS 13 differs from that proposed by International Valuation Standards (IVS), which are the generally accepted standards for professional appraisal practice in valuing real estate internationally. The fair value framework set out in IFRS 13 contains specific requirements relating to ‘highest and best use’, valuation premise, and principal market. This may require entities and their appraisers to re-evaluate their methods, processes and procedures for determining fair value. It is applicable from 2013/14 but not yet adopted by the EU. This standard is unlikely to have a major impact on CNWL. |
| IAS 12 | For the purposes of this standard, income taxes include all domestic and foreign taxes which are based on taxable profits. Income taxes also include taxes, such as withholding taxes, which are payable by a subsidiary, associate or joint venture on distributions to the reporting entity. It is applicable from 2012/13 but not yet adopted by the EU. As the NHS is not subject to taxation, the standard will have no impact on the organisation. |
| IAS 11 | The IASB recently issued amendments to IAS 1 Presentation of Financial Statements on the presentation of other comprehensive income (OCI). Currently, only a limited number of transactions are recognised in OCI. However, ongoing changes to IFRS, such as IFRS 9 Financial Instruments and the recent amendments to IAS 19 Employee Benefits, will lead to increased recognition of items within OCI. The amendments to IAS 1 change the grouping of items presented in OCI. Items that could be reclassified (or ‘recycled’) to profit or loss at a future point in time (for example, upon derecognition or settlement) would be presented separately from items which will never be reclassified. Grouping of OCI items under the amendments to IAS 1. OCI items that can be reclassified into profit or loss:  
  - Foreign exchange gains and losses arising from translations of financial statements of a foreign operation (IAS 21)  
  - Effective portion of gains and losses on hedging instruments in a cash flow hedge (IAS 39)  
OCI items that cannot be reclassified into profit or loss:  
  - Changes in revaluation surplus (IAS 16 and IAS 38)  
  - Actuarial gains and losses on defined benefit plans (IAS 19 93A)  
  - Gains and losses from investments in equity instruments measured at fair value through OCI (IFRS 9)  
For those liabilities designated at fair value through profit or loss, changes in fair value attributable to changes in the liability’s credit risk (IFRS 9) It is applicable from 2013/14 but not yet adopted by the EU. These principles have been applied to the current financial statements. |
**Standard** | **Impact on CNWL accounts**
--- | ---
**IAS 27**  
Separate financial statements  
The objective of IAS 27 is to enhance the relevance, reliability and comparability of the information that a parent entity provides in its separate financial statements and in its consolidated financial statements for a group of entities under its control. The standard specifies:  
- The circumstances in which an entity must consolidate the financial statements of another entity (being a subsidiary);  
- The accounting for changes in the level of ownership interest in a subsidiary;  
- The accounting for the loss of control of a subsidiary; and  
- The information that an entity must disclose to enable users of the financial statements to evaluate the nature of the relationship between the entity and its subsidiaries.  
It is applicable from 2013/14 but not yet adopted by the EU. There are no plans to operate under a parent/subsidiary structure and therefore the requirements under IAS 27 will have no impact on the organisation.

**IAS 28**  
Associates and joint ventures  
The objective of IAS 28 (as amended in 2011) is to prescribe the accounting for investments in associates and to set out the requirements for the application of the equity method when accounting for investments in associates and joint ventures. IAS 28 applies to all entities that are investors with joint control of, or significant influence over, an investee (associate or joint venture). It is applicable from 2013/14 but not yet adopted by the EU. This is unlikely to have an impact on CNWL in the immediate future.
Appendices
Appendix 1

Glossary of terms

Abbreviations

A & E  Accident and Emergency
BME  Black and Minority Ethnic
CAF  Common Assessment Framework
CAMHS  Child and Adolescent Mental Health Service
CDAT  Community Drug & Alcohol Team
CPSAS  Counter Fraud and Security Management Service
CRACH  Confidential Enquiry into Maternal and Child Health
CMHT  Community Mental Health Team
CNWL  Central and North West London NHS Foundation Trust
CPA  Care Programme Approach
CPS  Camden Provider Services
CQMG  Care Quality Management Group
CQC  Care Quality Commission
CQIN  Commissioning for Quality and Innovation
CRIHT  Crisis Resolution Home Treatment
DESMOND  Diabetes Education and Self Management for Ongoing and Newly Diagnosed
DoH  Department of Health
DIN  District nursing
DV  Domestic violence
E and D  Equality and Disability
EBITDA  Earnings Before Interest, Tax, Depreciation and Amortisation
EPDS  Edinburgh Postnatal Depression Scale
EPDOC  Electronically powered indoor/outdoor wheelchairs
EPR  Electronic Patient Record
FT  Foundation Trust
FT ARM  Foundation Trust Annual Reporting Manual
GBS  Government Banking Service
GP  General Practitioner
GUIM  Genito Urinary Medicine
HCH  Hillingdon Community Health
HIV  Human Immunodeficiency Virus
HMP  Her Majesty’s Prison
HMYOI  Her Majesty’s Young Offenders Institution
HCPCS  Health of the Nation Outcome Scales
HV  Health visiting
ICTA  Income and Corporation Tax Act
IFRS  International Financial Reporting Standards
IGSbC  Information Governance/Statement of Compliance
IT  Information Technology
JCC  Joint Consultative Committee
JP  Justice of the Peace
K & C  Kensington and Chelsea
KPI  Key Performance Indicator
LD  Learning Disabilities
LINA  Local Involvement Networks
LPC  Lead Professional Care
LSG  London Specialist Commissioners
MHA  Mental Health Act
MRSA  Methicillin-resistant Staphylococcus aureus
NACRO  National Association for the Care and Re-settlement of Offenders
NBV  Net Book Value
NED  Non-Executive Director
NSIH  National Confidential Inquiry into Suicide and Homicide
NHS  National Health Service
NHSLA  National Health Service Litigation Authority
NICE  National Institute for Health and Clinical Excellence
NHFR  National Institute for Health Research
NHSA  National Patient Safety Agency
OATS  Out of Area Treatments
OSCE  Objective Structured Clinical Examination
PALS  Patient Advice and Liaison Service
PCT  Primary Care Trust
PDC  Public Division Capital
PEAT  Patient Environment Action Teams
PFI  Private Finance Initiative
PID  Patient Identifiable Data
PMC  Performance Management Committee
PMQH  Prescribing Observatory for Mental Health
PPE  Property, Plant and Equipment
PRN  Pro re nata (as required)
QA  Quality Account
QS  Quality Governance
QIPP  Quality, Innovation, Productivity and Prevention
QI  Quality Information System
RAG  Red, amber, green
RICS  Royal Institute of Chartered Surveyors
RTA  Road Traffic Act
SGA  Safeguarding Adults
SMT  Senior Management Team
SoC  Statement of Comprehensive Income
SHP  Statement of Financial Position
UK CIP  United Kingdom Climate Impacts Programme
UK GAAP  United Kingdom Generally Accepted Accounting Practice
VAT  Value Added Tax
WTE  Whole time equivalent

Appendix 2

Explanation of key terms

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.

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.

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.

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

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.

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.

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.
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