Developing a Trust Wide Service User and Carer Strategy
1. Our Vision

Our Trust Vision of ‘Wellbeing for life’ commits us to working in partnership with all who use our services to improve health and wellbeing. It recognises that lived experience is just as valuable as the expertise of health professionals. We know that service users and their families have unique experiences, skills and abilities that enable them to offer expert advice to us about their treatment and support needs and how services can better meet these needs in the future.

Our aspiration is trust wide co-production at every level of service; delivering our services in an equal and reciprocal relationship between professionals, people using services, their families and communities.

- Front line/individual
- Team
- Learning & Development
- Service line
- Strategic/corporate
- Research & Development

2. Aims of a Service User Strategy

The aim of our strategy is to provide a trust wide framework for service user and carer involvement that supports a stepped approach towards embedding co-production as business as usual. As such it must build on the work undertaken to fully involve service users in their care and:

- Develop trust wide recognition of the value of involving service users, their carer and families in their own care, in developing and improving the services they use, and in the development of strategy and policy to drive excellence across all the services we deliver
- Develop a trust wide understanding of co-production, the different types of service user involvement; the opportunities, benefits, limitations and how to best realise the potential of our service users as assets.
- Develop centralised leadership, support and guidance that encourages innovation and trust wide sharing of good practice and learning
- Transform the views often held that people who use services are passive recipients of services and burdens on the system into ones where they are recognised as partners in designing and delivering services

3. Our Principles

We recognise that services are more effective if they are developed and delivered with the direct involvement of the people and families who use them. This is why our strategic objectives include involving, informing, empowering and being guided by the people we serve. We are committed to the following principles to support meaningful involvement that affects real change:

- Engagement and involvement should happen at the earliest possible stage
- Involvement should be well planned, well supported and embedded as a key component of service delivery
- Involvement should not be ‘one size fits all’, it must value diversity and seek to appropriately involve all service users
• Supporting service users and carer to exercise their influence and power and encouraging service user and carer empowerment which is central to effective involvement
• Involvement should be recognised and rewarded
• Involvement should be used to improve and develop services and affect change on an individual, service and organisational level
• The opportunities for and the impact of involvement should be clearly communicated

4. Our Framework

Our ultimate goal is to support the development of co-production that is meaningful and appropriate to each service line whilst feeding into, supporting and influencing trust wide and corporate co-production in strategy, quality and performance. We know that there is already a huge amount of activity being undertaken across the trust but understanding of, and therefore levels of service user and carer involvement differ significantly across service lines and individual services.

It is important to acknowledge that planning and activity must be meaningful to our service users, carers and staff and support the trust to meet and evidence the required standards and expectations set by our commissioners and governing bodies. Whilst some standards are national and therefore trust wide, others are set as locally part of contracted KPIs, CQUINS and QUIPP plans. This is not always going to be an easy fit and this section therefore provides a framework of definitions, expectations and standards that includes these non-negotiable areas and supports an approach to service user involvement that is flexible enough to meet all needs.

4.1 Definitions

| Co-production | • Staff and service users/carers develop ideas for action, share all major decisions and responsibility for implementation, evaluation and review |
| Representation | • Service users and carers represent the views of their peers on specific issues |
| Consultation | • Service users and carers are invited to share their views and give feedback on proposals, decisions and actions |
| Information | • Service users and carers are provided with information |

4.2 Expectations

Service user and carer involvement is the responsibility of all staff. It is a vital part of service delivery and no service should be considered competent unless they are appropriately and meaningfully involving their service users, carers and families. The ‘what’ and ‘how’ must be appropriate to the type of service delivered and their service users’ wants, needs and abilities; however we must find a way to ensure we challenge any assumptions and associated low expectations. It will therefore be largely the decision of each service line and their service users.

The process MUST acknowledge and explore creative ways which support individuals to engage and contribute; and which will bring about sustainable change. For example we might consider engaging service users who have been through our services and are further along their recovery journey to inform developments if current patients are too unwell to engage with the specific task.

There is also a need for the trust to more widely evidence, share and use good practice and the feedback it produces to drive the quality of our services and respond to National and local quality standards. In response, we have developed a set of expectations and minimum standards that will allow service lines to continually expand and strengthen service user involvement in the best way
for their service users, whilst supporting the trust to better understand, evidence and develop strategic responses to common themes, gaps and barriers that prevent service users from receiving and experiencing excellent support.

### 4.2.1 Minimum Standard Expectations for Planning and Review

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Guidance</th>
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| **1. Each Service Line and corporate department has an annual service user involvement plan** | The plan should benchmark current activity and impact; and outline actions for improvement. Services/departments should be free to develop their own plans so that they appropriately reflect the wants, needs and abilities of their service users, however the plan MUST be developed in consultation with staff and service users and must reflect;  
- Relevant CQC Essential Standards  
- CNWL Quality Priorities  
- Any CNWL minimum standards not yet reached  
- National and local CQUINs  
- Individual commissioner/contract requirements |
| **2. All services produce a quarterly Service User and Carer Report for Senior Management Teams** | This must summarise activity, feedback, responses and impact of service user and carer involvement as well as highlighting issues/challenges and good practice/innovation for discussion at Senior Management Team Meetings |
| **3. All Service Lines/corporate departments produce a quarterly Service User and Carer Involvement Report for Divisional Directors** | This must summarise performance against plan, activity, feedback, responses and impact of service user and carer involvement and performance against the annual plan. It should also highlight issues/challenges and good practice/innovation for discussion at Divisional/Trust Meetings |
| **4. All meetings discuss service user and carer involvement** | This will promote regular reporting, review and responses to feedback. Minutes must reflect regular reports and discussions at team, business/planning and quality meetings. |
| **5. All service/department reviews, development plans and new initiatives ask the following 3 governance questions** | Minutes and documents must evidence that service users were involved, how they felt about their involvement and what impact it had  
a. To what extent were service users involved?  
b. Were service users satisfied with their level of involvement?  
c. Did service user involvement make a difference? |
| **6. Each service line/corporate department has a well communicated named contact for providing information and evidence** | This will promote fast and effective responses to trust wide calls for evidence, FOI’s and inspections and aims to reduce the impact of these often short notice requests on individual teams. It is up to service lines to decide who is best placed to meet this need. The name and contact details of this person... |
about service user and carer involvement activity across the service line and someone who can be contacted if they are absent must be supplied to the Trust Service User and Carer Involvement Coordinator

7. All staff have service user involvement included in their appraisal objectives and access to training and support to develop skills and confidence All staff must have at least one objective that supports the achievement of the objectives set out in their relevant service user involvement plan. Staff development and job plans must include access to and evidence participation in training and support to develop service user involvement skills and confidence

4.2.2 Minimum Requirement Expectations

- Front line/individual Level

<table>
<thead>
<tr>
<th>Minimum Standard</th>
<th>Evidence Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Service users and carers know how to complain</td>
<td>• Complaints leaflets and posters are available in reception areas • A process is in place to disseminate information to patients • Patients report that they know how to make a complaint</td>
</tr>
<tr>
<td>Process must be; a. displayed in reception and other areas used regularly by patients/carer/families b. provided and explained to service users and carers on or before first face to face contact</td>
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- Team Level

<table>
<thead>
<tr>
<th>Minimum Standard</th>
<th>Evidence Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Printed and electronic service information is available</td>
<td>• Leaflets/posters or other information is available • Information is age, ability and language appropriate • Website</td>
</tr>
<tr>
<td>2. Activities are be supported by a project outline</td>
<td>• Documented project/task outline and associated selection criteria</td>
</tr>
<tr>
<td>This details what we are asking service users to engage in/with; for how long; in what capacity and what they can realistically influence and the skills required</td>
<td></td>
</tr>
<tr>
<td>3. All services/departments have mechanisms in place for eliciting feedback/developing co-production projects</td>
<td>• Service user groups FORUMS/events • Meetings dates and minutes • Surveys, suggestion boxes, newsletters • Service user representation</td>
</tr>
</tbody>
</table>
4. Regular feedback is provided to service users about the impact they have had
   - You said, we did notice boards, newsletters, website feedback, etc

5. Quarterly service user involvement report to SMTs
   - Report

6. Service user involvement is reviewed discussed and considered as part of business, planning and clinical meetings
   - Minutes
   - Reports

- Service Line Level

<table>
<thead>
<tr>
<th>Minimum Standard</th>
<th>Evidence Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Service users are involved appropriately in recruitment of staff</td>
<td>Recruitment training, process and records</td>
</tr>
<tr>
<td>2. Service users are consulted about service developments or changes that have a significant impact on the service they receive</td>
<td>Consultation documentation and feedback reports</td>
</tr>
<tr>
<td>3. All service users/carers have access to training &amp; development opportunities in relation to ‘getting involved’.</td>
<td>Workshops and courses detailed in the Recovery College prospectus</td>
</tr>
</tbody>
</table>
| 4. Activities are be supported by a project outline
  This details what we are asking service users to engage in/with; for how long; in what capacity and what they can realistically influence and the skills required | Documented project/task outline |
| 5. Regular feedback to staff and service users regarding impact | You said/we did reports, annual service user feedback report, information on website, etc. |
| 6. Service user involvement is reviewed discussed and considered as part of business, planning and clinical meetings | Minutes
   - Reports |
| 7. Quarterly service user involvement report to Divisional Director | Report |

- Learning and Development Level

<table>
<thead>
<tr>
<th>Minimum Standard</th>
<th>Evidence Examples</th>
</tr>
</thead>
</table>
| 1. All Recovery College workshops and courses are co-produced | Recovery College audit of workshops and courses
   - Annual report |
| 2. Workshops are available which support shared decision making and co-production at all levels of the organisation | Recovery College audit of workshops and courses
   - Annual report |
<table>
<thead>
<tr>
<th>Minimum Standard</th>
<th>Evidence Examples</th>
</tr>
</thead>
</table>
| 1. Trust level leadership and coordination is in place that provides a strategic overview of all activity and supports trust wide initiatives | • Identified Director level lead  
• Identified co-ordinator/team  
• Governance structure  
• Policy documents |
| 2. Service user involvement is discussed as part of all trust/corporate department meetings | • Minutes,  
• reports,  
• service user representation |
| 3. Trust Board identifies and responds to cross cutting issues which may transcend division/service line and may be organisation wide e.g. Friends and Family tests etc. | • Minutes  
• Reports |
| 1. Trust wide activities are undertaken to address/explore cross cutting issues | • Project outlines, feedback reports, impact evaluation, etc |
| 4. Service User and Carer Involvement impact is part of annual reports           | • Annual report |
5. **Recommendations and Timescales**

Well-structured central leadership, co-ordination and support is vital if the to developing, embedding and sustaining a trust wide approach to service user and carer involvement. With the imminent changes Trust structures, it is recommended that the following actions are undertaken over the next 6 months with a view to developing a co-produced strategy once future structures are clear.

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Lead and Timescale</th>
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</table>
| **Develop Trust wide Service User Carer Involvement Team/Board** | This should not be new investment. It should concentrate on re-developing/widening existing roles in order to provide strategic oversight and guidance that will support a trust wide co-ordination by developing;  
  - A single point of contact for trust wide evidence collection/reports  
  - An integrated approach to service user involvement that supports links to internal and external cross cutting public, patient and staff involvement groups and activities (i.e. internal work within recovery college, corporate depts. - Quality, E&D, etc and external orgs/boards such as PALS, Healthwatch and other Borough focussed groups/meetings)  
  - Policy and protocol and guidance  
  - A way to encourage, communicate and share best practice and innovation  
  - Training and support to promote workforce development and best practice in service user and carer involvement at every level  
  - Access to money/benefit advice and support for service users who want to get involved Opportunities for service user and carer involvement at trust wide strategic level i.e. developing and supporting Trust level Service User and Carer Groups and representation | Andy Mattin and Trust Board  
July 2014 |
| **Develop a Service User Involvement dashboard** | This should integrate existing indicators and form part of the existing Trust quality indicators dashboard and be used to support;  
  - Measurement of quality from a user and carer perspective  
  - Measurement of impact/change  
  - Planning of audit work  
  - Development of workforce training plans | Andy Mattin and Divisional Directors  
July 2014 |
| **All Services reach minimum standards** | Service User and Carer Involvement plans and quarterly reporting in place | Andy Mattin  
Divisional Directors  
November 2014 |
<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Lead and Timescale</th>
</tr>
</thead>
</table>
| Co-produce a Trust Service User and Carer Involvement Toolkit | This should contain  
- Suggestions of appropriate activity, including good practice examples from across the trust and feedback from service users/carers about how they want/would like to be involved  
- Guidance on developing service user forums, groups, events and meaningful representation structures  
- Guidance on planning and evaluating short, medium and long term task, projects and activities  
- Guidance on measuring and evidencing impact  
- Guidance for recruitment and reward of service users and carers  
- Details of learning and development opportunities, for staff, service users and carers, to ensure knowledge and skills which will facilitate their involvement | Andy Mattin and Service User and Carer Involvement Team/Board September 2014 |
| Develop a Trust Peer Bank network | A ‘peer bank’ would develop a network of service users and former service users with lived experience AND other clearly identified skills/expertise (i.e. IT, HR, strategy, teaching/training, youth work, project management, etc) that would support trust wide access to the right service users for the job and provide service users with a huge range of opportunities to get involved and shape services at all levels. Development would require  
- A formal and regular recruitment and selection process  
- Job descriptions and person specifications  
- A robust, accessible training programme  
- Choice based reward guidelines  
- Trust investment (innovation)  

Centralising this function would prevent duplication across service lines and therefore provide a more cost effective approach | Andy Mattin and Service User and Carer Involvement Team/Board November 2014 |
| CNWL commit to an annual co-produced trust wide ‘test’ of one of the CQC Essential Standards. | This annual activity would test each service line’s performance against one of the standards | Andy Mattin and Service User and Carer Involvement Team/Board To be undertaken Jan – March 2015 |
Appendix 1: Patient Experience Feedback Surveys

All service lines are using patient experience surveys that support measurement of the Trust's Quality Priorities from a service user perspective. The feedback is used to develop and implement improvement plans that are monitored by Quality and Performance Committees. In most cases feedback can be broken down to individual service level and is then also used to develop service specific improvement plans that are monitored as part of team meetings. This appendix provides some examples of how the surveys are undertaken and response rates across services lines and within individual services.

1. CNWL Community Health Patient Survey (Hillingdon, Camden and Milton Keynes)

   a. Purpose
   This annual survey is undertaken by an external provider to gather feedback on patient experience of service, staff and involvement in care and identify areas of good practice and areas for improvement in the following services:
   - Community health services for children and families
   - Community dental and nursing services
   - Disability support services
   - Foot care (podiatry) services
   - Neurological & community rehabilitation, and falls prevention services
   - Palliative care services
   - Therapies

   b. Response Rate
<table>
<thead>
<tr>
<th>Community Services</th>
<th>Response Rate</th>
<th>Completed Questionnaires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milton Keynes</td>
<td>22%</td>
<td>644</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>28%</td>
<td>806</td>
</tr>
<tr>
<td>Camden</td>
<td>24%</td>
<td>678</td>
</tr>
<tr>
<td>OVERALL TOTAL</td>
<td></td>
<td>2,128</td>
</tr>
</tbody>
</table>

2. CNWL Mental Health Patient Surveys

   a. Purpose
   These telephone surveys are conducted by a team of service users who are DBS checked and trained. The purpose is to gather feedback on patient experience of service, staff and involvement in care and identify areas of good practice and areas for improvement across the following services:
   - Community recovery
   - ABT
   - Rehab
   - Eating disorders
   - Addictions
   - Acute mental health
3. **Quick Feedback Cards for Sexual Health & HIV Services**

   **a. Purpose**
   Feedback cards are given to every service user using the service. The purpose is to gather feedback on patient experience of service, staff and involvement in care and identify areas of good practice and areas for improvement across the following services:
   - Community recovery
   - ABT
   - Rehab
   - Eating disorders
   - Addictions
   - Acute mental health

   **b. Response Rate**

<table>
<thead>
<tr>
<th>Service</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total Completed 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>103</td>
<td>51</td>
<td>118</td>
<td>91</td>
<td>368</td>
</tr>
<tr>
<td>Community</td>
<td>468</td>
<td>386</td>
<td>546</td>
<td>733</td>
<td>2,133</td>
</tr>
</tbody>
</table>

4. **Eating Disorders: patient Satisfaction survey**

   **a. Purpose**
   Patients are all asked to complete a questionnaire at the start and end of their treatment packages to gather feedback on patient experience of service, staff and involvement in care and identify areas of good practice and areas for improvement across the following Eating Disorder services:
   - Inpatient
   - Outpatient
   - Day patient

   **b. Response Rate**

<table>
<thead>
<tr>
<th>Service</th>
<th>Total Completed Q4 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>11</td>
</tr>
<tr>
<td>Outpatient</td>
<td>45</td>
</tr>
<tr>
<td>Day patient</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>64</td>
</tr>
</tbody>
</table>
Appendix 2: Co-production Projects

This Appendix gives an example of some of the co-production projects that have been undertaken across the trust in the last 12 months

1. Learning Disabilities ‘Journey to Self Discovery – making My Life Better’

The aim of this project was to co-produce a way for people with learning disabilities, their families, friends, carers and the staff who work with them, to become experts in their own care. A group of Learning Disabilities service users worked in partnership with staff and the recovery college and the end result is the Journey to self discovery course that develops the skills and confidence of service users in managing their own recovery journey.

The Pilot course was extremely well received by service users, carers and staff and it will now become part of the rolling programme delivered by the recovery college and co-facilitated by staff and peer trainer service users.

2. Psychological Medicine ‘Simon and Meg’

The aim of this project was to develop a training video as part of a package of training for both mental health and acute staff who might be working with people with mental health problems in the Emergency Department.

A group of service users worked with staff in developing a script based on lived experiences of both patients and staff and testing it to make sure it was portrayed as realistically as possible. The following is a link to the trailer for the final training video: http://vimeo.com/user6280103/review/55941547/59a8684645

This package has now been rolled out to all the Trusts acute hospital sites and it has been very well received. We are now also delivering training for Hertfordshire and WLMHT.

3. CAMHS and Me Website

The aim of this project was to develop a CAMHS website that provides children, young people and their families with the information they want and need in relation to mental health.

Service users from across the 5 CAMHS delivery boroughs worked with staff to undertake consultation, procure a provider and work with them to design the content, look, navigation and promotion of the site.

The site provides information to support children, young people and their families to understand what emotional/mental health is, information on diagnosis and different mental health disorders and difficulties, resources to support good mental health, self management and recovery, signposts local support and resources and includes lived experience and experience of service stories.

A CAMHS and Me Twitter account will be used to promote website which launches next month at jointly planned and delivered event.
4. Mental Health Rehabilitation and Digital Social Inclusion

This project aimed to explore the use of digital technologies for supporting independent living for those with severe and enduring mental health problems. A project group of service users and staff worked together to pilot an approach and develop a business case for investment. The end result was a business case that identified:

- Potential commissioning savings through reduced use of out-of-borough funding by facilitating more rapid move-on through the step-down services
- Potential in-house savings through reducing staff roles such as on-site waking night staff.
- A quality improvement case that focuses on a shift of the staff functional role from safety monitoring to supporting digital engagement and confidence-building for service users through digital skills training and self-advocacy.

This successfully secured the approval of the Rehabilitation Service’s Senior Management Team and a digital inclusion programme based on the pilot findings will now run for 12 months.
Appendix 3: Other Areas of Involvement

All our staff and service users share decisions about their individual care and the trust is building on this to develop shared decision making on a team, service line and strategic level. This appendix provides some examples of the ways service users are more widely influencing and sharing decisions about their services, who delivers them and how they are delivered.

1. Recruitment and Selection of Staff
A range of training programmes have been developed for both staff and service users that support active involved in the recruitment of staff at all levels. This includes short listing, interview and selection as part of interview panels and assessment centre recruitment processes.

2. Workforce Training and Development

- **Milton Keynes**
  As part of the Friends and Families Questionnaire, service users are invited to leave their contact details if they would like to share their experiences in more detail. As a result 9 patient story films have now been made and are used internally for training and (where permission is given) posted on the website. These stories cover experience of District Nursing, Speech and Language, Health Visiting and Mental Health

- **Acute 'Telling your Story'**
  This initiative is currently being piloted at the Gordon Hospital and if successful, will be rolled out to all other acute sites. Service User’s are invited back to the unit to speak to ward staff within a supported learning environment about their experiences of being an inpatient. This not only supports service users to feel empowered to tell their story but staff get to see the later part of their recovery journey as opposed to only having contact when they are acutely unwell/in crisis. This supports us to really listen to our service users’ experiences, learn from it and work with them to review and develop our workforce and services in response

- **Recovery College**
  The CNWL recovery college staff includes service users and works trust wide to support the development of workforce, patient and carer understanding, knowledge and skills in order to explore what recovery means and effectively support service users to take charge of their own lives.

3. Peer Support/Review

- **Addictions**
  Paid peer support workers have been recruited in each sector. All are current or ex CNWL service users.
• Mental Health Acute 'Tree of Hope' and Peer Support
The Tree of hope is a wall painting of a Tree on Gerrard Ward that was designed by its residents and enables all inpatients to leave messages of hope for others. Peer support workers have now also been introduced to the inpatient wards

• Learning Disabilities Peer Review Project
Led by a peer review officer (a former service user), this project supports service users to review the service in terms of safeguarding, health and safety, communication, food and nutrition, care and welfare, environment and clinical delivery such as groups, 1:1 support, CPA and community access.

4. Representation

• Mental Health (Rehabilitation)
Director of Brent Service User Group sits on Service Line Quality Board to represent the views of service users

• Learning Disabilities
Peer review officer attends corporate and borough meetings to speak on behalf of service users

• Addictions
  o A strategic Service User Group of elected representatives meets with service directors on a monthly basis
  o Peer support workers and service user representatives are part of care quality and performance management groups and have regular meetings with sector managers
  o Addictions hosts the London User Forum, hosting meetings and providing hot desk space and liaison support with other substance misuse providers
  o Annual Service user conference

5. Tender and Service Design
The Addictions service line have involved service users in design of service models, tender interviews and implementation of new services

6. Research
A new initiative where a central group of 10-12 Service Users and Carers will be appointed by ballot to serve for 1 year. The Group will coordinate and organise the involvement of Service Users and Carers in the co-production of research conducted within CNWL and affiliated organisations.
Appendix 4: Impact and Feedback

Services use a range of methods to feedback to service users about the impact of feedback from surveys and other involvement activities, as well as how service users, their carers, friends and families can get involved. This appendix provides some examples of the changes that have been made as a result of feedback over the last 12 months and the ways we feedback about what has changed.

1. Impact

Providing integrated, high-quality, timely services based on the needs of the individual
- District Nursing: Now provide 2 hour time band for visits following feedback that waiting in for a Nurse visit impacted on planning
- Speech and Language Service: Now provide an additional speech and language therapist at the drop in clinic to prevent the need for separate assessment appointments/unnecessary return visits
- Sexual Health: Waiting times are continually raised on feedback cards. As a result the has agreed that patients who have waited longer than 20mins should be encouraged to raise this with staff so that support can be sought and any wait of more than 60mins should be reported as an incident so that root causes of very long waits can be identified.
- Sexual Health: patients are now informed of the clinician’s gender for certain procedures in case they have a preference. This ensures an appropriate appointment is booked first time.

Involving, informing and empower the people we serve
- CAMHS: Co-produced service information leaflets have been developed that provide what service users, their families and carers and have told us they want to know rather than what we think they need to know
- Older People: meal choice is now displayed on a white board in response to feedback that meal times felt chaotic
- Offender Care: A prisoner healthcare forum is now in place in response to the Friends and Family Test feedback. It will focus on Health Promotion and Education
- Addiction, The Junction: Co-produced service user involvement event to review and plan and improve engagement and involvement and develop a service user group to take actions forward
- Sexual Health: Co-ordinated effort to develop and maintain links with external linked services following reports from patients of incorrect information being available on their websites.
- Trust wide: CNWL Quality Indicators and the annual plan are developed in consultation with service users and carers

Ensure our healthcare facilities are well maintained and fit for purpose
- Brent Community Rehab Houses: An improvement budget has given to each house Residents will lead decisions on improvement work for communal areas; furniture and
equipment, cleaning and replacement and the garden areas. They will also choose lighting, paint colours, soft furnishings and plants, etc.

**Recruiting, retaining and developing skilled and compassionate people who embody our values of care.**

- Service users share decision making in the recruitment of the staff who provide, plan and shape their services
- Service users are involved in developing, delivering and evaluating staff training within individual service lines and as part of the recovery college (i.e. staff induction, CPA process, section 12 refresher training, developing engagement skills, understanding and supporting recovery). In many areas training courses and workshops are open to patients, staff, carers, families and friends in order to support respect, partnership and empowerment.

2. **Methods**

- **Newsletters and magazines**

- ‘You said we did’ information on websites, information boards and in newsletters
  Most services have these in place or have an active plan to roll them out in the coming year

- **Twitter**
  The Eating Disorder service use Twitter to gather and disseminate real time feedback. The account has been live for over a year and has a growing number of followers

- **Events**
  **Addictions annual service user ‘Engage’ conference**: The strategic service user group plan, design and manage an annual conference which normally has more than 100 participants. It normally features guest speakers on hot topics, an art award, live music and poetry, sector showcases, service user awards and a lunch. 2014 will be the third ‘engage’ event.
Objective

The objective of this document is to report the conclusions and recommendations of the CNWL Executive Board on an extensive internal review of complaints and Patient Advice and Liaison Services (PALS) across CNWL and the implementation programme to create a trust-wide Patient Support Service to manage all forms of patient feedback. Further, for the Board of Directors to endorse and authorise the Executive Board to establish the new trust-wide Patient Support Service.

Executive summary

Since the progress report to the BoD on 15th January 2014, the scope of the Complaints and PALS Review Programme has been widened to include process, structure, policy and cultural considerations. The previous conclusions of the Executive Board around the need to centralise the complaints and PALS functions into a Patient Support Team and strengthen the roles and responsibilities of local services to respond to complaints remain valid. The Programme has also considered the need for changes to the Service Model and Policy so that CNWL can bring about an organisational culture that values and uses patient feedback to affect service improvement.

This paper sets out the proposed service model and implementation plans to create a CNWL Patient Support Service that will replace the current Complaints and Patient Advice and Liaison Service functions across all CNWL localities and services.

The proposed model is a result of reviews and Executive Board scrutiny of a review carried out between October and December 2013, with subsequent reports presented to Executive Board and Board of Directors.

The service model is designed to fit with development of the CNWL divisional structure and is ‘future proof’ in that it can be extended to cover new services that are acquired by CNWL.

A broad range of CNWL staff, patient/carer and governor workshops and consultation has been undertaken with cross-referencing to national review papers. An option appraisal has also been previously documented to decide the best model to be proposed to
maximise future CNWL patient feedback and optimise organisational learning at all levels of CNWL.

The service model proposed includes a centralised co-located team of staff who will provide procedural support to patients who wish to give feedback across a spectrum of comments, enquiries, complaints and compliments. These staff will be redeployed from dispersed posts around the Trust subject to and following a consultation process. The model further proposes strengthening the roles and responsibilities of Divisional Directors and Service Line staff to ensure timely responses to feedback including complaints investigation.

This paper also sets out an implementation plan which is supported by the following:

- Fundamental Service Principles and patient, staff and governance principles
- Scrutiny of the proposed service model against recommendations made by the Clywd/Hart Report
- Governance structures and reporting
- Tracking and reporting requirements including quality standards
- Cultural considerations and Duty of Candour
- Policy and procedural documentation
- Implementation programme interdependencies and consideration of major risks to implementation
- Communications plans, both external and internal to CNWL
- Training and organisational development

A review of the CNWL Complaints Policy has been being undertaken. The draft new Patient and Carer Feedback (Complaints) Policy that will replace the former complaints policy is attached. The new policy and associated procedural document will be launched as part of the Patient Support Service Implementation Programme.

A programme to roll-out the full use of the web-based Datix database reporting system across all CNWL localities is also underway. The Datix programme aims to provide trust-wide coverage that enables the Patient Support Service to function efficiently.

The new Patient Support Service, Feedback Policy and Datix system roll-out will each be co-ordinated to ‘go-live’ in a synchronised plan, which is supported by an extensive internal and external communications plan.

Post-implementation, a review to assure the Executive Board that the service is delivering the intended benefits will be undertaken involving the Internal Audit Programme 2015-16 and the Expert Reference Group.

The proposed model has been reviewed and supported by a former Deputy Health Service Ombudsman, who considered that the general approach of a Single Point of Contact for all types of comments about services and a central team was most appropriate.
**Recommendation**

The Board of Directors is asked to endorse the recommendation of the Executive Board to establish the Patient Support Service and associated changes to the service model, structure, governance and reporting described within this report to enable an implementation programme to proceed. The implementation will be managed via a dedicated Programme Board.

The Board is also recommended to approve the Patient and Carer Feedback Policy (Complaints Policy) which is also attached.

Andy Mattin  
Director of Operations and Nursing  

6 May 2014
1.0 The Service Model; Patient Support Service

1.1 Service Principles

The principles by which CNWL wishes to provide for patient and carer feedback on our services are:

Fundamental Principles

CNWL welcomes all types of feedback on its services and will respond in a timely manner, with openness and a keenness to learn from the feedback.

Patient and Carer feedback covers a range of types of issue raised by our patients, their carers and family/friends. The range includes comments, enquiries, complaints and compliments.

CNWL will apologise if we did the wrong thing, do what we can to put things right and make sure that it does not happen again.

Function of the Service – A Patient Support Service will deal with a complete spectrum of patient feedback; from enquiries (formerly PALS enquiries), comments, compliments and complaints.

Patient support will occur at the point in the organisation which is closest to the point of service provision - initial responses to enquiries and comments will be resolved at a local level, with adequate training to staff to allow rapid identification of issues that can be locally resolved; thus reducing the number of complaints.

Patients

CNWL will give time to allow feedback to be heard and acted upon.

Litigation or threat of litigation will not be a barrier to investigation of a complaint.

Patients will be informed about how to provide feedback (including how to raise concerns and complaints) from the commencement of treatment with CNWL. All CNWL sites should have clearly visible information telling patients how to raise any issue with Trust staff including complaints; the right to gain independent advice and support whilst raising concerns with the Trust and the right to refer to the Health Ombudsman if not satisfied with CNWL's response to their complaint.

Advocacy and Support to Patients or Family/Carers who wish to complain will be made available via services such as Voiceability.

Single Point of Contact (SPOC) – Access to the service will be as simple and easy as possible without complex stages or varied contact points; the details of access need to be in one location. The SPOC will consist of access by:

- Freepost postal address
- Dedicated e-mail address
Dedicated telephone number
Online fast feedback form

The Process of Investigation of issues and complaints will be carried out by suitably trained/qualified staff who are sufficiently distant from the point of care delivery to be acceptably deemed impartial from the service provider to avoid services investigating themselves.

Investigations will include the use of external fully independent investigators where appropriate; especially in cases that involve a serious incident.

Follow-up letters – A written response will be sent following all complaints raised with the Trust. Following compliments, enquiries and comments, a written response will be sent where appropriate.

All closure communications will invite the patient or carer to give feedback on the patient experience of using the service.

Referral to the Health Ombudsman is a right for patients/carers if they are not satisfied with the Trust’s response to their complaint. They should be made aware of this right by CNWL.

Staff

The response of CNWL staff to the person raising an enquiry, comment or complaint should be empathetic, quick and focused on what is most important to that person.

Professional Behaviour when handling a complaint is described as:
- Getting it right
- Customer focused
- Honest and open
- Fair and proportionate
- Willingness to listen to the complainant
- Understanding and working with the complainant to put things right

CNWL will train, support and supervise its staff to have the confidence, capacity and expertise to deal with all forms of patient and carer feedback.

Front-line staff should be adequately resourced, trained and supported to provide a professional service. This includes suitable training packages suited to the levels of need amongst staff, namely: formal training for Divisional Director level on the process and skills of managing complaints investigations and finalising complaint responses; Specific training courses for Complaint Investigators; Awareness training for front line staff to equip them with skills to professionally respond to patient feedback and customer focused training for the Patient Support Team.

Governance

Board-led Scrutiny of Complaints – An executive director will have responsibility for the management of complaints performance (e.g. response time, patient satisfaction with complaint resolution).
**Independent Investigation** - When a complaint is concerned with issues that amount to a serious incident, professional misconduct or performance of senior managers or needs expert clinical advice, an independent investigation should be considered from sources that are external to CNWL.

**Single Database** – The service should use an organisation-wide database that staff can access to input data and that provides reporting across the whole organisation. The database should provide functionality to allow tracking of all feedback types and appropriate access for different levels of staff to be able to input data and view progress reports for individual items of feedback (most importantly Complaints turnaround) and for divisional/service line performance.

**Patient Services integrated with quality and governance teams** – co-location or close communications links with other teams in quality and governance will enhance possibilities of making more appropriate responses when a complainant’s comments highlight issues in these areas.

**Centralised processes** – Process-driven activities can be more efficiently performed within a pooled skill environment.

**Local investigation** – Experts in the service provision should be tasked with investigation of complaints. However, it is important to avoid situations where investigation is not objective because ‘a service is investigating itself’. Appropriate choice of investigator is key to ensuring that the investigation is seen as objective.

**Continuous Improvement** of our handling of feedback and complaints will be driven by monitoring the experiences of patients/carers who have used the Patient Support Service.

The documents that these service principles are based upon are listed below. Each has been used in the development of the reviews and reports previously presented to the Executive Board or Board of Directors.

- CNWL complaints staff workshop, August 2013
- Good Practice Areas identified in the Complaints and PALS Review Report, January 2014
- CNWL Governors’ Workshop on Complaints and PALS Brief Report, December 2013
- Recommendations made by the Francis Inquiry (2013)
- Recommendations made by the Clwyd/Hart Report (2013)
- Hard Truths. The Journey to Putting Patients First, DH January 2014

### 1.2 Scrutiny against Clwyd/Hart recommendations

The recommendations of the Clwyd/Hart Report (A Review of the NHS Hospitals Complaints System, Putting Patients Back in the Picture) are set out in Appendix A with details of how the Patient Support Service model addresses each of the recommendations that relate to complaints and patient feedback.
1.3 The Proposed Patient Service Model

The service model will comprise of:

- The development of a Trust-wide culture that values patient and carer feedback as a learning opportunity and a chance to improve our services.

- A Single Point of Contact based on information being readily available across CNWL service locations to enable patients and carers to effectively provide feedback via e-mail, letter, electronic feedback form and by telephone.

- Centralised Patient Support Team that is sufficiently resourced and trained to receive feedback and support services in their responses.

- Devolved responsibilities for responding to feedback, including final complaint responses within 25 working days. Divisional and service staff will have responsibility for resolving feedback issues at the point that is closest to the point of service delivery and in the shortest time possible.

- Datix web-based system rolled out across all CNWL localities with access for all staff involved in responding to user/carer feedback, so that the system provides real time status tracking of progress and details of all forms of feedback across the Trust.

- Reporting tailored to needs at appropriate levels of the organisation: service performance; response tracking; performance reporting; organisational learning.

- Patient/Carer satisfaction monitoring and reporting via regular and systematic surveying of people who have used the Patient Support Team.

The proposed service model brings about a change to the dispersed and fragmented approach to handling the CNWL response to patient feedback, including complaints. Staff who currently work directly on complaints and PALS functions at different localities of the Trust would be brought into a single team.

The centralisation of these staff into a single central team and revised roles/responsibilities for local investigation have been previously approved by the Executive Board in February 2014 (see Appendix B).

1.4 Process Diagrams

The following diagram illustrates the process by which the spectrum of patient feedback will be received at a single point of contact and investigation or responses made at appropriate levels of the organisation. The diagram therefore has four streams for the spectrum of feedback: compliments, enquiries, comments and complaints, reflecting the different levels of response needed.
The second diagram also illustrates the additional part of the process that takes place for complaints as the Divisional Directors are responsible for allocating a complaint investigator and for the final draft and send-out of the response to the complaint.

Both illustrations are colour coded to show the responsibility for the action at each stage of the process.
Central and North West London NHS Foundation Trust

**Process Stage**
- Compliment
- Enquiry
- Comment
- Complaint

**Single Point of Contact**
- RECEIPT of Patient/Service User / Carer / Family Feedback
- Patient Support Service processing
- Investigation or Response
- RESPONSE to Patient/Service User / Carer / Family

**Logging on Datix**
- Allocation / Send to Divisional Director for local action

**Compliment**
- Sent to Team/Ward Manager or Staff Manager
- Acknowledgement / Thanks sent from Patient Support Team

**Enquiry**
- Send to appropriate staff or Senior Service Manager
- Response sent directly from Service Copy to Patient Support Team

**Comment**
- Send to Senior Service Manager
- Acknowledgement sent from Patient Support Team

**Complaint**
- Allocated to Divisional Director for INVESTIGATION See separate detail
- Final Response sent from Divisional Director Copy to Patient Support Team

**Key:**
- Process
- Patient Support Team
- CNWL Service
- Service User

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Allocation to Investigation Officer

- Qualified and knowledgeable member of staff
- Independent from the service about which the complaint has been made

Checking with Complainant

- Investigation Officer contacts complainant to check understanding of the nature of the complaint (point by point)
- Agreement of deadline for response
- Note: Response deadline is 25 working days from receipt of complaint unless longer period needs to be negotiated with complainant. Deadlines greater than 25 working days to be authorised by Divisional Director in writing

Investigation

- Clarification meetings with complainant if required
- Draft Response to Divisional Director

Final Response

- Letter to complainant sent with Divisional Director Signature

Datix Logging

- Copy to Patient Support Team
- Datix response date logged

Key:

- Process
- Patient Support Team
- CNWL Service
- Service User
1.5 Staff Structure

The following diagram shows the proposed team structure.

The proposed structure provides clear lines of accountability for a single team of staff who would coordinate and, where appropriate, lead the response to all patient feedback.
2.0 System changes required to support a Patient Support Model

2.1 Governance Structures

The following diagram shows the proposed governance reporting structure, which has been cross-referenced to the review of CNWL Governance structure currently being undertaken in parallel with the development of a Divisional Organisational Structure.

Reporting between the committees/groups and services are detailed in the tracking and reporting tables that follow the diagram.

The governance will be strengthened by the establishment of an Expert Reference Group (ERG) consisting of Patients, Carers, Healthwatch representative and Governors with an independent chair. The chair may be one of the CNWL Non-Executive Directors. The purpose of the ERG would be to give an independent critique of the quarterly Patient Feedback reports and to supplement this with a critical review of a sample of complaints. The work of the ERG would be reported to the Executive Board via the Organisational Learning Group.
Intelligent Analysis includes:
- Feedback data
- Complaints/Issues
- Incidents
- Patient Experience
- Risk Assessments
2.2 Reporting Structures

Broadly speaking, The Patient Support Service needs to be able to provide governance assurance of two business critical objectives:

- **Procedural Compliance**, e.g. ensuring that complaint responses are delivered before the 25 working day deadline; ensuring that feedback comments and complaints are professionally investigated and responded to
- **Organisational Learning**, e.g. provision of data and analysis that allows CNWL to identify trends in patient feedback at service and Trust levels and hence areas of concern and thereby the need for remedial or developmental action

In order to provide CNWL with timely organisational learning and delivery of change as a result of patient/carer feedback, reporting ‘from ward to board’ needs to be integral to the reporting delivered by the Patient Support Team. This is achieved by reporting ‘intelligent analyses’, including activity data generated from Datix, qualitative analysis, patient experience and risk analysis, enabling trends and issues to be rapidly identified and acted upon.

There are two levels between ward and board at which the Patient Support Team need to provide reporting:

- **Performance and quantitative trend analysis on a monthly and quarterly basis**
- **Tracking of feedback activities in real time to support Divisional staff in being able to respond to change**

2.3 Tracking Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>To whom</th>
<th>Tracking Element</th>
<th>Frequency</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback/Complaint Status</td>
<td>Divisional Directors</td>
<td>Datix report of feedback by type/Division and Service/Status of response (e.g. logged, allocated, investigation in progress, response drafted, response sent)</td>
<td>Daily real time status</td>
<td>Patient Support Team</td>
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<td></td>
<td>Patient Support Team</td>
<td></td>
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<tr>
<td>Frequency of contact with complainant</td>
<td>Divisional Directors</td>
<td>Datix report of frequency distribution by Feedback type and Division/Service</td>
<td>Monthly</td>
<td>Patient Support Team</td>
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<tr>
<td>Response Deadline</td>
<td>Divisional Directors</td>
<td>Datix report of number of responses to feedback by met/not met deadline</td>
<td>Monthly</td>
<td>Patient Support Team</td>
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2.4 Reporting Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>To whom</th>
<th>Reporting Element</th>
<th>Frequency</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Performance and Organisational Learning</td>
<td>Board of Directors</td>
<td>Intelligent analysis of feedback data including:</td>
<td>Monthly</td>
<td>Associate Director, Corporate Governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Activity data</td>
<td>Quarterly &amp; Annual Summary</td>
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<td></td>
<td></td>
<td>• Performance against quality standards</td>
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<td></td>
<td></td>
<td>• Qualitative analysis of trends and issues</td>
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<td></td>
<td></td>
<td>• Patient Experience data</td>
<td></td>
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<tr>
<td>Trust Performance</td>
<td>Executive Board</td>
<td>As above with quarterly executive summary</td>
<td>Monthly</td>
<td>Associate Director, Corporate Governance</td>
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<td>and Organisational Learning</td>
<td></td>
<td></td>
<td>Quarterly &amp; Annual Summary</td>
<td></td>
</tr>
<tr>
<td>Trust Performance</td>
<td>Quality &amp; Performance Committee</td>
<td>As above with quarterly executive summary</td>
<td>Monthly</td>
<td>Head of Safety Patient Support Team</td>
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<tr>
<td>and Organisational Learning</td>
<td></td>
<td>Template Report</td>
<td>Quarterly &amp; Annual Summary</td>
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<tr>
<td>Organisational Learning</td>
<td>Organisational Learning Group</td>
<td>Feedback data including:</td>
<td>Monthly</td>
<td>Head of Safety Patient Support Team</td>
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<td></td>
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<td>• Activity data</td>
<td>Quarterly</td>
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<td>• Performance against quality standards</td>
<td>Summary</td>
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<td></td>
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<td>• Qualitative analysis of trends and issues</td>
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<td></td>
<td></td>
<td>• Patient Experience data</td>
<td></td>
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<tr>
<td>Performance Management</td>
<td>Divisional Directors</td>
<td>Patient feedback (including compliments, concerns, enquiries and complaints) to be</td>
<td>Monthly</td>
<td>Patient Support Team: to provide data and analysis.</td>
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<tr>
<td></td>
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<td>considered at divisional and service levels in conjunction with incident reports</td>
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<td>Divisional Directors: to ensure local analysis</td>
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<td></td>
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<td>and risk management logs</td>
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<td>and service improvement</td>
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2.5 Quality Standards

The main performance indicator will be the number/percentage of complaint responses that are provided to the complainant within a 25 working day standard or before an extended date agreed between the investigator and the complainant. Monitoring of activity data and numbers of complaints upheld is currently provided with reporting of complaint categories.

It is intended that the key performance indicators should be widened to include:

- Response to complaint times from receipt to response
2.6 Cultural Considerations

There is much topical debate about the way in which public services need to change their attitude towards feedback from patients and particularly changing from a state of wishing to suppress complaint numbers to a state of valuing and using all forms of feedback as a tool to drive continual service improvement. The Berwick Report (A promise to learn – a commitment to act: improving the safety of patients in England, 2013) advocates the creation of a culture of transparency, openness and continual learning with patients firmly the heart of organisational learning.

The overall numbers of complaints and variance in the number of feedback activities in each CNWL service suggest that we are at best ‘under-reporting’ on our feedback activities and this suggests that process, access and attitudes to feedback are neither sufficiently aligned with the business aims of the Trust or with the recommendations of the Berwick Report. There is clearly a need for a change in the ‘culture’ of handling patient feedback that would support our patients to be confident that raising issues, giving feedback and complaining will make a measurable difference to CNWL services.

Further details of how such changes would be base-lined and implemented are given below in the Training and Organisational Development, paragraph 3.4.

2.7 Policy

A review of the policy and procedures has been commissioned to reflect the changes that need to be made to make the CNWL Patient Support Team fit for purpose.

The policy review will be based on the service principles detailed in this report and will include statements of the roles and responsibilities for all staff involved in the management of patient feedback; in effect that means all CNWL staff. The new policy on patient feedback will replace the previous CNWL policies on Complaints and PAL Services in readiness for the implementation of the re-branded service.

A procedural document will also be developed to replace previous statements on the process by which CNWL will invite, respond to and act upon the full range of patient feedback.

2.8 Duty Of Candour

The Department of Health is currently consulting on the introduction of a statutory Duty of Candour (DoC) as a requirement for CQC registration with a timeframe for DoC becoming a Registration Requirement by October 2014. The regulations will place a legal requirement for NHS Trusts to inform patients when an error has occurred regardless of whether the patient knows about the error or makes a complaint at the time or subsequently.
The review and update of the CNWL Complaints Policy will include DoC responsibilities and hence training and cascade of the policy will include raising awareness of staff responsibilities under the new regulations. The responsibilities will include reporting of the error on the Datix system, making formal arrangements for informing and supporting the patient and reporting progress and conclusions on the Datix System.

2.9 Information and Communication Technology

The current DatixWeb system is used across approximately 80% of CNWL localities and is the preferred option for database systems that could support patient feedback in CNWL. The Datix functionality provides access for multiple staff at different levels of the organisation with restrictions on the levels of access according to need. The system also provides different modules, including those to manage complaints, patient experience, litigation and feedback.

A DatixWeb Consolidation Project Board has been commissioned by the Executive with the aim of providing a rapid appraisal of the ICT needs of the Patient Feedback Service and implementation of the system to provide CNWL-wide coverage.

This process has begun in March 2014 and is estimated to take 6-9 months before complete implementation of Datix.

2.10 Estates

Centralising the present complaints and PALS staff will require an office location to be provided that will facilitate the Patient Services Team being co-located. The estate will need to provide sufficient space for 5.1 wte staff and access to telecommunications and private meeting rooms to facilitate face to face meetings with patients and CNWL staff when required.

The estate requirements will be fed into the Estates Strategy team.
3.0 Implementation

3.1 Programme interdependencies and major risks

There are two critical programme inter-dependencies that have been identified within the Review Programme:

Roll-out of the Datix System.
This is critical because the Datix system provides a single database with which all staff involved in patient feedback will need to record, track, and report and analyse patient feedback.

Estates
This is critical to support the development of a team with the ability to provide cross-cover and mutual support.

Programme Risks

The major risks to the programme are:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Detail</th>
<th>Mitigation Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources: efficiently redeploying staff to a centralised Patient Support Team</td>
<td>Staff consultation and ability to bring staff (including part-time staff) from across the Trust into one centralised team within a short timescale.</td>
<td>• Regular and open communications to staff affected. • Lead HR Manager advice and input to the Programme before, during and after staff consultation/changes to staffing.</td>
</tr>
<tr>
<td>ICT: availability of a single database system at all CNWL localities.</td>
<td>Three different databases are in use across Trust localities. None of the databases are used consistently across complaints, PALS and litigation etc. Datix system is the most widely used and is the system of choice for a large proportion of NHS Trusts. A project to review provision; provide an option appraisal and procure a system across all localities commenced in late March 2014. The expected timeframe is 6 months provided the project is driven to deliver with key decisions taken in a timely manner.</td>
<td>• System Review Project will be managed by the same CNWL staff. • Programme Board to receive regular updates from the System Review Programme • Patient Support Service can go-live ahead of full implementation if necessary.</td>
</tr>
<tr>
<td>Estates: availability of office accommodation to house centralised Patient Support Team of 5.1 wte staff.</td>
<td>2.8 wte of the staff are currently located at CNWL Trust Headquarters. The implementation of the Patient Support Service will require all 5.1 wte staff to be accommodated in the same location with dedicated access to computers, telephones, photocopier and secure file storage.</td>
<td>• Early specification of the estate requirements will be made to the CNWL Estates and Facilities Directorate to ensure procurement of adequate accommodation and facilities. • Location of the Patient Support Team ideally would be at Trust Headquarters as a major source</td>
</tr>
</tbody>
</table>
3.2 Communications

Communicating the changes that will be made to create an effective Patient Support Service will be a crucial part of the work needed to successfully implement the service and support the change in the way that CNWL values patient feedback. This will include external and internal communications messages. The Director of Communications has been involved in developing the following strategy for communications.

External Communications

The primary message to patients that use CNWL services will be that we invite, value and will act upon their feedback throughout and after their treatment and this will be communicated with clear and consistent messages. This will be achieved by development of a feedback message in corporate style with details of the Single Point of Contact (SPOC), including posters in all service locations and personal feedback message cards (e.g. at patient bedside or presented to patients at first appointment or assessment). The message would also be reflected on the SPOC webpage on the CNWL website.

The first draft communications message has been suggested as:

“Would you complain about the NHS? No? But we welcome, value and want to hear your feedback at CNWL”

CNWL External Website

Information about access to CNWL patient feedback would be clearly set out on a single webpage of the CNWL external website as the SPOC, including:

- Postal address – freepost
- Telephone number – a dedicated freephone number
- E-mail address – a dedicated address
- Rapid feedback form – online feedback submission portal

The Patient Support Team would be responsible for Datix logging, allocations to Divisional Directors and tracking of all forms of patient feedback received via the SPOC. The webpage would be search engine optimised to ensure that searches for previous incarnations of the complaints or PALS functions would provide access to the CNWL Patient Support Service (e.g. a search on ‘Camden complaints’ would provide the CNWL Patient Support Services webpage).

Internal Communications

An ‘immersion’ campaign to alert all staff to the changes to the service and the Trust policy
on feedback will be implemented using weekly news, roadshows and staff briefings. The campaign would last a minimum of three months, starting one month ahead of the Patient Support Service go-live date in September 2014. The campaign material would centre on the message that patient feedback and learning from it is the responsibility of all CNWL staff. This would be backed up by a requirement for Divisional Directors to ensure that the new service and policy are discussed and disseminated within operational teams.

Beyond the initial campaign, regular ongoing awareness would be provided by regular reminders included in weekly news. These will be based on the response times performance and any headline trends/issues identified by the Trust. Other forms of communication that reinforce the need for all staff to be vigilant on spotting opportunities for feedback and acting upon it will include a complaints newsletter to be published quarterly and widely distributed. A ‘CNWL Complaints Month’ will also be considered as an annual event; providing an opportunity for CNWL to celebrate positive changes as a result of patient feedback and re-focus staff attention to the subject of feedback.
3.3 Training

Training requirements to support the new Patient Support Service fall into three areas where knowledge and skills need to be improved across the Trust. These areas are:

- Process knowledge covering how the feedback process works and understanding of roles and responsibilities
- Policy awareness and knowledge of how to apply it
- Datix System usage for logging, tracking and reporting of data

The requirements will need to be delivered in differing formats at different levels of the Trust. The following table sets out the type of training required to deliver at each level. Training below senior management staff will largely be achieved via cascade training and team learning.

<table>
<thead>
<tr>
<th>Patient Support Team</th>
<th>Policy awareness and application</th>
<th>Process and responsibilities</th>
<th>Datix usage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Team building event or specific training sessions (delivered by Datix if required or transfer of skills from CNWL staff already using Datix)</td>
<td>Management briefings - Cascaded to senior staff Self-learning E-learning module</td>
<td>Module specific training Data entry and management Reporting /system interrogation</td>
</tr>
<tr>
<td>Divisional Directors and Service Directors</td>
<td>Management briefings - Cascaded to senior staff Self-learning E-learning module</td>
<td>Management briefings - Cascaded to senior staff Self-learning E-learning module</td>
<td>Data entry and management Reporting /system interrogation</td>
</tr>
<tr>
<td>Senior Operational Staff, e.g. Matrons, Team Leaders</td>
<td>Management briefings Self-learning E-learning module</td>
<td>Management briefings Self-learning E-learning module</td>
<td>Data entry and management Reporting /system interrogation</td>
</tr>
<tr>
<td>All other Front Line staff</td>
<td>E-learning module Local awareness events Team discussions/learning, including engagement skills for dealing with face to face feedback with patients</td>
<td>Not required</td>
<td></td>
</tr>
</tbody>
</table>

3.4 Organisational Development

In terms of providing organisational development as a result of the review of complaints and PALS in CNWL, it is proposed that a programme of cultural enquiry is developed using a diagnostic approach to determine the desired change (see paragraph 2.6, Cultural Considerations). This is because we need to be careful to understand what the current cultural thinking/behaviours are before we can affect the pervading culture. This needs to be considered very much across the breadth and hierarchy of the Trust (from ‘chief executive to patient contact point’). 

The outline of the proposed programme of change would be as below. The Cultural enquiry or diagnostic stage would be congruent with the Patient Support Service Implementation Programme.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Actions</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>Surveying of staff (managers and front line) to determine the state of culture. Use of interviewing, survey monkey, focus groups, patient process mapping.</td>
<td>3 months</td>
</tr>
<tr>
<td>Design</td>
<td>Develop specification for interventions that will change cultural style, e.g. team based interactive learning, classroom learning sets, e-learning for policy or process orientated knowledge Principles applied: value adding; LEAN</td>
<td>4-6 months</td>
</tr>
<tr>
<td>Implementation</td>
<td>Commission and pilot training interventions via Recovery College or externally</td>
<td>12 months</td>
</tr>
<tr>
<td>Review</td>
<td>Review of effectiveness and take up of interventions</td>
<td></td>
</tr>
</tbody>
</table>

### 3.5 Outline Implementation Plan

#### Timescales

6 – 9 months including staff consultation. Staff consultation may be 28 days (3 months) duration.

#### Programme Board

The Programme Board will consist of:

- Executive Director of Operations and Nursing (Executive Sponsor)
- Associate Director, Corporate Governance
- Associate Director, Programmes
- Programme Manager
- Head of Safety
- Human Resources Manager
- Estates Project Manager

The following chart illustrates the programme as a 6 month timescale from approval by the Board of Directors in May 2014 with a go-live date for the Patient Support Service of 1st September 2014.

#### Post-implementation Review

The Implementation Programme Board will undertake a critical review at the end of the implementation process to assure the Executive Board that the new service is delivering the intended benefits across all levels of CNWL. This will include considering the use of the internal audit programme 2015-16 and review by the Expert Reference Group.
<table>
<thead>
<tr>
<th>ID</th>
<th>Task Name</th>
<th>Duration</th>
<th>Start</th>
<th>Finish</th>
<th>Qtr 1, 2014</th>
<th>Qtr 2, 2014</th>
<th>Qtr 3, 2014</th>
<th>Qtr 4, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient Support Service Programme</td>
<td>154 days</td>
<td>Mon 07/04/14</td>
<td>Fri 28/11/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Phase 1 - Programme Governance and Enabling</td>
<td>50 days</td>
<td>Mon 18/04/14</td>
<td>Mon 02/06/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Sign off at Executive Board: Review Paper and Policy</td>
<td>1 day</td>
<td>Wed 23/04/14</td>
<td>Thu 24/04/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Sign off at Board of Directors</td>
<td>1 day</td>
<td>Wed 14/05/14</td>
<td>Thu 15/05/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Procedure Document development</td>
<td>10 days</td>
<td>Thu 15/05/14</td>
<td>Fri 30/05/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Set up Implementation Programme Board / Confirm PID &amp; Programme Plan</td>
<td>10 days</td>
<td>Mon 12/06/14</td>
<td>Tue 27/05/14</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td>Implementation Programme Board</td>
<td>140 days</td>
<td>Mon 14/04/14</td>
<td>Fri 14/11/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Expert Reference Group</td>
<td>140 days</td>
<td>Tue 15/04/14</td>
<td>Mon 17/11/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>ICT System Project</td>
<td>136 days</td>
<td>Mon 07/04/14</td>
<td>Mon 09/11/14</td>
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<tr>
<td>26</td>
<td>Option Appraisal</td>
<td>20 days</td>
<td>Mon 07/04/14</td>
<td>Fri 09/05/14</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>27</td>
<td>Specification development</td>
<td>10 days</td>
<td>Mon 12/05/14</td>
<td>Tue 27/05/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>28</td>
<td>Procurement</td>
<td>20 days</td>
<td>Mon 02/06/14</td>
<td>Tue 01/07/14</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>29</td>
<td>Implementation Phase</td>
<td>80 days</td>
<td>Wed 02/07/14</td>
<td>Thu 30/10/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>System Training</td>
<td>42 days</td>
<td>Mon 01/09/14</td>
<td>Fri 31/10/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Phase 2 - Implementation of Changes</td>
<td>120 days</td>
<td>Mon 02/06/14</td>
<td>Fri 28/11/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Centralised Team</td>
<td>70 days</td>
<td>Thu 15/05/14</td>
<td>Fri 29/08/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Plan for staff consultation</td>
<td>10 days</td>
<td>Thu 15/05/14</td>
<td>Fri 30/05/14</td>
<td></td>
<td></td>
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<tr>
<td>34</td>
<td>Staff Consultation</td>
<td>28 days</td>
<td>Mon 02/06/14</td>
<td>Fri 11/07/14</td>
<td></td>
<td></td>
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<tr>
<td>35</td>
<td>Team formation and building</td>
<td>15 days</td>
<td>Mon 14/07/14</td>
<td>Tue 05/08/14</td>
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<tr>
<td>36</td>
<td>Team Training Plan</td>
<td>30 days</td>
<td>Mon 14/07/14</td>
<td>Thu 28/03/14</td>
<td></td>
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<tr>
<td>37</td>
<td>New Single Point of Contact</td>
<td>46 days</td>
<td>Mon 09/06/14</td>
<td>Mon 18/08/11</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>38</td>
<td>Set up freepost address</td>
<td>15 days</td>
<td>Mon 09/06/14</td>
<td>Tue 01/07/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Set up Freephone telephone number</td>
<td>15 days</td>
<td>Mon 09/06/14</td>
<td>Tue 01/07/14</td>
<td></td>
<td></td>
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### Complaints Process

#### Central and North West London NHS Foundation Trust

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<tr>
<th>ID</th>
<th>Task Name</th>
<th>Duration</th>
<th>Start</th>
<th>Finish</th>
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<th>Qtr 2 2014</th>
<th>Qtr 3 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>Set up electronic web feedback form</td>
<td>15 days</td>
<td>Thu 03/07/14</td>
<td>Fri 25/07/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Set up dedicated e-mail address</td>
<td>15 days</td>
<td>Thu 24/07/14</td>
<td>Fri 15/08/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Development of Webpage</td>
<td>62 days</td>
<td>Mon 02/06/14</td>
<td>Wed 03/09/14</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>43</td>
<td>Single webpage design</td>
<td>15 days</td>
<td>Mon 02/06/14</td>
<td>Tue 24/06/14</td>
<td></td>
<td></td>
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<tr>
<td>44</td>
<td>Single contact details</td>
<td>5 days</td>
<td>Mon 07/07/14</td>
<td>Mon 14/07/14</td>
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<tr>
<td>45</td>
<td>Webpages go-live</td>
<td>0 days</td>
<td>Mon 01/09/14</td>
<td>Mon 01/09/14</td>
<td></td>
<td></td>
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<tr>
<td>46</td>
<td>Implementation Phase - Localised Changes</td>
<td>21 days</td>
<td>Thu 12/06/14</td>
<td>Tue 15/07/14</td>
<td></td>
<td></td>
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<tr>
<td>47</td>
<td>Removal of Patient Liaison Role</td>
<td>1 day</td>
<td>Mon 14/07/14</td>
<td>Tue 15/07/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Definition of Roles/Responsibilities</td>
<td>20 days</td>
<td>Thu 12/06/14</td>
<td>Fri 11/07/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Training Plan</td>
<td>44 days</td>
<td>Mon 02/06/14</td>
<td>Wed 06/08/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Development of Plan</td>
<td>20 days</td>
<td>Mon 02/06/14</td>
<td>Tue 01/07/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Management Briefings</td>
<td>20 days</td>
<td>Mon 07/07/14</td>
<td>Tue 05/08/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Service level team briefings</td>
<td>20 days</td>
<td>Mon 07/07/14</td>
<td>Tue 05/08/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Develop e-learning module on process and policy</td>
<td>20 days</td>
<td>Mon 16/06/14</td>
<td>Tue 15/07/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Estates</td>
<td>74 days</td>
<td>Mon 14/07/14</td>
<td>Mon 03/11/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Develop specification for Patient Support Team accommodation</td>
<td>18 days</td>
<td>Mon 14/07/14</td>
<td>Fri 08/08/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Estates procurement</td>
<td>55 days</td>
<td>Mon 11/06/14</td>
<td>Fri 31/10/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Communications</td>
<td>40 days</td>
<td>Wed 30/07/14</td>
<td>Tue 30/09/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>External website</td>
<td>20 days</td>
<td>Wed 30/07/14</td>
<td>Fri 29/08/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Internal Communications Plan</td>
<td>20 days</td>
<td>Fri 21/08/14</td>
<td>Tue 23/09/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Immersion Campaign: September is Feedback Month!</td>
<td>20 days</td>
<td>Mon 01/09/14</td>
<td>Tue 30/09/14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Project:** Patient Support Service  
**Date:** Thu 10/04/14

---

**Manual Summary Rollup**

**Manual Summary**

**Start-only**

**Finish-only**

**Deadline**

**Progress**

---

**Page 2**
<table>
<thead>
<tr>
<th>ID</th>
<th>Task Name</th>
<th>Duration</th>
<th>Start</th>
<th>Finish</th>
<th>Qtr 1, 2014</th>
<th>Qtr 2, 2014</th>
<th>Qtr 3, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>Planning for on-going awareness communications</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Organisational Development</td>
<td>60 days</td>
<td>Mon 01/09/14</td>
<td>Fri 28/11/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Cultural Enquiry</td>
<td>60 days</td>
<td>Mon 01/09/14</td>
<td>Fri 28/11/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Patient Support Service GO-LIVE</td>
<td>1 day</td>
<td>Mon 01/09/14</td>
<td>Tue 02/09/14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Direction of Travel

A wide-range of work has been undertaken to review and consider the best options for developing a patient feedback function that is fit for purpose and satisfies the requirement for CNWL to respond to national and local thinking on patient feedback. This has placed CNWL Executive in a strong position to implement robust plans to change a dispersed and varied function into a trust-wide system that supports service improvement.

The CNWL Executive will wish to implement the programme of change in the next 6 months with the new Patient Support Service going live on 1st September 2014. Subsequently the Executive will seek to ensure that the new service is delivering the expected quality of ‘board to ward’ reporting and organisational learning by reference to the internal audit programme in 2015-16 and careful consideration of performance and patient experience data by the Executive Board and the Expert Reference Group.
Appendix A - Summary of Recommendations contained in the Clwyd/Hart Report*

The following table sets out the recommendations from the Clwyd/Hart Report which are aimed at action for NHS Trusts and details how each recommendation is addressed by the current review of the CNWL Complaints and PALS Services and the establishment of a Patient Support Service.

*A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture
Final report
Right Honourable Ann Clwyd MP and Professor Tricia Hart

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Recommendations for Trusts and Boards</th>
<th>How does the CNWL Complaints and PALS Review Programme and development of a Patient Support Service deliver action on the Clwyd/Hart Report recommendations?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improving the quality of care</td>
<td>Every Trust should ensure any rebranded patient service is sufficiently well sign-posted and promoted in their hospital so patients know where to get support if they want to raise a concern or issue. <strong>Action: Trusts</strong></td>
<td>Rebranding of the Patient Support Service with simplified access via a Single Point of Contact will allow patients to rapidly find details of freephone, freepost, e-mail and rapid feedback forms. A CNWL branded information set including posters and patient cards will be introduced across all Trust services. Staff training and awareness will be centred on the requirement for all staff to be ambassadors for patient feedback, responding efficiently and openly to issues raised by patients. Intelligent analysis of feedback data, patient experience data and risk analysis will be reviewed at all levels of the organisation. Patients will be supported in actions to make a complaint with access to organizations such as Voiceability to support the patient throughout the process.</td>
</tr>
<tr>
<td>• Staff providing basic care should be adequately trained, supported and supervised. <strong>Action: Trusts, professional bodies and representative organisations, HEE, clinical leaders and managers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• There should be annual appraisals linked to the process of medical revalidation which focus on communication skills for clinical staff and dealing with patient concerns positively. This goes hand in hand with ensuring that communication skills are a core part of the curriculum for trainee clinical staff. <strong>Action: HEE, professional bodies and representative organisations, clinical leaders and managers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trusts should ensure that there is a range of basic information and support available on the ward for patients, such as a description of who is who on the ward and what they do; meal times and visiting times; and who is in charge of care for the patient. Care should be taken to ensure that differences in language, culture and vulnerability are taken account of in this. <strong>Action: Trusts, clinical leaders and managers, clinicians and practitioners</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patients should be helped to understand their care and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations for Trusts and Boards</td>
<td>How does the CNWL Complaints and PALS Review Programme and development of a Patient Support Service deliver action on the Clwyd/Hart Report recommendations?</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>treatment. While written information is helpful, it is always important to discuss diagnoses, treatments and care with a patient. Patients frequently need to revisit topics already addressed. Where appropriate, their relatives, friends or carers may be included in discussions. <strong>Action:</strong> Trusts, professional bodies and representative organisations, HEE, clinical leaders and managers, clinicians and practitioners, patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trusts should provide patients with a way of feeding back comments and concerns about their care on the ward including simple steps such as putting pen and paper by the bedside and making sure patients know who to speak to if they have a concern – it could be a nurse or a doctor, or a volunteer on the ward to help people. <strong>Action:</strong> Trusts, education and training organisations, clinical leaders and managers, clinicians and practitioners, patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospitals should actively encourage volunteers. Volunteers can help support patients who wish to express concerns or complaints. This is particularly important where patients are vulnerable or alone, when they might find it difficult to raise a concern. Volunteers should be trained. <strong>Action:</strong> Trusts, volunteer organisers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Improvements in the way complaints are handled</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Attention needs to be given to the development of appropriate professional behaviour in the handling of complaints. This includes honesty and openness and a willingness to listen to the complainant, and to understand and work with the patient to rectify the problem.</td>
</tr>
<tr>
<td>• Every Chief Executive should take personal responsibility for the complaints procedure, including signing off letters responding to complaints, particularly when they relate to serious care failings. <strong>Action:</strong> Trusts</td>
</tr>
<tr>
<td>• CNWL CEO has and will continue to champion the reputation of CNWL as a caring organization and takes personal responsibility to ensure that patient feedback is regularly, thoroughly and systematically reviewed and acted upon.</td>
</tr>
<tr>
<td>• Complaint responses will be</td>
</tr>
</tbody>
</table>
### Recommendations

<table>
<thead>
<tr>
<th>Recommendations for Trusts and Boards</th>
<th>How does the CNWL Complaints and PALS Review Programme and development of a Patient Support Service deliver action on the Clwyd/Hart Report recommendations?</th>
</tr>
</thead>
</table>
| **Action**: Trusts, professional bodies and representative organisations, clinical leaders and managers, clinicians and practitioners  
- Staff need to record complaints and the action that has been taken and check with the patient that it meets with their expectation. **Action**: Trusts, professional bodies and representative organisations, education and training organisations and clinical leaders and managers, clinicians and practitioners  
- Complaints are sometimes dealt with by junior staff or those with less training. Staff need to be adequately trained, supervised and supported to deal with complaints effectively. **Actions**: Trusts, education and training organisations, clinical leaders and managers  
- There should be NHS accredited training for people who investigate and respond to complaints. **Action**: Trusts, HEE  
- Trusts should actively encourage both positive and negative feedback about their services. Complaints should be seen as essential and helpful information and welcomed as necessary for continuous service improvement. **Action**: Trusts, HEE, clinicians and practitioners  
- There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals. **Action**: Trust Chief Executives and Boards  
- Every Trust has a legislative duty to offer complainants the option of a conversation at the start of the complaints process. This conversation is to agree on the way in which the complaint is to be handled and the timescales involved. **Action**: Trusts  
- Where complaints span organisational boundaries, the Trusts involved should adhere to their statutory duty to cooperate so they can handle the complaint effectively. **Action**: Trusts  
- There should be proper arrangements for sharing good practice on complaints handling between hospitals, including examples of service improvements which result from action taken in response to complaints. **Action**: DH, Trusts | signed off at Divisional Director level due to the size of the Trust and complaint volumes. However, complaints relating to serious incidents that require external investigation or review will receive a response from the CEO.  
- Reporting across the entire governance of CNWL patient feedback is on a monthly basis, with Quarterly and Annual reports/review.  
- Current and future revisions of the CNWL Complaints Policy and Procedure follow the practice of ensuring that an investigating officer makes contact with a complainant to ensure that the issues of the complaint are understood and that opportunity to agree the handling of the investigation and response timeframes. Response deadlines of 25 working days will be normal. Extension to this will only be allowed following prior agreement of the Divisional Director  
- Cross-organisational investigation of complaints and mutual cooperation are included in Complaints Policy and Procedures  
- The CNWL Organisational Learning Group has responsibility for identifying and recommending action on themes/issues suggested by patient feedback data. All levels of service management are responsible for local review and service improvement resulting from Feedback, Incidents, Patient Experience and Risk Analysis. |
| 3. Greater perceived and actual independence in the complaints process  
- Hospitals should offer a truly independent investigation where serious incidents have occurred. **Action**: Trusts  
- When Trusts have a conversation with patients at the start of the |  
- CNWL refers investigation of serious incidents to external agents and frequently uses Ombudsmen review as an appropriate safeguard against institutional bias in the handling |
<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Recommendations for Trusts and Boards</th>
<th>How does the CNWL Complaints and PALS Review Programme and development of a Patient Support Service deliver action on the Clwyd/Hart Report recommendations?</th>
</tr>
</thead>
<tbody>
<tr>
<td>complaints process they must ensure the true independence of the clinical and lay advice and advocacy support offered to the complainant. <strong>Action: Trusts</strong></td>
<td>• Patient services and patient complaints support should remain separate so patients do not feel they have to go through PALS first before they make a complaint. <strong>Action: Trusts</strong></td>
<td>• Divisional Directors are responsible for ensuring that investigating officers are sufficiently independent from the service that received a complaint. • All complainees are offered support that includes advocacy and lay advise as a matter of course. • The Single Point of Contact provides a response to the entire spectrum of patient feedback, from compliments, issues, concerns through to formal complaints. There is no requirement for a patient to highlight any issues before making a formal complaint to the Patient Support Team. • Healthwatch will be involved in the CNWL Expert Reference Group as well as independent expert advice provided by senior Health Ombudsman staff. • The Expert Reference Group will include lay representatives which will report to the Executive Board via the Organisational Learning Group</td>
</tr>
<tr>
<td>• Patients, patient representatives and local communities and local HealthWatch organisations should be fully involved in the development and monitoring of complaints systems in all hospitals. <strong>Action: Trusts</strong></td>
<td>• Board level scrutiny of complaints should regularly involve lay representatives. <strong>Action: Trusts</strong></td>
<td></td>
</tr>
<tr>
<td>• Board level scrutiny of complaints should regularly involve lay representatives. <strong>Action: Trusts</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B - Outcome of Discussions at Executive Board of Directors and Board of Directors Meetings

An internal Complaints and Patient Advice and Liaison Service (PALS) Review Programme was commissioned by the Executive Board in October 2013, building on a previous review published in September 2012. The Programme Board published a report on the findings of the review, which was considered by the Executive Board on 18\textsuperscript{th} December 2013.

Progress on the review was reported to the Board of Directors on 15\textsuperscript{th} January 2014.

The following concerns were raised at the Executive Board in December 2013:

1. \textit{Performance in some areas of CNWL meets the required standard of 95\% of complaint responses being delivered within either 25 working days or within a deadline that is negotiated with the complainant.}

2. \textit{Staff WTEs contained in localities are inaccurate in the report.}

3. \textit{The Review needs to adequately define the proposed new Service Model to include definition of what aspects are centralised and those that are decentralised. Concern was expressed about the need for local management and this is not clearly addressed in the report.}

4. \textit{Concerns regarding the proposal to centralise the complaints and PALS staff and the capacity to deal with all patient feedback across the Trust.}

The Programme Board commissioned an update and response to the concerns expressed by the Executive Board, which was reported to the meeting of the Executive Board on 25\textsuperscript{th} February 2014.

The conclusions of the report were:

1. \textit{Performance against complaint response times for CNWL remains below the target of 95\% of complaints receiving a response within 25 working days.}

2. \textit{Staff WTEs within each CNWL locality have been revised. The total staffing for complaints and PALS across the Trust is 5.1 WTE.}

3. \textit{Based upon the service principles summarised in this paper, the outcome of the previous review, i.e. to centralise the complaints and PALS service and restructure, remain a valid option for improving the service offered to patients and carers/families. The proposed service model is presented in terms of management structures, governance and changes that need to be made to centralise the functions of the service. The local responsibilities for investigation of complaints remain with service line staff. This proposal fits with the organisational development of the Service Divisions as they evolve; responsibility for local investigation and response to complainants will rest with the Divisional Directors, supported by the centralised...}
4. The staffing capacity required to provide a centralised Complaints and PALS service to the entire CNWL trust is calculated as 2.97 WTE staff. The centralised team will consist of 3.0 WTE Band 5/6 staff supported by 1.0 WTE administrative staff. Hence there would be sufficient capacity within the available resources.

This report demonstrates that the proposal to centralise the Complaints and PALS Service remains viable.

The Executive Board approved the revised report conclusions at the Executive Board meeting on 25th February 2014. This approval covered the proposed structural and process-orientated changes.

Subsequently, the Chief Executive Officer has requested that the scope of the review and planning be widened to include policy review, cultural change and governance (particularly around reporting requirements for service performance and tracking of the management of individual complaints).

This report addresses the widened scope and is structured to show the current and proposed model; Systems that will need to be in place to support the new model and implementation plans that deliver a new service and address longer terms needs for cultural shift within the organisation.
Patient and Carer Feedback Policy  
(Complaints Policy)

**Purpose** : This policy provides the framework by which the Trust receives feedback on its services, this includes the handling of complaints.

**This policy is essential reading for the following groups of staff**

1. – Board of Directors
2. – Divisional Directors
3. – Patient Support Team
4. – Senior Managers
5. – Team & Ward Managers

**The following groups of staff need to be aware of the existence of this policy:**

1. - All staff

**Key points of the policy**

1. CNWL welcomes all types of feedback on its services and will respond in a timely manner, with openness and a keenness to learn. Feedback includes the handling of comments, enquiries, complaints and compliments.

2. CNWL will aim to ensure that all feedback is used positively to shape our services and support our vision of wellbeing for life. Wherever possible an initial response to queries and comments will be provided from the location and people in the organisation which is closest to the point of service provision.

3. CNWL will apologise if we did the wrong thing, do what we can to put things right and make sure that it doesn’t happen again.

4. Within CNWL, complaint handling will be empathetic, quick and focused on what is most important to the individual. We will make sure that all the causes for concern or complaint are identified with the necessary changes to support learning.

5. This policy outlines the reporting and tracking of feedback within the Trust and provides an overview of the roles and responsibilities of the Patient Support Service.

6. As part of the complaints process, the Trust will ensure that complainants are updated on progress, advised of the outcome of the investigation into their complaint, including an explanation of the findings and confirmation of any action taken or proposed as a result.

7. This policy will be applied without discrimination, harassment or victimisation of any patient, employee or member of the public in line with the Trust’s Equality Diversity and Human Rights policies.

To support this policy the Trust has in-place a detailed operational procedure for complaints management. This can be accessed via the link below: (insert)
**PATIENT AND CARER FEEDBACK POLICY**  
*(COMPLAINTS POLICY)*

**Policy lead:** Director of Operations and Nursing

**Ratifying Committee / Group:** Board of Directors

**Status of policy:**

**Policy Reference:**

| Signed: | Dorothy Griffiths, Chair |
| Approval date: | |

---

**Essential reading for the following staff groups:**

1. Board of Directors
2. Divisional Directors
3. Patient Support Team
4. Senior Managers
5. Team & Ward Managers

**Following staff groups should be aware exists for references purposes:**

1. All staff
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2. Responsibilities ........................................................................ P.4
3. Definitions ............................................................................... P.5
4. Policy .................................................................................... P.5
   4.1 Complaints handling principles
   4.2 Recording feedback
   4.3 Training and support for staff
   4.4 Aggressive and vexatious complainants
5. Monitoring Requirements ......................................................... P.8
6. Consultation ............................................................................ P.8
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Appendix A Responsibilities .................................................. P.9
Appendix B Staff Training ......................................................... P.11
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Appendix E Equality Impact Assessment - to follow ................. P.15
1 Purpose and scope

1.1 This policy provides the framework by which the Trust receives feedback on its services. This includes compliments, enquiries, comments and complaints.

1.2 Feedback including complaints can be made by current or former patients, individuals referred to the Trust or any person who is affected by or likely to be affected by an action, omission or decision of the Trust.

1.3 This policy and its associated procedure will support the Trust in ensuring that complaints are handled in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

1.4 This policy is also underpinned by the Ombudsman’s Principles of Good Complaint Handling and Listening, Responding, Improving: A Guide to Better Customer Care, a Review of the NHS Hospitals Putting Patients Back in the Picture and the Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust.

1.5 Actual or intended litigation will not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the complaint handling system will be to respond to complaints as entirely separate from the considerations of litigation.

1.6 Complaints which allege or indicate a risk to patients will automatically result in a safeguarding alert being raised and may be investigated in accordance with the relevant Safeguarding Policy and Procedure. Following completion of a safeguarding investigation, if necessary a response will be provided to the complainant under the Complaints Procedure.

1.7 In certain circumstances it will be necessary to investigate a concern or complaint via the Trust’s Serious Incident Policy. Following completion of any Serious Incident investigation, if necessary, a response will be provided to the complainant under the Complaints Procedure. Investigations will include the use of impartial investigators where appropriate; especially in cases that involve a serious incident.

1.8 Under the aforementioned complaints regulations, complaints must be made within 12 months of the event subject to the complaint or within 12 months of the complainant becoming aware of the issue. The Trust can exercise its discretion to investigate complaints outside of this range. In such instances the relevant Divisional Director will consider the evidence available to determine whether a viable investigation may be completed.

2 Responsibilities

Please see appendix A for a list of associated roles and responsibilities.
3 Definitions

Compliment
A compliment is defined as “a polite expression of praise or admiration” and can be provided both in writing and orally.

Enquiry
An enquiry is the process whereby a patient, carer or member of the public requests information from the Trust. This covers a range of areas and includes, but is not limited to, a specific period of care and treatment and details of the types of services provided by the Trust.

Comment
A comment is a verbal or written remark relating to the Trust and / or its services.

Complaint
For the purpose of this policy a complaint is defined as “an expression of dissatisfaction requiring a response” received from patients, carers and anyone who may be affected by the actions or decisions of the Trust.

Complaints can be made in a variety of ways; verbally, in person, by telephone, in writing, including electronically by email and fax.

Informal complaints / oral concerns
The decision to determine whether an oral concern is dealt with informally rather than as a formal complaint is determined by whether or not the concern can be resolved, to the complainant’s satisfaction, by the next working day, or a longer period with their agreement. This wide definition empowers our staff to resolve minor problems immediately and informally. Staff will ensure that patients and carers receive advice and support in accessing the complaints handling options available to enable informed choices to be made on whether they wish to make an informal or formal complaint.

Staff must also be aware that certain comments, concerns, suggestions or inquiry may present issues that need to be brought to the attention of managers in the Trust. This includes patient safety and safeguarding matters.

Formal Complaints
As indicated above, an oral concern that cannot be resolved by the next working day, or where the complainant has expressed a preference for their concern to be subject to a formal investigation will be treated as a formal complaint. Formal complaints can be made verbally and in writing.

4 Policy

4.1 Complaints handling principles

Complaints handling will be complainant led and collaborative in approach. The Trust’s core values will be at the forefront when handling a concern or complaint.
Trust will strive to ensure that complaints are handled in accordance with the Health Service Ombudsman’s Principles of Good Complaint Handling:

- Getting it right by acting in accordance with the law and relevant guidance
- Being customer focused
- Listening to the complainant to understand their concerns and the outcome they are seeking
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

Open and transparent complaints handling, with clear lines of communication with the complainant is central to the addressing negative experiences. Responses to complaints will acknowledge where mistakes have been made and apologise whilst also explaining what happened in terms of any care or service delivery problems. The response will also include details of any actions being taken to facilitate lessons learnt.

**Resolving complaints within the Trust**
The Trust will strive to resolve formal complaints in an open and transparent manner. The response to all formal complaints will normally be from a Divisional Director of the relevant Division. Where a complainant remains dissatisfied with this response, the Trust will continue its efforts to resolve the complaint via a process of management review.

**Management review of complaints handling**
In the event that a complainant is dissatisfied with any aspect of the handling of their complaint, they will have the right to ask for a management review. This will be carried out by a manager not previously involved in either their care or the complaint and will follow detailed guidance included in the Complaints Procedure.

**Independent reviews**
If a complainant is dissatisfied with the outcome of the Trust’s investigation and review process they have the right to ask the Health Service Ombudsman to independently review their complaint. Information on how to obtain an independent review is contained within all responses to formal complaints and any subsequent review. The Health Service Ombudsman may take a number of actions including referring the complaint back to the Trust for local resolution or undertake its own investigation. CNWL will work the Health Service Ombudsman and consider all formal recommendations made in response to their independent review of a complaint.

**Duty of candour**
The Trust will inform patients or other duly authorised persons of any errors that are identified through feedback as resulting in moderate harm or greater to a patient. This will be done as soon as is practicable with such information and explanation as the patient reasonably requests.

**Patient confidentiality**
The handling of all concerns and complaints will be dealt with in accordance with the legal obligations upon the Trust to maintain patient confidentiality. No patient
Consent
Where a concern or complaint is raised by a third party, written consent from the patient will be obtained for the matter to be investigated and where relevant for disclosure of clinical information.

Capacity
Should a patient lack capacity appropriate actions will be taken to ensure that the best interests of the patient are pursued. Clinical staff will lead on decisions relating to capacity and best interest in accordance with the relevant Trust policy and procedure. Where consent or the patients best interests indicate that the complainant is not considered to be an appropriate representative, they will receive written notification stating the reason for the decision referencing relevant legislation such as the Data Protection Act, Access to Health Records Act and Mental Capacity Act. Regardless of the outcome of this decision, the Trust will ensure that the concerns raised are reviewed and reported internally.

Complaints relating to the care of a deceased patient
When addressing a complaint relating to the care of a deceased patient, careful consideration will be given prior to the release of information. In such instances consideration should be given to the Access to Health Records Act. Further advice on this matter can be obtained from the Head of Information Governance.

Information and support for complainants
The support needs for the complainant will be considered and discussed from the outset and include support in accessing Advocacy and Interpreting Services. The Trust will provide a Single Point of Contact (SPOC) with access to the Patient Support Team easily accessible with access via Freepost, dedicated email and telephone number as well as an online fast feedback form. The Trust will ensure that within 3 working days, all complainants receive a written acknowledgement of their complaint in line the NHS Constitution. To aid the on-going development of the Patient Support Service, all closure communications will invite the patient or carer to give feedback on the patient experience of using the service. The Trust is fully committed to ensuring that complaints do not have an impact upon the way in which any patient or carer is treated with complaints information is held separately from the patient care record.

Interagency complaints
Interagency complaints will be handled in accordance with the lead agencies policy. The complainant will be asked to clarify whether they are seeking a single or joint response and provide their consent for the sharing of information relating to the complaint.

4.2 Recording feedback
Feedback will be recorded on a single database which is able to report on the whole Trust. The database will provide functionality to allow tracking of all feedback types and appropriate access for different levels of staff. The Trust will strive for continuous improvement with our handling of feedback driven by the experiences of patients and carers who have used the Patient Support Service.
4.3 **Training and Support for Staff**

CNWL will train, support and supervise its staff to have the confidence, capacity and expertise to deal with all forms of patient and carer feedback. Open and transparent handling of this feedback will support the Trust in delivering arrangements that staff will be proud of and view as fair and objective.

Front-line staff will be adequately resourced, trained and supported to provide a professional service.

Details of training packages can be found in Appendix B.

4.4 **Aggressive and Vexatious Complainants**

There may be occasions where complainants may be aggressive or vexatious. In these instances the Patient Support Team will work with clinicians and where appropriate managers to agree an appropriate way forward. Further detail on how the Trust deals with aggressive and vexatious complainants can be found in the Complaints Procedure.

5 **Monitoring Requirements**

5.1 **Tracking Requirements**

Please see Appendix C for an outline of the tracking requirements of this policy.

5.2 **Reporting Requirements**

Please see Appendix D for an outline of the reporting requirements of this policy.

6 **Consultation**

A broad range of CNWL staff, patient/carer and governor workshops and consultation was undertaken as part of the Trust’s review of how it handles patient and carer feedback. This policy has been cross referenced against national review papers with careful consideration of both the Francis Report and Clwyd review of Complaints Handling to further support best practice.

7 **References**

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, Department for Health (2009)
- A guide to better customer care, Department of Health, February (2009)
- Principles of Good Complaint Handling, Parliamentary and Health Service Ombudsman (2008)
- Recommendations made by Francis and Clywd/Hart Reports (2013)
### Responsibilities

<table>
<thead>
<tr>
<th>Individual</th>
<th>Key Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Under the Complaints Regulations, the Chief Executive is responsible for ensuring compliance with this policy and ensuring that follow up action is taken where necessary.</td>
</tr>
<tr>
<td>Director of Operations and Nursing</td>
<td>The Director of Operations and Nursing is the Executive Director responsible the development of this policy and its implementation.</td>
</tr>
<tr>
<td></td>
<td>The post holder also ensures that complaints are handled in line with the Complaints Procedure, providing and presenting reports as to the Trust Board and Quality and Performance Committee.</td>
</tr>
<tr>
<td>Head of Safety</td>
<td>The Head of Safety will manage the Patient Support Services Manager and oversee the implementation of the Trust’s Complaints Procedure.</td>
</tr>
<tr>
<td></td>
<td>The post holder retains oversight of all complaints reviews that are commissioned, reporting on these to the Associate Director of Corporate Governance.</td>
</tr>
<tr>
<td>Patient Support Services Manager</td>
<td>This post holder will manage the Patient Support Services Team who provides a single point of access to persons wishing to raise a complaint or seek advice.</td>
</tr>
<tr>
<td></td>
<td>The Patient Support Services Manager holds day to day responsibility for the implementation of this policy and its procedure across the Trust.</td>
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<tr>
<td></td>
<td>The post holder will ensure that all complainants receive timely information on the support they will receive.</td>
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<tr>
<td></td>
<td>They will monitor attainment of Trust-wide targets. This will include ensuring all complaints are acknowledged within 3 days and responded to within the agreed timescale.</td>
</tr>
<tr>
<td></td>
<td>The Patient Support Services Manager will oversee the training of staff in the use of the Complaints Procedure</td>
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<tr>
<td></td>
<td>The team will produce Trust-wide reports to the Complaints, Claims and PALS group to aid organisational learning.</td>
</tr>
<tr>
<td></td>
<td>They will feed information back into the Divisions for local discussion.</td>
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<tr>
<td></td>
<td>They will provide support to staff investigating complaints and to staff named in complaints.</td>
</tr>
</tbody>
</table>
Divisional Directors  Divisional Directors will have overall responsibility for complaints raised about the services they oversee.

Divisional Directors will ensure that appropriate systems are in-place to support effective and efficient complaint handling and follow up, and compliance with the requirements of this policy.

All complaints will be signed off by the relevant Divisional Director or their nominated deputy.

Investigating Managers  Investigating managers will ensure that complainants are fully involved in the complaints process.

The investigating manager will provide an impartial investigation that is open and transparent; maintaining regular contact with the complainant throughout the investigation.

All Staff  Dealing with concerns and complaints is everyone’s business.

It is up to staff to ensure that people are provided with the space and time to talk through any concerns they have.

All staff will follow this policy and cooperate with investigations.

Staff are responsible for ensuring that they listen to complainants and provide them with the opportunity to raise their concerns.

An open and transparent approach will be adopted with compassion and respect at the forefront of the support provided.
# Training Packages for Staff

<table>
<thead>
<tr>
<th>Group</th>
<th>Policy awareness and application</th>
<th>Process and responsibilities</th>
<th>Datix usage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Support Team</strong></td>
<td>Team building event or specific training sessions (delivered by Datix if required or transfer of skills from CNWL staff already using Datix)</td>
<td></td>
<td>Module specific training</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data entry and management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reporting /system interrogation</td>
</tr>
<tr>
<td><strong>Divisional Directors and Service/Borough Directors</strong></td>
<td>Management briefings - Cascaded to senior staff, Self-learning, E-learning module</td>
<td>Management briefings - Cascaded to senior staff, Self-learning, E-learning module</td>
<td>Data entry and management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reporting /system interrogation</td>
</tr>
<tr>
<td><strong>Senior Operational Staff, e.g. Matrons, Team Leaders</strong></td>
<td>Management briefings, Self-learning, E-learning module</td>
<td>Management briefings, Self-learning, E-learning module</td>
<td>Data entry and management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reporting /system interrogation</td>
</tr>
<tr>
<td><strong>All other Front Line staff</strong></td>
<td>E-learning module, Local awareness events, Team discussions/learning, including engagement skills for dealing with face to face feedback with patients</td>
<td></td>
<td>Not required</td>
</tr>
</tbody>
</table>

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**Notes:**
- Policy awareness and application: Team building event or specific training sessions (delivered by Datix if required or transfer of skills from CNWL staff already using Datix).
- Process and responsibilities: Management briefings, Self-learning, E-learning module.
- Datix usage: Module specific training, Data entry and management, Reporting /system interrogation.
## Tracking Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>To whom</th>
<th>Tracking Element</th>
<th>Frequency</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback/Complaint Status</td>
<td>Divisional Directors/ Patient Support Team</td>
<td>Datix report of feedback by type/Division and Service/Status of response (e.g. logged, allocated, investigation in progress, response drafted, response sent)</td>
<td>Daily real time status</td>
<td>Patient Support Team</td>
</tr>
<tr>
<td>Frequency of contact with complainant</td>
<td>Divisional Directors</td>
<td>Datix report of frequency distribution by Feedback type and Division/Service</td>
<td>Monthly</td>
<td>Patient Support Team</td>
</tr>
<tr>
<td>Response Deadline</td>
<td>Divisional Directors</td>
<td>Datix report of number of responses to feedback by met/not met deadline</td>
<td>Monthly</td>
<td>Patient Support Team</td>
</tr>
</tbody>
</table>
### Reporting Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>To whom</th>
<th>Reporting Element</th>
<th>Frequency</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Performance and Organisational Learning</td>
<td>Board of Directors</td>
<td>Intelligent analysis of feedback data including: • Activity data • Performance against quality standards • Qualitative analysis of trends and issues • Patient Experience data</td>
<td>Monthly Quarterly &amp; Annual Summary</td>
<td>Associate Director, Corporate Governance</td>
</tr>
<tr>
<td>Trust Performance</td>
<td>Executive Board</td>
<td>As above with quarterly executive summary</td>
<td>Monthly Quarterly &amp; Annual Summary</td>
<td>Associate Director, Corporate Governance</td>
</tr>
<tr>
<td>Trust Performance and Organisational Learning</td>
<td>Quality &amp; Performance Committee</td>
<td>As above with quarterly executive summary Template Report</td>
<td>Monthly Quarterly &amp; Annual Summary</td>
<td>Head of Safety Patient Support Team</td>
</tr>
<tr>
<td>Organisational Learning</td>
<td>Organisational Learning Group</td>
<td>Feedback data including: • Activity data • Performance against quality standards • Qualitative analysis of trends and issues • Patient Experience data</td>
<td>Monthly Quarterly Summary</td>
<td>Head of Safety Patient Support Team</td>
</tr>
<tr>
<td>Performance Management</td>
<td>Divisional Directors</td>
<td>Patient feedback (including compliments, concerns, issues and complaints) to be considered at divisional and service levels in conjunction with incident reports and risk management logs</td>
<td>Monthly</td>
<td>Patient Service Team: to provide data and analysis. Divisional Directors: to ensure local analysis and service improvement</td>
</tr>
</tbody>
</table>
Objective:

This report is for information and the Board will be updated on the progress of the work in six months’ time.

The Board is asked to:

Discuss any areas of concern or issues raised and note the report for information.

Executive summary:

Patient safety is the prevention of harm to patients caused by the things which the health care system does, harm by commission, and things which it does not do which it should have done, harm by omission. The trust safety development programme is aimed at augmenting and improving existing safety work through innovation and evaluation.

Following pilot work in early 2012 the trust has invested significant funding in the programme. This will be augmented by external funding. There is a particular need for high quality work in mental health and community services.

The programme is built around a number of key issues in patient safety. Our initial targets are organisational learning, making systems simpler and more accessible, co-production and building a safety culture.

John Green
May 2014
Patient Safety Development Programme

1. Background

Patient safety is the prevention of harm to patients caused by the things which the health care system does, harm by commission, and things which it does not do which it should have done, harm by omission. While all patient safety work is about good practice, not all good practice is about patient safety. Patient safety is relatively new as a distinct field of academic endeavour. While there have been real gains in knowledge in a short period of time, there is an enormous amount that we do not know. Innovation, rigorous evaluation and dissemination are key elements in improving patient safety across the health care system.

CNWL has always been concerned with patient safety at all levels of the organisation. The trust has robust systems in place for learning from serious and untoward incidents, there is an active safety committee and safety is prioritised at all levels of the organisation. Pharmacy are very active in innovating to reduce medication errors, a key issue in patient safety in mental health just as it is across the whole of the healthcare system.

The trust safety development programme is aimed at augmenting and improving existing safety work through innovation and evaluation. It arose out of a strong commitment at CEO and Executive level to finding ways of improving patient safety within the trust and a recognition that doing so necessitated extending the evidence base.

It is expected that the programme will be of value not only to the trust but to the wider health care system. We are committed to rigorous evaluation of what we do and dissemination through scientific papers and reports. The first publications are being submitted and we are in the early stages of planning an open conference to bring together interested parties nationally to exchange information and strengthen partnerships.

Following pilot work in early 2012 the trust has invested significant funding in the programme. This will be augmented by external funding. There is a particular need for high quality work in mental health and community services. Most patient safety work internationally has been in acute services, particular hospital services, and the focus has been predominantly on errors of commission. There has been much less systematic work on patient safety in mental health, and even less on safety in community and primary care. Most published work is descriptive and evaluations of interventions to improve patient safety are rare.

The programme has been developed and is being delivered with Professor Charles Vincent, formerly head of the Centre for Patient Safety and Quality at Imperial College, now at Oxford University. Professor Mike Crawford of Imperial College who works within the trust and has a key role in safety at the Royal College of Psychiatrists is also a key academic collaborator. The programme is led personally by the R&D Director and has a research staff of two with further recruitment planned.
With Professor Vincent’s involvement we began by identifying priorities and ways of addressing them and also by building the human and IT infrastructure necessary to pursue an ambitious patient safety programme. We now have in place a real-time data collection system and the necessary analytic and data collection software to pursue the programme effectively.

Internally the programme links to the Associate Director for Governance and the Director of Nursing. We have had strong support at all levels of the trust from senior managers to front line staff. The CEO takes a personal interest in the programme. Early on in the process of developing the programme we identified the lack of an evidence synthesis as a key barrier to improving patient safety in mental health nationally. Much patient safety work in the NHS goes unreported or is reported in “grey literature”, reports and policy documents which are scattered, hard to identify and sometimes hard to access. We are currently awaiting the results of an NIHR outline application on which both Professors Vincent and Crawford are co-applicants to systematically review published and grey literature on patient safety in mental health. As part of the project we propose to survey patient safety activity in mental health across the NHS, and internationally, to try to form a picture of what is happening and to identify potentially valuable innovations.

We have recently secured a SHINE grant from the Health Foundation to develop care bundles for the physical health care of mental health patients, a key safety topic covered in more detail below.

Externally we collaborate with CLAHRC North West London and with the North West London AHSN, who are about to start a programme of board level seminars for trusts on patient safety. At a national level we are waiting for an announcement on the proposed regional safety collaboratives which will have their own programmes and funding.

2. Key Themes

The programme is built around a number of key issues in patient safety. Our initial targets are organisational learning, making systems simpler and more accessible, co-production and building a safety culture.

a. Organisational Learning

It is impossible to foresee everything that might go wrong in a complex organisation but it is important to try to avoid the same thing going wrong more than once. Examining Serious and Untoward Incidents (SUI’s) is both essential for assurance and a valuable tool for learning. Root cause analysis of SUI’s provides a systematic way of examining individual cases as well as a basis for teams and organisations to reflect on their practice. However the majority of investigations of higher level SUI’s in mental health nationally do not identify a root cause. CNWL, like most other trusts, aggregates information across multiple SUI’s on an annual basis to identify trends and common patterns. CNWL, like other trusts, uses content analysis to do this.
We started with a small scale review of a convenience sample of 31 level 3-5 SUI’s and carried out our own content analysis. Reassuringly, themes identified showing a good match against the trust’s routine analyses. 2/20 severe (level 5) incidents had an identified root cause and 5/11 serious (levels 3-4) incidents had an identified root cause. It is often, of course, impossible to know if there is a root cause until one has gone through the process. Examination of the reports suggested that these judgements were reasonable. It is, for instance, often beyond the ability of a mental health service to prevent a suicide in the community. Risk assessments are poor predictors of suicide except where that risk is very immediate and acute. The evidence base for the value of particular suicide prevention interventions is, with some limited exceptions, currently unsatisfactory.

RCA also identifies a whole range of system issues which are not root causes, ie they neither caused nor could have prevented the incident, but which are deviations from good practice. In our analysis problems in communication between organisations and individuals were by far the most common (24/31 incidents) with poor care or errors of care, often minor (15/31) and poor co-ordination of care (16/31) being the next most frequent. It is not known in any health setting whether such system issues are more common in cases which end in SUI’s than in those that do not. That is an important thing to understand, and something we will be examining further through comparative analysis of matched cases.

Content analysis is a descriptive tool which is very valuable but has limitations in what it can tell us. As we aggregate reports detail which might lead to action can sometimes get lost. We have begun analysising all the trust’s SUI’s over a five year period including those less serious ones which were not subject to RCA. The larger data will allow us a) to achieve more stability in qualitative analysis b) to explore different qualitative approaches to data analysis c) to carry out quantitative analyses to identify patterns d) to look for trends in SUI’s e) to consider what other information might be collected by the trust as part of the investigative process to improve the value of the whole process of reviewing SUI’s. This should extend and illuminate the trust’s existing longitudinal monitoring of trends.

These are issues of importance to the wider healthcare system, not just issues for CNWL.

b. Making systems simpler and more accessible

Patient safety errors are rarely the sole responsibility of an individual. Individuals make mistakes, they will always do so. It is important to build safer systems which have the ability to prevent error at multiple points. Systems need to fail safe. For a system to be safe, those within it need to understand what it is, and what is expected of them. A system should be as simple and streamlined as possible since simple systems leave less scope for error. It is vital to make sure the necessary information to decide what to do is easily and quickly available to the person making a decision.

Information overload is now becoming a patient safety threat in its own right at a national and international level. For the individual clinician the volume of relevant
information is a major problem across healthcare. For an older person with a fracture of the neck of the femur, there are over 70 different sources of guidance and advice which apply, guidance which does not always agree. No individual clinician can possibly absorb and keep up to date with everything now being produced in their specialty. Streamlining information and making it more accessible is an urgent need across healthcare.

Policies, protocols and procedures are a key way of preventing information overload and turning the evidence base into everyday safe practice. The average NHS trust has between 200-400 policies which will probably occupy around 4000-5000 A4 pages. These will be regularly updated. It is arguable that the format of these policies has historically owed more to providing assurance and meeting a set of arbitrary standards than to consideration of how usable they are.

We set out to produce out of the 60 key trust clinical policies brief 2-3 page standard operating procedures (SOPs). We also sought to identify the ten most important policies. That work has now been completed. The idea is not to replace policies at this stage, but to provide information in a form which front line staff might reasonably be expected to be familiar with and which is easy and quick to consult in an emergency. A similar approach is taken in aviation, probably the safest of industries. It is unlikely that a pilot faced with a sudden power failure will wish to read a thirty page document and unlikely that nurse faced with a patient absconding will have the leisure to check for updates of a lengthy policy.

The objectives are:

- To provide all front line staff in booklet form the ten most important SOPs and to make sure these are covered in induction and staff training
- To provide an SOP manual for every ward and team which will be regularly updated
- To provide a “front sheet” for each trust policy containing a brief digest.
- To evaluate the programme with a view to informing other providers and the wider healthcare system.

Front sheets are now going onto trust policies. We have checked the ten policy booklet with policy development leads and amended in line with their comments. This work is due to be reviewed at the next trust safety committee before we start printing and distributing copies. We are working on the SOP manual. We will formally evaluate the SOP approach.

Care bundles are another way of streamlining processes and making key information immediately accessible. Developing care bundles involves identifying the essential core tasks in a particular area, including appropriate measures of outcome and producing systems which are simple, efficient and effective in getting things done. They are developed iteratively with front line staff through improvement science methodology. The complete system should support clinical practice. For instance documentation about cardiac risk should clearly identify what information needs to
be collected, how to interpret it and what steps to take and/or who to refer to. Integration is crucial, the details of who to refer to with addresses and numbers should be on the paperwork in front of the referrer. Ideally the whole process should be automated so that referral can be done at the press of a button.

Care bundles have been successfully used in physical health care but their use in mental health has been limited. The trust has a strong record in this area, notably Dr Bowden-Jones’s work on the use of care bundles in testing for blood borne viruses in addictions. The project team on care bundles, funded by the Health Foundation, will work together with front line staff to develop care bundles to improve physical health care for SEMI patients.

c. Enhancing and supporting a safety culture

A positive safety culture is one which supports staff in recognising safety issues and supports them in reporting those issues, even when they are reporting an error they have made personally. They need to feel able to report “near misses” in which errors did not lead to an adverse outcome, or much valuable information will be lost. A positive safety culture is one which recognises that people inevitably make mistakes and safety failures are rarely the result of a failure by a single individual. It is a whole system issue which needs managers and front line staff to work together to find practical solutions.

The government recognises that organisations which report more patient incidents are not necessarily less safe than other organisations, often they are better at recognising and reporting them. It is impossible to establish a baseline expected reporting level for heterogeneous organisations.

The local LETB has patient safety as one of its priorities. We are at an early stage of planning for a patient safety training programme. A whole systems approach to patient safety is a key endpoint, but as an immediate target we are looking at how to strengthen patient safety training and awareness within the trust. Training needs, of course, to be evaluated to make sure it achieves what it sets out to achieve. We intend to use standardised measures of safety culture as one of the outcomes as well as incident reporting. There is some uncertainty about the best measure to use to measure safety culture and the choice is partly dependent on what one is hoping to achieve. We are about to pilot possible measures with a view to comparing relative utility.

d. Co-production with service users and carers

We have held a series of consultations with users and carers on research, patient experience and patient safety. These issues provide a good match since they overlap strongly. So far work on safety has concentrated on inpatient care. Additionally we have carried out a small scale interview survey of inpatient concerns about safety.

In interviews with 51 users who had been inpatients three quarters of users said they
had felt safe or quite safe on wards. When asked what their main fear had been, if any, ten users identified the possibility of verbal or physical abuse from other patients. Other issues identified were fearing staff (4), not being allowed out (3), safety of property (2), ward rounds (2). We need to repeat this on a larger more representative sample, nonetheless it is helpful. The findings are consistent with national and international research. A consultation with carers and users identified the same key safety issues but added concerns around the side-effects of medication. Staff behaviour and staff being available were seen as the main source of reassurance about safety both in the survey and the consultation.

The next steps are gathering more information and looking at how to improve things. We plan to start to look systematically at specific incidents where people felt threatened. It is also important to be able to find out what specific staff behaviours make patients feel safe, is it mere presence, or are there specific things staff do which are important? Putting the information together should help us to identify possible steps we can take to make people safer and feel safer. At the same time it is important to link up to wider programmes on inpatient safety. For instance the trust was one of the sites for the national Safewards research project on improving patient safety on wards. Prediction of violence is more robust than prediction of suicide and we will be reviewing the currently available measures to see if they can be incorporated into everyday clinical practice.

The trust has a newly constituted user/carer research steering group and we will involve users and carers as researchers, as well as guides and research initiators, in the patient safety programme.

3. The Future

We expect to develop the safety programme further and, in particular, to develop work in community services and in community mental health. Besides being used to improve safety within the trust, outputs will be published so that they are available to a wider audience. We will also work closely with partners on safety work that they are doing, for instance in work at a regional level on junior doctor induction procedures and work on integrating mental and physical health care across the sector.

We will update the Board in six months time.

John Green
Director of Research and Development
SUI Analysis
- SUI analysis
- Report for Board
- Prepare academic paper and submit

SOPs
- Finalise SOPs
- Evaluate SOPs
- Prepare and distribute SOPs
- Prepare academic paper and submit

Care Bundles
- SHINE Project

Training for Safety
- Evaluate safety culture measures
- Upload measure onto e-system
- Develop face-to-face content
- Develop e-learning materials in pilot form
- Pilot training obtain feedback
- Refine package
- Finalise video content e-package
- Carry out training/evaluation
- Disseminate outside trust

Co-Production Programme
Detailed timetable to be agreed with user/carer research group
Report on complaints, incidents and serious incidents – Q4 2013/14

Objective:
The objective of this report is to provide the Board with an overview of complaints, compliments, PALS activity, incidents and serious incidents across the Trust during Quarter 4 of the 2013/14 reporting period. As part of the Trust’s response to the Francis report, the details of all upheld and partially upheld complaints are attached as an appendix.

The Board is asked to:
Note the report for information.

Executive summary:
This report has been compiled from the Quarter 4 (Q4) governance reports which each service area (Mental Health and Allied Specialties, Milton Keynes, Community Services and Sexual Health) submit to the Quality and Performance Committee.

Since September 2013 the Trust has been monitoring its performance in responding to complaints within the required timescales. The table below provides an overview of performance since formal monitoring began.

<table>
<thead>
<tr>
<th>% of complaints completed within target timescale</th>
<th>Sep 13</th>
<th>Oct 13</th>
<th>Nov 13</th>
<th>Dec 13</th>
<th>Jan 14</th>
<th>Feb 14</th>
<th>Mar 14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>41%</td>
<td>51%</td>
<td>71%</td>
<td>84%</td>
<td>71%</td>
<td>94%</td>
<td>100%</td>
</tr>
</tbody>
</table>

A total of 123 formal complaints were received across the Trust, which represents an 8% reduction when compared against Q3.

There were 3790 incidents and accidents reported across the trust during Q4 and the report gives an indication of the level and type of incident that occurred within each of the service areas.

Details of those incidents that are classified as serious are included in each service report. Across the Trust the number of Level 5 incidents (i.e. the most serious level) was 8, of which 7 were in MH&AS and 1 in Milton Keynes.

Andy Mattin
Director of Operations and Nursing
1 Mental Health & Allied Services

Complaints

Number of complaints

<table>
<thead>
<tr>
<th>Q1 2013/14</th>
<th>Q2 2013/14</th>
<th>Q3 2013/14</th>
<th>Q4 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints</td>
<td>76</td>
<td>88</td>
<td>75</td>
</tr>
</tbody>
</table>

During quarter 4 there were 61 complaints made within the mental health and allied services, significantly lower than the other quarters. The acute inpatient, ABT and Community Recovery service lines accounted for 75% of all formal complaints. This trend is in keeping with earlier quarters.

Analysis of complaints by borough does not identify any obvious themes or trends.

Complaints made – by subject

During quarter 4 there was a significant reduction in the proportion of complaints about the attitude of staff, although it remained the largest category. Complaints about the attitude of staff are reported across the MH&AS however, the Service Lines with the highest volume of complaints are the services with the greater number of complaints in this category.

Referrals to the Ombudsman

One complaint received during the quarter has been referred to the Ombudsman and remains under consideration. The trust investigation did not uphold the complaint.

Performance and learning from upheld complaints:

95% of the responses during the quarter were made within 25 working days. In March, the figure was 100%

3 were fully upheld and 26 partly upheld. Many had an element upheld which indicated that communication or the sharing of information could have been improved. In all of the upheld cases, an apology was expressed to the complainant. In addition the majority had a further action taken or identified to lessen the recurrence or remedy the difficulty for the complainant. Details of the upheld complaints within MH&AS can be found within Appendix A.

Compliments

24 compliments were forwarded to the Complaints Team for recording, and related both to inpatient and community care received by patients. Included were 9 compliments to a member of an older adult team who was retiring.
The enquiries were categorised as follows:

<table>
<thead>
<tr>
<th>PALS Enquiries</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems for resolution</td>
<td>37</td>
<td>56</td>
</tr>
<tr>
<td>Requests for advice &amp; Information</td>
<td>58</td>
<td>33</td>
</tr>
<tr>
<td>Requests for work placements &amp; experience</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>Compliments, general feedback and miscellaneous contacts</td>
<td>9</td>
<td>35</td>
</tr>
</tbody>
</table>

**Problems**

The problems being raised most frequently were:

- Concerns about quality of care/treatment (20)
- Administrative issues (10) Communication Issues (4)
- Assault/violence issues (2)
- Attitude/behaviour (2)
- Other/various (18)

**Requests for advice and information**

Requests for information varied, and concerned both CNWL and non-CNWL services, but primarily the former. Types of advice and information requests included the following:

- Requests for Trust HQ/Site/Service email addresses, postal addresses, contact names
- Enquiries re Trust policies/procedures (e.g. re patient care post discharge)
- Requests for complaint information leaflets
- Requests for GP contact details
- Enquiries re how to make a formal complaint against Trust or a local service provider, or requests for an update on progress of an existing complaint.
- Enquiries re how to contact either patients, members of staff, departments, or specific mental health services etc.

**Incidents**

<table>
<thead>
<tr>
<th>Incidents</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidents</td>
<td>2466</td>
<td>2519</td>
</tr>
</tbody>
</table>

In Q3 the Acute Service Line had the highest level of all incidents, followed by OPHA, Offender Care and Rehabilitation.

In Q4 the pattern was Acute followed by OPHA, Learning Disabilities and Rehabilitation. Three service lines had large increases - OPHA (203 incidents) and LD (155 incidents).

In both Q3 and Q4 ‘Disruptive behaviour’, ‘Assault/Violence: Against Staff’ remain in the highest reported category of incidents.

In Q4 there was an increase across some categories but ‘Assault/Violence Patient to Patient’.
The majority of incidents were reported as ‘No’ or ‘Low’ harm in both Q3 and Q4. In Q3 K&C was the highest reporter, followed by Brent, Harrow and Westminster. In Q4 K&C was the highest reporter, followed by Brent and Harrow – in other words, no change.

**Serious Incidents**

During quarter 4 there were 7 level 5 serious incidents reported across Mental Health and Allied Specialties. In the whole of 2013/14 there were 36 L5 serious incidents, which represent a 28% reduction when compared against the same reporting period in the previous year.

<table>
<thead>
<tr>
<th>SI Level</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>8</td>
<td>11</td>
<td>10</td>
<td>7</td>
<td>36</td>
</tr>
</tbody>
</table>

SIs are identified by staff at the point of reporting and then initially categorised by local management. An Initial Management Report is prepared and sent to HQ where a final grading of the level of incident is made. If it is a level 5, a Root Cause Analysis investigation is required. 6 of the level 5 incidents in Q4 relate to unexpected deaths of service users, in most cases where suicide is suspected. The 7th relates to a former patient who has been charged with murder. Completed investigation reports from across the service lines identified a range of areas requiring attention. The principal areas were:

**Clinical risk assessment and management** - 5 references were made to this area. These related to failures to follow the policy, to identify risk escalation factors, to review an earlier incident of self-harm and risk assessments not being up to date or having a risk management plan.

**Documentation** - 6 references to this including the Care Records Policy not being followed, data not being copied onto JADE, poor monitoring of mail from the patient and a failure to send a closure of case letter.

**Communication** - 3 problems identified relating to inadequate system of feedback to the MDT, poor transfer and sharing of information between teams and 1 regarding lack of contact with a private psychiatrist.

The three key points identified from Q4 data are:

- The rate of L5 SIs in the whole of 2013/14 has markedly reduced on the previous year.
- The single largest area of concern identified in investigations completed in Q4 relate to documentation.
- Clinical risk assessment and management remains an area where many issues are identified.
2 Community Services

Complaints

<table>
<thead>
<tr>
<th></th>
<th>Q3 - Number of complaints received in the reporting quarter</th>
<th>Number of complaints upheld</th>
<th>Q4 - Number of complaints received in the reporting quarter</th>
<th>Number of complaints upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCH</td>
<td>5</td>
<td>2 Upheld</td>
<td>10</td>
<td>1 Upheld</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 partially upheld</td>
<td></td>
<td>6 partially upheld</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 not upheld</td>
</tr>
<tr>
<td>CPS</td>
<td>8</td>
<td>2 upheld</td>
<td>12</td>
<td>6 upheld</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 partially upheld</td>
<td></td>
<td>2 partially upheld</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 not upheld</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 still under investigation</td>
</tr>
</tbody>
</table>

There was a significant increase in the number of complaints reported in Q4 compared to the previous quarter, many of which were fully upheld. Details of the upheld complaints are included in the attachment at Appendix B.

Compliments

Number received during the quarter

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCH</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>CPS</td>
<td>54</td>
<td>58</td>
</tr>
</tbody>
</table>

Compliments included appreciation of good clinical care, kindness and support shown by nursing staff.

PALS

<table>
<thead>
<tr>
<th></th>
<th>Contacts received in the reporting quarter</th>
<th>Problems / concerns</th>
<th>Information requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter</td>
<td>Q3</td>
<td>Q4</td>
<td>Q3</td>
</tr>
<tr>
<td>HCH</td>
<td>22</td>
<td>27</td>
<td>17</td>
</tr>
<tr>
<td>CPS</td>
<td>96</td>
<td>136</td>
<td>16</td>
</tr>
</tbody>
</table>

There were no particular themes emerging. The problems were resolved by referring them to a team manager for example missed appointments or incorrect size of continence supplies having been delivered. The information requests were for external agencies as well as requests for internal service information.
**Incidents**

<table>
<thead>
<tr>
<th>Quarter 4</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCH</td>
<td>438</td>
<td>355</td>
<td>352</td>
</tr>
<tr>
<td>CPS</td>
<td>352</td>
<td>313</td>
<td>312</td>
</tr>
</tbody>
</table>

The top incident categories were Pressure Ulcers, Medication Incidents, Patient Falls, Referral issues, Equipment issues and Patient care issues

**Pressure Ulcers**

**Camden:**

Of the 48 incidents, reported in Camden, 21 were attributable to Camden services. Of the 21 incidents; nine were Grade 2 pressure ulcers, eleven were Grade 3 and one was Grade 4. (For Grade 3/4 pressure ulcers see ‘Serious Incident’ section for details).

The Pressure Ulcer Board continues to work on its action plan. An update of the plan was discussed at a recent commissioners meeting. Work has continued in a number of areas including the implementation of SSKIN Care Bundles on the Inpatient Rehabilitation units. These are to be audited on a regular basis. The Tissue Viability Nurse is now in post and is currently working on the inpatient wards.

**Hillingdon:**

Of the 99 incidents reported in Hillingdon 32 were attributable to Hillingdon services. 20 were grade 2 pressure ulcer incidents all of which all were assessed as being unavoidable. 12 were grade 3 and 4. Seven investigations have been completed, which concluded that 3 were avoidable. The rest are still under investigation.

**Serious incidents**

In CPS 12 Pressure Ulcer Serious incidents occurred in this quarter. 6 serious incident RCAs have been completed, which concluded that 3 were avoidable and 3 unavoidable. The rest are still under investigation.

In HCH 12 pressure ulcer serious incidents were reported in this quarter and 2 patient care issues. Seven investigations have been completed, which concluded that 3 of the pressure ulcers were avoidable. The rest are still under investigation.
Complaints figures have remained relatively constant over the year, with a slight increase in Q2; this corresponded with service-changes in several parts of the organisation, for example mental health and podiatry. This highlights the importance of communication with all stakeholders at times of change.

The numbers of complaints as a percentage of all patients on the caseload demonstrate that there are 10 times more complaints in mental health than in all other services. This appears to be attributable mainly to the rapid changes in the service which have resulted in some communication issues.

Complaints outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upheld</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Partly upheld</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Other outcome /indeterminate finding</td>
<td>29</td>
<td>20</td>
</tr>
<tr>
<td>Not upheld</td>
<td>35</td>
<td>24</td>
</tr>
<tr>
<td>On-going (including suspended)</td>
<td>21</td>
<td>14</td>
</tr>
</tbody>
</table>

The majority of complaints are upheld fully or in part; this is the case especially when the complaint relates to a communication problem or staff attitude, or when treatment is delayed. People sometimes complain when they do not meet the criteria for a service and a referral is declined. In these cases the complaint is not upheld; there are still lessons to be learnt, relating to the management of referrers’ expectations.
Types of complaints

The three most widely reported complaints relate to attitude of staff, all aspects of clinical intervention and communication to patients and carers.

The complaints about manner and attitude include claims by service-users that staff have not taken their concerns seriously, and perceived rudeness. The root causes of complaints of this nature are addressed on a case-by-case basis by the relevant service-manager. Increases in this type of complaint are also compared with incident trends and workforce issues (such as sickness and increased agency use) as they can highlight problems in services.

All aspects of clinical treatment is a category which includes lack of service-provision. This is a particular feature of complaints from HMP Woodhill, and also in services which are experiencing staff shortages.

Almost all complaints include some evidence of communication difficulties, and many – 25 this year – relate purely to poor communication. In the last two quarters there has been an increase in complaints about diagnosis in the Mental Health Directorate, corresponding with the drive to ensure all patients have an ICD 10 code. This may highlight a training need for junior doctors.

Details of the upheld complaints within MH&AS can be found within Appendix C.

Compliments

In CNWL-MK, compliments are only collected centrally if they are submitted by services (or the people paying the compliment) to the Complaints and Customer Care Manager; numbers of compliments collected in this way are quite low – around 10 per quarter. We do, however survey our patients on a monthly basis through the Friends and Family test and supplementary questions, and by asking people to tell us their stories.

General trends can be seen for all of these by looking at the comments written on the questionnaires as to why they said they would be “Extremely Likely” to recommend our service.

Examples include:

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Q1 Apr - Jun 13</th>
<th>Q2 Jul - Sep 13</th>
<th>Q3 Oct - Dec 13</th>
<th>Q4 Jan- Mar 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Hearing</td>
<td>Very Helpful, Very Professional</td>
<td>Very Helpful, Punctual, Professional</td>
<td>Very helpful, Friendly service</td>
<td>Prompt efficient Service</td>
</tr>
<tr>
<td>Community Matrons</td>
<td>Very Helpful. Supportive Service</td>
<td>Supportive Service</td>
<td>Friendly, Helpful, Caring</td>
<td>Supportive</td>
</tr>
<tr>
<td>Dental</td>
<td>Very Good Service</td>
<td>Lovely Staff</td>
<td>Friendly, Helpful, Caring</td>
<td>Helpful, friendly, Kind</td>
</tr>
<tr>
<td>Health Visiting</td>
<td>Friendly, Welcoming</td>
<td>Friendly, Helpful, Reassuring</td>
<td>Very good, friendly, helpful</td>
<td>Helpful, friendly, good service.</td>
</tr>
</tbody>
</table>
### Incidents

<table>
<thead>
<tr>
<th>Category</th>
<th>Total in Q4</th>
<th>Change Since Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>124</td>
<td>▲ (28)</td>
</tr>
<tr>
<td>Transfer of Care</td>
<td>62</td>
<td>▼ (3)</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>68</td>
<td>▼ (8)</td>
</tr>
<tr>
<td>Fall</td>
<td>73</td>
<td>▲ (21)</td>
</tr>
<tr>
<td>Records/Data/communication</td>
<td>111</td>
<td>▲ (54)</td>
</tr>
<tr>
<td>Staffing Levels</td>
<td>13</td>
<td>▲ (11)</td>
</tr>
<tr>
<td>Violence</td>
<td>187</td>
<td>▲ (82)</td>
</tr>
<tr>
<td>Absconding</td>
<td>11</td>
<td>▲ (5)</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>52</td>
<td>▼ (17)</td>
</tr>
<tr>
<td>Sharps &amp; Hygiene</td>
<td>21</td>
<td>▲ (1)</td>
</tr>
<tr>
<td>Equipment</td>
<td>81</td>
<td>▲ (37)</td>
</tr>
</tbody>
</table>

There has been an overall increase in incident reporting in Q4 quarter; particularly from the Adult and Older People’s, and Mental Health Directorates.

The top trends are transfer of care, falls, pressure ulcers, challenging behaviours (including self-harm) medication, equipment and data/communication issues.

### Serious incidents

There were 17 incidents reportable via STEIS under the Serious Incident regulations this quarter. This represents a 48.5% decrease in the number of reportable incidents.

One SI can be classed as ‘Level 5’ i.e. resulted in the death of a service-user. The remainder resulted in moderate or major harm and met the threshold for reporting which is set out in CCG policy and NRLS guideline.

<table>
<thead>
<tr>
<th></th>
<th>Adult and older People</th>
<th>Children’s Services</th>
<th>Mental Health</th>
<th>Patient Safety</th>
<th>Offender Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3</td>
<td>12</td>
<td>4</td>
<td>16</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Q4</td>
<td>14</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>4</td>
<td>16</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

43 SIs were closed/downgraded this quarter following assessment of the investigation at the Serious Incident Assurance Meeting with the Commissioner:
• 1 Downgrade – Community Equipment
• 10 Admission of young person under 18 to Adult Inpatient MH Facility – CAMHS
• 1 Attempted Suicide – Mental Health
• 23 Pressure Ulcer Grade 3 – District Nursing
• 1 Discharge Incident – MKHFT/District Nursing
• 1 Ward/Unit Closure - WICU
• 4 Unexpected Death of Community Patient – Mental Health
• 1 Unexpected Death of In Patient – Mental Health
• 1 Allegation Against Staff Member – Mental Health
4 Sexual Health

Complaints

<table>
<thead>
<tr>
<th>Total number of complaints, concerns and comments received</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>64 (10 from quick feedback cards) (6 complaints)</td>
<td>82 (21 from quick feedback cards) (5 complaints)</td>
<td></td>
</tr>
</tbody>
</table>

| Total number of compliments received | 419 (72 from quick feedback cards) | 459 (80 from quick feedback cards) |

<table>
<thead>
<tr>
<th>Top issues received in complaints, concerns and comments</th>
<th>Waiting times</th>
<th>Appointments / appointment systems</th>
<th>Poor communication/method of conveying information to patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3</td>
<td>Q4</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>26</td>
<td>41</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2013/14</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint was not upheld</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Complaint was partially upheld</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Complaint was upheld</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>4*</td>
</tr>
</tbody>
</table>

Trend analysis - Complaints, Concerns and Comments:

- Complaints, concerns, comments and compliments are recorded (coded) by their primary theme, with other themes coming secondary. Most feedback received has more than one theme.
- Waiting times to be seen for appointments are still prominent in contacts for all services. This accounts for 8% of all feedback received and is the main theme from negative feedback. Data from the quick feedback surveys shows that 11-12% of respondents still report that they feel the wait they experience is too long, though this varies across the service (7.5% - 13.8%).
- Appointment/Appointment System accounts for 1% (7 comments) of feedback received. These comments include difficulty making appointments, length of time to reschedule an appointment and comments about not being able to book an appointment (walk in centres).
- Poor communication / Method of conveying information to patient also accounted for 1% of feedback (5 comments). 3 of these comments related to poor information about waiting times in clinics.
- Trends for compliments
- In the same way as more negative feedback, we can look at the themes arising from positive compliments. 459 compliments were logged in this quarter, compared to 419 reported for quarter 3 in the previous report. The following table details the top 5 themes of compliments:

Details of the upheld complaints within MH&AS can be found within Appendix D.
Compliments

<table>
<thead>
<tr>
<th>Top 5 themes in compliments</th>
<th>Staff manner, attitude, etiquette</th>
<th>377</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient experience</td>
<td>237</td>
<td></td>
</tr>
<tr>
<td>Good communication with patient/family</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>Operating system</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Positive environment</td>
<td>37</td>
<td></td>
</tr>
</tbody>
</table>

Incidents

<table>
<thead>
<tr>
<th></th>
<th>Q4 2012 / 13</th>
<th>Q3 2013 / 14</th>
<th>Q4 2013 / 14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Same quarter last year</td>
<td>Previous quarter</td>
<td>Current quarter</td>
</tr>
<tr>
<td>Total number of incidents reported</td>
<td>58</td>
<td>107*</td>
<td>116</td>
</tr>
<tr>
<td>Top themes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test samples and results incl. results not available on system; missing test results</td>
<td>1</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Incidents affecting staff only</td>
<td>12</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>Medicines management</td>
<td>11</td>
<td>7</td>
<td>32*</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>0</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>IT hardware and infrastructure (including telephony problems)</td>
<td>2</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Types</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient safety incidents</td>
<td>42</td>
<td>82</td>
<td>85</td>
</tr>
<tr>
<td>Incidents affecting staff only</td>
<td></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Estates and Facilities</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Public / contractors</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>IT, telephones and applications</td>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

*includes 20 incidents relating to HIV Medicine Home Delivery, which are unlikely to have been reported previously

Themes and trends:

- The number of incidents relating to test samples and results is broadly similar to that seen in the previous quarter.
- There has been 4 staff injuries reported this quarter, including 2 reports of injury from a slip, trips or fall (1 when getting up from a desk) at the Margaret Pyke Centre and 1 report of several near misses. Corrective action was taken and this was reviewed by the Health and
Safety Manager who visited the site and concluded that the most likely cause of any slips would be water carried into the building on people’s footwear.

- 22 incidents were reported in relation to the home delivery of HIV medication, particularly by Healthcare at Home, in most cases an emergency supply of medication was made available to the patient, but the reports received this quarter include 3 cases in which the patient missed between 2 – 7 days of their medication.
- There were 4 incidents involving some form of confidentiality breach and 4 IT hardware and infrastructure (including telephony problems) (4)

**Serious incidents**

There were 2 serious incidents during Q4.

One was a confidentiality breach involving a large number emails sent to nonCNWL employees in which email addresses were included in the cc: field rather than in the Bcc field. This was investigated and found to be caused by a human error.

The other was an unintended pregnancy detected at 25 weeks gestation in a patient who had received contraceptive care within the service. This incident is currently being investigated (Management Report)
## Key

<table>
<thead>
<tr>
<th>Part</th>
<th>Partially Upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPH</td>
<td>Upheld</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Outcome</th>
<th>Description</th>
<th>Finding</th>
</tr>
</thead>
</table>
| ABT     | PART    | 1. Insufficient notice of appointment with Consultant meant she could not arrange time off work.  
2. Staff failed to book follow up appointments or to reply to text messages.  
3. No copy of her discharge letter received and only learnt of inaccurate content when she saw her occupational health doctor.  
4. Psychiatric Service had not liaised with Eating Disorder Unit | 1. PART: As the team had not received notification of her inability to attend patient had been discharged instead of rebooked.  
2. UPH: Copy of letter to GP was sent to her previous address.  
3. PART: Communication had not taken place with Eating Disorder Unit and referral to Psychology was later closed as Eating Disorder service better suited to offering this. |
<p>|         | PART    | Changes in arrangements for getting access to mental health services in the last two years led to a violent outburst in the family. The Duty worker from his local team had refused to assist without a GP referral. Months passed before he was offered opportunity to go on a course designed to help with managing emotions or have sessions with his Consultant Clinical Psychologist. | UPH: Confirmed the complainant could have had access to another clinician earlier but felt it would be best if someone who had helped him in the past was used. Should have been communicated to the complainant. Noted his concerns on his file so future consultations and response rate could improved even if his usual doctor is not available. |
|         | UPH     | Although suffering from depression, follow-up appointment was given 7 months after first consultation. Wanted to know why she had to wait so long and why medication was not reviewed sooner. | UPH: The clinician that saw her had not indicated on the check out note that she needed a follow up appointment within 3 months so not picked up by the administrator. |
| PART | The meeting went ahead even after she informed the local service she was unable to attend as she had recently had some operations, and was unable to use public transport. | PART: The meeting was cancelled after she told previous care coordinator not going to attend. While staff were aware of the request to have a taxi, patient was told a letter from GP is needed to obtain a card. GP letter had been passed to previous worker not sent to new team until after date of meeting. Meeting not rescheduled as team accepted the transfer. Home assessment completed within 2 weeks. |
| PART | The attitude and conduct of a clinician who had carried out a mental health assessment. Wrote notes on a scrap paper and patient was given the impression of wasting time. Complainant also felt he was taping the meeting on the Dictaphone on the desk. | PART: Doctor was clear he had not intended to appear nonchalant but that he had used a serviette to make notes and would use the feedback as part of his supervision. The Dictaphone is only used to record clinical letters at the end of each appointment. Confirmed copies of the final letter in this case were sent to the GP and the complainer. |
| PART | Complainant was discharged from the service without prior warning. | PART: Service should have explained more clearly why her requests to be referred to one clinic were not thought appropriate for the complexity and severity of her condition. However, staff had found it difficult to communicate with patient due to the threats and way they were spoken to. |
| ACUTE | Legal Representative reported that a client's medical notes had been mixed up with details of another patients' details and information, which created an incorrect picture about the client's past history and current risk assessment. | UPH: There had been some inaccuracies in the paperwork that the solicitor had access to. |</p>
<table>
<thead>
<tr>
<th>PART</th>
<th>Lack of communication by the Trust with complainant in the three months following the incident.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UPH: Unsuccessful attempts to contact the complainant were made by the initial family liaison officer and it was only when the second family liaison officer was appointed was contact by email and telephone achieved to arrange a meeting. Complainant's details were passed to the investigation team who failed to contact him in a timely manner.</td>
</tr>
<tr>
<td>PART</td>
<td>Lack of communication by the clinical team about the moves despite his requests to be kept informed when these were planned.</td>
</tr>
<tr>
<td></td>
<td>UPH: Unsuccessful attempts to contact the complainant were made by the initial family liaison officer and it was only when the second family liaison officer was appointed was contact by email and telephone achieved. To arrange to meet, his details were passed to the investigation team who failed to contact him in a timely manner.</td>
</tr>
<tr>
<td>PART</td>
<td>1. Failure to administer anti-depressant and other medication as required because it was out of stock placed parent at high risk and next of kin not notified of the medication issue as staff wanted to hide the incident.  2. Despite bringing it to the attention of staff that their parent had arthritis and varicose veins, this part of her care was not attended to during the period of the admission.  3. Ward did not provide access to an interpreter every second day as had been agreed at the outset.</td>
</tr>
<tr>
<td></td>
<td>1. UPH: Specific medication was a not formulary drug held on the ward. While ward pharmacy technician had approved the order, no evidence reached pharmacy before it closed at midday. No evidence was there that staff made family aware medication taken before admission could be brought to the ward, if in original packaging and clearly marked. Staff failed to notify next of kin or raise an incident form.  2. UPH: Consultant aware of the physical health issues from ward pharmacists notes but overlooked prescription. No evidence she was asked to review physical care during the admission.  3. PART: An interpreter was booked but not told of the ward move so turned away and parent first seen by Consultant without an interpreter. At all other time seen every second day as agreed.</td>
</tr>
</tbody>
</table>
| UPH | 1. Ward staff had alleged he brought alcohol onto a Psychiatric Ward during a visit to a friend. This was defamation of his character and he wanted all references removed from hospital records.  
2. Should have carried out a bag check on him before he entered the ward. Wanted his standard visitor access rights reinstated. |
| --- | --- |
| PART | UPH: There had been a misinterpretation of staff notes by the clinical team leader which lead to the complainant being denied entry to the ward.  
2. UPH: Should have taken steps to check the bag in a discrete way as per protocol. |
| CAMHS | Unhappy that relative was left waiting for lengthy period in small lounge area and it was 24 hours before she was allocated a bed at a different hospital.  
PART: Confirmed it was accepted that relative needed an inpatient admission but as there were no beds of the type needed at the unit, it was necessary to try and locate to one where she normally resided. |
| COMMUNITY RECOVERY | Complained about the standard of music therapy facilities provided by the Arts Psychotherapy Department. In particular, concerned with the failure to sound-proof the room for privacy. Privacy in another therapy room is violated on a continual and constant basis. Also a breach of legal responsibility to ensure patient confidentiality.  
UPH: Accepted that there is a need to improve the sound proofing of the room and this is now being explored. Other users of the basement are to be spoken to and attempt is to be made to reroute journeys to the mental act office to the back staircase. |
<table>
<thead>
<tr>
<th><strong>UPH</strong></th>
<th><strong>PART</strong></th>
</tr>
</thead>
</table>
| 1. His care coordinator had not assisted him with obtaining a freedom pass.  
2. Had missed his Care Programme Meeting despite being sent a text.  
3. Allegation that he was aggressive towards his Forensic Social Worker in a meeting.  
4. Clinician appeared to have too high a caseload to be able to offer an appropriate level of support  
5. Requested to be allocated to a new worker. | 1. UPH: There had been confusion over obtaining a freedom pass which could not be applied for in the area local to the care coordinator as the complainant's place of residence was in another borough. Arranging for this to be processed in the other borough had caused a delay.  
2. UPH: The member of staff had misunderstood the date that the meeting was to be held.  
3. PART: The patient had been animated when he was discussing a point with the complainant's forensic social worker but was clear he had not intended to appear aggressive. Social worker accepted the need to be mindful of interpretation by observers of his methods of communication.  
4. UPH: Staff member did have higher than average workload but this was the current average in that team. It was agreed he had not had frequent visits since his placement began and this was because there was an expectation that this would be done by the forensic service and staff on site but member of staff still should have checked if a visit was needed earlier.  
5. UPH: Allocated to a new member of staff. |
| 1. UPH: There had been confusion over obtaining a freedom pass which could not be applied for in the area local to the care coordinator as the complainant's place of residence was in another borough. Arranging for this to be processed in the other borough had caused a delay.  
2. UPH: The member of staff had misunderstood the date that the meeting was to be held.  
3. PART: The patient had been animated when he was discussing a point with the complainant's forensic social worker but was clear he had not intended to appear aggressive. Social worker accepted the need to be mindful of interpretation by observers of his methods of communication.  
4. UPH: Staff member did have higher than average workload but this was the current average in that team. It was agreed he had not had frequent visits since his placement began and this was because there was an expectation that this would be done by the forensic service and staff on site but member of staff still should have checked if a visit was needed earlier.  
5. UPH: Allocated to a new member of staff. | 1. PART: Had been a lengthy time before the GP had started the planned medication reduction but this was partly down to the brother not attending an appointment. Family participation could not always be offered but in future complainant would be invited to formal reviews.  
2. PART: Confirmed some previous confusion over the appointment venue but that his brother had been allocated adequate time for a comprehensive discussion of his needs but now service would notify family members of appointments. |
| **1. Patient remains 2 years later on medication prescribed by his previous doctor for 2 months because it was difficult to come off. Concerned has been left on medication for so long without any regular monitoring, of side effects or damage. Little support provided to patient to date to come off medication.  
2. Although brother suffers from severe panic attacks and is unable to travel by public transport, all recent appointments have taken place at a site that is difficult and costly to reach. Previously all appointments 5 minutes walk from his home.** | **1. Patient remains 2 years later on medication prescribed by his previous doctor for 2 months because it was difficult to come off. Concerned has been left on medication for so long without any regular monitoring, of side effects or damage. Little support provided to patient to date to come off medication.  
2. Although brother suffers from severe panic attacks and is unable to travel by public transport, all recent appointments have taken place at a site that is difficult and costly to reach. Previously all appointments 5 minutes walk from his home.** |
<table>
<thead>
<tr>
<th>UPH</th>
<th>Took 6 phone calls to resolve a noise disturbance caused by service user living next door, leaving his bedroom TV/radio on for at least 9 days before he was escorted home from hospital to turn it off.</th>
<th>UPH: Accepted more should have been done to resolve the problem after the first phone call.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART</td>
<td>1. Procrastination by a member of staff had delayed progress with his son's assessment. 2. The lack of timeliness in moving the referral forward had impacted on the care of his son.</td>
<td>1. PART: While the member of staff had not procrastinated in progressing the assessment, the complainant was not offered the expected level of communication in such cases. 2. PART: The assessment had begun 5 weeks after the referral as there had been a need to initially seek some clarification from the complainant and then follow this up with the reasons for the referral with the CCG. Following receipt of this information it had been necessary to transfer the case to the Behavioural Support Service in another borough. Although the CCG were advised of the transfer the complainant was not immediately updated.</td>
</tr>
<tr>
<td>LEARNING DISABILITIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PART</td>
<td>1. Lack of response by members of the Senior Management Team to complainant's communications. 2. Letters sent in the post despite him requesting all communication be sent by email. 3. Staff had not followed up meetings with minutes outlining issues discussed and decisions/actions agreed. 4. Requested confirmation recommendations made in relation to his care had been implemented.</td>
<td>1. PART: All except one item had been responded to within a short period. The delay was due to the member of staff concluding that the opportunity provided by a prescheduled meeting to discuss the point would be more helpful than by phone. 2. UPH: Member of staff had sent email copies as soon as his preference was brought to her attention but accepted request had not been noted in this instance. 3. PART: No evidence of specific agreement to provide detail requested but accepted may not have been noted in first meeting. In the second meeting agreed to send a summary key issues and this was done. 4. PART: Confirmed complainant was provided with a copy of the action plan and draft statement for his medical records but accepted had taken a long time to make these available.</td>
</tr>
<tr>
<td>CORPORATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPHA</td>
<td>PART</td>
<td></td>
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<tr>
<td>---</td>
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<td></td>
</tr>
</tbody>
</table>
| 1. Complained that when her mother is admitted to hospital she is subjected to short notice transfers to other units. Causes considerable stress to both patient and family and would like the policy reviewed.  
2. Daughter had not been invited to any meetings about mother's progress, medication etc., and no contact had been made by phone either in the first four weeks of her mother's inpatient stay in hospital.  
3. Marks & Spencer night gowns plus pair of shoes (total cost: £40) had gone missing and nurses were unable to locate them. Would like to see an improved system for monitoring resident's personal effects at point of admission to a ward. | 1. UPH: Accepted mother was moved but that on the last occasion it was to accommodate a frail individual and her mother was considered the most settled patient. Move was done in agreement with the consultant and ward team but patient's concerns were noted.  
2. PART: There was evidence of discussions with the complainant, although she had been invited to attend a care planning meeting, this was not completed. This was as a result of the transfer to another ward before meeting was held.  
3. PART: Confirmed at admission her mother wanted to keep her property with her rather than put them in safekeeping. Expectation is that items should be labelled when brought to the unit. Confirmed staff had packed belongings at point of transfer but acknowledged might have been items misplaced. Investigation confirmed that there is a system in place to monitor patient's property however, in this instance the patient retained property upon admission. However, it was documented that on the date in question the complainant did drop off some clothing, no specific details were noted. |

<table>
<thead>
<tr>
<th>HCH</th>
<th>PART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of treatment elderly mother received from inpatient unit - Mother showered very early morning in a cold shower room with cold water, which required her having to pull herself up from seating position on a plinth holding a handle. This was difficult to do given her mobility difficulties and caused significant stress.</td>
<td>UPH: For a period time the unit did experience intermittent issues around heating and hot water but nursing staff made every effort to minimise the impact this caused to patient care using potable heaters and warm water from the kitchen until the problem was sorted by estates.</td>
</tr>
</tbody>
</table>
| PART | 1. Nurses attending to her sisters care in last few days had not been qualified to administer intravenous flush procedure.  
2. Dressings on heels and lower legs only changed every 3 days which was not frequent enough.  
3. Supply of dressings not looked after properly by District Nurses so on at least 3 occasions no dressings were available.  
4. Delay in specialist equipment being ordered.  
5. Prescriptions for important medications not ordered via GP as promised by District Nurses, so not ready for collection when sister went to pick them up. Caused high levels of stress and panic, especially the day before death of sister when she was in severe pain and deteriorating. |
| PART: One occurrence where a nurse visiting the complainant’s relative was not skilled in flushing the PICC line. It was accepted staff allocation needed to improve.  
2. UPH: When complainant had requested more changes to dressing frequency a full assessment should have been carried out.  
3. PART: While timelines for processing prescriptions for dressing rested with the GP Practice, it was accepted that nurses should have been more proactive in following up the requests and have an immediate plan to ensure patient had adequate supplies. Also should have escalated ongoing problems to the management team to address directly with the GP.  
4. UPH: Specialist bed with side tails was ordered before the air loss mattress, when they should have been ordered together.  
5. UPH: Anticipatory medication discussed but there was a delay in placing the request. Medication then not checked when arrived so it was not noted that insufficient drugs were delivered. |
| UPH: Accepted miscommunication and lack of a proactive response over the test results from the staff in the service providing care to her children.  
2. PART: It was only when the second letter was received from the unit that it became clear her children had been discharged by the other clinic. Clinician spoke to the complainant on the following day and an appointment was arranged within a fortnight which led to a referral to the local dietary service. Accepted time frames for the appointment should have been clarified in the call. |
| PART | 1. After her children had blood tests it took 6 contacts to get the results.  
2. Staff had not acted on recommendation that her twins be referred to a local dietician. |
| UPH: It was only when the second letter was received from the unit that it became clear her children had been discharged by the other clinic. Clinician spoke to the complainant on the following day and an appointment was arranged within a fortnight which led to a referral to the local dietary service. Accepted time frames for the appointment should have been clarified in the call. |
| PART | Length of time and difficulties in obtaining supplies of incontinence pads following discharge from care home. Even when ordering procedure is followed correctly, waits up to a month for supplies to be delivered. | UPH: There was a breakdown in communication between the bladder and bowel service so patient did not receive incontinence supplies for 10-11 weeks after the original community assessment. |
| PART | Complained about the tone and inferences made in a letter written by an Occupational Therapist. Feels exercise programme did not take full account of her fibromyalgia, and her knee replacement or the constant pain she is in. | PART: Found that while the OT had not intended to cause offence by letter written, accepted it was not clear in meaning or in line with values of the service in its tone. |
| UPH | When arrangements were made to have nurses administer his mother's medication, deliveries had not been arranged, visits had not taken place and medication had not been administered at agreed times which had put her at risk. | UPH: Accepted service was unsatisfactory. One visit had not taken place because an administrator had not added it the planner that the nurses follow. After carers notified the team a visit took place. Due to poor handover of the delay earlier in the day, the night team were too early in administrating the next dose so complainant's mother's pain control was compromised. The following month another day visit did not occur because of a further administrative error. On the third occasion the nurse who visited had not been able to locate the home notes as these had been removed, and not returned before the night member of staff called. This prevented the nurse from administering the controlled drug. |
| UPH | 1. His father had been left unattended when eating and taking medication.  
2. Father fell from his commode and banged his head.  
3. Poor continence management led to his father being left in soiled clothing throughout the night. Urine bag not attached properly or emptied in a timely manner causing part of it to dig into patient's leg and testicles. |
|---|---|
| 1 UPH: Although there were protected meal times, it was not possible to evidence the extent that his meals were supervised as prescribed by the speech and language therapist to address his swallowing issues. His medication was supervised after a concern was brought to the senior nurse.  
2 UPH: While father was being transferred in a hoist to the commode he fell. Neurological observations showed normal function after the incident and medical team confirmed no other injuries other than a laceration to his eyebrow.  
3 UPH: Continence care was not up to standard and changes have now been made to practices including hourly comfort rounds and training for staff. |
| UPH | 1. The refusal of the podiatrist to see her elderly diabetic mother when she came 10 minutes late for her 3-monthly appointment even though no other patients were waiting and nail cutting procedure only takes approx 5-10 minutes.  
2. After students indicated they could not complete the procedure the Podiatrist told her daughter who was with her to book another appointment for the following week even though this would require her to take another day off work. |
| 1. PART: The clinic was already running late and was busy so that accommodating another late patient would have led to the service being delayed even further behind the schedule.  
2. UPH: Having reflected the podiatrist saw that he might have insisted that the student nurse undertake the procedure after an appointment for the following day was refused. Mother given another appointment within two weeks. |
**PART**

1. Nurse arrived late  
2. Nurse had administered medication from blister pack even though medication was missing without checking with relative as to whether it had already been given.

1. UPH: The member of staff had arrived outside of the agreed visiting time highlighted on the visit schedule. The delay had been caused by seeing another patient and had been unavoidable but she should have called to explain.  
2. UPH: On realising that the blister pack for the day was empty the nurse should have made contact with the nurse in charge for advice. Learnt only after she had administered medication that the complainant had given it earlier in day. Went back to see mother and sought immediate advice from GP and Pharmacist who advised no clinical risk but to check blood pressure. On two occasions was within safe limits. He was contacted by the Senior Nurse in Charge and updated about the incident.

**PART**

1. The number of care staff involved in his care  
2. Progress notes not available  
3. Lack of communication about the ending of his package of care.

1. UPH: Found a total of 30 staff had visited in the course of his care and this was excessive for an early supported discharge package.  
2. UPH: One new member of staff had not followed the care link policy. Further training to be given and arrangements made to monitor their future compliance.  
3. PART: Although he had understood his package would continue for another six weeks, the team had not felt it needed to continue given his level of independence but this was not clearly communicated to him. He also should have been referred to the Red Cross Re-enablement Service for interim support following the discharge.

**MK - COMMUNITY**

UPH: Delay in responding to referral  

UPH: The referral was emailed late on a Friday afternoon and was not picked up until Monday. All referrals that are received by email also need to be followed up by telephone to ensure they have been received.
### PART
A relative complained that a District Nurse spoke to him in an argumentative and confrontational manner when asked to lock the door when visiting.

### UPH
A relative felt that a District Nurse rushed a visit because it was nearly their lunch time, leaving the patient feeling intimidated.

### UPH
A complaint that a District Nurse failed to wash her hands before treating patient and spoke to the patient in an argumentative manner

### UPH
Missed an appointment due to poor signage.

### PART
A parent said she received detrimental comments about breastfeeding and feels that the Service does not support breastfeeding.

### PART
A parent complained that her child has been waiting for 10 months for an assessment.

### UPH
Parent raised a concern to a therapist, and felt they breached confidentiality by copying the reply to their child’s school potentially damaging the relationship between the parents and the school.

### UPH
Feels his care coordinator is ambivalent about his needs, is always late for appointments and on occasions does not turn up.

### PART
The Nurse had been concerned about being locked in and acknowledged her anxiety about this influenced her communication. Another member of the team has been allocated.

### UPH
Patients are at times left for short periods following catheter insertion, however due to the anxiety caused it is documented that the nurse did not act in the best interest of the patient at that time.

### UPH
The Nurse acknowledged comments made were unprofessional. Another member of the team has been allocated.

### UPH
The Service manager agreed that the appt letter should have included directions and will enclose this going forward and contacted NHS England (responsible for the signage) to rectify the lack of signage.

### PART
Assurances were given that the Service is committed to promoting breastfeeding. The service manager agreed questions about feeding could have been better phrased. The health visitor’s are due to attend further training in the year.

### PART
A date had been identified for the assessment. Additional funding from the commissioner has been agreed as it was recognised that it did not meet demand. The service is now recruiting additional staff.

### UPH
The therapist thought it was ok to share the reply as consent to share information with another stake holder had been gained. On reflections they understood why this was not appropriate. The service has reviewed the process for recording consent to share information.

### UPH
The Care coordinator did acknowledge that they had arrived late but gave assurances that his needs had been taken seriously. A senior therapist will be undertaking a re-assessment.
<table>
<thead>
<tr>
<th>PART</th>
<th>Unhappy that there changes to the service have been made without the Therapeutic Community's involvement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPH</td>
<td>Delay in arranging an assessment with a physiotherapist.</td>
</tr>
<tr>
<td></td>
<td>PART: Unexpected changes to the staff at Therapeutic Community had been made because of a Human Resource process, the service review is planned for later in the year and assurances were given that patient involvement would be key to any changes.</td>
</tr>
<tr>
<td></td>
<td>UPH: The agency that provides a physiotherapist took several weeks to send a suitably qualified therapist to carry out an assessment. A review of the agency is under way.</td>
</tr>
</tbody>
</table>
Central and North West London NHS Foundation Trust

BOD May/2014

This report is for publication

Board of Directors

Performance Summary Month 12 of 2013-14
14th May 2014

Objective:
The objective of this report is to provide a summary of performance against statutory indicators and internally set priorities at month 12 and Quarter 4 to assure the Board of the Trust’s compliance against statutory targets and identify the management plans that are in place to address any areas of underachievement.

The Board is asked to:
Note the report for information

Executive summary:
Monitor Indicator Performance:
In month 12, the Trust achieved the target for 13 out of 13 Monitor indicators, including all community services Monitor indicators. Although all Monitor indicator targets were achieved, there was some underperformance at Service Line/Borough level.

Comparison to last month:
There was a downward trend in six Monitor indicators (but by less than 0.5% in three cases) which were:
- Delayed Transfers of Care
- Gate Keeping by Crisis Resolution Teams
- Data completeness: Identifier
- Community Treatment Activity - Referral to Treatment Information
- Community Treatment Activity - Referral Information
- Community Treatment Activity - Activity Information

There was an upward trend in three Monitor indicators, which were:
- 7 Day Follow-Up (CPA Only)
- CPA Reviews within 12 months
- Data completeness: Outcomes

The remaining four Monitor indicators maintained performance of 100%.

Other Indicator Performance:
Four out of four Internal Priority indicators achieved target in month 12, with an improving trajectory in three out of four. All six Drug and Alcohol measures achieved target levels and all maintained or improved performance compared to last month. Of the 21 Offender Care indicators, two did not achieve target in March.

Quality Indicator Performance:
CNWL has 14 Quality Account Priority indicators (6 relating to CNWL, and 8 relating to CNWL-MK). In Q4, 9 (64%) achieved their targets and the remaining 5 (36%) nearly met their targets.

Of the additional 13 Quality Indicators (representing Quality Account Priority indicators from previous years still measured), 8 (62%) were met, which is a slight improvement in performance from Q3, when 7 were met.

Responsible Director: John Vaughan, Director of Strategic Development and Community Services
Date: 7th May 2014
1.0 Summary Trend Analysis

The Trust position for March can be seen on the Internal Performance Scorecard on p15.

1.1 Monitor Indicators

CPA 7 Day Follow Up: The Trust has achieved target and performance improved to 98.5% in March. Overall, the target level has been achieved for all four quarters of 2013-14 and full year to date performance is reported as 96.1%. The two most persistently underperforming areas, Milton Keynes and Westminster Older Adults, both achieved target in March, however both areas failed the threshold for Quarter 4 and for the whole year to date. Learning Disabilities also failed to achieve target for the whole year to date although this was due to low performance in Quarter 2 and the service has since achieved 100% in Quarters 3 and 4. Further details can be found on p4.

CPA 12 Month Reviews: The Trust has achieved target in every month in 2013-14 for this indicator and March performance was at 97.2%. Each of the four quarters of the year have met target and full year to date performance is reported as 96.1%. Learning Disabilities failed to achieve the target threshold for Quarters 3 and 4 and for the full year 2013-14, however the service’s performance has improved gradually since January. Eating Disorders also failed to achieve the target for the full year 2013-14 which was mainly due to low performance in Quarter 2 and the service has since achieved target in Quarters 3 and 4. Further details can be found on p4.

Delayed Transfers of Care: This indicator target has been achieved by the Trust every month in 2013-14 and March performance was at 4.7%. Each of the four quarters of the year have achieved target and full year to date performance is reported as 4.7%. Three areas did not achieve the target for the year. Learning Disabilities failed to achieve target in every month and quarter of 2013-14, Westminster Adults failed to achieve target in seven months and Quarters 1, 3, and 4 and Hillingdon Older Adults failed to achieve target in nine months and Quarters 1, 2 and 3, however the latter service area has improved considerably to report 0.0% for the last three months. Further details can be found on p5.

Crisis Resolution Team Gatekeeping: The Trust has achieved target in every month in the 2013-14 for this indicator and performance was at 96.4% for March. The Trust met the target in each of the four quarters of the year and full year to date performance is reported as 96.2%. Milton Keynes is the only area where performance has dropped below target more than once, with four out of the last six months underperforming, including in March. Further details can be found on p5.

Early Intervention in Psychosis New Cases: At Trust level the target has been exceeded every month in the year to date since May, with one area, Westminster Adults, unable to achieve target on a regular basis. The reasons for Westminster Adults underperformance are well documented as being related to CCG boundary changes and are being addressed through contract negotiations for an appropriately revised target. Further details can be found on p6.

Data Completeness: The Trust achieved the target for this indicator in March and in each month in 2013-14, with full year to date performance at 99.2%.

Data Completeness: Outcomes: The Trust achieved the target for this indicator in March and in each month in 2013-14, with full year to date performance at 97.5%.

Access to Healthcare for People with a Learning Disability: This indicator target has been achieved by all Trust areas in March. Milton Keynes had reported non-compliance for this measure for the first five months of the year but, as planned, has achieved this from September onwards.

All five Community Service Monitor indicator targets were achieved in March, as has been the case for each month in the year to date. Further details can be found on p6.

Patients waiting less than 18 weeks from point of referral to treatment - non admitted patients (%) and incomplete pathway (%): Performance in both these indicators has been maintained at 100% in March and has been reported at 100% for each month in the year to date.

Community Treatment Activity - Referral to Treatment Information: Performance has been maintained at 100% in March and the target has been achieved for each month in the year to date. Full year 2013-14 performance is reported as 99.2%.

Community Treatment Activity - Referral Information: Performance was at 89.3% in March which was a small decrease compared to February, however the target threshold was met by all three areas and has been for each month in the year to date. Full year 2013-14 performance is reported as 91.8%.

Community Treatment Activity - Activity Information: March performance was at 77.6% which was a decrease compared to February, however the target threshold was met by all three areas and has been for each month in the year to date. Full year 2013-14 performance is reported as 87.9%.
1.2 Drug and Alcohol Services
Due to reporting limitations of the National Drug Treatment Monitoring System, all Drug and Alcohol performance reports are one month delayed, meaning that the data in this report is for February.

All Drug and Alcohol measures achieved target levels in February. Further details can be found on p6.

1.3 Offender Care
Due to the number of Key Performance Indicators for the Offender Care service line their performance is reported on the Offender Care Scorecard, which is attached as a separate paper.

The Offender Care service line has 21 indicators in total. In month 12, at Trust level, 15 indicators achieved target, five indicators were borderline (shown as amber on the scorecard) and two indicators did not achieve target. A common factor across the below target indicators is underperformance by HMP Winchester. Just one indicator, KPI 12, failed to achieve target for the year to date. KPI 4 (Number of patients who successfully complete structured psychosocial Intervention as a percentage of the total caseload), which failed to achieve target in February, has improved to meet the target in March and for the full year to date. The two KPIs that underperformed in March are:

KPI 11: Patients offered and accepted Hep B Vaccination, 65 % of those that accept complete the course. The overall KPI is not been met at a result of HMP Winchester Primary Care underperformance for the last three months. This is related to a data quality issue regarding poor recording of patient vaccinations breakdown on Systm1. We have developed a new template on Systm1 as a mandatory item for recording this data set, rather than a manual excel spreadsheet. Clinical IT Training with Primary Care nurses and Systm1 administrator have been scheduled for the first week of May 2014 which is been led by Mel Clewer from CNWL IT Project. Improvement in reporting is expected by the end of May 2014.

KPI 12: Patients with long term conditions have care plans in place. This relates to data quality and recording issues which have been ongoing over the year and remain a challenge. A DQIP has been agreed with the Service. HMP Winchester Primary Care has a data quality issue relating to recording of long term conditions (LTC) with agreed care plans on Systm1. A new LTC Recording template has been reviewed.

Further details at Trust and HMP area level can be found on the Offender Care Scorecard.

1.4 Internal Priority Areas
These are internal indicators, which have no impact on our Monitor rating. Two are related to just Mental Health Services (Emergency readmissions and 7 Day Follow up (all)) and two are related to all services (DNAs - First Appointment and DNAs - Follow Up Appointment).

In March, the Trust achieved the targets for all four Internal Priority indicators for the first time in the 2013-14. There was also improvement in the performance of three of the four indicators.

Further details for the Internal Priority indicators can be found on p7-8.

The remaining three Community Services Internal Priority indicators are included on the Scorecard (see pages 15 and 17, indicators 32, 33 and 34) but these have not yet been RAG-rated as it has not yet been possible to set one Trust wide target due to variance in the level of resources and needs in the different boroughs. The negotiation and setting of these targets will be covered in the 2014/15 contracting round with the local commissioners and will depend on the level of resourcing and performance to date.
1.5 Quality Indicators

Further to discussion at the July Quality and Performance Committee, Quality data is now reported by:

a) Quality Account Priorities (QAPs)
b) Quality Indicators (QI)
c) Organisational Learning Indicators (QL)

Further detail can be found on pages 9 - 14.

Quality Account Priority indicators (n=14):

CNWL has 14 QAP indicators. In Q4, CNWL met 9 (64%) of these indicator targets, and nearly met 5 (36%)
The five areas of underperformance at Q4 are:
- Patient satisfaction measure (target very narrowly missed);
- We record offering patients a copy of their care plan (target missed but improved from Q2);
- Patients have their ‘carer status’ identified;
- To improve on the 2012 CNWL-MK score based on the CQC national community mental health patient survey for responsiveness to patients needs in 2013;
- For CNWL-MK to improve on the 2012 national staff survey results for the Friends and Family test in the 2013 survey;

Mental Health and Allied Specialties have achieved the target for those respondents feeling they were ‘definitely’ involved in the decisions about their care plan, and maintained this position from Q3 to Q4.

Quality indicators (n=13):

These indicators are old/retired Quality Account Priorities from previous years, which we have to continue to report unless we can show good reason not to do so.
8/13 (62%) quality indicators were achieved; a slight improvement since Q3.
Four out of the five remaining indicators underperforming in Q4 have underperformed since Q2; and these relate to:
1. Patients being offered a copy of their care plan (they tell us);
2. Patients’ risk assessments completed and linked to care plans;
3. Patients’ satisfaction with call bell service at the St Pancras Hospital Inpatient Wing; and
4. Patients reporting ‘definitely’ getting the help they wanted from the Urgent Advice Line

Finally, MHAS inpatient service users with a physical health assessment after admission (nursing), which was achieved for all previous quarters, was just missed by 1% in Q4.

For details of service line improvement action examples, see main report (pages 9-14).
2.0 Monitor

2.1 CPA 7 Day Follow Up

All areas achieved the target threshold in March except for Horton Villas where one patient was not followed up in time.

Horton Villas (75.0%): This breach relates to one patient was due to incorrect data on JADE. This has now been amended and the record is correct.

2.2 CPA 12 Month Reviews

*For Eating Disorders the requirement is for a review to be carried out every 6 months

Learning Disabilities (88.9%): There were no new breaches in March. This underperformance relates to seven patients whose review dates had been breached in previous months, predominantly in December. To address this, the service have a plan in place to complete all previously missed CPA reviews by the end of April 2014. Training workshops have been completed for teams and the checklist is to be reviewed with clinicians and circulated to all clinicians thereafter.
2.3 Delayed Transfers of Care including Health and Social Care (Target <7.5%, Performance 4.7%)

**Westminster Adults (10.1%)**: There were 16 patients with delays in the month, some of whom have subsequently been discharged. They were delayed for a range of reasons, including legal and accommodation (hostel, rehab) and repatriation. The Acute Service Line are initiating a project to identify ways in which delayed discharges can be minimised. The project will focus on identifying clearly what the reasons are for delays and subsequently identify suitable actions and forward planning processes to support timely discharges.

**K&C Older Adult (10.5%)**: Three patients had a delayed transfer of care, attributable to social care in March. All three patients had delays due to a lack of availability of an appropriate placement. One patient has since been discharged. The Ward Manager will continue to seek an interim placement for the two patients who remain on Ward and will follow this up with the Social Worker.

**Learning Disabilities (16.5%)**: This relates to five patients who were delayed in February, all for social care reasons. At the Carlton Unit, placements were identified for two patients and one patient was discharged in March however the other patients is still waiting for funding agreement. One patient at Preston Unit is also waiting for funding agreement for a support package to be put in place. Placement is are still being sought for one patient at Seacole East and one patient at Jubilee Unit. The Unit Manager, Lead Nurse, Clinical Director and Service Director continue to escalate with commissioners and social workers as appropriate.

2.4 Crisis Resolution Team Gatekeeping (Target 95%, Performance 96.4%)

**Brent Adults (90.6%)**: There were two breaches which were due to data entry issues. Both service users were gate kept and the contact is on the clinical system but was entered incorrectly. The breaches have now been corrected on the clinical system and the staff involved will be informed, and training provided. The patient flow manager and the Home Treatment manager monitor this closely to ensure all patients admitted are gatekept prior to admission.

**Milton Keynes (89.3%)**: This relates to three cases in March that were not gatekept due to being directly admitted and bypassing the Home Treatment Team. Since 11th April, the Home Treatment Team have been working 24 hours and this will continue at least until the end of August. All admissions will now be assessed by the Home Treatment Team prior to admission.
2.5 Early Intervention in Psychosis New Cases

Central London CCG (Westminster) (89.2%): The team is currently six cases under target. The amendment of the CCG boundary has affected the team’s ability to meet the target for new cases with a Westminster GP. The contracts team is currently negotiating an appropriately revised target with completion expected by end of March 2014.

3.0 Drug and Alcohol

Performance information for Addictions is now available after several months of no data. However, due to limitations of the National Drug Treatment Monitoring System, all reports are one month delayed meaning that the data in this report is for February.

All Drug and Alcohol measures achieved target levels in February.

- Drug Users in Effective Treatment (Target 85%, Performance 88.0%)
- Opiate and Crack Users (OCU) New treatment episodes in effective treatment (Target 85%, Performance 90.0%)
- 3-weeks Waiting Time Target Compliance (Target 95%, Performance 99.0%)
- Drug Users with a Care Plan (Target 95%, Performance 100%)
- Unplanned Drug Discharges (Target 40%, Performance 36.0%)
- Unplanned Alcohol Discharges (Target 40%, Performance 28.0%)

2.6 Community Services

Hillingdon Community Health (HCH), Camden Provider Service (CPS) and Milton Keynes achieved all five Community Service Monitor targets in March, as has been the case for every month in the year to date.

These five indicators form part of the Monitor Compliance Framework for 2013/14 and are used by Monitor to assess the quality of governance at NHS foundation trusts. The three data completeness measures are based on the Community Information Data Set (CIDS) definitions.

- Patients waiting less than 18 weeks from point of referral to treatment - non admitted patients (Target 95%, Performance 100%)
- Patients waiting less than 18 weeks from point of referral to treatment - incomplete pathway (Target 95%, Performance 100%)
- Community Treatment Activity - Referral to Treatment Information (Target 50%, Performance 100%)
- Community Treatment Activity - Referral Information (Target 50%, Performance 89.3%)
- Community Treatment Activity - Activity Information (Target 50%, Performance 77.6%)
4.0 Internal Priorities (MH)

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Readmissions</td>
<td>&lt;=8.1%*</td>
<td>3.8%</td>
<td>4.5%</td>
<td>4.0%</td>
</tr>
<tr>
<td>DNAs - First</td>
<td>&lt;=13.3%**</td>
<td>11.6%</td>
<td>11.0%</td>
<td>11.6%</td>
</tr>
<tr>
<td>DNAs - Follow up</td>
<td>&lt;=11%**</td>
<td>10.8%</td>
<td>10.6%</td>
<td>9.9%</td>
</tr>
<tr>
<td>7 Day Follow up (all)</td>
<td>95%</td>
<td>91.1%</td>
<td>94.9%</td>
<td>95.8%</td>
</tr>
</tbody>
</table>

* Targets changed from month 3. Was <11%

** CAMHS target remains at 15%

4.1 Emergency Readmissions (Target <8.1%, Performance 4.0%) The maximum threshold has reduced from 11% to 8.1% as a result of CCG agreements

K&C Older Adults (25.0%): This relates to one patient who was discharged on 25 February and later readmitted on 6 March. The reason for the readmissions was that the family could not cope despite the additional care package that was put in place. The plan is to assess the patient with a view to identifying a suitable placement and progressing the funding process.

Milton Keynes (12.1%): There were four readmissions to Campbell Center during March. The main causes are around effective discharge planning, which is being reviewed with the aim of making this as robust as possible, with particular emphasis around accommodation issues.

4.2 DNAs First Appointments (Target <13.3%, Performance 11.6%): The target for this measure was revised from 15% to 13.3% for Adult and Older Adult Services since June as a result of CCG agreements. The CAMHS target has remained at 15%.

Brent Adults (14.8%): Work is ongoing with all the service lines in Brent to bring DNA’d first appointments down to within the target but this is challenging considering the demand and capacity issues in ABT which recorded the most DNAs. The ABT Team is taking practical steps such as telephone reminders, text messaging and sending reminder letters to service users. DNA’d first appointment is discussed and monitored at the Brent Interface meeting regularly where all the service lines are tasked to identify ways to reduce this. Brent Service Lines, especially ABT, have worked to reduce DNAs since the last financial year where DNA numbers were averaging around 37.2%. This year DNA numbers have gone down significantly.

K&C Adults (15.8%): The majority of DNAs for first appointments occurred within Community Recovery Teams and Psychological Medicine. A small number also occurred within the Acute Service Line teams. Within the community recovery teams, there has been an improvement in performance this month and the teams are continuing to actively follow up on their DNA’s. DNA rates are discussed monthly with team managers at a Performance and Finance meeting. Within Psychological Medicine, a new system of reminders has been implemented to remind patients of upcoming appointments, including letters, phone calls and text messages. The increase in DNAs in March is being reviewed to identify if any specific themes are apparent. The Service are also planning a review of the reminder system to assess the impact of it on DNA rates.

Milton Keynes (14.0%): There are four services with consistently high DNA rates, which are ASTI, Memory Assessment Service, Personality Disorder, and Psychological Therapy Service. A comprehensive analysis of DNAs will be completed during April and May, concentrating on these four services. The analysis will investigate causal factors such as variances in booking and recording processes and organization of clinical sessions. An action plan for each service will be implemented following the analysis.
### 4.3 DNAs Follow Up Appointments (Target <11%, Performance 9.9%)

The target for this measure has been revised from 15% to 11% for Adult and Older Adult Services since June as a result of CCG agreements. The CAMHS target has remained at 15%.

**K&C Adults (11.2%)**

The teams have struggled to meet the 11% target for DNAs for follow up appointments since this was reduced in 2013, though there has been improvement over the year. During March 2014, a project was completed to validate JADE DNA rates by comparing data to manual records. It was found that under recording of seen appointments has adversely affected the DNA rate, in a small but significant way. Throughout this process, training needs and JADE access issues were identified and work is now underway to resolve the issues that arose. Within the community recovery teams, there has been an improvement in performance this month and the teams are continuing to actively follow up on their DNA’s. DNA rates are discussed monthly with team managers at a Performance and Finance meeting.

### 4.4 7 Day Follow Up (All) (Target 95%, Performance 95.8%)

**K&C Adults (88.5%)**

This relates to three patients, of which two were patients from other Trusts. Contact was established with the receiving trusts to ascertain wellbeing of patient, however, telephone calls from CNWL wards to the patients were unsuccessful. The third patient was not responding to telephone calls, despite leaving messages on his phone and with the hostel at which he was staying. Patient discharges are monitored daily and the Business Support Officer sends reminders to teams for those patients who are yet to be followed up. If staff are unable to contact the patient directly, then they continue to try and establish contact with carers or others who may be in contact with the patient.
5.0 Quality Indicators

5.1 Q4 summary of results

CNWL has 14 Quality Account Priorities indicators (QAPs) in total, which feed 5 overarching Quality Account Priority areas. See Chart 1 which illustrates that 3 Quality Account Priority areas were almost achieved and two areas fully achieved.

Six of these 14 indicators relate to our Mental Health and Allied Specialty services (MHAS), Community Health Services (CHS) and Sexual Health Services (SHS), and 8 relate to our services in Milton Keynes (CNWL-MK). This is because the CNWL-MK indicators were agreed prior to the merger with CNWL in April 2013.

The quarterly performance of the 14 indicators which support each of these 5 areas is presented in Chart 2. At quarter four CNWL achieved 9 (64%) of its Quality Account Priority measures and almost achieved the remaining five. Detail of each of these is provided in section 5.2 below.

Chart 1.

1. Helping our patients to recover by involving them in decisions about their care
   - Patients have a copy of their care and treatment plans (where appropriate)

2. Supporting carers to look after their loved ones
   - Patients tell us they are ‘definitely’ involved as much as they want to be in decisions about their care and treatment

3. Making sure people who use our services get the best care we can provide
   - Thematic review and actions based on how supported carers feel and that they know how to access services in a crisis

4. Safe transfer of care in CNWL Milton Keynes
   - Our patient satisfaction measures from the different services we provide (4% measures)

5. Reducing the harm of pressure ulcers in CNWL Milton Keynes
   - Thematic review and actions based on patient satisfaction ratings
   - Reducing CNWL-MK transfer of care indicators that result in serious harm to less than 5%

Chart 2.

- Not confirmed
- Not met
- Nearly met (<10% of target)
- Met
### 5.2 Detailed Analysis

#### 5.2.1 Quality Account Priorities: The detail (n=14)

The table below indicates the Trust-wide achievement for the 14 QAPs, including a comparison to previous quarters, with exceptions/actions as appropriate.

<table>
<thead>
<tr>
<th>Quality Account Priority</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Change</th>
</tr>
</thead>
</table>
| 1. We record inpatient and community patients have been offered or given a copy of their care plan (MHAS) / have an agreed care plan (CHS Q2 & Q4) (n=2098) (CQC Outcome 1 – Respecting and involving) | 95% | 80% (MHAS only) | 68% (MHAS/CHS) | 75% (MHAS only) | 93% (MHAS/CHS) | Breakdown as follows:  
• MHAS inpatient: Q1: 80%; Q2: 72%; Q3: 81%; Q4: 85%  
• MHAS community: Q1: 81%; Q2: 81%; Q3: 73%; Q4: 81%; MHAS inpatient/community combined: 82%.  
• CHS: Q2: 66%; Q4: 96%  
MHAS service lines not achieving: ED, Recovery, ABT, Acute, Rehabilitation, OPHA  
Action plans are in place and examples include:  
• All named nurses to document that patients have been offered a copy of care plans, and to be picked up during supervision sessions as a standing item; Practice development nurse to carry out weekly audits and feedback to teams; Modern Matron to oversee that all patients have been recorded as offered a copy of their care plan; business support officer working with the clinical audit facilitator to support local monthly audits are carried out, and provide feedback. |
| 2. Community patients report they were ‘definitely’ involved as much as they wanted to be in decisions about their care plan/care and treatment (MHAS, CHS, SHS) (n=2389) (CQC Outcome 1 – Respecting and involving) | 65% | 78% | 79% | 82% | 82% | Breakdown as follows:  
• MHAS: Q1: 58%; Q2: 56%; Q3: 70%; Q4: 71%  
• CHS: Q1: 70%; Q2: 67%; Q3: 68%; Q4: 75%  
• SHS: Q1: 87%; Q2: 87%; Q3: 89%; Q4: 88%  
MHAS service lines not achieving: Rehabilitation,  
Service line actions are in place and examples include:  
• Care co-ordinators will now specifically ask the question ‘do you feel you have been involved in the decisions about your care’. If this is negative, more probing questions will be asked to support the client to express areas they feel they were not get the chance to be involved. |
| 3. Patients have their ‘carer status’ identified (this target will be increased to 70% for Quarter 4 as signed off within the Quality Account 2012-13) (n=1986) (CQC Outcome 4 – Care and welfare) | Q1&2: 55%; Q3: 65%; Q4: 70% | Not achieved | 68% (MHAS/CHS) | 68% (MHAS only) | 68% (MHAS/CHS) | Breakdown as follows:  
MHAS: Q1: 80%; Q2: 63%; Q3: 68%; Q4: 77% (Q2 onwards involved change in data collection methodology due tightening of the business rule for recording); CHS: Q2: 70%; Q4: 66%.  
Service lines not achieving: ED, CHS  
Service line actions are in place and include:  
• Standard LPC Assessment letter/care plan to include carer status and details for new clients, and details to be added to relationships tab on JADE.  
CHS: Work continues with all services to improve the consistency of recording this information. A number of services are revising their record keeping processes with the launch of the new RiO2 system including looking at reducing the number of forms and documents that are used. It is envisaged that this will assist in the recording of the information. This quality priority will continue to be monitored both locally and via the mandatory record keeping audit later in the year. |
| 4. Thematic review and action report on feedback from carer focus groups/surveys (MHAS, CHS) about feeling supported/having access in a crisis. (CQC Outcome 4 – Care and welfare) | Thematic review & report | Achieved | Achieved | Achieved | Achieved | Key themes:  
• Monitoring carer identification (early) and the provision of information on services/sign-posting information, and contact points; Listening: Staff to have a better understanding of the carer’s role which has resulted in the production of a carers film including testimonies to educate staff; Provision of carer training courses - resulting in the Recovery College co-developing courses for carers e.g. Managing Difficult Behaviour and various taster sessions; Supporting carers in crisis and providing them with the information of who to contact in a crisis - resulting in the production and dissemination of carer contact cards and the urgent advice line telephone number. These cards are to be re-launched in the next year to reflect local changes. |
### 3. Making sure people who use our services get the best care we can provide

#### 5. Measured and calculated in two ways:
- Patients’ rating of CNWL services as ‘good’ or ‘very good’ (MHAS survey, reported in percentages (n=765)
- Patients’ likelihood to recommend services to family/friend (CHS, SHS survey questions reported by net promoter score* (n=1697)

(CQC Outcome 16 – Assessing and monitoring quality)

<table>
<thead>
<tr>
<th></th>
<th>MHAS (%)</th>
<th>CHS/SHS (%)</th>
<th>Baseline established</th>
<th>Net Promoter Score</th>
<th>Thematic Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>71%</td>
<td>71%</td>
<td>69%</td>
<td>70%</td>
<td></td>
<td>Thematic review: Through regular telephone surveys service users are asked to provide an overall rating of the service they have received and to provide an explanation of their rating score. In both inpatient and community services it is apparent that the relationship between staff and their service users is an important factor affecting levels of satisfaction with the services. For inpatient services the physical environment and the implicit sense of safety that patients feel in relation to staff and patients are important, whilst in the community the organisation and adaptability of the service to the needs of service users plays a significant role, as well as satisfaction with administration services, waiting times and staff attitude. Individual experiences vary greatly even in the same service or unit, and it cannot be stressed enough how individual experiences are based on the interpersonal communication between staff and patients.</td>
</tr>
</tbody>
</table>

This target was narrowly missed: MHAS achieved their target, while CHS/SHS missed their target by one net promoter score, having an combined effect of ‘not achieved’. (Note: SHS individually achieved this target with a net promoter score of 75). For a better understanding of performance in CHS/SHS: Those who responded ‘likely’ or ‘extremely likely’ to recommend CNWL services achieved 95% overall. Respondents rationale is considered to understand where best to focus improvement action.

- MHAS service lines not achieving: AET, Acute
- Service line actions are in place and examples include:
  - A focus on staff attitude, behaviour, and professionalism through supervision and performance management, recruitment to reduce reliance on bank staff, incorporating into handover a discussion about how the patient is feeling about being on the ward and what emotional support is needed.

#### 6. Achieve a thematic review of patients comments based on the follow up question to QAP 5 (above) as to the main reason for their response

(CQC Outcome 16 – Assessing and monitoring quality)

<table>
<thead>
<tr>
<th>Thematic review</th>
<th>Achieved</th>
<th>Achieved</th>
<th>Achieved</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve on 2012</td>
<td>Awaiting national results</td>
<td>Not achieved</td>
<td>Thematic review: Through regular telephone surveys service users are asked to provide an overall rating of the service they have received and to provide an explanation of their rating score. In both inpatient and community services it is apparent that the relationship between staff and their service users is an important factor affecting levels of satisfaction with the services. For inpatient services the physical environment and the implicit sense of safety that patients feel in relation to staff and patients are important, whilst in the community the organisation and adaptability of the service to the needs of service users plays a significant role, as well as satisfaction with administration services, waiting times and staff attitude. Individual experiences vary greatly even in the same service or unit, and it cannot be stressed enough how individual experiences are based on the interpersonal communication between staff and patients.</td>
<td></td>
</tr>
</tbody>
</table>

This target was narrowly missed: MHAS achieved their target, while CHS/SHS missed their target by one net promoter score, having an combined effect of ‘not achieved’. (Note: SHS individually achieved this target with a net promoter score of 75). For a better understanding of performance in CHS/SHS: Those who responded ‘likely’ or ‘extremely likely’ to recommend CNWL services achieved 95% overall. Respondents rationale is considered to understand where best to focus improvement action.

- MHAS service lines not achieving: AET, Acute
- Service line actions are in place and examples include:
  - A focus on staff attitude, behaviour, and professionalism through supervision and performance management, recruitment to reduce reliance on bank staff, incorporating into handover a discussion about how the patient is feeling about being on the ward and what emotional support is needed.

#### 7. To improve on the 2011/12 CNWL-MK score based on the CQC National Community Mental Health patient survey for responsiveness to patient needs in 2012/13

To improve on 2012

<table>
<thead>
<tr>
<th>F&amp;P test roll out, and achieve national result in top 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awaiting year end position results</td>
</tr>
</tbody>
</table>

This target was narrowly missed: MHAS achieved their target, while CHS/SHS missed their target by one net promoter score, having a combined effect of ‘not achieved’. (Note: MHAS individually achieved this target with a net promoter score of 75). For a better understanding of performance in CHS/SHS: Those who responded ‘likely’ or ‘extremely likely’ to recommend CNWL services achieved 95% overall. Respondents rationale is considered to understand where best to focus improvement action.

- MHAS service lines not achieving: AET, Acute
- Service line actions are in place and examples include:
  - A focus on staff attitude, behaviour, and professionalism through supervision and performance management, recruitment to reduce reliance on bank staff, incorporating into handover a discussion about how the patient is feeling about being on the ward and what emotional support is needed.

#### 8. To deliver the Friends and Family Test across all CNWL-MK services, and achieve a year-end position within the top 50% of the national result

<table>
<thead>
<tr>
<th>F&amp;P test roll out, and achieve national result in top 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awaiting year end position results</td>
</tr>
</tbody>
</table>

This target was narrowly missed: MHAS achieved their target, while CHS/SHS missed their target by one net promoter score, having a combined effect of ‘not achieved’. (Note: MHAS individually achieved this target with a net promoter score of 75). For a better understanding of performance in CHS/SHS: Those who responded ‘likely’ or ‘extremely likely’ to recommend CNWL services achieved 95% overall. Respondents rationale is considered to understand where best to focus improvement action.

- MHAS service lines not achieving: AET, Acute
- Service line actions are in place and examples include:
  - A focus on staff attitude, behaviour, and professionalism through supervision and performance management, recruitment to reduce reliance on bank staff, incorporating into handover a discussion about how the patient is feeling about being on the ward and what emotional support is needed.

#### 9. For CNWL-MK to improve on the 2012 National Staff Survey result for the Friends and Family Test in the 2013 national staff survey

<table>
<thead>
<tr>
<th>F&amp;P test roll out, and achieve national result in top 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.70/5</td>
</tr>
</tbody>
</table>

This target was narrowly missed: MHAS achieved their target, while CHS/SHS missed their target by one net promoter score, having a combined effect of ‘not achieved’. (Note: MHAS individually achieved this target with a net promoter score of 75). For a better understanding of performance in CHS/SHS: Those who responded ‘likely’ or ‘extremely likely’ to recommend CNWL services achieved 95% overall. Respondents rationale is considered to understand where best to focus improvement action.

- MHAS service lines not achieving: AET, Acute
- Service line actions are in place and examples include:
  - A focus on staff attitude, behaviour, and professionalism through supervision and performance management, recruitment to reduce reliance on bank staff, incorporating into handover a discussion about how the patient is feeling about being on the ward and what emotional support is needed.

- Update: The National Staff Survey result for the Friends and Family Test in the 2013 national staff survey has been released and CNWL scored an average of 3.70 for CNWL-MK. Compared to last year we have improved in all areas apart from our Mental Health and Learning Disabilities services. It is in this area that there has been focussed work to improve standards of care, staffing levels and the calibre of nursing staff appointed. Work will continue as part of a directorate-wide transformation plan for Mental Health and Learning Disability Services. We will also be carrying out quarterly staff surveys to monitor our progress against this measure to better inform any improvements needed.

- Update: The 2012/13 patient survey results showed that we had scored ‘about the same’ as other trusts for responsiveness to patient’s needs, with some results slightly weaker than 2011/12 scores - meaning overall, this target was ‘just missed’. These scores however, were based on patient’s experience before improvements were put in place.

- A great deal of work has taken place over the past year across the Mental Health Services including the implementation of the Crisis Line, introduction of new Care Plan Folders, Medicines Helpline, Service User and Carer Improvement Group and bi-monthly open forums. We are already seeing improvements in the feedback received from service users through weekly inpatient surveys and our monthly Friends and Family Test Questionnaire. We would therefore expect to see an improvement when the 13-14 results are published in September 2014.

- Update: The Friends and Family Test question continues to be collected across all services.

- Quarter 4 saw 1423 responses collected and over the year we have surveyed 5401 patients.

- The base line ‘net promoter’ score was set at 56 at the end of Q4 2012-13 and at Q4 2013/14 it has risen to 65.

- National data for the Friends and Family Test is currently based on Acute and Maternity services only and the results are published monthly. To date only the February results are available and they show that excluding dependent providers the average net promoter score for the Friends and Family Test in the 2013 national staff survey has been released and CNWL scored an average of 3.70 for CNWL-MK. Compared to last year we have improved in all areas apart from our Mental Health and Learning Disabilities services. It is in this area that there has been focussed work to improve standards of care, staffing levels and the calibre of nursing staff appointed. Work will continue as part of a directorate-wide transformation plan for Mental Health and Learning Disability Services. We will also be carrying out quarterly staff surveys to monitor our progress against this measure to better inform any improvements needed.

<table>
<thead>
<tr>
<th></th>
<th>73% (MHAS, amber)</th>
<th>71* (CHS/SHS, green)</th>
</tr>
</thead>
<tbody>
<tr>
<td>net promoter</td>
<td>73% (MHAS, amber)</td>
<td>71* (CHS/SHS, green)</td>
</tr>
<tr>
<td>baseline</td>
<td>77% (MHAS, green)</td>
<td>69* (CHS/SHS, amber)</td>
</tr>
<tr>
<td>achieved</td>
<td>77% (MHAS, green)</td>
<td>70* (CHS/SHS, amber)</td>
</tr>
</tbody>
</table>
4. CNWL-MK Safe Transfer of Care

10. CNWL-MK will forward 100% of transfer of care incidents reported by staff to the relevant organisation for investigation within one week (n=55)
(CQC Outcome 4 – Care and welfare)

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
<th>-</th>
</tr>
</thead>
</table>

Update: 100% transfer of care incidents reported by our staff, and attributable to other organisations have been reported to the relevant organisation for investigation. In Q4 there were 55 such incidents which is a decrease from Q3 (62). Year to date, we have recorded 219 transfer of care incidents, 13 of these resulting in moderate or serious harm attributable to CNWL-MK.

11. CNWL-MK: The proportion of transfer of care incidents originating from CNWL-MK, that result in moderate or major harm/death will fall below 10% of the total by October (and below 5% by year end)
(CQC Outcome 4 – Care and welfare)

<table>
<thead>
<tr>
<th></th>
<th>&lt;6.6%</th>
<th>0/65 (0.0%)</th>
<th>0/102 (0.0%)</th>
<th>0/164 (0.0%)</th>
<th>0/219 (0.0%)</th>
</tr>
</thead>
</table>

Update: In total over the year 13 transfer of care incidents were attributable to CNWL-MK, out of a total of 219. Of these 13, none resulted in moderate/major harm or death. All incidents have been investigated to maximise opportunities to improve the transfer processes.

5. Reducing harm from pressure ulcers

12. CNWL-MK will undertake a survey once a month using the NHS Safety Thermometer tool (n=12)
(CQC Outcome 4 – Care and welfare)

<table>
<thead>
<tr>
<th></th>
<th>Monthly survey</th>
<th>3/3</th>
<th>6/6</th>
<th>9/9</th>
<th>12/12</th>
<th>-</th>
</tr>
</thead>
</table>

Update: CNWL-MK have a robust process in place for data collection; the NHS Patient Safety Thermometer (PST) survey is completed each month by relevant services.

13. CNWL-MK to achieve a year end baseline for the number of recorded avoidable pressure ulcers to be measured against in the following year

<table>
<thead>
<tr>
<th></th>
<th>Set baseline</th>
<th>Result calculated post Q4</th>
<th>16 (Q3)</th>
</tr>
</thead>
</table>

Update: We have developed a system to accurately identify avoidable and unavoidable pressure ulcers, and data is collected on a monthly basis via the NHS Safety Thermometer. To ensure accuracy and validity, the data is triangulated with incident reporting data and provides robust information to inform action and improve patient safety overall. Actions have included the provision of training on pressure ulcer prevention and management and use of equipment, provision of information for patients and the development of a Pressure Ulcer Management Policy. The uptake of training is monitored on a monthly basis, and pressure ulcers are investigated to identify and share learning points for further improvements. In our progress towards achieving a year-end baseline for the collection of avoidable pressure ulcers, we recorded 16 by quarter three. Three of these were grade 2, and 13 were grade 3. These are all routinely further investigated to identify the cause and inform action plans. These figures will be updated for Quarter 4 once all investigations have concluded, and will form our baseline for assessment during 2014-15.

14. CNWL-MK to achieve a level of recorded avoidable pressure ulcers less than the national average for this measure using the NHS Safety Thermometer
(CQC Outcome 4 – Care and welfare)

<table>
<thead>
<tr>
<th></th>
<th>&lt;6.6%</th>
<th>4.01%</th>
<th>5.06%</th>
</tr>
</thead>
</table>

Update: CNWL-MK is compliant against national benchmarking. The median number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer during Q4 is 5.06%, slightly up from 4.01% in Q3. This is against the National Prevalence level of 6.6%.

Key: MHAS: mental health and allied specialties; CHS: community health services; SHS: sexual health services

* Net promoter score (as per DH methodology), has a range of 100 to -100, and is calculated by subtracting the proportion of negative or indifferent responses from the ‘extremely likely response’
### 5.2.2 Quality Indicators (n=13)

This section reports on the achievement of the remaining Quality Indicators which include old QAPs (reported in the back of the Quality Account) as well as other indicators required by the Board (n=13). The chart below represents the achievement of these indicators for Q1 to Q4.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MH patients reported that they felt safe after their most recent inpatient stay (target 75%): 80% based on 52 responses from Q4, and, due to low numbers, 80% based on 456 responses over the year</td>
<td>80%</td>
<td>56%</td>
<td>60%</td>
<td>62%</td>
<td>63%</td>
<td></td>
</tr>
<tr>
<td>2. Community MH patients report that they have a phone number to call in a crisis (target 65%): 75% based on 719 responses from Q4</td>
<td>75%</td>
<td>71%</td>
<td>70%</td>
<td>70%</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td>3. MH inpatients recorded as having a medical physical health care assessment after admission (target 95%): 96% (based on 155 responses from Q4)</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>4. Inpatients report that they got enough care for their physical health: 76% (target 65%)</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>5. Patients on CPA report that they got enough advice and support of their physical health (target 65%): 88% based on 73 responses, and due to low numbers, 86% based on 370 responses over the year</td>
<td>88%</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>6. MH patients who care plans contained at least one personal recovery goal (target75%): 81% based on 211 responses)</td>
<td>81%</td>
<td>81%</td>
<td>81%</td>
<td>81%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>7. 80% of patients with an appointment, who arrive on time, are seen within 30mins (sexual health services): 89% based</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>8. At least one communication each year with a patients GP who have consented to letters being sent to their GP: 100% (target 90%) based on 3052 cases.</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Of the 13 Quality Indicators, 8 (62%) were met and 5 (38%) were not.

For the detail of those that were met:
1. MH patients reported that they felt safe after their most recent inpatient stay (target 75%): 79% based on 52 responses from Q4, and, due to low numbers, 80% based on 456 responses over the year
2. Community MH patients report that they have a phone number to call in a crisis (target 65%): 75% based on 719 responses from Q4
3. MH inpatients recorded as having a medical physical health care assessment after admission (target 95%): 96% (based on 155 responses from Q4)
4. Inpatients report that they got enough care for their physical health: 76% (target 65%)
5. Patients on CPA report that they got enough advice and support of their physical health (target 65%): 88% based on 73 responses, and due to low numbers, 86% based on 370 responses over the year
6. MH patients who care plans contained at least one personal recovery goal (target 75%): 81% based on 211 responses
7. 80% of patients with an appointment, who arrive on time, are seen within 30mins (sexual health services): 89% based on 27866 cases
8. At least one communication each year with a patients GP who have consented to letters being sent to their GP: 100%

For the detail of those that were not met:

**MHAS service lines not achieving: ED, Recovery, ABT, OPHA, Addictions, CAMHS, Rehabilitation**

Service line actions are in place and examples include:

- Clinical director writing monthly to individual staff that have more than 10 breaches across all KPIs, including care plan not being completed, which could result in performance management of staff; All breaches are followed up by team managers and embedding requirements in supervision and job plans; Urgent assessment care pathway forms amended so that we can record that client has been cc'd; This issue to be raised at the May Senior Team Meeting to ensure action across all teams.

**MHAS service lines not achieving: ED, Recovery, OPHA, Addictions, ABT, CAMHS, Rehabilitation**

Service line actions are in place and examples include:

- Modern matron to ensure that all current patients have completed risk assessments linked to care plans; on-going internal audit; performance being individualised and low performers being addressed through supervision; and more structured supervision processes being implemented to ensure specific clinical issues are addressed; Cases in breach have been rectified and new staff member and supervisor informed (24.3.14) and additional support provided and implications explained.

**Urgent Advice Line exception:**

Considering the follow-up question asking respondents for the reason for their rating: Many of the comments suggest that rather than dissatisfaction with the Urgent Advice Line per se, their unhappiness is about other CNWL services they are receiving, or frustrations around what the Urgent Advice Line is not able to provide, e.g. being sign-posted elsewhere.

Also, for a number of respondents who answered ‘Yes to some extent’ or even ‘No’, when asked to say what was helpful they were actually positive about their experience of calling the Line. Responses will continue to be collected and analysed for particular trends.

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**5.2.2.1 Quality Indicators: Targets not met**

The 5 indicators which were not met in Q4 are identified below with details of quarterly performance and action plans/exception reports.
5.3 Organisational Learning (OL) indicators (n=8)

The following table details the 8 OL indicators reported on the Integrated Dashboard, including year to date figures and commentary explaining reasons for any significant changes or issues to note. Note that both columns include CNWL-MK data, to ensure like for like comparisons.

<table>
<thead>
<tr>
<th>OL Indicator (Trust-wide, year to date)</th>
<th>Q1-4, 12-13</th>
<th>Q1-4, 13-14</th>
<th>Change</th>
<th>Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incidents: Number of all incidents</td>
<td>12291</td>
<td>13108</td>
<td>↑</td>
<td>Whilst there has been an increase in the number of incidents reported, this should be viewed as further evidence of the positive reporting culture that exists within CNWL.</td>
</tr>
<tr>
<td>2. Incidents: Number of patient on staff assaults</td>
<td>1280</td>
<td>1029</td>
<td>↓</td>
<td>Reduction is partially attributable to the discharge of one service user from the LD service who accounted for over 60 assaults during the reporting periods. Further to this the violence reduction program continues to support the ongoing reduction.</td>
</tr>
<tr>
<td>3. Incidents: number of Level 5 serious incidents/Grade 1/2 incidents</td>
<td>112</td>
<td>151</td>
<td>↑</td>
<td>The large increase can be attributed to the variation in reporting requirements between MHA &amp; AS and CNWL-MK.</td>
</tr>
<tr>
<td>4. AWOL: Number of incidents of patients under section absconding from an inpatient ward</td>
<td>225</td>
<td>269</td>
<td>↑</td>
<td>The small year-on-year rise can be attributed to improved reporting and categorisation of incidents within MH&amp;S. Further work to explore this will be undertaken as part of the Incidents Annual Report.</td>
</tr>
<tr>
<td>5. Cumulative number of all formal complaints</td>
<td>470</td>
<td>525</td>
<td>↑</td>
<td>The number of formal complaints continues to show a year-on-year increase, this can be partially attributed to the increased publicity that complaints have received within the press following the publication of the Francis and Clwyd Reports. Further work to review this increase is being undertaken as part of the Complaints Annual Report.</td>
</tr>
<tr>
<td>6. Cumulative number of complaints upheld/partially upheld</td>
<td>218</td>
<td>235</td>
<td>↑</td>
<td>Whilst the number of complaints upheld or partially upheld has shown a year on year increase the percentage has remained stable.</td>
</tr>
<tr>
<td>7. Cumulative number of complaints overdue for response</td>
<td>256</td>
<td>171</td>
<td>↓</td>
<td>The Trust has introduced a range of additional controls to support Services in responding to their complaints within the agreed timescale. As a result the Trust has seen the number of overdue complaints reduce significantly across the year.</td>
</tr>
<tr>
<td>8. Cumulative number of compliments received</td>
<td>333</td>
<td>1848</td>
<td>↑</td>
<td>The Trust has seen a significant rise in the number of compliments reported, this is attributable to the recording and reporting of compliments made to the Trust’s Sexual Health Services.</td>
</tr>
<tr>
<td>Strategic Areas</td>
<td>Key Performance Indicator</td>
<td>Targets</td>
<td>YTD Position</td>
<td>Achieving (YTD)</td>
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<tr>
<td>1</td>
<td>7 Day Follow-Up (CPA Only)</td>
<td>&gt;= 95.0%</td>
<td>96.1%</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>CPA Reviews within 12 months</td>
<td>&gt;= 95.0%</td>
<td>96.1%</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Delayed Transfers of Care (Quarterly Position v Previous Quarter)</td>
<td>&lt;= 7.5%</td>
<td>4.7%</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>Gate Keeping by Crisis Resolution Teams</td>
<td>&gt;= 95.0%</td>
<td>96.2%</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Meeting Commitment to serve New Psychosis Cases by Early Intervention Teams (% Of Commissioners target met)</td>
<td>&gt;= 95.0%</td>
<td>100.0%</td>
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<tr>
<td>6</td>
<td>Data Completeness: Identifier</td>
<td>&gt;= 97.0%</td>
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<tr>
<td>7</td>
<td>Data completeness: Outcomes (CPA only -Employment, Accommodation, HoNOS in 12 months)</td>
<td>&gt; 50.0%</td>
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<tr>
<td>8</td>
<td>Access to Healthcare for People with a Learning Disability</td>
<td>= 8</td>
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<td>9</td>
<td>Patients waiting less than 18 weeks from point of referral to treatment - non admitted patients (%)</td>
<td>&gt;= 95.0%</td>
<td>100.0%</td>
<td>✓</td>
</tr>
<tr>
<td>10</td>
<td>Patients waiting less than 18 weeks from point of referral to treatment - incomplete pathway (%)</td>
<td>&gt;= 95.0%</td>
<td>100.0%</td>
<td>✓</td>
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<td>11</td>
<td>Community Treatment Activity - Referral to Treatment Information</td>
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<tr>
<td>12</td>
<td>Community Treatment Activity - Referral Information</td>
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<tr>
<td>13</td>
<td>Community Treatment Activity - Activity Information</td>
<td>&gt;= 50.0%</td>
<td>87.9%</td>
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</tbody>
</table>

Addictions 15 - 23 Targets are measured by Borough. Please see the Directorate Performance Dashboard

Offender Care 24 - 34 Targets are measured by Borough. Please see the Offender Care Dashboard

15. Emergency Readmissions <= 8.1% | 4.5% | ✓ | 4.0% | ↑ | 4.4% |
16. DNA First <= 11.7% | 11.6% | ✓ | 10.0% | ↓ | 10.9% |
17. DNA Follow-Up <= 11.4% | 9.9% | ✗ | 10.9% | ✓ | 10.6% |
18. 7 Day Follow-Up (All) >= 95.0% | 93.9% | ✗ | 95.8% | ↑ | 94.9% |
19. Patients ending their lives in preferred place of care
20. 12-13 year olds receiving HPV Immunisation
21. New mothers receiving a new birth visit within 14 days post delivery

Wellbeing for life
Compassion | Respect | Empowerment | Partnership
London | Milton Keynes | Kent | Surrey | Hampshire

Page 15
### Directorate Performance Scorecard

#### 2013/14

<table>
<thead>
<tr>
<th>Strategic Areas</th>
<th>KPIs</th>
<th>Service</th>
<th>Targets</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon</th>
<th>K &amp; C</th>
<th>Westminster &amp; Fulham</th>
<th>Edgware</th>
<th>All</th>
<th>CPS</th>
<th>HOS</th>
<th>Financial Health</th>
<th>Overall Trust Performance</th>
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<td>4 Gate Keeping by Crisis Resolution Teams</td>
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<td>Adult &gt;= 95%</td>
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<td>5 Meeting commitment to serve new psychosis cases by EIS (Ytd Actual / target as reported to the Quarterly V3MR)</td>
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<td>6 Patients waiting less than 18 weeks from point of referral to treatment - non-admitted patients (%)</td>
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<td>Comm &gt;= 95.0%</td>
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<td>10 Patients waiting less than 18 weeks from point of referral to treatment - incomplete pathway (%)</td>
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<td>11 Community Treatment Activity - Referral to Treatment Information</td>
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<td>16 Drug Users in Effective Treatment (New treatment episode)</td>
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<td>23 Unplanned Alcohol Discharges</td>
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<td>AOD &lt;= 40%</td>
<td>20.0%</td>
<td>N/A</td>
<td>27.0%</td>
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<td>27.0%</td>
<td>19.0%</td>
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<tr>
<td>26 Emergency Readmissions</td>
<td><strong>Adult</strong> &lt;= 8.1%</td>
<td>6.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>7.0%</td>
<td>12.1%</td>
<td>4.0%</td>
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<tr>
<td>27 DNA's -First</td>
<td><strong>Adult</strong> &lt;= 13.3%</td>
<td>14.8%</td>
<td>9.1%</td>
<td>6.4%</td>
<td>15.8%</td>
<td>11.7%</td>
<td>14.0%</td>
<td>11.5%</td>
<td></td>
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<tr>
<td>28 DNA's -F/Up</td>
<td><strong>Adult</strong> &lt;= 11.0%</td>
<td>6.3%</td>
<td>8.6%</td>
<td>9.5%</td>
<td>11.2%</td>
<td>9.4%</td>
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<tr>
<td>29 7 Day Follow-Up (All)</td>
<td><strong>Adult</strong> =&gt; 99%</td>
<td>98.7%</td>
<td>98.4%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>95.8%</td>
<td></td>
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<tr>
<td>32 Patients ending their lives in preferred place of care</td>
<td>Comm</td>
<td>82.1%</td>
<td>100.0%</td>
<td>83.9%</td>
<td>100.0%</td>
<td>92.1%</td>
<td>88.5%</td>
<td>88.5%</td>
<td></td>
<td></td>
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<tr>
<td>33 12-13 year olds receiving HPV Immunisation</td>
<td>Comm</td>
<td>15.3%</td>
<td>0.0%</td>
<td>87.9%</td>
<td>54.1%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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<tr>
<td>34 New mothers receiving a new birth visit within 14 days post delivery</td>
<td>Comm</td>
<td>85.9%</td>
<td>89.4%</td>
<td>85.9%</td>
<td>88.5%</td>
<td>88.5%</td>
<td>88.5%</td>
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Objective:
The Board is asked to note this report which highlights issues from the March and April meetings of the Committee and which it is felt should be drawn to the Board’s attention. Details of other considerations are contained in the minutes of the meetings.

The Board is asked to:
- Note the report for information

Executive summary:

CQC compliance
The Committee held a major discussion on how it can most effectively provide assurance that quality standards are being met. As part of this we considered how the Trust can effectively use provider compliance assessments to identify areas where standards might not be met and to direct improvement activity. We noted that the PCAs may need to be revised to reflect the CQC refocus on five outcome standards but in any case need a system which enables staff to focus on their areas of concern.

The Committee also received an update on the Campbell Centre progress and noted that there had been progress against the actions. The plan is being reviewed to ensure it fully reflects more recently identified issues and to ensure outcomes are being appropriately measured.

Performance
The Committee were advised that all Monitor indicators had been achieved at the end of quarter 4.

It was also noted that Addictions services met their performance targets. Offender care did not achieve two of their performance targets, which are being reviewed by the service line.
It was noted that the integrated dashboard is continuing to be developed, including ensuring that there is appropriate focus on the key areas for the Trust and ensuring that quality and safety is monitored with the most appropriate, and where necessary service specific, indicators. The move to divisions and the associated governance work will also bring about changes in the way information is gathered and reviewed.

**Quality**
The Committee considered the quality report and Quality Account. It was noted that of the five quality account priority areas, three were almost achieved and two were fully achieved. Nine of fourteen of the quality account priority indicators were met, and of the five that were not met, three were narrowly missed and have seen steady improvement through the year.

The Committee in March also considered the draft Quality Account, and noted the three proposed areas for consultation. These are: involvement in care planning, competent and compassionate workforce, and supporting carers. The overarching quality measurement is patient satisfaction. The Committee approved the Quality Account to go out for consultation.

**CQUIN**
The Committee were advised that 96% of the CQUIN target for 2013/14 was achieved. The 2014/15 CQUIN are still to be agreed. The Committee has reiterated that CQUINs should focus on improving quality of services and discussions with commissioners should reinforce this point.

**HR Dashboard / ward staffing**
The Committee has received drafts of the new HR dashboard, which is monitoring staffing against a number of key metrics. This is presented to the Board under a separate item.

The Committee also held a discussion around ward staffing and the requirement to publish staffing levels following recommendations from the Francis report. The Trust has successfully trialled this and will look to fully implement it by the end of June 2014. The report is presented to the Board under a separate item.

**Local Authority targets**
The Committee received a presentation on the work being taken forward around local authority targets - to streamline the reporting process and better enable services to interrogate the data.

Helen Edwards  
Non-Executive Director  
7 May 2014
BoD 58/2014
This report is not for publication

Board of Directors
14 May 2014

DRAFT QUALITY ACCOUNT 2013-14: Sign-off and recommendation to Audit Committee

Objective:
This report presents CNWL’s final draft Quality Account 2013-14 for incorporation into the Trust’s annual report, and onward submission to Monitor and NHS Choices website.

The Board is asked to:
- Provide final comment on this document, and recommend the final version of the Quality Account to the Audit Committee for final sign-off.

Points to note:
- The draft Quality Account has been reviewed by the QPC
- Internal audit by BakerTilly reported a result of “green” stating: “Taking account of the issues identified, the Board can take substantial assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied and effective”.
- KPMG are currently carrying out their external audit of assurance to be completed in May and provide their independent auditor report which will be published in the final Quality Account
- There will be some very minor changes to this version 8.0.1 before Audit Committee submission (areas highlight in yellow in text).

Executive summary: Quality Account walk-through:
- **Part 1:** Chief Executive statement.
- **Part 2:** Priorities for improvement last year (13/14): Reports full achievement of 2/5 Quality Account Priority areas, and part achievement in 3/5; overall this reflects achievement of 9/14 indicators.
- **Five indicators narrowly missed are:** the identification of carer status, recording patients been offered copy of their care plan, overall service satisfaction measure (net promoter), CNWL-MK responsiveness to patient needs, and CNWL-MK staff friends and family test. Detail of actions and data by borough included.
- **Part 2:** Priorities for improvement next year (14/15): Stakeholder consultation process and the three Quality Account Priorities for 2014/15 detailed: a) Helping our patients to recover by involving them in their care/treatment, b) Supporting carers to look after their loved ones, and c) A competent and compassionate workforce. Indicators and commitments detailed.
• **Part 2: Mandatory internal statements** on review of services, participation in local/national audit and research, CQUIN achievement, CQC inspection findings and data quality.

• **Part 3: Other information**: Containing a) data overall and by-borough tables of mandatory indicators and historic Quality Account Priorities still reported via the Quality Account, b) statements from staff and patient satisfaction, complaints and equalities and diversity, c) Annex 2 - formal statements from stakeholders who responded to the Quality Account 30-day consultation with local Healthwatch, Commissioners and Overview and Scrutiny Committees, and d) Annex 3 – Statement of director’s responsibilities.

Alex Lewis, Medical Director
May 2014
Draft Quality Account
2013-14
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Part 1 – Chief Executive’s Statement

I want CNWL to be known for high quality in all we do. That can only come when patients feel we provide effective treatments, delivered by staff who show consideration, kindness and compassion. Patients will make that judgement themselves. Our staff must also feel they are doing a great job; so much so that they will recommend it to others and would be happy to be treated here themselves.

We want the community to trust in what we commit to. So we want to candidly show you where we are doing well and where we need to do more; and how we arrive at the views we do. You can then draw your own conclusions, and ask you to tell us about them.

This report – our fifth Quality Account - presents all the ways we judge quality – what the data says, what patients and their families say, what the regulators and commissioners say and how we have responded to it all.

We grounded our Quality Strategy in our values and set ourselves ambitious goals.

CNWL Quality Strategy

Milton Keynes community and mental health services joined the CNWL family in April 2013. This has widened our scope for learning and sharing good practice. In this Account we look at the specific Quality Priorities Milton Keynes had agreed with their local communities before they joined us.
We’ve invested in these new services too – upgrading buildings to modern standards. But we all know that any service is only as good as the staff providing it, so we are also prioritising recruitment; giving it special attention. We want to recruit people who share our values, people who other staff can bring into their teams and rely on. And it’s a move that saves precious resources too because it reduces our dependence on agency staff, saving a huge amount. We will always need the back-up of agency, so here’s a case where a quality improvement brings financial savings too.

So what have we achieved?

We set ourselves 5 challenging Quality Account Priorities and these in turn had indicators against which we measured ourselves. We believe that quality is best measured by outcome information and so we use a mixture of measures like audits, surveys, thematic reviews as well as data taken from our information systems. This means that over the year we have heard from approximately 8,000 patients and reviewed approximately 2,200 care records.

Our Quality Account Priorities were:

• Helping our patients to recover by involving them in decisions about their care
• Supporting carers to look after their loved ones
• Making sure people who use our services get the best care we can provide
• Safe transfer of care in CNWL Milton Keynes
• Reducing the harm of pressure ulcers in CNWL Milton Keynes

We have wholly achieved 2 of our priorities and have almost achieved the remaining three. (For a full breakdown see page 7).

We are disappointed not to have wholly met the indicators which tell us about the recording of carer status, patient involvement and satisfaction. However, there are some achievements I am proud of:

For the first time since we introduced the measure (in 2011/12) mental health patients tell us they were ‘definitely’ involved as much as they wanted to be in decisions about their care (71% at quarter four). When we combine our community and sexual health services this rises to 82%. We do however need to continue to engage our patients making sure they receive a copy of their care or treatment plan. We know that to improve this performance the further involvement of patients and their families has to be at the heart of our services. So in the coming year this will be one of our priorities and we will establish ways to systematically collect and respond to patient views in every service we provide; and we will tell you what we do about it too.

We did not wholly achieve our measure on overall satisfaction with services. We achieved this for mental health services but have narrowly missed this for our other patients in quarter four. We have run focus groups to find out what makes patients satisfied or dissatisfied with our services; and these have contributed to setting our quality priorities for next year. We are so disappointed to have missed our indicator on the recording of carer status by just 2%. We are committed to recognising and supporting our carers in the invaluable work they do to look after their loved ones, which is why this is a Quality Account Priority for us next year.
This year twelve of our services were inspected by the Care Quality Commission (CQC), seven of these were judged to be fully compliant and one had a minor compliance action.

I have to report the CQC judged the remaining three not to be meeting the standards and issued enforcement notices at two of our locations in March 2014 at The Campbell Centre, Milton Keynes, and 3 Beatrice place, Kensington. We have taken prompt action to rectify the situation, learnt from our mistakes and apologised to patients and families who feel let down. I know our staff felt that too; we’re proudly NHS and want services to be the best they can be. Safety is our top priority and we’re investing in it but that’s a denting claim when inspectors do not see accurate paperwork, training up to date and recorded, and every legality and protection observed – the demands of which, as a nurse myself, I know very well. CQC inspectors can visit us at any time to check but I rely on our ‘inspectors’, our staff, to deliver the standards they would want their own relatives and friends to receive.

Monitor announced on 8 April that they are investigating governance concerns at the Trust triggered by theses Care Quality Commission warning notices. They said, “We have decided to open an investigation … to identify if there are any problems with the way the Trust is run that would prevent it providing high quality care for patients.”

My view is that this is healthy. No Trust wants to feel that it is failing or not doing a good job and we are no exception! That said, we face up to issues when they are raised – we are conscientious. The Monitor process is actually a good way for our systems to be checked, refreshed, and even strengthened. I’m sure we have good answers for Monitor; our job is to show them that’s the case.

Recognising that our staff are our most valuable asset, this year our focus is on a ‘competent’ and ‘compassionate’ workforce. We are proud to have been ranked 8th in the country in terms of our staff survey results but want to take this further. To be the best that we can be we have to rely on our staff; those delivering direct care to patients, those providing back office functions and those leading our teams. We want all our staff no matter what their functions to continue to put patients and their families or friends at the centre of what they do, recognising that each and every one of us has a role in making sure our patients get the best care we can provide.

We know that our quality of care is enhanced by listening, involving and supporting the families and carers who nurture their loved ones on their journey to recovery. And so this year we will continue to emphasise our role in this area. We will continue to listen to and act on what our carers tell us. We will continue to strengthen the carer voice being guided by the Carers’ Council.

We know that quality does not begin and end with the Quality Account. More than ever we recognise that to ensure our patients are safer, more effectively cared for and better satisfied we have to focus our energies in three key areas:

- patient and family involvement,
- compassionate and competent staff and
- supported and engaged carers.
As ever we expect to be held to account for delivering these.

I would like to thank all who helped us monitor these quality priorities - patients, carers, Governors, Healthwatch, staff and commissioners in the NHS and local government. We have listened to you all; we want you to see we heard you!

Here’s the evidence; please let us know what you think.

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

Claire Murdoch RMN
Chief Executive
Independent Auditor’s report to Council of Governors of Central and North West London NHS Foundation Trust on the annual Quality Report

< Final report and opinion issued by KPMG due on 20 May 2014 for inclusion >
Part 2 – Priorities for improvement

2.1. A review of our performance in 2013-14 against our Quality Account Priorities

CNWL strives to provide safe, personal and high quality healthcare services to the population it serves. This is achieved through:

- Listening to and partnering with our patients, carers, staff, governors and communities,
- Closely monitoring our performance and implementing innovation and change, and
- Strong leadership and the support of our most valuable asset, our staff.

In this section we demonstrate how we performed against our current Quality Account Priorities, what we plan to focus on for 2014-15 based on wide analysis of data and consultation, and finally, our formal statements required by our regulator, Monitor.

2.1.1. Summary of performance against our Quality Account Priorities 2013-14

Last year, CNWL set five Quality Account Priorities which were determined through wide consultation with our internal and external stakeholders.

CNWL’s five Quality Account Priorities for 2013-14, were:

1. Helping our patients to recover by involving them in decisions about their care
2. Supporting carers to look after their loved ones
3. Making sure people who use our services get the best care we can provide
4. Safe transfer of care
5. Reducing the harm of pressure ulcers

We measured and monitored our progress in these five priority areas by 14 indicators. Six of which related to CNWL, and eight of which related to CNWL-Milton Keynes (CNWL-MK). This is because healthcare services in Milton Keynes joined CNWL in April 2013, and so had followed their own consultation and agreement process. In the coming year, we will align all our Quality Account Priorities so they apply to all our services.

We gathered data and information from a great variety of sources giving us a rich, informed view of the quality of services, and what improvements were needed. For example, our 14 indicators included patient and carer experience and outcome measures (qualitative and quantitative) from surveys and focus groups, as well as measures of our processes and systems which support the achievement of high quality services.

Our performance against our Quality Account Priorities was monitored by the Quality and Performance Committee, and overseen by the Board of Directors. These were in turn a key focus for our service lines to monitor performance and design and implement improvement programmes where required. Progress against the priorities endured robust testing by the Chief Operating Officers at our service line quarterly reviews, as well as presented to our Council of Governors.

We also reported our performance externally. On a quarterly basis our borough directors met with our Healthwatch either locally within the borough or at central quarterly meetings. The
aim was to facilitate open dialogue; to discuss quality of services, share monitoring information and feedback key messages. We also report to our commissioners quarterly through the Clinical Quality Group.

The diagram below shows how we performed across our five Quality Account Priorities for 2013-14. Each priority is measured by a number of indicators, and overall we achieved nine out of the 14 of these, with the remainder narrowly missed.

Overall achievement: Quality Account Priorities 2013-14

1. Helping our patients to recover by involving them in decisions about their care
   - Patients have a copy of their care or treatment plan (where appropriate)
   - Patients tell us they are ‘definitely’ involved as much as they want to be in decisions about their care and treatment

2. Supporting carers to look after their loved ones
   - Patients have their carers identified (where appropriate)
   - Thematic review and actions based on how supported carers feel and that they know how to access services in a crisis

3. Making sure people who use our services get the best care we can provide
   - Our patient satisfaction measures from the different services we provide (includes 4 indicators)
   - Thematic review and actions based on patients’ reasons for their satisfaction ratings

4. Safe transfer of care in CNWL Milton Keynes
   - Sharing all incidents of unsafe transfer with relevant organisations
   - Reducing CNWL-MK transfer of care incidents that result in serious harm to less than 5%

5. Reducing the harm of pressure ulcers in CNWL Milton Keynes
   - Carry out a monthly survey using the NHS Safety thermometer
   - Set a baseline for avoidable pressure ulcers to measure against next year
   - Reduce the number of avoidable pressure ulcers to below the national average

Key: □ Indicator achieved □ Indicator almost achieved

It is important to note that depending on methodology used to collect the data against each indicator, our year-end reporting figures are either ‘year to date’ (YTD) or ‘at quarter four’ (Q4). In some cases, where our data based on responses from patient survey was particularly low, we have aggregated our performance across the four quarters to produce a more meaningful year to date result. This will be made clear throughout the Quality Account.

To demonstrate a well-rounded view of the quality of CNWL services, we have included a number of other indicators of quality which are detailed in Part 3. These include historic Quality Account Priority indicators, performance in national staff and patient surveys, and details of complaints and equalities and diversity developments during 2013-14.
2.1.2. The detail of performance against our Quality Account Priorities 2013-14

The following five sections describe our performance achieved for each of our Quality Account Priorities, and the work which either took place to achieve our targets, or actions planned or in place to ensure improvements continue to be made.

- Helping our patients to recover by involving them in decisions about their care

This priority builds on CNWL’s focus from previous years to truly embed a culture of inclusivity, co-production and personalisation throughout the organisation and our services. Evidence tells us that key to achieving recovery and well-being is the patients’ active involvement and participation in shaping a personalised care or treatment approach: tailored specifically to their needs.

This approach ensures patients understand what is in their care or treatment plan, what the alternative approaches are, the possible side-effects, where to get help if things go wrong; and encourages empowerment, shared ownership and responsibility on their journey to wellness.

A Trust-wide project, known as the Improving Involvement Project, was initiated during quarter two to drive up performance in this area and creating a culture of partnership and co-production. With the involvement of patients, we have designed, developed and implemented our new mental health Care Plan folders, within which care plans, medication information leaflets and other information can be kept together. This folder is aimed to be a ‘conversation starter’ to facilitate involvement and partnership in care planning. It also details useful telephone numbers such as that of the care co-ordinator, PALS, medicines information service, and the urgent advice line.

Alongside this, posters have been designed and disseminated to all mental health services prompting patients/services users to ask for a copy of their care plan if they have not had one offered already, as well as the training of reception staff to prompt and begin the conversation.
The Improving Involvement Project has also focused on sharing examples of good practice between service lines and boroughs and encourages services to adopt these through team discussion and individual clinical supervision.

This year we assessed and monitored our performance in this area through two measures; first, to determine that our mental health patients had been offered or given a copy of their care plan, or that our community physical healthcare patients had an agreed treatment plan in place, and second, to determine the extent to which all our community patients receiving mental or physical healthcare report feeling ‘definitely’ involved as much as they wanted to be in decisions about their care.

**Measure 1: Patients have been offered or given a copy of their care plan (mental health) / Patients have an agreed care plan (community physical health)**

![Bar chart showing percentage of patients involved](chart.png)
As this is a new measure for our physical community services in Camden and Hillingdon, our performance has varied throughout the year. Overall, based on the audit of clinical systems, at quarter four we recorded 93% of patients had been offered a copy of their care plan or had an agreed care plan. As presented above, this narrowly missed our 95% target. Considering these results separately, mental health achieved 82%, while our physical community services achieved 96%, an increase of 30% from quarter two.

This shows there is still work to do to improve on this performance further in our mental health services. For example, local action has included staff and auditor training sessions, awareness raising via local communication networks, ward/team managers completing monthly audits with issues followed up during individual supervisions sessions and data reviewed at local care quality management meetings, and staff putting in place action immediate remedial action on a patient by patient basis where any issues were highlighted.

Measure 2: At least 65% of patients report being ‘definitely’ involved as much as they wanted to be in decisions about their care plan

This measure is based on our monthly telephone surveys of our patients, which are carried out by a group of especially trained patients, and quick feedback cards used in our sexual health services.
In focus: Involvement and responsiveness in our sexual health services

In our 2013 Staff Survey results 93% of our sexual health services staff felt ‘the organisation acts on concerns raised by patients’ (CNWL overall: 77%). This reflects a culture in our sexual health services which is highly responsive to the needs of patients. This is confirmed by the sexual health services results for this measure, which achieved 89% of patients reporting that they were ‘definitely’ involved as much as they wanted to be in the planning of their care and treatment.

Overall, including our community mental, physical and sexual healthcare services, we achieved 82% at quarter four (based on 2389 patient responses), exceeding our target.

We are pleased to report that for the first time since this measure was introduced in 2011-12 our mental health services are now achieving this challenging target, which considers only those who stated they were ‘definitely’ involved as much as they wanted to be in their care planning. In quarter four our mental health services achieved 71%, and a steady upward progression over the previous years, as demonstrated by the graph above.

We are very proud of this result which is a reflection of all the hard work implemented. When we consider those who reported being involved ‘definitely’ and ‘to some extent’, we achieved 90%. To ensure this level of performance is sustained and a culture of inclusion and partnership is embedded into practice we will be rolling this priority forward next year.

Other actions have included initiatives such as patients offered to chair their own meetings, the involvement of peer support workers to support patients in person centred planning, and the analysis and feedback of commentary through survey to shape our understanding of patients’ values to match these. Training programmes run by our Recovery College further supports our achievement in this priority area, which involves patients, carers and staff training and learning alongside one another.

- Supporting carers to look after their loved ones

Family and friends (carers) provide a vital role in the wellbeing, safety and recovery of our patients. The first step in our process is therefore to make sure that we have accurately identified when a patient has a carer, or does not have a carer. We term this their ‘carer status’. Once this is accurately recorded on our information systems we can follow up with the appropriate assessment and support.

Measure 1: Patients have their carer status identified

This measure is assessed through the audit of our patient information systems. We set ourselves a challenging target for 2013-14; one which increased from the 55% in 2012-13 to 65% by quarter three and finally 70% by quarter four. We also rolled this measure out to our physical community services in Camden and Hillingdon, applying these targets.

The chart below shows our progress year-on-year; performance demonstrated by the bars, and the rising target demonstrated by the target line.
Overall, we have just missed our target in quarter four by two percent. Reported separately, we achieved 77% in our mental health services and 66% in our physical community services in Camden and Hillingdon.

The reasons are two fold: Firstly, as this is a new measure for our physical community services, we expected performance to dip and be improved during the year as action is put in place and awareness raised amongst our staff in those services. Secondly, a dip was expected due to a change in how we record and collect this data due to the introduction of a new ‘carer activity record’ on our patient information system in our mental health services. Clinicians and auditors were informed of the changes in requirements and business rules updated and disseminated. We have since begun to see an increase in our performance for quarters three and four, and expect this to rise further next year. This is due to the continued commitment of our staff and services in recognising and valuing the role of carers.

**Measure 2: Do carers feel supported by CNWL and know how to access support in a crisis?**

CNWL has established a Carers Council, chaired by a Carer Governor, and has carer and staff representatives from a variety of services and demographic backgrounds. Work to deliver a better carer experience is co-ordinated and supported by this group.

We are committed to working in partnership with carers. We wanted to fully understand how we can better support our carers, ensuring they have the information they need and how to access services in crisis. This is especially important for our carers who care for individuals who may not be able to speak for themselves, for example those in our Learning Disability and Older People and Healthy Ageing services. It is important that all of our services include carers in care and treatment planning for the person they are supporting.

To achieve this we ran carer focus groups with different carer groups which included 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.

2013-14 also saw the strategic collaboration between CNWL and the Spectrum Centre at Lancaster University. This collaboration has provided the Trust with a unique opportunity to review and improve carer experiences, especially in mental health care. A report was produced based on a review of our policies and procedures to support carers, and interviews with carers, patients and staff undertaken to establish the current experience of these. Trends from this data were positive but also showed there is more work to be done to embed these policies and procedures. CNWL’s Carers Council will monitor and review progress on this in 2014-15.

Our carer feedback
The carer focus groups were positively received by both carers and staff who felt that these groups were a useful way to discuss any concerns and look at ways to address these, as well as provide feedback about the carer experience of the service. Such was the success of the carer focus groups that service lines committed to run at least two focus groups during the year to continue to work in partnership with and support carers. In addition, carer groups were also run in the Addictions Service and the Admiral Nurse Service.

Hillingdon and Camden Community Services have also successfully run awareness training sessions for community staff. A Carer Telephone Survey to contact newly identified carers to hear about their experiences of services was developed and initially piloted in Hillingdon and rolled out to Camden within the year.

- Monitoring carer identification and providing information
We heard from carers that, while we have improved staff awareness of carers and recording the ‘carer status’, we now need to focus on their early identification and ensure that carers are given local service information and sign-posted to accessible local support and contact points. This requirement directly feeds our Quality Account Priority for next year which builds on this priority, supporting the implementation of local patient and carer information leaflets, while continuing to facilitate carer feedback and action planning through the year.

- Learning
Carers told us that staff should have a better understanding of the role of carers. We have co-developed with carers a carer film. The film is based on the personal testimony of a range of carers and told from their perspective. It is to be used as a learning tool to educate staff of the often complex carers’ perspective and provoke discussion, insights and learning.

A learning set was co-developed and piloted in our acute services on ‘Engaging with Families’. Positively received by staff, this learning opportunity will be reviewed with plans to roll-out during 2014-15.

Carers have also told us they needed training courses. CNWL’s Recovery College has co-developed a number of courses specifically for carers, for example, ‘Telling Caring Story’, ‘Health and Wellbeing for Carers’ and ‘Confidentiality and Information Sharing with Carers’. ‘Managing Difficult Behaviour’ and dementia courses have also been developed and are available to carers. Taster sessions are regularly run to offer carers the opportunity to try
courses available. The Recovery College provides a unique opportunity for individuals (patients, carers and staff) to learn through shared experience.

- **Support in a crisis**
  
  Carers told us that they need clear information on who to contact when out-of-hours advice is needed. The Urgent Advice Line Out-of-Hours service was launched and widely promoted to carers. The service is regularly monitored to ensure any carers who contact the service feel listened to, understood and they receive a satisfactory service.

In conjunction with carers, we developed Carer Contact Cards which received positive feedback. These will be updated to reflect local changes to carer and young carer support and re-launched in 2014-15.

- **Making sure people who use our services get the best care we can provide**

  It is important that our patients receive care and treatment that is safe, effective, responsive, compassionate, professional and well led.

  Our approach is that a quality healthcare service is one in which the service understands, learns from and delivers beyond the expectations of its patients. To achieve this we set out to understand our patients’ satisfaction with our services; with the aim of identifying, sharing and developing good practice across the Trust where things are working well, and make changes and innovate where things were not working as well.

  We tested our patient satisfaction in five ways to make sure we have measured this in the most appropriate way for that particular service:

**In focus: CNWL equalities and diversity of patients and staff**

Stonewall is Europe’s biggest lesbian, gay and bisexual charity, has praised the Trust for its efforts and cited its practice of delivering LGBT equality and awareness training.

Stonewall coordinates a Healthcare Equality Index, open to all providers or commissioners of healthcare in the UK (whether NHS, private or third sector) looking at how ‘gay friendly’ the organisation is towards **lesbian, gay and bisexual (LGB) patients**. In March 2014 CNWL was awarded the **top place** within the Index. Stonewall praised a number of the specialist services that CNWL runs to target LGB communities and patients, and our efforts to improve the monitoring of patients by sexual orientation.

Also, annually, Stonewall rates those employers it feels are most ‘gay-friendly’. In January 2014 CNWL was ranked as the **23rd best** employer overall, while being the **3rd best** NHS organisation in their Top 100. Organisations are required to not only explain what they do to improve their workplace for lesbian, gay and bisexual staff, but also to demonstrate how that has had a real and lasting impact on their organisation.

We tested our patient satisfaction in five ways to make sure we have measured this in the most appropriate way for that particular service:
Measure 1a: We asked our mental health patients to ‘rate the care they had received from our services in the last 12 months’

Excludes our mental health services in CNWL-MK

As this was a new measure for our mental health services we display performance quarter on quarter in the chart above. The baseline target was set based on the ‘good’ and ‘very good’ responses from our quarter one survey, achieving 73%. Data was collected via our monthly telephone surveys carried out by trained patients. We are pleased to report that we achieved an overall improvement during the year exceeding our target at quarter four (based on 765 patient responses). Actions to improve and sustain this are based on feedback from measure 2 below.

Measure 1b: We asked our community (physical) and sexual health care patients their ‘likelihood of recommending our services to friends or family if they needed similar care or treatment’

As above, we measured our performance based on the feedback from our monthly telephone surveys, and set our target based on the quarter one result. The chart below displays our performance quarter-on-quarter, and the results are displayed as “net promoter scores”, not percentages.

The net promoter score

The results of this measure are calculated using a specific methodology laid out by the Department of Health, for national benchmarking purposes, known as the net promoter score.
However, although this has yet to be rolled out to mental health and community health care services we have begun to measure patient satisfaction with our services in this way in our community physical and sexual health care services.

As by explanation, the net promoter score has a range from -100 to 100; and is calculated by simply subtracting the proportion of those who responded as ‘neither likely nor unlikely’, ‘unlikely’ and ‘extremely unlikely’ from those who responded ‘extremely likely’. The ‘likely’ responses are not included in the calculation as they are deemed ‘passive’ responses.

The chart above displays our net promoter scores quarter-on-quarter and shows that we narrowly missed our baseline target at quarter four by just one net promoter score. This was based on 1697 responses.

Reported another way: Overall, those who would be ‘likely’ or ‘extremely likely’ to recommend our services to family or friends, ranges between 95% and 96% across the four quarters. This result is particularly strong in our sexual health services who, from a comparatively larger sample have achieved up to 97% for this measure during the year.

Improving performance of measures 1a and 1b is based on a review of the reasons patients give for their satisfaction scores.

**Measure 2: A thematic review of the follow-up question ‘Please can you tell us the main reason for the score you have given’ to inform action plans for development**

The responses from measure 1a and 1b were supplemented by a follow-up question which asked for the main reason for the satisfaction score provided. The following themes emerged as consistent from quarter one to four, and so are the ‘main predictors’ of patient satisfaction:

- The patient – staff relationship (the strongest theme in determining patient satisfaction)
- Staff attitude and approach, with the following attributes as being most valued: inclusivity, supportiveness, flexibility, promptness and professionalism
In focus: Quick feedback cards

Over the course of the year, our sexual health services have improved their systems for encouraging, reviewing and capturing patient comments (particularly those made via Comment Cards available in all clinics). Each quarter quick feedback cards were also distributed to all patients seen over the course of a week. These cards ask key questions, such as the patients’ feeling of ‘involvement’ or the ‘friends and family test question’. This has resulted in over 1958 comments being logged as a result of feedback captured via these routes.

1664 (85%) of these comments were entirely positive. Key themes in the feedback include the professionalism of staff, overall experience of using the service having been good and the operating system / efficiency of our clinics.

As a result of this feedback, we will strengthen our efforts to reduce waiting times (as was the theme in 6% of the feedback we received).

In our mental health services for example, action has already begun with the consultation and involvement of patients in the development of ‘Our commitments’: 15 key messages which outline what our patients value most, to inform and shape our delivery of care and treatment. These have been published via the ‘Our commitment’ flyer available in waiting areas and on our wards, as well as printed inside the newly developed care plan folder. The flyer reflects the key principles of personalisation, to ensure that personal goals and aspirations are incorporated into the care designed and agreed. This flyer encourages service users and carers to use this “patient charter” in their conversations with their care providers and co-ordinators to ensure their needs are being met.
The following three patient satisfaction measures relate to CNWL-Milton Keynes (CNWL-MK).

**Measure 3: To improve on the 2012 CNWL-MK score based on the CQC national community mental health patient survey for responsiveness to patient needs in 2013**

This score is based on the average of answers to five questions in the CQC national community survey. Each question is scored on a scale of 1-10, where 10 represents the best possible response, therefore, the higher the score for each question, the better the performance.

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Section Score</td>
<td>8.2</td>
<td>8.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Did this person listen carefully to you</td>
<td>8.3</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Did this person take your views into account</td>
<td>7.9</td>
<td>7.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Did you have trust and confidence in this person</td>
<td>7.7</td>
<td>7.5</td>
<td>Slightly Worse</td>
</tr>
<tr>
<td>Did this person treat you with respect and dignity</td>
<td>9.0</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Were you given enough time to discuss your care and treatment?</td>
<td>8.1</td>
<td>7.8</td>
<td>Slightly worse</td>
</tr>
</tbody>
</table>

'Our commitment' flyer

We want you to know that you are listened to and involved in the decisions that are made about your care.

![Flyer Image]

If you think that your mental health worker is not doing these things you could use this leaflet to:

- Talk to them
- Talk with their manager
- Talk with someone from the Patient Advice and Liaison Service (PALS):
  - For confidential advice and information about CNWL services
  - Phone: 020 3124 5773
  - Email: pals.cnwl@nhs.net
  - www.cnwl.nhs.uk

PALS: Patient Advice and Liaison Service

About the same

![Section Score]

About the same

![Did this person listen carefully to you]

About the same

![Did this person take your views into account]

About the same

![Did you have trust and confidence in this person]

Slightly Worse

![Did this person treat you with respect and dignity]

About the same

![Were you given enough time to discuss your care and treatment?]

Slightly worse
The results for the 2013 survey show that this target was not achieved, however, it is important to note that the sample of patients had already been pulled for the 2013 survey before the majority of our actions to address this had been implemented.

We believe that these responses are not an accurate reflection of the large programme of work we have implemented throughout 2013-14 given that the survey data collection took place in early part of the year. We therefore expect to see much improvement in these scores in the 2014 national community survey. Examples of our work are detailed below:

- **Service User and Carer Improvement Group**
  Consisting of representatives of service users, carers, advocacy services and staff, this group was initially set up to support and inform changes within our Campbell Centre, an inpatient mental health facility in Milton Keynes. Successes included a review of all the notice boards in the unit and an update of all the information to include ‘you said, we did’ posters and signposting for information other languages for example. The group now focus their attention on an ongoing basis throughout the year on all feedback received from both our inpatient and community surveys and patients stories, and will soon consider incidents and complaints. The Group compiles a newsletter for dissemination to services, and will soon be offering service users within the group training to get involved in our interview and recruitment process.

- **Campbell Centre Weekly Survey**
  A ‘real time’ tracker is used to capture the views of inpatients at the Campbell Centre each week. Service Users are asked questions about their environment, how safe they feel, and their care plans. The results are fed back to the unit and ‘you said we did’ posters are displayed showing any changes made. The feedback has steadily improved throughout the year in particular how safe patients feel on the unit.

- **Forums**
  A programme of evening focus groups for all service users/carers of our Mental Health Services was set throughout the year. Topics have included Dementia, Meeting the Needs of Young People, Support for Carers and Understanding the CPA Approach. The results of the event are fed back to those who attended updating them on actions that have been taken as a result of their feedback.

- **Friends and Family questionnaire**
  The Friends and Family questionnaire is distributed across all services on a monthly basis. A variety of methods are used to collect this information including paper based surveys, ‘real time’ trackers, the website and will soon be introducing an email option. Results are collated and fed back to teams in the first week of each month to inform actions needed. Teams feed back changes via ‘you said we did’ posters and the results are discussed with staff at team meetings.

- **Patient Stories**
  As part of the Friends and Family questionnaire, patients are invited to leave their contact details if they would like to tell us more about their experience. Following on from this, patients are contacted and given an option to fill out an open questionnaire to tell us more about their experience. These are then returned to services anonymously as more in-depth feedback, and used to inform service improvement action. They are also used to choose service users for filming and are presented at the service user/care group.
To date we have filmed nine patient stories including Service Users from Mental Health, Intermediate care, District Nursing, Speech and Language Therapy and Health Visiting. The films are used internally for training and where we have permission, are posted on our website.

- **Our annual programme of Patient Campaigns**

  Our responsiveness to patient/service user/carer need is underpinned by our annual Patient Campaigns. Each year we design a programme of campaigns in conjunction with our patients, carers, staff and Healthwatch which identify specific areas within which to facilitate patient/service user/carer feedback to inform improvements.

  This year’s Patient Campaigns have focussed on the following:
  - Reducing the health inequalities of people with learning disabilities
  - Review of the Milton Keynes complaints process
  - Improving experience of patients in our District Nursing Services
  - Introducing the 15-Step Challenge in our Health Visiting Teams

  In all campaigns patient/service user perspectives are collected through the year to inform action plans for improvement. Examples of plans for improvement include:
  - Developing a training programme for paid carers
  - To identify the health and advice information needs of our learning disability patients to provide greater support
  - Developing a Health Action Team leaflet in our Learning Disability services
  - Development of a ‘how to complain’ poster, and the roll-forward of the complaints campaign to next year
  - To engage patients in nurse training to give their perspective

Our Patient Campaigns for 2014-15 are currently being decided with our key stakeholders. We are hopeful that the evidence of this year’s work will be improved scores in our 2014 Community Survey results. These results and continued progress of our Patient Campaigns will be reported on internally over the coming year.

Finally, CNWL-Milton Keynes wanted to assess the quality of services through the satisfaction of patients and staff with services using the national “friends and family test” survey. As described above, the friends and family test asks the respondent to state how likely they are to recommend our services to their friends or family if they ever needed similar care or treatment.

**Measure 4: For CNWL-Milton Keynes to deliver the Friends and Family test across all services, and achieve a year-end position within the top 50% of the national result for this measure**

We are pleased to report that we have achieved this measure.

CNWL-Milton Keynes ‘Friends and Family test’ was rolled out across all services using an agreed representative sample from each service, and data was collected monthly throughout the year. Services receive monthly reports which are discussed at local team meetings and action is planned for improvements. To feedback initiatives and progress to patients and staff, ‘you said, we did’ posters are produced and disseminated.

At quarter four we achieved a net promoter score of 65, based on 1423 responses. This achieved our internal target of 56 which was set based on our year-end performance for 2012-13. Compared nationally; at the time of reporting the England results were available to
February 2014 with a net promoter score of 63, placing us in the top 50% of the results for this measure. (See page 15 for an explanation of ‘net promoter scores’).

This achievement has been enabled through the wide variety of work undertaken in our services (detailed above): proactively opening channels of communication between services and patients and carers to hear views, respond and improve our services in line with their needs.

**Measure 5: Improve on the 2012 national staff survey result for ‘staff reporting that they would recommend CNWL-Milton Keynes healthcare services to their friends or family’ in the 2013 national staff survey result**

We also seek the views of our staff and how they determine the quality of our services. Last year CNWL-MK set out to improve on their achievement of the number of staff likely to recommend CNWL-MK services to their friends or family. This is reported nationally as a score out of five; and in 2012 a score of 3.76/5 was achieved and set as the baseline.

As demonstrated by the graph above, while we narrowly missed our target achieving 3.70/5 in the 2013 national NHS staff survey, we far exceeded the national average of 3.55 when compared to similar Trusts.

Our overall result (3.70/5) is broken down across our CNWL-MK services as follows:

- Corporate services: 4.02/5
- Children’s services: 3.74/5
- Adult community services: 3.71/5
- Mental health and learning disability services: 3.35/5

Compared to last year we have improved in all areas apart from our mental health and learning disabilities services, who fair comparably below the other services in the 2013 survey. It is in this area that there has been focused work to improve standards of care, staffing levels and the
calibre of nursing staff appointed. Work will continue as part of a directorate-wide transformation plan for mental health and learning disability services.

Across all CNWL-MK services there is continued emphasis on good management and leadership at every level. We recognise that there is still further work to do and will continue to build our value base with our staff, and test these with our staff and patients. At each stage of the employee journey we will test out the standards of behaviour that we expect aligned to our values so that we have a ‘competent’ and ‘compassionate’ workforce. We are reviewing our selection methods to ensure that we appoint caring, compassionate staff with the skills and standards of behaviour that reflect our values. This work is reflected in our priorities for next year.

Also in the coming year we will begin to carry out quarterly ‘snap shot’ staff surveys to closely monitor our progress against this measure and to understand the issues for improvement action. This is to be taken forward as a priority for next year. With this focus we expect to see good progress against this measure and an improved picture when compared nationally.

- **Safe transfer of care**

The safe transfer of care priority was identified and set as a priority for our services in Milton Keynes.

We wanted to make sure that when our patients, especially those who are vulnerable and have complex needs, are transferred from one clinical setting to another that they are kept safe, and that we have effective systems in place to ensure this.

As transfer of care includes other local healthcare providers and strong partnership working and communication to ensure patient safety at all times, we have worked closely with them throughout the year to reduce harm to our patients.

Our focus was two-fold:

**Measure 1:** To forward 100% of transfer of care incidents reported by our staff to the relevant organisation for investigation within one week, and

**Measure 2:** To reduce the number of those incidents originating from our services that result in moderate or major harm or death to below 5% by year end.

We have achieved both of these targets; however we are mindful of the need to continue to work with our partner organisations in order to sustain the improvements.

We send a weekly incident report to our local healthcare partners covering all transfer of care incidents originating from their services for investigation. It is positive to note that we now receive feedback on their investigations which has enhanced our partnership working and allows for better opportunities for shared learning.

Many of the incidents relate to medication, and we have been encouraged by the level of engagement from the hospital’s Chief Pharmacist who has supported investigations and assisting in addressing issues. Further, the Single Point of Access, which was set up to manage
referrals to Community Nursing teams, is helping to prevent inappropriate or wrongly routed referrals. Underpinning this, we now meet with the local hospital, local authority and commissioners on a monthly basis to monitor the action plan which is in place to develop both operational and strategic solutions.

We are also pleased to report that we have had no transfer of care incidents originating from our services that have resulted major harm or death throughout the year.

Transfer of care problems arising from our own services remain low, accounting for 5.9% of the total throughout the year. When these incidents do occur, staff report and investigate the issue so lessons can be learned and shared. The Mental Health Service pathway redesign, for example, is likely to reduce the frequency of these incidents still further, as it will clarify and streamline the interfaces between services.

As we have now developed close partnership working with our local agencies, introduced systems to increase safe transfer of care further, and are confident that the systems which have been set up to monitor progress both internally and by commissioners are robust, this priority will not be reported in the Quality Account next year.

- Reducing harm from pressure ulcers

Pressure ulcers are also known as ‘bed sores’. Pressure ulcers usually develop in those who have limited mobility and are caused by a sustained pressure on a particular part of the body, for example, the hard surface of a wheelchair. Those cells under pressure are deprived of blood, oxygen and nutrients and eventually die, causing a sore. As the area is also devoid of white blood cells (our immune system), the area is easily infected and can cause considerable pain. Pressure ulcers are graded from one to four with four being the most severe.

Preventing pressure ulcers was a priority identified in our healthcare services in Milton Keynes, with the long-term ambition of achieving zero avoidable pressure ulcers. Work is overseen by the Zero Pressure Ulcer Ambition Group who report data to the Quality and Performance Committee. Three Quality Account Priorities were developed to monitor and drive our plans forward in this area. These were to:

Measure 1: Undertake a survey once a month using the NHS Safety Thermometer tool;
Measure 2: Achieve a year-end baseline for the number of recorded avoidable pressure ulcers to be measured against in the following year;
Measure 3: Achieve a level of recorded avoidable pressure ulcers less than the national average for this measure using the NHS Safety Thermometer tool;

We are pleased to report that at quarter four we have achieved our targets.

We have developed a system to accurately identify avoidable and unavoidable pressure ulcers, and data is collected on a monthly basis via the NHS Safety Thermometer. To ensure accuracy and validity, the data is triangulated with incident reporting data and provides robust information to inform action and improve patient safety overall.
Actions have included the provision of training on pressure ulcer prevention and management and use of equipment, provision of information for patients and the development of a Pressure Ulcer Management Policy. The uptake of training is monitored on a monthly basis, and pressure ulcers are investigated to identify and share learning points for further improvements.

In our progress towards achieving a year-end baseline for the collection of avoidable pressure ulcers, we recorded 23 by quarter four. Six of these were grade 2, and 17 were grade 3/4. These are all routinely further investigated to identify the cause and inform action plans and safeguarding alerts where relevant.

Learning from investigation findings is shared via the regular Pressure Ulcer Ambition Group where this is a standing agenda item; as well as individual team action plans shared with other relevant teams and the production of a bi-monthly flyer to share key learning from any clinical incidents, including pressure ulcers. Earlier in the year key themes included issues with ‘record keeping’ and ‘on-going assessment’, however both have improved due to the introduction of local policy and training. A further theme is ‘transfer of care information’, and improvement in communication pathways is currently being developed to address this.

This total will form our baseline for assessment during 2014-15 in our progression towards our zero pressure ulcer ambition.

To put our performance in context we compare ourselves against the national average (using the NHS Safety Thermometer tool), and our aim is to do better that it. We are pleased to report that our actions are working and that at quarter four, patients recorded as having a grade 2-4 pressure ulcer was 5.06%, compared to the national prevalence level of 6.6%.

These measures will not be included in the Quality Account for 2014-15 because the NHS Patient Safety Thermometer, which includes Pressure Ulcer Management, is mandated through CQUIN and this will ensure ongoing monitoring and provision of assurance to our commissioners. We are confident that our processes in place for the collection and monitoring of pressure ulcer data are robust and performance is improving.
## 2.1.3. A borough breakdown – Our Quality Account Priority 2013-14 performance by borough

<table>
<thead>
<tr>
<th>Measure</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon</th>
<th>Kensington &amp; Chelsea</th>
<th>Westminster</th>
<th>CAMHS</th>
<th>Learning Disabilities</th>
<th>Eating Disorders</th>
<th>Addictions</th>
<th>Camden community (physical)</th>
<th>Hillingdon community (physical)</th>
<th>Sexual health services</th>
<th>Trust-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helping our patients recover by involving them in decisions about their care plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. We record inpatient/community patients have been offered/given a copy of their care plan (mental health) / Patients have an agreed care plan (community physical health) (Q4; n=2098)</td>
<td>95%</td>
<td>90%</td>
<td>90%</td>
<td>73%</td>
<td>78%</td>
<td>74%</td>
<td>100%</td>
<td>100%</td>
<td>83%</td>
<td>100%</td>
<td>94%</td>
<td>97%</td>
<td>-</td>
</tr>
<tr>
<td>2. Community patients report that they were involved as much as they wanted to be in decisions about their care plan (definitely) (Q4; n=2389)</td>
<td>65%</td>
<td>62%</td>
<td>64%</td>
<td>67%</td>
<td>73%</td>
<td>77%</td>
<td>89%</td>
<td>-</td>
<td>100%</td>
<td>80%</td>
<td>72%</td>
<td>77%</td>
<td>88%</td>
</tr>
<tr>
<td>3. Community patients report that they were involved as much as they wanted to be in decisions about their care plan (definitely and to some extent) (Q4; n=2389)</td>
<td>65%</td>
<td>94%</td>
<td>86%</td>
<td>88%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td>-</td>
<td>100%</td>
<td>88%</td>
<td>89%</td>
<td>96%</td>
<td>99%</td>
</tr>
<tr>
<td>Making sure we support carers in looking after our loved ones</td>
<td></td>
<td></td>
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<tr>
<td>3. Percentage of patients that have a ‘carer status’ identified (Q4; n=1986)</td>
<td>70%</td>
<td>93%</td>
<td>85%</td>
<td>81%</td>
<td>66%</td>
<td>58%</td>
<td>-</td>
<td>94%</td>
<td>57%</td>
<td>100%</td>
<td>67%</td>
<td>65%</td>
<td>-</td>
</tr>
<tr>
<td>Making sure people who use our services get the best care we can provide</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>4. Overall, how would you rate the care you have received from CNWL services in the last 12 months (‘good’ or ‘very good’; Q4; n=765)</td>
<td>73%</td>
<td>72%</td>
<td>74%</td>
<td>68%</td>
<td>75%</td>
<td>87%</td>
<td>89%</td>
<td>-</td>
<td>83%</td>
<td>83%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. How likely are you to recommend CNWL services to family or friends if they needed similar care or treatment (Q4; net promoter score followed by percentage of ‘likely’ and ‘extremely likely’ responses; n=1697)</td>
<td>71%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>43 (83%)</td>
<td>35 (80%)</td>
<td>75 (97%)</td>
</tr>
</tbody>
</table>

Key: “n=” denotes total sample size  
“Q4” denotes results as at quarter four
2.2. Our Quality Account Priorities for 2014-15

In this section we describe the journey we have taken to develop and agree our Quality Account Priorities for the coming year. We include the rationale for their selection, and how we will measure, monitor and report on them.

How we agreed our Quality Account Priorities for 2014-15

We value the views of both our internal and external stakeholders and actively facilitate dialogue and engagement at all times: Feedback, and sharing messages and lessons from as many sources as possible makes for the most informed decision making in which everyone is brought on the journey, and supports the Trust’s aims and objectives for safe, high quality care.

The building up of our Quality Account Priorities began at the very start of year. This has involved:

- Our ongoing conversations with and feedback from our Healthwatch,
- Feedback and analysis from our patient, carer and staff surveys,
- Triangulation of our audit results, complaints, claims, incidents, and PALS data to inform our annual organisational learning themes,
- Feedback from our internal and external site inspections, and
- The development and integration of our priorities within our Annual Plan

Based on this information we have developed five key areas for improvement in 2014-15 and on which to base our draft Quality Account Priorities for 2014-15:

- Improving patient user experience
- Improving involvement in care/treatment planning
- Supporting carers to look after their loved ones
- A competent and compassionate workforce; and
- Integrated physical and mental healthcare

In refining and shaping our draft Quality Account Priorities for 2014-15 we consulted with our key stakeholders through a series of workshops. We consulted with patients, carers, Council of Governors, staff, union representatives, Healthwatch, commissioners, Overview and Scrutiny Committees and lead GPs.

Based on the key messages received from our individual stakeholder consultations the refreshed Quality Account Priorities for 2014-15 were proposed for further feedback and refinement at our annual ‘all-stakeholder’ consultation event (held on Thursday, 6 March 2014). This half-day event included the attendance of around 70 delegates, with representatives from all our stakeholder groups. Each individual had the opportunity to feedback their views, share personal insights and experiences, and network. The event received very positive feedback.

Consultation: Key messages

Through our consultation programme a number of key themes emerged in relation to the principles that should apply to the Quality Account Priorities for next year. The priorities should:
Be written in the patient’s voice to be easily ‘accessible’ and understandable to all
Be consistent and applicable to all parts of the organisation for benchmarking purposes
Cover no more than three areas to ensure focus and embedding of key quality improvements
Focus on our processes, as well as outcomes and experiences of our patients and carers, and
Include both quantitative and qualitative measures to ensure a rich and well-rounded understanding of the quality of services and where improvements are needed.

Feedback from our consultation programme provided clear and supportive direction for the development of the Quality Account Priorities. It was agreed that the three Quality Account Priorities for 2014-15 should be:

- **Priority 1:** Helping our patients to recover by involving them in their care or treatment
- **Priority 2:** Supporting carers to look after their loved ones
- **Priority 3:** A competent and compassionate workforce

Based on feedback it was decided that rather than be a Quality Account Priority, ‘Improving patient experience’ should be reported as an overarching measure of quality services, as it depends on getting all other aspects of care ‘right’. In response, this will be reported as standard in future Quality Accounts.

Finally, ‘integrated physical and mental health’, while vitally important and rigorously worked towards, was felt to be ‘too early’ for development in 2014-15. Integration processes are embedding across our physical and mental health services, and in light of current organisational re-structure to support this aim, ‘Integrated physical and mental health’ will be proposed as a Quality Account Priority for 2015-16.

The tables on the following pages display each of the three Quality Account Priorities planned for 2014-15. Each table describes:

- The aim, objective and rationale for the priority area,
- ‘Our commitments’ or projects we are planning to carry out during the year, and
- The ‘measures’ or indicators we are planning to monitor and report on to drive up performance in that priority area, and so the quality of our services.

It should be noted that these are not the only measures of the quality of our services that we monitor. Where stated, the Quality Account Priorities from previous years will continue to be measured and reported on in future Quality Accounts, as well as triangulated with all our other data sources throughout the year. This is described in more detail in 2.3 Monitoring and sharing how we perform.
Priority 1 - Helping our patients to recover by involving them in their care or treatment

Aim and objective:

- Involving our patients in their care and treatment is key to their on-going recovery or well-being: ‘Involving patients’ is a proxy measure for a number of other clinical practices, such as a personalised approach, explaining treatment or medication choice and side effects, the importance of concordance, what to do in a crisis, additional services available and how to effectively manage conditions
- CNWL introduced this priority to its mental health services in 2010-11, and rolled this out to its community (physical) and sexual health services in 2013-14
- While our community (physical) and sexual health services have shown encouraging results throughout the year, it is in CNWL’s mental health services which have shown the greatest shift. Our consistent focus and improvement actions have taken effect with patients reporting a year-on-year increase that they were ‘definitely’ involved as much as they wanted to be in their care and treatment (see Section 2.1.2). Our mental health services achieved this for the first time in quarter three this year, and early results for quarter four report similar/increased figures
- While this is to be celebrated, it is not to become complacent: Through our commitment to continue the roll-out of our Improving Involvement Project we plan to drive up and maintain this performance, and ensure a culture shift of ‘empowerment’ and ‘partnership’ is made and embedded throughout our services. “Empowerment” and “partnership” reflects two of CNWL’s four core values
- We will continue to measure, as appropriate, that we have offered our patients a copy of their care plan, but develop this further for next year by asking patients to report on care plan implementation: “how well does your care co-ordinator or lead professional organise the care or services you need”? (This is a CQC national patient survey item and so can be benchmarked against next year).
- Finally, to support all our aims in this area, CNWL will undertake a review of its care or treatment planning processes across the Trust with the aim of ‘simplification’, removing unnecessary bureaucracy to release staff time from administration to caring for patients; and ‘integration’, facilitating a holistic approach to healthcare where physical healthcare services are prompted to capture mental health issues (and vice versa), and pathways developed for integrated healthcare management.

Commitment 1a. To undertake a review of care and treatment planning across the Trust

Commitment 1b. Improving Involvement Project continued roll-out in our mental health services

<table>
<thead>
<tr>
<th>Measures</th>
<th>Target</th>
<th>2013-14 achievement or new measure</th>
<th>Collected by</th>
<th>Service applicability</th>
<th>National benchmark available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1a. Community patients who tell us they were ‘definitely’ involved as much as they wanted to be in decisions about their care or treatment</td>
<td>Q1: 65% Q2: 65% Q3: 65% Q4: 65%</td>
<td>82%</td>
<td>Telephone survey/ Quick feedback cards</td>
<td>All</td>
<td>Yes</td>
</tr>
<tr>
<td>Measure 1b. How well does your care co-ordinator/lead professional organise the care or services you need?</td>
<td>Baseline set at quarter one</td>
<td>New measure</td>
<td>Telephone survey</td>
<td>Mental health only</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Priority 2 - Supporting carers to look after their loved ones

Aim and objective:

- Our carers are our allies in healthcare provision, and so it is essential that they are given the appropriate support to enable them to care for their loved one(s), to keep them safe and well
- Based on strong stakeholder support, this priority is a roll-forward from 2013-14: Throughout last year we heard many key messages from our carers (as described in Section 2.1.2), and so it is essential that these are responded to and built upon, to continue to drive up the culture of routinely identifying and involving carers, and providing them with the help, training, access to services, and advice and information they need
- Throughout 2014-15 the development work for carers will be managed and co-ordinated by CNWL’s Carers Council (chaired by a carer governor). Based on feedback from our carers, work-streams include:
  a) to continue to measure the identification of carers on our patient information systems,
  b) the provision of accessible information about services and better sign-posting through the co-production of information leaflets,
  c) the 2014-15 launch of the co-developed Carer Film, to be used a learning tool to better understand the complex issues faced from the carers perspective and provoke discussion and enhanced learning
  d) the roll-out of a learning set co-developed and piloted in our acute services on ‘Engaging with Families’; this was positively received by staff and plans are in place for wider roll-out in 2014-15
  e) to continue to gain carer feedback throughout the year from survey and focus groups, as well as learning from complaints and carer experience stories, to inform improvement action; and continue to benchmark results from national patient surveys. For example, we have seen a steady increase in the results for patients reporting that they were told that they can ‘bring a friend, relative or advocate to your care review meeting’
- The Carers Council will continue to ensure its membership reflects the diverse services provided by CNWL, as well as the population it serves, and that it continues to partner with appropriate external organisations

Commitment 2a. To provide patients and carers with local information on services available, including, Urgent Advice Line details, advice on medication and side effects, how to contact PALS or make a complaint, and how to receive supportive training through the Recovery College, via leaflets and crisis card distribution.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Target</th>
<th>2013-14 achievement or new measure</th>
<th>Collected by</th>
<th>Service applicability</th>
<th>National benchmark available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 2a. Thematic review of carer feedback based on their experience of the support and information received from CNWL services, to inform action plans for improvement</td>
<td>Thematic review and action</td>
<td>Achieved</td>
<td>Focus groups and surveys</td>
<td>All, except sexual health services</td>
<td>-</td>
</tr>
</tbody>
</table>

29
Priority 3 - A competent and compassionate workforce

Aim and objective:

- Our aim is not only for our workforce to be ‘competent’ but also have a human touch; approaching patients with ‘compassion’ and ‘respect’ as supported by two of CNWL’s four core values
- There is an evidence base that states that staff who are well led, supported, listened to and receive regular feedback through supervision, appraisal or listening forums, for example, are better engaged, motivated and provide better quality care
- Our 2013 national staff survey results suggest that, even though above national averages, opening communication channels between management and staff is necessary: 40% believe senior managers involve staff in important decisions, 48% believe communication between senior management and staff is effective, and 39% believe senior management act on staff feedback
- To achieve this, our approach is multifaceted:
  - Starting with recruitment and employing the best candidates, we will implement an online recruitment screening tool to aid the efficiency and effectiveness of identifying the best candidate for the job – with not only the right skills, experience and qualifications, but also the right attitude and ethos; and getting them in as soon as possible;
  - We will encourage stronger, consistent and responsive leadership opening and facilitating lines of communication between our staff and management, through on-going supervision and appraisal on a one-to-one basis, but also through staff listening events – empowering a ‘staff voice’ and being responsive to it;
  - We will ensure our inpatient wards are safely staffed to ensure our patients receive a safe, effective and comfortable experience of care;
  - Finally, to assess overall effectiveness of our approach to a ‘competent and compassionate workforce’, we will ask our patients and staff for their views to inform our actions for improvement.

Commitment 3a. Improve the efficiency in the recruitment process through development and implementation of an online assessment screening tool

Commitment 3b. Development of a programme of staff listening events, to facilitate open dialogue between management and frontline staff for mutual feeding back, shared action planning and sharing of messages

Commitment 3c. To publish the staffing levels on our inpatient wards, as recommended by NICE, for the information of patients, carers and staff

<table>
<thead>
<tr>
<th>Measures</th>
<th>Target</th>
<th>2013-14 achievement or new measure</th>
<th>Collected by</th>
<th>Service applicability</th>
<th>National benchmark available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 3a. The percentage of staff who have had their annual appraisals</td>
<td></td>
<td>New measure</td>
<td>Internal database</td>
<td>All</td>
<td>-</td>
</tr>
<tr>
<td>Measure 3b. The percentage of patients who tell us that they were treated with ‘dignity and respect’</td>
<td>Baseline set at quarter one</td>
<td>New measure</td>
<td>Telephone survey/Quick feedback cards</td>
<td>All</td>
<td>-</td>
</tr>
<tr>
<td>Measure 3c. The percentage of staff who would recommend Trust services to family or friends if they needed similar care or treatment</td>
<td></td>
<td>New measure</td>
<td>Staff survey</td>
<td>All</td>
<td>Yes</td>
</tr>
</tbody>
</table>
2.2.1. Monitoring and sharing how we perform

Reporting our performance and achieving our targets

The measuring and monitoring of the clinical safety, effectiveness and experience of patient, carer and staff of CNWL services is a top priority.

This work is closely overseen and scrutinised by the 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), who in turn provide assurance and recommendation to the Board of Directors.

Service lines scrutinise their local data, action plan as appropriate and report on progress at local monthly care quality management groups and quarterly service line reviews. Service line reviews are attended by the Director of Operations, service line heads, business managers and other corporate and clinical staff to provide robust challenge, receive assurance regarding exception reports and on-going improvement actions and to learn and share lessons.

Where feedback or data indicates that Trust-wide action is required, a working project group will be arranged with clear terms of reference and objectives to design, consult on, and implement the change programme or initiative. Progress will be monitored through the Quality and Performance Committee and our key stakeholders will be kept updated throughout the project’s life-cycle.

CNWL values the support, partnerships and conversation with both our internal and external stakeholders in our quest to provide the best services possible. On a quarterly basis we meet and report to our Healthwatch to share and gain feedback from their local communities as well as our Council of Governors. Further, to support effective internal messaging to the front line regarding we will publish quarterly messages via our internal staff bulletins to support progress against our key quality and safety targets and to share lessons learned.

The Quality and Performance Committee, Operations Board and service lines have a variety of tools and information streams to effectively triangulate intelligence, and monitor and facilitate their achievement of safe and high quality services.

Our systems and tools for measuring and monitoring safety and quality of services

- **Integrated dashboard:**
  Our Quality Account Priorities, historic priorities and other indicators of quality include both quantitative and qualitative indicators. This enhances the richness of the intelligence we collect and enables us to put in place focused and informed action plans for improvement.

  To achieve this, our data is collected from automatic reporting from our information systems (such as Datix Web), clinical audit, patient and carer telephone and postal survey, focus groups and listening events. This information is collected on a monthly and quarterly basis and a reported via the Trust’s Integrated Dashboard. For further
triangulation, the dashboard also includes achievements against Monitor, HR, CQUIN and financial measures, and is broken down by service line and borough. Where targets are missed action plans are put in place and progress monitored in the following report.

- **Organisational learning:**
  We also actively compare, analyse and triangulate the messages from our incidents, complaints, claims, PALS, audits and surveys to produce organisational learning themes. These themes, as described in the previous section, are used to inform action plans with executive leads to ensure improvements in the areas identified, and are used to inform the Quality Account Priorities for the next year. This work is undertaken by the Organisational Learning Group which reports directly to the Quality and Performance Committee.

- **Quarterly quality reporting:**
  Key messages from a wide variety of work-streams from across the organisation are collated in one quarterly Quality Governance Report under the three headings of a) compliance with regulatory requirements and good practice guidance, b) management of concerns, problems and issues, c) quality improvement, and d) patient, carer and public involvement. These reports allow for further triangulation, scrutiny and assurance of the quality and safety of services.

- **Care Quality Commission’s (CQC) essential standards for quality and safety:**
  We monitor our services’ compliance with the CQC’s regulatory standards on an ongoing basis. Tools known as Provider Compliance Assessment tools (PCAs) are updated with action plans where gaps in assurance are identified on a quarterly basis, and reported via an on-line system to the Quality and Performance Committee and Operations Board. As PCAs are self-assessments of compliance, declarations are tested by internal audit, a programme of mock internal inspection of our services and CQC inspection reports.

  We also rigorously review our Quality and Risk Profile (QRP) which the CQC publish on a monthly basis. This document collates all the intelligence the CQC hold on CNWL from third party information and intelligence from their local inspections. Based on this information the QRP determines possible areas of risk and plays a part in informing their inspections. We track any changes closely and ensure any new information is logged and action in put in place as required.

  We provide monthly updates on the compliance with CQC’s standards to the Quality and Performance Committee and Operations Board.

- **Service Improvement and Special Measures Programme:**
  Where we hear frequent messages or “noise” in the system from a variety of sources about a particular site or team, we instigate an initial assessment to determine whether there are fundamental or systemic issues which require further detailed investigation and improvement. If it is agreed that further action needs to be taken we deploy a level of response that appropriate to the seriousness of the issues found.
Our service improvement intervention has three levels: Level 1 warrants local management and reporting to resolve issues; Level 2 is an executive-led Accelerated Service Improvement Programme (ASIP); and Level 3, where systemic failings are found, requires a Board monitored Special Measures Programme.

**Benchmarking**

CNWL is a member of the NHS Benchmarking Network. The network’s purpose is to perform nationwide comparisons, or benchmarking, across all mental health and community services across a variety of performance measures, such as ‘re-admission rates’ for example.

CNWL is also a member of Prescribing Observatory for Mental Health (POMH-UK). POMH-UK run a rolling programme of clinical audits which focus on medication prescribing and monitoring of physical health side effects. CNWL partakes in these audits and is benchmarked against all other similar participating Trusts, as well as able to assess improvements since the previous audit. Participation and performance monitoring is carried out by the Medicines Management Group (MMG), with actions for improvement agreed and implemented by our services.
2.3. Statements relating to the quality of NHS services provided

Review of services

During 2013-14 CNWL provided and/or sub-contracted seven healthcare services.

These included:

- Mental health (including adult, older adult and CAMHS)
- Eating Disorders
- Learning Disabilities
- Addictions
- Offender Care
- Sexual Health/HIV Services
- Community physical health services (Camden, Hillingdon and Milton Keynes)

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

The income generated by the NHS services reviewed in 2013-14 represents 100% of the total income generated from the provision of NHS services by CNWL for 2013-14.

Where we provide our seven healthcare services:

<table>
<thead>
<tr>
<th>Area</th>
<th>Mental health services</th>
<th>Eating disorders</th>
<th>Learning disabilities**</th>
<th>Addictions</th>
<th>Offender care</th>
<th>Sexual health services</th>
<th>Community physical healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brent</td>
<td>y</td>
<td>-</td>
<td>y</td>
<td>y</td>
<td>y</td>
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<tr>
<td>Harrow</td>
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<td>y</td>
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<td>-</td>
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<tr>
<td>Hillingdon</td>
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<td>y</td>
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<td>y</td>
<td>y</td>
<td>y</td>
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<tr>
<td>Kensington &amp; Chelsea</td>
<td>y</td>
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<td>y</td>
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<tr>
<td>Westminster</td>
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<td>Camden</td>
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<td>Enfield</td>
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<td>Hounslow</td>
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<td>Ealing</td>
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<td>Hammersmith &amp; Fulham</td>
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<td>Kingston</td>
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<td>Surrey</td>
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<tr>
<td>Kent</td>
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<td>Hampshire</td>
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<tr>
<td>Buckinghamshire</td>
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<td>y</td>
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<tr>
<td>Milton Keynes</td>
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<td>y</td>
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<td>y</td>
</tr>
</tbody>
</table>

* Provided in partnership
** Referrals accepted nationwide and includes offender, diversion and treatment services
Participation in clinical audit

During 2013-14, 7 national clinical audits and 1 national confidential enquiries covered NHS services that CNWL provides.

During that period, CNWL participated in 100% of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that CNWL was eligible to participate in during 2013-14 are as follows:

- National Audit of Intermediate Care (NAIC)
- Falls and Fragility Fractures Audit Programme (FFFAP)
- Sentinel Stroke National Audit Programme (SSNAP)
- National Parkinson’s Audit
- National Audit of Schizophrenia (NAS)
- Prescribing Observatory for Mental Health (POMH)
- Epilepsy 12 Audit (Childhood Epilepsy) MK
- Mental Health Clinical Outcome Review Programme: National Confidential Inquiry into Suicide and Homicide for People with Mental Illness

The national clinical audits and national confidential enquiries that CNWL participated in during 2013-14 are as follows:

The national clinical audits and national confidential enquiries that CNWL participated in, and for which data collection was completed during 2013-14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.
The reports of 4 national clinical audits were reviewed by the provider in 2013-14 and CNWL intends to take the following actions to improve the quality of healthcare provided:

- **National Audit of Intermediate Care**: In Hillingdon community services, the audit results have been discussed at the Hillingdon’s Clinical Effectiveness and Professional Advisory Group (CEPAG) and the results have been disseminated to the participating services, Community Rehabilitation Team, Hawthorn Intermediate Care In-Patient Unit and the Rapid Response Team. These services have reported to CEPAG group that recommendations from the report have been reviewed with an action plan in progress. In Milton Keynes Community Services the audit results have been shared with the teams that were involved in this audit and recommendations from the report are currently under review.
• **Epilepsy 12 Audit (Milton Keynes):** Epilepsy12 is a UK-wide multicentre collaborative audit which measures systematically the quality of health care for childhood epilepsies. The ‘12’ refers to the 12 measures of quality applied to the first 12 months of care after the initial paediatric assessment and care is compared to National Institute of Clinical Excellence (NICE) Guidelines. The audit is in its second stage from 2012-2014 and our Paediatric Team continues to participate in this audit and have implemented the recommendations from the first round.

• **POMH-UK Lithium Audit:** The audit findings have been circulated to relevant Service Directors, Clinical Directors, the Trust’s Clinical Safety Group and all teams that have participated in the audit. The majority of data submitted was from the Community Recovery Service and they have considered the results and developed an action plan.

• **POMH-UK Audit of Prescribing for Attention Deficit Hyperactivity Disorder (ADHD) in Children, Adolescents and Adults:** The audit findings have been circulated to Service Directors, Clinical Directors, and all teams that have participated in the audit.

The reports of approximately 300 local clinical audits were reviewed by the provider in 2013/14 and CNWL intends to take the following actions to improve the quality of healthcare provided:

Local quality governance structures are in place across the organization 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:

**Community services in Camden**

Audit title: Audit of the effectiveness of an exercise group for patients following Stroke on balance, walking speed and quality of life

*Actions:*
- To include anyone with a neurological diagnosis who had goals that could be achieved within 6 weeks
- To develop two levels of exercise circuits to suit clients with varied abilities
- Repeat audit in six months when changes made

Audit title: Diabetic Risk Assessment (Podiatry Service)

- The purpose of this audit was to measure that annual risk assessments were undertaken for people identified with diabetes. Also that the assessments are recorded in the patient’s record and a printed copy is sent to the patient’s GP. The standards are in line with those detailed in the national NICE guidance.
- The results showed an improvement to those from the 2012 audit and demonstrated that the service had met its key performance indicator targets. The data also provided details of individual clinician performance against the standards. This information is being used to share and discuss with clinicians in order to set objectives and to continue further improvements.
Community services in Hillingdon

Audit title: An audit of current screening practices: Hillingdon Community Health staff and care/nursing home knowledge of the 'Malnutrition Universal Screening Tool' ('MUST')

**Actions:**
- A Replacement of all Standard BAPEN MUST nutritional screening tools used in care/nursing home patient folders with laminated versions of the screening tool.
- Further training of the MUST nutritional screening tool required among care/nursing/residential homes – group and individual sessions to Hillingdon staff.
- Dieticians to link in with doctors training/GP Master class.

Audit Title: The Management of Allergic Conditions in Hillingdon Schools (School Nursing Service)

**Actions:**
- To ensure that all schools in Hillingdon have a policy on managing allergic conditions in schools
- To ensure that medication held in schools are kept unlocked with regular spot checks to be undertaken and monitored. All medication should be in an unlocked cupboard to ensure immediate anaphylaxis treatment can be received without having to find a key. This is in line with the guidelines form the anaphylaxis campaign.
- To offer annual training/information sessions to each school.

Milton Keynes Services

Audit title: Handover Audit. BMA guidance (Safe handover, safe patients) states “good doctor to doctor handover is vital to protect patient safety and that “systems need to be put in place to enable and facilitate handover.” There was a perceived problem with handovers and the data collected during the audit supported that the quality of handovers were inconsistent. As a result of the Audit the following actions have been implemented:

**Actions:**
- Junior Doctors Training Committee met and discussed the issues
- Sub-group formed to draft a new local procedure which has been implemented
- Trainees consulted and informed
- The process has helped to improve the quality of handovers which has been evidenced by further data collection

Audit title: Joint Audit of coverage of the health surveillance for children with Down Syndrome (Milton Keynes Hospital, Milton Keynes Community Services, Acute Paediatrics and Neonates).

The Royal College of Paediatric Child Health (RCPCH) proposed new service standards for children with Down Syndrome. The rationale for the audit was to evaluate the quality of service provided locally through both audit and parent/carer satisfaction survey, and to assess coverage of surveillance against current DSMIG (Down Syndrome Medical Interest Group) guidelines and the proposed new standards from the RCPCH with the view to identify any gaps in current service provision.

**Recommendations:**
- Produce information packs in collaboration with local support group and seek their views on what sort of support would be helpful.
• Explore feasibility of having dedicated Neonatal Nurse /HV input at time of diagnosis/ongoing input at dedicated clinic respectively.
• Offer early appointments with Community paediatrician (ideally within 4 weeks)

Mental Health and Allied Specialties

Audit title: Observation and Engagement Audit
This audit looked at whether those carrying out observations have appropriate training, staff knowledge of the patients they are observing, and whether staff felt properly supported to carry out observations. Overall the review showed that staff are well informed about close observation and are able to translate this into practice in order to manage risk and engage patients. Recommendations included:
• Provision of observation and engagement training for bank and agency staff should be reviewed to ensure that it is available.
• Staff to be reminded of the need to document the outcome of their time spent on close observation in the care record.

Audit title: Section 12 Project
• The audit aimed to evaluate the implementation of an internal Section 12 rota within the Trust.
• The evaluation of the project identified that the introduction of the rota has had a positive impact on the completion of Mental Health Act Assessments (MHAAs) and use of Independent Section 12 doctors within the Trust. Analysis has shown that the implementation has had an impact on financial cost, which at present is serving to reduce the level of spend on independent S12 doctors.
• In addition the majority of AMHPs and doctors reported that the rota provided an improved quality of MHAAs, particularly in terms of clinical expertise, knowledge of local services, governance and accountability.

Audit title: Consent Audit (HMP Rochester)
Actions: Adjust consent to transfer information form to: clearly specify the services/agencies the patient wants to allow their information to be shared with; that information has been read and understood by the patient; and whether the patient has capacity to consent.

Sexual Health Services

Audit Title: Audit of Prescribing Errors
The main audit findings were that the number of errors has decreased sharply compared to the results of the previous two years. Many of the errors appear to be repeat errors - uncorrected from previous prescriptions.
Main action points:
• Future audits will be prospectively undertaken and will include home delivery prescriptions.
• Incorrect prescriptions will be corrected electronically to reduce mistakes with repeat prescriptions.
Audit Title: Audit of Initial Consultation for Emergency Contraception (EC)

- The audit was undertaken to determine that documentation in patients’ notes demonstrates compliance with local and national guidelines for the provision of EC. There are currently 3 options for Emergency Contraception, these are: Levonelle®, EllaOne® and the insertion an intrauterine device (IUD). All patients were appropriately offered emergency contraception where a pregnancy risk was identified.
- It was noted that EllaOne® was used infrequently (12% of EC prescriptions) during the period audited. It had been recently introduced and after the audit period the pathway for provision of emergency contraception was updated in relation to EllaOne® which will likely increase its use where appropriate.
- Documentation in relation to offering an IUD could be improved.

Research

The number of patients receiving NHS services provided or sub-contracted by CNWL in 2013-14 that were recruited during that period to participate in research approved by a research ethics committee was 1590.

Throughout the year, the Trust has been involved in 74 studies; 65 were funded (of which 4 were commercial trials), and 9 were unfunded.

Over the past year researchers associated with the Trust have published 160 articles in peer reviewed journals.

Goals agreed by commissioners

The new commissioning landscape has given rise to an immediate, material and significant increase in the number of commissioning organisations with whom CNWL conducts business. In addition to the advent of Clinical Commissioning Groups (CCGs) and their respective Commissioning Support Units (CSUs), the disaggregation of various service commissioning responsibilities to the regional offices of the newly – created National Commissioning Board (subsequently renamed NHS England (NHSE)) and to local authorities has necessitated swift adaptation of contract negotiation and management. The higher number of commissioners, when combined with the scope of the Trust’s services and the geography within which it provides them, has placed even greater emphasis on the need to develop and maintain effective working relationships. Many of the new commissioning organisations work collaboratively and are keen to involve CNWL in developing new, innovative services and service delivery. The Trust now serves in the order 11 CCGs, 3 CSUs, 7 local authorities and several area offices of NHSE in London, southern England, the Midlands and elsewhere.

A proportion of CNWL’s income in 2012-13 was conditional on achieving quality improvement and innovation goals agreed between CNWL and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2013-14 and for the following 12 month period are available electronically at www.cnwl.nhs.uk.
Last year (2012-13) CNWL achieved 99% of its CQUIN goals, securing the total CQUIN income of £5,969,351.

For 2013-14, CNWL’s CQUIN income equates to approximately £5,348,060. Achievement against the CQUINs is provided to the Commissioning Support Unit each quarter. The year end position was that 96% of CQUIN goals were met.

The key aim of the CQUIN framework is to support improvements in the quality of services and the creation of new, improved patterns of care. The following are a few examples of where the 2013-14 CQUINs have resulted in positive change for patients who use CNWL services:

- 95% of people using mental health services on CPA, identified as having diabetes, CHD, COPD, hypertension and/or obesity have had a completed health check. In Offender Care, Eating Disorders, Perinatal and CAMHS inpatient services, we met our targets around physical health screening. This is very important for these vulnerable groups who can neglect themselves and who have high physical health needs.
- In HIV services, 82% of patients were supported to voluntarily disclose their condition to their GP, and of those that did agree to this, there was communication around the patient’s needs in 100% of cases.
- From discussion with patients and carers using mental health services, a key concern is discharge, with fears around changes to benefits and access to known clinicians. Joint work between CNWL clinicians and GPs has produced a set of processes which ensure that communication around discharge is improved. At the end of the year, 97% of eligible patients in the Community Recovery Service Line had received this service.
- We have seen a reduction in A&E attendance of people with mental health issues, through our targeted work with frequent A&E attendees and working in partnership with Acute Trusts.
- The Smoking Cessation CQUINs have successfully raised the profile of smoking cessation across the Trust. In Camden, a focused programme has been rolled out in schools and a third of adult smokers agreed to be referred to smoking cessation. In mental health services, 61% of our staff had been trained, in year, to deliver advice on how to stop smoking. The recruitment of a smoking cessation lead for the Trust, introduction of the Smoke Free Strategy Group, and implementation of a new e-learning package will ensure these positive developments remain a focus for the Trust.
- In Milton Keynes, a focus on falls has seen a 44% reduction – that is 107 less people falling than the previous year. This was achieved through 100% of eligible staff (98 people) being provided with specialist training and assessment.
**In-focus: CNWL Improves Access to Psychological Therapies (IAPT)**

CNWL IAPT services have made strong progress in both delivering access (i.e. people entering treatment), and recovery this year.

Our access targets: Once the resources deployed were reconciled and as a result targets revised with our commissioners, all IAPT services including Brent, Harrow, Hillingdon and Central and West London achieved their access targets.

Our recovery targets: We are pleased to report that targets were exceeded in Brent and Harrow, with Hillingdon delivering the highest of the five London boroughs. In Central London, whilst above the London average, was below target; and in West London the inclusion of Step 4 and Primary Care Liaison Nurse (PCLN) data, as anticipated, reduced recovery rates as well as a disappointing IAPT performance. [Actions to be inserted]

**In-focus: Dementia community services**

[To be inserted]

What others say about CNWL

CNWL is required to register with the Care Quality Commission and its current registration status is ‘unconditional registration’. CNWL has no conditions on its CQC registration.

The Care Quality Commission has taken enforcement action against CNWL during 2013-14. CNWL has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013-14: See table below for details of the Trust locations inspected by the CQC.

CNWL intends to take the following action to address the conclusions or requirements reported by the CQC: The Trust is committed to delivering high quality care and immediate action 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 2014 in taking such action: See table below for details of the Trusts response to CQC inspections.

**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>North Westminster Recovery Team</td>
<td>Fully compliant with CQC Essential Standards assessed</td>
<td>None required</td>
</tr>
<tr>
<td>The Campbell Centre</td>
<td>Inspected twice during 2013/14. Compliance action and enforcement action taken.</td>
<td>The Trust has an action plan in place and reports on progress to the CQC on a regular basis.</td>
</tr>
<tr>
<td>HMP Bronzefield</td>
<td>Fully compliant with CQC Essential Standards assessed</td>
<td>None required</td>
</tr>
<tr>
<td>Addictions Community Teams: Hillingdon, Ealing, Brent</td>
<td>Fully compliant with CQC Essential Standards assessed</td>
<td>None required</td>
</tr>
<tr>
<td>Location</td>
<td>Outcome of Review</td>
<td>Progress with actions</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>HMP Holloway</td>
<td>Fully compliant with CQC Essential Standards assessed</td>
<td>None required</td>
</tr>
<tr>
<td>Seacole Centre</td>
<td>Fully compliant with CQC Essential Standards assessed</td>
<td>None required</td>
</tr>
<tr>
<td>Max Glatt Unit, SK&amp;C Mental Health Unit</td>
<td>Fully compliant with CQC Essential Standards assessed</td>
<td>None required</td>
</tr>
<tr>
<td>3 Beatrice Place</td>
<td>Inspected twice during 2013/14. Compliance action and enforcement action taken.</td>
<td>The Trust has an action plan in place and reports on progress to the CQC on a regular basis.</td>
</tr>
<tr>
<td>St Charles Mental Health Unit</td>
<td>Compliance action required</td>
<td>The Trust has an action plan in place and reports on progress to the CQC on a regular basis.</td>
</tr>
<tr>
<td>Kingswood Centre</td>
<td>Fully compliant with CQC Essential Standards assessed</td>
<td>None required</td>
</tr>
<tr>
<td>HMP Woodhill</td>
<td>Compliance action required</td>
<td>The Trust has an action plan in place and reports on progress to the CQC on a regular basis.</td>
</tr>
<tr>
<td>HMP Winchester</td>
<td>Awaiting CQC Inspection Report as at 31st March</td>
<td></td>
</tr>
</tbody>
</table>

**Data quality**

**NHS number and General Medical Practice Code Validity**

CNWL submitted records during 2013-4 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient’s valid NHS number was (at month 12):

- 95.2% for admitted patient care;
- 98.9% for out-patient care; and
- N/A for accident and emergency care.

The percentage of records in the published data which included the patient’s valid General Medical Practice code was (at month 11):

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

**Information Governance Toolkit attainment level**

CNWL Information Governance Assessment Report score overall score for 2013-14 was 86% and was graded satisfactory (green).

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

- Monitor progress across all service lines against nationally set measures and provide a holistic view of services including HR, Finance, Quality and Performance via the Integrated Dashboard
- Continue to refresh QIS (the Trust’s business intelligence system) reports daily to support the business ability to audit and validate reports against the clinical systems and provide assurances to relevant stakeholders.
Highlight anomalies in data via a scorecard to improve the quality of data, positively impacting reporting.

Continue to engage and consult across services to produce/update business rules using national guidance to ensure standardization and compliance.

Use internal and external benchmarking information to monitor data quality and support improvement. Participate in national benchmarking work, such as the NHS Benchmarking Network, to ensure favourable comparison with leading mental health and community service providers.

**Clinical coding error rate**
CNWL was not subject to the Payment by Results clinical coding audit during 2013-14 by the Audit Commission.
### Part 3 – Other information

#### 3.1. 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 Account Priorities which we continue to monitor and report on.

The indicators are grouped as per the three quality dimensions of patient safety, clinical effectiveness and patient experience as per Lord Darzi’s High Quality Care For All report.

Tables 3.1.1 to 3.1.3 below present these indicators by year-on-year achievement and comparisons with national averages (where available). Tables 3.2.1 to 3.2.3 that follow present results broken down by borough for our mental health services where applicable.

### 3.1.1 Patient Safety

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
<th>Benchmark (where available): National average; and highest and lowest scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CPA 7-day follow-up</td>
<td>Clinical system scan</td>
<td>95%</td>
<td>96.1%</td>
<td>97%</td>
<td>95.2%</td>
<td>Not available</td>
</tr>
<tr>
<td>2. Risk assessment and management</td>
<td>Internal audit</td>
<td>95%</td>
<td>92%</td>
<td>92%</td>
<td>96%</td>
<td>Not available</td>
</tr>
<tr>
<td>3. Infection control</td>
<td>Internal database</td>
<td>Year on year reduction</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Not available</td>
</tr>
<tr>
<td>a. The number of cases of MRSA (MRSA bacteraemia) annually (YTD M12)</td>
<td>Internal database</td>
<td>Year on year reduction</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>Not available</td>
</tr>
<tr>
<td>b. The number of cases of Clostridium Difficile annually (YTD M12)</td>
<td>Internal database</td>
<td>Year on year reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Central and North West London**

**Central and North West London NHS Foundation Trust**
<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
<th>Benchmark (where available): National average; and highest and lowest scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Patient safety</td>
<td>Patient survey</td>
<td>75%</td>
<td>80%</td>
<td>79%</td>
<td>75%</td>
<td>Not available</td>
</tr>
<tr>
<td>5. Access in a crisis</td>
<td>Patient survey</td>
<td>65%</td>
<td>75%</td>
<td>75%</td>
<td>72%</td>
<td>54%^</td>
</tr>
<tr>
<td>a. Community mental health patients report that they have a phone number to call in a crisis** (Q4; n=718)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental health patients report that they ‘definitely’ received the help they wanted from the CNWL urgent advice line when they contacted them in a crisis **+(Q4; n=125)</td>
<td></td>
<td>65%</td>
<td>48% (84%)^^</td>
<td>67% (85%)^^</td>
<td>44%</td>
<td>48%^ (79%)^^</td>
</tr>
<tr>
<td>6. Sexual health services</td>
<td>Internal audit</td>
<td>90%</td>
<td>100%</td>
<td>97%</td>
<td>90%</td>
<td>Not available</td>
</tr>
<tr>
<td>7. Incidents</td>
<td>Datix scan</td>
<td>N/A</td>
<td>15,702</td>
<td>11,622</td>
<td>10,924</td>
<td>Not available</td>
</tr>
<tr>
<td>a. Number of patient safety incidents for the reporting period (01/04/13-31/03/14);</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Percent of patient safety incidents that resulted in severe harm or death; and reported as per 100,000 population</td>
<td>Datix scan</td>
<td>N/A</td>
<td>0.71% (113) 3.35 per 100,000</td>
<td>0.79% (92) 6.46 per 100,000</td>
<td>0.98% (107) 7.52 per 100,000</td>
<td>Not available</td>
</tr>
</tbody>
</table>
Measure 1 CPA 7-day follow up: This measure is in place to ensure our patients remain safe and have their needs cared for after discharge from hospital to community care. We are pleased to report that, year to date, 96.1% 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 on a daily basis via the Trust’s Business Intelligence Systems (e.g. QIS) which reports all discharges so that local business teams can track patients who have or have not been followed up. Clinicians are alerted of those patients still requiring follow up, so that they are able to take focussed and informed action. The CPA policy supports operational delivery of follow up contacts, and the business rules are published and shared across the Trust to ensure data captured is representative of activity. This indicator is also published monthly via an internal 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 patient’s care plan. This is to ensure the patient’s ongoing safety and management of any risk issues. This was achieved in 92% of cases for quarter four, narrowly missing the target. This is a slight decrease from quarter three where this target was achieved. Those teams who have not achieved this target are putting in place action plans which will be detailed in the final version of the Quality Account. We will continue to closely monitor and report on this indicator next year.

Measure 3 Infection control: We have a duty to ensure that our patients do not get any healthcare acquired infections whilst in contact with our services. At year end we are pleased to report that we achieved no MRSA bacteraemia cases, however two Clostridium Difficile cases within our Milton Keynes services.

Measure 4 Patient safety: It is important to understand our mental health patients’ sense of safety on the ward. This impacts on their care experience and satisfaction of our services. We are pleased that we have consistently achieved this target over the past three years, achieving 80% at the end of 2013-14. This represents a cumulative result of all the surveys that took place throughout this year due to relatively low numbers in each individual survey. While we are proud of our performance in this area, we feel this is a key indicator to maintain at all times and so will continue to focus on this measure next year.
Measure 5 Access in a crisis: We want to monitor that our community mental health patients have a phone number to call in a crisis to ensure they get help when they need it most. We consistently exceeded our target throughout the year achieving 75% at quarter four (based on 718 responses), exceeding the national average of 54%. This has been due to our development of CNWL’s Argent Advice Line (UAL) number and distribution of our crisis cards and care plan folders to our mental health patients, including those in Milton Keynes.

We also want to ensure that mental health patients not only have access in a crisis, but also get the help they need from UAL. We survey those who called the UAL number to assess this: At quarter four in 48% (target 65%, national average 48%) of cases, patients report that they ‘definitely’ got the help that they wanted (and 84% report they got the help they wanted ‘definitely’ and ‘to some extent’; national average 79%). This is a decrease from last year due to the change in survey methodology where, in 2013/14, only those who called the new UAL specifically were surveyed. As the Urgent Advice Line is a ‘sign-posting’ service, callers get the help they need from the onward service they are directed to resulting in lower scores for the UAL for this question. Nonetheless, to understand the satisfaction issues fully and to ensure expectations are set correctly, we will be reviewing our questionnaire in quarter one to ask specifically if callers were directed to the service they needed correctly, got they help they needed from that service, and overall satisfaction with the Urgent Advice Line, requesting rationale for responses to inform action plan – not only for the Urgent Advice Line, but also to flag to any onward services the UAL refers to. We will continue to monitor and report on this measure next year.

Measure 6 HIV services: This measure is 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 consistently achieved against this 90% target throughout 2013/14, and will continue to monitor and report on it internally.

Measure 7 Incidents: We take reported incidents very seriously at CNWL. We have an electronic reporting system to support the positive reporting culture we have within the organisation. Incidents are graded, analysed and, where required, undergo a root cause analysis investigation to inform actions, recommendations and learning. The Trust has a quarterly Incidents and Serious Incident Group who review relevant information and data before it is distilled by the Organisational Learning Group and reported to the Board.

This measure indicates the total number of safety incidents reported during 2013-14 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 patients, 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. The data covers all services provided by the Trust.

CNWL has taken the following actions to improve this number, and so the quality of its services:

- Strengthened its arrangements for ensuring learning is shared across the Trust as well as developing its systems for monitoring the implementation of actions following root cause analysis investigations. The Trust has now established a central root cause analysis investigation team which has strengthened the arrangements for investigation and reporting within the Trust;
Conducting non-executive director chaired panels of inquiry into the highest level incidents. The reports are reviewed by the Board of Directors, along with the action plans into the recommendations;

The Trust’s Clinical Risk Assessment and Management Policy has been reviewed in the past year, with strengthened timescales, a focus on care planning and risk assessment being linked and immediate risks being entered onto progress notes;

The Trust has invested heavily in addressing potential ligature risks at the Campbell Centre in Milton Keynes. We have removed a large number of potential ligature points from this inpatient facility acquired in April 2013;

The Trust has led a London-wide benchmarking process with all other providers of Mental Health services in the London area into probable suicide over a 3 year period.

### 3.1.2 Clinical Effectiveness

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
<th>Benchmark (where available): National average; and highest and lowest scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Re-admission rates</td>
<td>Clinical system scan</td>
<td>&lt;8.1%</td>
<td>4.5%</td>
<td>5.3%</td>
<td>4.1%</td>
<td>Not available</td>
</tr>
<tr>
<td>a. For patients aged 0 - 14:</td>
<td>a. 0; b. 4.5%</td>
<td>a. 0; b. 5.3%</td>
<td>a. 0; b. 4.1%</td>
<td>Not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. For patients aged 15 or over:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Crisis Resolution Team gate keeping</td>
<td>Clinical system scan</td>
<td>95%</td>
<td>96.2%</td>
<td>99.4%</td>
<td>98%</td>
<td>Not available</td>
</tr>
</tbody>
</table>
### 3. Early Intervention Teams

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
<th>Benchmark (where available): National average; and highest and lowest scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did our Early Intervention Teams meet the commitments (set by commissioners) to serve new psychosis cases? (YTD M12)</td>
<td>Clinical system scan</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>99.5%</td>
<td>Not available</td>
</tr>
</tbody>
</table>

### 4. Mental Health Minimum Data Set (data completeness)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
<th>Benchmark (where available): National Avg: 96.7%; National Max: 100%; National Min: 84.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Identifiers (YTD M12)</td>
<td>Clinical system scan</td>
<td>97%</td>
<td>99.5%</td>
<td>99.1%</td>
<td>99.1%</td>
<td>National Avg: 96.7%; National Max: 100%; National Min: 84.5%</td>
</tr>
<tr>
<td>b. Outcomes (YTD M12)</td>
<td>Clinical system scan</td>
<td>50%</td>
<td>98.1%</td>
<td>97.6%</td>
<td>97.2%</td>
<td>Not available</td>
</tr>
</tbody>
</table>

### 5. Physical health checks

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
<th>Benchmark (where available): Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The percentage of mental health inpatients with physical health assessment after admission (Nursing)** (Q4; n=155)</td>
<td>Internal audit</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>96%</td>
<td>Not available</td>
</tr>
<tr>
<td>b. The percentage of mental health inpatients with physical health assessment after admission (Medical)** (Q4; n=155)</td>
<td>Internal audit</td>
<td>95%</td>
<td>96%</td>
<td>89%</td>
<td>80%</td>
<td>Not available</td>
</tr>
<tr>
<td>c. Patients on CPA report that they got enough advice and support for their physical health # + (YTD M12; n=370)</td>
<td>Patient survey</td>
<td>65%</td>
<td>86%</td>
<td>75%</td>
<td>66%</td>
<td>63%</td>
</tr>
</tbody>
</table>

---

**Note:**
- **YTD M12**: Year to Date as of Month 12
- **Q4**: Quarter 4
- **Nursing**: Nursing Department
- **Medical**: Medical Department
- **CPA**: Care Plan Assessment

---

^ Source: Patient survey 65% 86% 75% 66% 63%
Measure 1 Readmission rates: Readmission rates describe how many patients 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 patients 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 8.1% target at 4.5%. CNWL considers that these percentages are as described for the following reasons: Performance is monitored locally via the Trust’s Business Intelligence Systems (e.g. QIS) which identifies all patients who were re-admitted. The business rules are published and shared across the Trust to ensure that activity is recorded and captured accurately. This indicator is also published monthly via an internal integrated dashboard, which is reported to the Quality and Performance Committee.

CNWL has taken the following actions to improve this number, and so the quality of its services: by undertaking a review of the patients who were re-admitted so that if any themes prevail, appropriate action can be taken to improve the patient pathway. The introduction of the supported discharge protocol last year has embedded this year, which has contributed to improved performance. This measure is closely monitored by the Acute Service Line to ensure that the care pathway is working.

Measure 2 Crisis resolution gate-keeping: Our crisis resolution teams assess patients when they are in crisis to quickly determine if they are suitable for home treatment rather than being admitted to hospital. It is important to treat our patients in the most appropriate settings to ensure their safety and that they receive the effective treatment. We are proud that we have done well on this measure for three years running, achieving 96.2% against our 95% target. CNWL considers that these percentages are as described for the following reasons: Performance is monitored daily via the Trust’s Business Intelligence Systems (e.g. QIS) which identifies all admissions and all associated gate-keeping information. The Crisis Resolution Team policy is published and shared with all staff to support operational delivery of gate-keeping activity and the business rules are published and shared across the Trust to ensure that activity is recorded and captured accurately. 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 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 4 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 population, and so we can plan and re-design services appropriately. We have exceeded our targets again this year for completeness of our outcomes and identifier data set. As these are Trust-level indicators we do not present performance by borough.

Measure 5 Physical health checks (mental health): Measure 5a and b indicate the percent of patients who have received nursing and medical physical health assessment respectively after their admission to a mental health inpatient unit. The results for quarter four indicate that we have marginally missed our nursing physical health assessment target, and achieved our medical health assessment target. Nursing physical health assessments have been achieved in all preceding quarters this year, and will be closely monitored and reported on throughout next year to ensure this is a temporary 'blip'.

Measure 5c asks from a community patient’s point of view, if they feel they have been given enough advice and support for their physical health care needs. We are pleased to report that this measure has demonstrated both a year-on-year and quarter-on-quarter (2013-14) improvement, exceeding the 65% target and 63% national average achieving 86% at year end (for this year, due to low numbers, responses from all surveys throughout the year were aggregated to produce this result). As the Trust works toward further integrating its mental and physical healthcare services, these measures will continue to be monitored and reported on in the Quality Account next year.
## 3.1.3 Patient and Carer Experience

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target 2013/14</th>
<th>Target 2012/13</th>
<th>Target 2011/12</th>
<th>Benchmark (where available): National average; and highest and lowest scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental health delayed transfers of care</td>
<td>Clinical system scan</td>
<td>&lt;7.5%</td>
<td>4.7%</td>
<td>6.3%</td>
<td>3.1% Not available</td>
</tr>
<tr>
<td>On average, what percentage of hospital beds are being used by patients who should have been discharged? (YTD M12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CPA 12 month review</td>
<td>Clinical system scan</td>
<td>95%</td>
<td>96.1%</td>
<td>95.9%</td>
<td>95.6% National Avg: 83% National Max: 99%; National Min: 41%</td>
</tr>
<tr>
<td>What percentage of our patients who are on CPA received a full CPA review within the last 12 months where appropriate? (YTD M12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Care plans</td>
<td>Patient survey</td>
<td>80%</td>
<td>63%</td>
<td>56%</td>
<td>51% 41%^</td>
</tr>
<tr>
<td>a. Community mental health patients report that they had been given/offered a copy of their care plan# (Q4; n=674)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Responsiveness to call bells at St. Pancras</td>
<td>Patient survey</td>
<td>95%</td>
<td>92%</td>
<td>95%</td>
<td>n/a Not available</td>
</tr>
<tr>
<td>Patients rating response to call bells as ‘satisfactory’ or ‘very satisfactory’ at St Pancras Hospital inpatient wing + (Q4; n=211)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Sexual health services waiting times</td>
<td>Internal audit</td>
<td>80%</td>
<td>89%</td>
<td>91%</td>
<td>n/a Not available</td>
</tr>
<tr>
<td>At least 80% of patients with an appointment, who arrive on time, are seen within 30 minutes + (Q4; n=27,866)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Measure 6. Access for people with a learning disability

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
<th>Benchmark (where available): National average; and highest and lowest scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Access for people with a learning disability</td>
<td>Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability (YTD M12)</td>
<td>Internal database</td>
<td>8/8</td>
<td>8/8</td>
<td>7/7</td>
<td>7/7</td>
</tr>
</tbody>
</table>

Key:

^ Source: Quality Health Ltd 2013 NHS community mental health service user survey
# This was a QP for 2011/12
+ This was a QP for 2012/13
“n=” denotes total sample size
“YTD M12” denotes year to date at month 12
“Q4” denotes results at quarter four

Measure 1 Mental health delayed transfers of care: This measure assesses the percentage of inpatient beds that are being used by those who should have been discharged to our partner agencies, but are being delayed. We work closely with our local authority partners to ensure discharge takes place at the right time to ensure patient satisfaction of services and that our beds are kept free for those who most need them. We have seen good performance in this area far achieving our <7.5% target.

Measure 2 CPA 12 month review: This indicator monitors whether those on CPA receive a full CPA review at least annually. This enables service provision to be updated as per the patient’s changing needs to ensure they are receiving the most effective care. We are pleased to report that we continue to achieve our target for this measure.

Measure 3 Care plans: Both 3a and 3b are fundamental to involving and developing a partnership with our mental health patients in their care journey. The first measure is based on patients telling us that they have been offered a copy of their care plan. Based on the Trust’s Improving Involvement Project, much work has gone into developing, together with our patients, new care plan folders, flyers and posters for waiting areas/wards encouraging patients to ask for their care plan. This has resulted in a steady quarter-on-quarter increase for this measure from 51% in quarter one, to 63% in quarter four, exceeding the national average of 41%.

Measure 3b assesses via internal audit the extent to which patients’ care plans contain at least one personal recovery goal. This is a goal set by the patient to encourage and empower them to take a degree of responsibility in the journey towards wellbeing. Last year the target was increased from 50% to 75% for 2013/14. At quarter four this year we achieved 81%, exceeding this new target.
Measure 4 Responsiveness to call bells: At St Pancras Hospital inpatient wing we have a rehabilitation unit for those who are recovering from a stroke, for example. We want to ensure that our service is as responsive as possible to the needs of our patients to ensure their safety and comfort at all times. We assess our patients’ satisfaction with the responsiveness to the call bell system through on-going patient survey. The target of 95% was set as our baseline from our quarter four performance last year. At quarter three we achieved 93% based on 44 responses, only three of which stated responsiveness was ‘poor’. For quarter four a shorter survey will be implemented to encourage a larger response rate, and together with the implementation of a new electronic call bell system, it is hoped this target will be achieved. As this measure has performed consistently well throughout the year it will be monitored internally and not be reported in next year’s Quality Account.

Measure 5 Sexual health services waiting times: Our sexual health services can be very busy dealing with both walk-in patients and those who have booked appointments. This measure is to monitor the waiting times of those who have appointments to ensure that they do not have to wait too long. Due to our booking and ‘check-in on arrival’ processes we have performed well at this measure, consistently achieving the 80% for the last two years. This measure will continue to be monitored and reported on internally.

Measure 6 Access for people with a learning disability: This measure assesses whether those with a learning disability have the same access to care rights as those who do not, to ensure they are not disadvantaged and receiving the care they need. The assessment is by seven questions based on the recommendations set out in ‘Healthcare for All’ (2008), the Independent Inquiry into Access to Healthcare for People with Learning Disabilities. We are proud to report that we achieved the maximum score (seven out of seven) at year end for this measure.
### 3.2 A borough breakdown: Our mental health and allied specialties performance against national priorities and historical quality priorities

The following three tables reflect the data relevant to mental health and allied specialties from sections 3.1.1 – 3.1.3 broken down by borough. Results for indicators for Hillingdon or Camden community (physical) and sexual health services can be found within the main tables from sections 3.1.1 – 3.1.3.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon</th>
<th>Kensington &amp; Chelsea</th>
<th>Westminster</th>
<th>CAMHS</th>
<th>Learning Disabilities</th>
<th>Eating Disorders</th>
<th>Addictions</th>
<th>CNWL-Milton Keynes Services</th>
<th>Trust-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Clinical Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. CPA 7-day follow-up</td>
<td>What percentage of our patients, who are on Care Programme Approach, did we contact within seven days of them leaving the hospital? (YTD M12)</td>
<td>95%</td>
<td>100%</td>
<td>96.9%</td>
<td>99.7%</td>
<td>97.0%</td>
<td>96.5%</td>
<td>100.0%</td>
<td>94.4%</td>
<td>97.4%</td>
<td>n/a</td>
</tr>
<tr>
<td>2. Risk assessment and management</td>
<td>What percentage of mental health inpatients have had a risk assessment completed and linked to their care plans? (Q4; n=157)</td>
<td>95%</td>
<td>90%</td>
<td>100%</td>
<td>89%</td>
<td>100%</td>
<td>80%</td>
<td>87%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>3. Patient safety</td>
<td>Mental health patients reported that they felt safe during their most recent inpatient stay (YTD M12; n=456)</td>
<td>75%</td>
<td>80%</td>
<td>74%</td>
<td>84%</td>
<td>79%</td>
<td>71%</td>
<td>-</td>
<td>-</td>
<td>63%</td>
<td>100%</td>
</tr>
<tr>
<td>4. Access in a crisis</td>
<td>Community mental health patients report that they have a phone number to call in a crisis (Q4; n=718)</td>
<td>65%</td>
<td>79%</td>
<td>78%</td>
<td>83%</td>
<td>83%</td>
<td>76%</td>
<td>56%</td>
<td>-</td>
<td>100%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Key: “-” = Not measured or no response received; n/a = Measure not applicable

“n=” denotes total sample size

“YTD M12” denotes year to date at month 12

“Q4” denotes results at quarter four
<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon</th>
<th>Kensington &amp; Chelsea</th>
<th>Westminster</th>
<th>CAMHS</th>
<th>Learning Disabilities</th>
<th>Eating Disorders</th>
<th>Addictions</th>
<th>CNWL Milton Keynes</th>
<th>Trust-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Clinical Effectiveness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Re-admission rates</td>
<td>What percentage of patients were re-admitted to hospital within 28 days of leaving? (YTD M12)</td>
<td>&gt;8.1%</td>
<td>8.2%</td>
<td>6.7%</td>
<td>3.5%</td>
<td>1.8%</td>
<td>2.5%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>9.2%</td>
</tr>
<tr>
<td>2. Crisis Resolution Team gate keeping</td>
<td>The percentage of patients admitted to acute adult inpatient beds who were assessed as to their eligibility for home treatment prior to admission? (YTD M12)</td>
<td>95%</td>
<td>99.0%</td>
<td>99.5%</td>
<td>99.4%</td>
<td>100.0%</td>
<td>99.8%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>82.6%</td>
</tr>
<tr>
<td>3. Early Intervention Teams</td>
<td>Did our Early Intervention Teams meet the commitments (set by commissioners) to serve new psychosis cases? (YTD 12)</td>
<td>95%</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>No*</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>yes</td>
</tr>
<tr>
<td>4. Mental health physical health checks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Inpatients with physical health assessment after admission (Nursing; Q4; n=155)</td>
<td>95%</td>
<td>100%</td>
<td>95%</td>
<td>89%</td>
<td>88%</td>
<td>83%</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>n/a</td>
<td>94%</td>
</tr>
<tr>
<td>b. Inpatients with physical health assessment after admission (Medical; Q4; n=155)</td>
<td>95%</td>
<td>80%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>n/a</td>
<td>96%</td>
</tr>
<tr>
<td>c. Patients on CPA report that they got enough advice and support for their physical health (YTD M12; n=370)</td>
<td>65%</td>
<td>84%</td>
<td>85%</td>
<td>81%</td>
<td>83%</td>
<td>93%</td>
<td>0%</td>
<td>-</td>
<td>71%</td>
<td>100%</td>
<td>n/a</td>
<td>86%</td>
</tr>
</tbody>
</table>

Key: "": Not measured or no response received; n/a: Measure not applicable
* Although we are meeting this target as a Trust, commissioners have not updated the targets for Westminster and K&C since part of Westminster population migrated to K&C, making Westminster appear as though it is underachieving. This will be rectified in the final version of the Quality Account.

“n=“ denotes total sample size
“YTD M12“ denotes year to date at month 12
### c. Patient and Carer Experience

<table>
<thead>
<tr>
<th>Measure</th>
<th>Brent</th>
<th>Harrow</th>
<th>Hillingdon</th>
<th>Kensington &amp; Chelsea</th>
<th>Westminster</th>
<th>CAMHS</th>
<th>Learning Disabilities</th>
<th>Eating Disorders</th>
<th>Addictions</th>
<th>CNWL Milton Keynes Services</th>
<th>Trust-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Delayed transfers of care</td>
<td>&lt;7.5%</td>
<td>5.6%</td>
<td>3.2%</td>
<td>4.4%</td>
<td>4.1%</td>
<td>6.9%</td>
<td>n/a</td>
<td>15.7%</td>
<td>n/a</td>
<td>n/a</td>
<td>0.0%</td>
</tr>
<tr>
<td>2. CPA 12 month review</td>
<td>95%</td>
<td>98.3%</td>
<td>97.5%</td>
<td>96.4%</td>
<td>97.4%</td>
<td>96.8%</td>
<td>100%</td>
<td>86%</td>
<td>93.8%</td>
<td>n/a</td>
<td>95.7%</td>
</tr>
<tr>
<td>3. Care plans</td>
<td>80%</td>
<td>66%</td>
<td>64%</td>
<td>62%</td>
<td>51%</td>
<td>67%</td>
<td>22%</td>
<td>-</td>
<td>50%</td>
<td>66%</td>
<td>n/a</td>
</tr>
<tr>
<td>a. Mental health community patients report that they had been given/offered a copy of their care plan (Q4; n=674)</td>
<td>75%</td>
<td>90%</td>
<td>78%</td>
<td>94%</td>
<td>81%</td>
<td>65%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>n/a</td>
</tr>
<tr>
<td>b. We record patients on CPA whose care plans contain at least one personal recovery goal (Q4; n=211)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key: "-": Not measured or no response received; n/a: Measure not applicable

"n=": Total sample size

"YTD M12" denotes year to date at month 12

"Q4" denotes results at quarter four
3.3. 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.

One of our key measures of workforce feedback is via the annual national staff survey. We are pleased to report that in the 2013 survey we are showing steady progress in improving staff experience with overall staff engagement continuing to remain in the highest (best) 20% when compared with Trusts of a similar type.

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>CNWL performance 2013</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>3.79 / 5</td>
<td>3.75 / 5</td>
<td>3.55 / 5</td>
<td>4.04 / 5</td>
</tr>
<tr>
<td>Staff motivation at work</td>
<td>3.96 / 5</td>
<td>3.88 / 5</td>
<td>3.85 / 5</td>
<td>4.01 / 5</td>
</tr>
<tr>
<td>Staff feeling satisfied with the quality of work and patient care they were able to deliver</td>
<td>81%</td>
<td>81%</td>
<td>77%</td>
<td>83%</td>
</tr>
<tr>
<td>Staff job satisfaction</td>
<td>3.75 / 5</td>
<td>3.64 / 5</td>
<td>3.67 / 5</td>
<td>3.85 / 5</td>
</tr>
<tr>
<td>Staff agreeing their role makes a difference to patients</td>
<td>92%</td>
<td>92%</td>
<td>90%</td>
<td>93%</td>
</tr>
<tr>
<td>Staff having well structured appraisal</td>
<td>49%</td>
<td>51%</td>
<td>42%</td>
<td>55%</td>
</tr>
<tr>
<td>Staff suffering work related stress</td>
<td>36%</td>
<td>43%</td>
<td>43%</td>
<td>36%</td>
</tr>
<tr>
<td>Staff reporting good communication between senior management and staff</td>
<td>40%</td>
<td>37%</td>
<td>31%</td>
<td>49%</td>
</tr>
<tr>
<td>Work pressure felt by staff</td>
<td>2.93 / 5</td>
<td>2.98 / 5</td>
<td>3.07 / 5</td>
<td>2.80 / 5</td>
</tr>
<tr>
<td>Effective team working</td>
<td>3.92 / 5</td>
<td>3.89 / 5</td>
<td>3.83 / 5</td>
<td>4.02 / 5</td>
</tr>
<tr>
<td>Fairness and effectiveness of reporting procedures</td>
<td>3.62 / 5</td>
<td>3.60 / 5</td>
<td>3.52 / 5</td>
<td>3.71 / 5</td>
</tr>
</tbody>
</table>

*With regards to staff recommending the Trust to work or receive treatment, CNWL considers that this score is as described for the following reasons:
There is continued 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 other senior staff 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.

We have followed through on our commitment to build upon our values with staff and test these with our patients and public. Over half our workforce report that they have a good understanding of CNWL values and recognise the values in day to life at CNWL.

We recognise that we need a culture of care that permeates every level of our organisation, and have aligned our HR mechanisms such as recruitment and selection, induction, supervision and appraisal to reinforce our standards, values and commitment to quality patient care at each stage of the employees’ journey through the organisation.

We want to retain and attract the highest quality of staff and to invest in their continued development and provide them with support through appraisal and supervision and access to opportunities for training and personal development.

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

We recognise that there is still further work to do and will continue to build our value base with our staff and test these with our staff and patients. At each stage of the employee journey we will test out the standards of behaviour that we expect aligned to our values so that we have a compassionate and caring workforce.

Assessment centres are now a key element of the recruitment process for band 5 nurses across the trust. Work is taking place to extend this to other roles. We have also introduced values based recruitment in some services and are planning to extend this across the Trust. This year we have rolled out a new appraisal system which links performance and staff development and we will continue to ensure that all staff receive an annual appraisal and have access to training opportunities as part of their development.

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 will review our equality objectives and ensure that we tackle staff perceptions of equality of opportunity and discrimination. The number of staff attending equality and diversity training has improved significantly and we will continue to target this training so that all staff are clear about standards of behaviour expected.

Whilst it is good to understand where staff’s 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 2014 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 committee.

Turnover has slightly increased this year, which would be expected in a year of transition, both with Milton Keynes joining the organisation, and with a number of changes in the way services are delivered. We monitor the position closely and take action to address any particular areas of concern.

There has been a focus on reducing the number of days lost to sickness absence this year, as we see this as an important way to improve the quality of service and reduce costs. It will continue to be a focus of activity in the coming year. The results of average staff turnover and sickness are displayed in the table below:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff turnover (excluding Milton Keynes) The number of staff leaving as a percentage of total staff</td>
<td>Year on year improvement</td>
<td>15.9%</td>
<td>14.6%</td>
<td>14.5%</td>
</tr>
<tr>
<td>Staff turnover (Milton Keynes only)</td>
<td>Year on year improvement</td>
<td>16.4%</td>
<td>15.2%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Average sickness per employee (excluding Milton Keynes to M11) The time lost to sickness per employee as a percentage of total time available</td>
<td>Year on year improvement</td>
<td>3.32%</td>
<td>3.6%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Average sickness per employee (Milton Keynes only to M10)</td>
<td>Year on year improvement</td>
<td>4.08%</td>
<td>4.5%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>
Patient experience

We proactively seek the views and feedback of our patients’ experience of services we provide in a multiple of ways on an on-going basis. For example, in our quick feedback cards in our sexual health services, monthly telephone surveys in our mental health and community services (run by trained patients), further annual surveys in our community (physical) health services, paper-based questionnaires in our older people and healthy aging services, and through actively consulting with our patients in Milton Keynes community services regarding the focus of their annual Patient Campaigns. We also engage with patients through local forums throughout our boroughs, for example, the Brent User Group and User Focus Monitoring in Kensington and Chelsea.

We closely monitor the results of our national patient surveys, benchmarking ourselves nationally to understand how we compare against similar Trusts and where action is needed.

CNWL is linked in with all its local Healthwatch organisations, who champion the needs of children, young people and adults, meeting with them on a quarterly basis; to together review performance and share feedback and learn lessons.

This feedback is highly valued and enables us to take action where we know it will make the most difference to our patients.

The table below presents the results for patient experience of community mental health services with regard to a patient’s experience of contact with a health or social care worker during the reporting period. The table includes the results from the National Community Mental Health Patient Survey for 2011 to 2013, and data relates to the NHS healthcare worker or social care worker the patients had seen most recently:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2013** CNWL</th>
<th>2012^ CNWL</th>
<th>2011^ CNWL</th>
<th>2013^ National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did this person listen carefully to you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes definitely</td>
<td>74%</td>
<td>81%</td>
<td>76%</td>
<td>78%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>21%</td>
<td>16%</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td>No</td>
<td>5%</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>
<td></td>
</tr>
<tr>
<td>Yes definitely</td>
<td>67%</td>
<td>73%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>28%</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>No</td>
<td>5%</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>
<td></td>
</tr>
<tr>
<td>Yes definitely</td>
<td>63%</td>
<td>70%</td>
<td>70%</td>
<td>69%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>28%</td>
<td>25%</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>No</td>
<td>9%</td>
<td>4%</td>
<td>5%</td>
<td>8%</td>
</tr>
<tr>
<td>Did this person treat you with respect and dignity?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes definitely</td>
<td>84%</td>
<td>88%</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>13%</td>
<td>10%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>No</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Were you given enough time to discuss your care and treatment?

<table>
<thead>
<tr>
<th></th>
<th>2013** CNWL</th>
<th>2012^ CNWL</th>
<th>2011^ CNWL</th>
<th>2013^ National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes definitely</td>
<td>67%</td>
<td>76%</td>
<td>72%</td>
<td>70%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>24%</td>
<td>20%</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>No</td>
<td>9%</td>
<td>3%</td>
<td>7%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Overall how would you rate the care you have received from Mental Health Services in the last 12 months?

<table>
<thead>
<tr>
<th>Rating</th>
<th>2013** CNWL</th>
<th>2012^ CNWL</th>
<th>2011^ CNWL</th>
<th>2013^ National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – I had a very poor experience</td>
<td>2%</td>
<td>N/A</td>
<td>N/A</td>
<td>2%</td>
</tr>
<tr>
<td>1</td>
<td>2%</td>
<td>N/A</td>
<td>N/A</td>
<td>2%</td>
</tr>
<tr>
<td>2</td>
<td>1%</td>
<td>N/A</td>
<td>N/A</td>
<td>3%</td>
</tr>
<tr>
<td>3</td>
<td>6%</td>
<td>N/A</td>
<td>N/A</td>
<td>4%</td>
</tr>
<tr>
<td>4</td>
<td>4%</td>
<td>N/A</td>
<td>N/A</td>
<td>4%</td>
</tr>
<tr>
<td>5</td>
<td>15%</td>
<td>N/A</td>
<td>N/A</td>
<td>10%</td>
</tr>
<tr>
<td>6</td>
<td>8%</td>
<td>N/A</td>
<td>N/A</td>
<td>8%</td>
</tr>
<tr>
<td>7</td>
<td>16%</td>
<td>N/A</td>
<td>N/A</td>
<td>14%</td>
</tr>
<tr>
<td>8</td>
<td>18%</td>
<td>N/A</td>
<td>N/A</td>
<td>20%</td>
</tr>
<tr>
<td>9</td>
<td>12%</td>
<td>N/A</td>
<td>N/A</td>
<td>15%</td>
</tr>
<tr>
<td>10 – I had a very good experience</td>
<td>15%</td>
<td>N/A</td>
<td>N/A</td>
<td>18%</td>
</tr>
</tbody>
</table>

Key:

^ National averages as supplied by Quality Health Ltd, who conduct the survey for the Trust and 85% of all mental health Trusts in England

** CNWL results incorporating the results from Milton Keynes community mental health survey, supplied by Quality Health Ltd.

N/A The response set for the ‘overall rating measure of services’ measure was changed in the 2013 national survey from “Very Poor” to “Excellent” on a 0-10 point scale. In 2011 and 2012, this was reported as ‘Excellent’ to ‘Very poor’ on a 6 point scale, and so comparisons are not directly possible. The 2014 community mental health survey will continue to use the 10 point scale.

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. However despite the improvement in 2012 from all the initiatives undertaken, the scores that CNWL achieved in the 2013 national survey were universally poorer than in 2012. This has driven the Trust to pay even more attention to the practice of clinicians involving patients in developing their care packages and nurturing the professional relationships that they have with their patients. Despite this, our internal monthly surveys result tell us that increasingly over the year patients have reported feeling ‘definitely’ involved in decisions about their care and treatment.

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

- Reinforcing patient involvement is a clear priority for the Trust with an overarching strategy and local implementation targets. This has involved the establishment of a high level Board with Executive Director lead, working in partnership with patients to develop documentation information and training materials, to embed good practice in personalised care planning and implementation, and monitor the feedback from patients of their experiences of services.
Conducting regular monthly telephone surveys of patients attending community and inpatient adult mental health, addictions, and eating disorders services, using a team of trained patients, to address issues of involvement and the overall level of satisfaction with services. This is now conducted using real-time feedback software so that services can access results immediately and develop action plans to address any areas of concern.

Continuing to ensure that CPA is conducted to the highest standards through refresher training.

Establishing patient participation at management level within service lines to scrutinize and monitor the results of patient and carer feedback, with feedback to the Trust Board.

Further developing new courses within the Recovery College, as suggested through patient feedback.

Finally, two key issues which will have direct impact on these scores next year have been selected as our Quality Account Priorities for 2014-15 for special focus and improvement, namely, ‘helping our patients recover by involving them in decisions about their care’, and ‘a competent and compassionate workforce’.

Whilst participation in a national patient survey is not mandatory for community physical healthcare services our Hillingdon, Camden and Milton Keynes services have conducted an annual patient survey which highlights very positive results. The Hillingdon and Camden services also conduct monthly telephone surveys run by the team of mental health patients. Milton Keynes services also conduct regular surveys of their patient experiences. This together with our Quality Account Priorities strongly reflect CNWL’s continued commitment to understanding and acting upon what we hear from our patients and carers.

Complaints

Complaints feedback provides the Trust with a valuable source of information to support learning at both a local and organisational level. We value the feedback we receive from our service users and carers and ensure that formal complaints are acknowledged, investigated and responded to in a timely manner, whilst ensuring that appropriate action is taken where required.

During 2013-14 536 formal complaints were made across the Trust. As of 30 April 2014 491 (92%) of these formal complaints had been investigated and responded to. The remaining complaints have a response which is being finalised, or remain under investigation.

During 2013-14 the Trust has improved its performance in its response timescales. This has been achieved through increased support to operational services from the central complaints teams as well as strengthening the arrangements for monitoring performance.

13% of all formal complaints were fully upheld and 33% were partially upheld during the 2013-14 reporting period, with four (0.7%) complaints referred to the Parliamentary and Health Service Ombudsman. Learning from complaints is driven by the Trust’s Complaints, Claims and PALS group which reports to the Organisational Learning group. Common themes identified are used to inform the Trust’s Organisational Learning report and action plan which will be presented to the Trust Board later this year.
The Trust has provided information on complaints received during the year to the Department of Health, in line with Regulation 18 of the Local Authority Social Services and NHS Complaints (England) Regulations 2009.

**Equalities and Diversity**

CNWL is well placed to demonstrate innovation in its responses to the equality and diversity agenda, and we see this report as an opportunity to not simply showcase what we are doing, but also to offer ideas for others.

Some of the highlights of 2013-14 have been the 4\textsuperscript{th} annual Trust – wide Faith and Spirituality Conference which this year included a focus on compassion, one of the Trust’s core values. Understanding what this means, informed by different spiritual traditions, has been an important initiative within the Trust. Compassion lies at the heart of good, humane and effective healthcare delivery.

During the past year over 9,500 face-to-face interpreting sessions have been provided for Trust patients and carers in over 60 languages. Ensuring the availability of quality and experience in interpreting provision is a crucial factor in delivering effective healthcare for many of our patients. This year has seen significant expansion of the Trust’s in-house Interpreting Service which now supplies the majority of our face-to-face interpreting requirements and it also offers a specialist health and social care interpreting service to other NHS organisations in London.

The Trust continues to work in achieving its five four-year Equality Objectives, as agreed in 2012 by the Trust Board of Directors. These can be accessed at \url{www.cnwl.nhs.uk/about-cnwl/equality-and-diversity/documents/}. Particular progress has been made in improving the monitoring of patients by three equality protected characteristics – religion, sexual orientation and disability.

In January 2014, the Trust published its third 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. This report showcases some great practice as well. By bringing this information together into a single document, it helps us to provide a cohesive overview of Trust commitment to equality, diversity and inclusion. The report is available at: \url{www.cnwl.nhs.uk/about-cnwl/vision-values/equality-and-diversity/documents/#complianceReports}

Stonewell, Europe’s biggest lesbian, gay and bisexual charity, praised the Trust for its efforts and cited its practice of delivering LGBT equality and awareness training. Each year it rates those employers it feels are the most gay-friendly and, in January 2014, CNWL was ranked as the 23\textsuperscript{rd} best employer overall, while being the 3\textsuperscript{rd} best NHS organisation in their Top 100. Organisations are required to not only explain what they do to improve their workplace for lesbian, gay and bisexual staff, but also to demonstrate how that has had a real and lasting impact on their organisation. As part of the submission, Stonewall asked lesbian, gay and bisexual CNWL employees to complete a confidential survey rating CNWL’s performance in LGB related matters. 92\% of respondents rated ‘the workplace culture in my organisation inclusive of lesbian, gay and bisexual (LGB) people’ and 98\% reported that ‘senior management were supportive of LGB staff’. All the CNWL employee feedback scores were significantly higher than the average Index entries.
Stonewall also coordinates a Healthcare Equality Index, open to all providers or commissioners of healthcare in the UK (whether NHS, private or third sector) looking at how ‘gay friendly’ the organisation is towards lesbian, gay and bisexual (LGB) patients. In March 2014 CNWL was awarded the top place within the Index. Stonewall praised a number of the specialist services that CNWL runs to target LGB communities and patients and also our efforts to improve the monitoring of patients by sexual orientation - one of the Trust’s Equality Objectives. Within adult mental health services the collection of sexual orientation data for new patients has increased from 37% collection (the 2010 baseline) to 65% collection in 2014. Child and Adolescent Mental Health Services (CAMHS), who are collecting this data from patients over the age of 13, have increased collection from 15% to 32% in the same period. Addictions Services show a 32% to 71% improvement and services within the Older People Healthy Ageing directorate are managing 98% collection, silencing critics who say that you cannot ask older people to define their sexual orientation.

In May 2014 we plan to publish a document to show how we are progressing against all of the Trust’s Five Equality Objectives, including further actions that have been identified.
Annex 1 – Quality Account glossary of terms

ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CNWL-MK</td>
<td>Central and North West London - Milton Keynes healthcare services</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>ED</td>
<td>Eating Disorders (service line)</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HONOSCA</td>
<td>Health of the Nation Outcome Scales (Child and Adolescent)</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disability (service line)</td>
</tr>
<tr>
<td>LPC</td>
<td>Lead Professional Care</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>OSC</td>
<td>Overview and Scrutiny Committee</td>
</tr>
<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
</tr>
<tr>
<td>POMH</td>
<td>Prescribing Observatory for Mental Health</td>
</tr>
</tbody>
</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.

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

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

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

Clinical/Specialist Care Plans
Clinical/specialist care plans give the detailed procedure for each service identified as being appropriate to support the patient within their overall CPA care plan.

Crisis Plan
A crisis plan is included within the CPA care plan. It sets out the action to be taken if the patient 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 patients and carers wherever possible.

Carer
A carer is someone who provides regular and substantial assistance/support to a patient. 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.

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

Service User
The term “service user” refers to those people receiving treatment and care.
Annex 2 – Statements provided by our commissioners, Overview and Scrutiny Committees (OSCs) and Healthwatch

Our commissioners
NHS Camden Clinical Commissioning Group
NHS Camden Clinical Commissioning Group is the lead commissioner for the commissioning of the Community Provider Service (community and sexual health services) from Central North West London NHS Foundation Trust on behalf of the population of Camden and associated commissioners.

NHS Camden Clinical Commissioning Group welcomes the opportunity to provide this statement on Central North West London NHS Foundation Trust’s Quality Account. We confirm that we have reviewed the information contained within the Account and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and confirm its accuracy in relation to the services provided.

We have reviewed the content of the Account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. Whilst we believe that the Account represents a fair and balanced overview of the quality of care at Central North West London NHS Foundation Trust, as lead commissioners of the Community Provider Services we would have welcomed a greater emphasis on community services in the Quality Account.

We have been given the opportunity to discuss the development of priorities taken forward in this Quality Account with Central North West London NHS Foundation Trust over the year and have been able to contribute our views on content and quality priorities for 2014/15.

We have taken particular account of the identified priorities for improvement for
1. Helping patients to recover by involving them in their care or treatment,
2. Supporting carers to look after their loved ones and
3. A competent and compassionate workforce
And how this work will enable real focus on improving the quality and safety of health services for the population they serve.

Overall we welcome the vision described within the Quality Account, agree on the priority areas and will continue to work with Central North West London NHS Foundation Trust to continually improve the quality of services provided to patients.

[Insert NWL Clinical Commissioning Group]

Our local Healthwatch
Healthwatch Central West London

Healthwatch Central West London (Healthwatch CWL) appreciates our working relationship with the Central & North West London NHS Foundation Trust. We recognise the priority areas for improvement and welcome the initiatives being undertaken to enhance quality in Kensington & Chelsea and Westminster.

We are pleased to have engaged with the trust this year via their quarterly quality account meetings, their stakeholder event, PLACE visits, the CNWL Council of Governor public meetings and our busy monthly Kensington, Chelsea and Westminster partnership meetings.

We are however most disappointed about the poor Care Quality Commission reports for Beatrice Place and St Charles. We have had sight of the detailed action plans to address the problems and will monitor the situation including via direct contact with CQC officials. As with our statements in previous years, we continue to be dismayed with the nature of the data provided and the trust performance on patient involvement, carers and satisfaction with services.

As Healthwatch is commenting on a draft account (v5), our local patients, carers and citizens look forward to seeing a much more user friendly version at the time of publication. A stakeholder steering group to test accessibility prior to finalisation would be helpful.

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

Whilst we welcome the various initiatives that CNWL has undertaken in the last year, we are concerned about the continued poor performance on providing patients with a copy their care plan (51% in K&C and 67% in Westminster). Local performance continues to be significantly below the 80% trust wide target and performance in other CNWL boroughs. Given this poor performance, the trust needs to highlight the service lines that are underperforming in this area.

Additional recent research carried out by Healthwatch CWL on local care planning with inpatient and community patients found only 51% of respondents felt they had jointly created care plans with staff. Further only 50% of respondents stated family, advocate or keyworkers were involved in care planning. When we couple this research with local poor performance on the inclusion of recovery goals in care planning and on risk assessments (80% in Westminster when target is 95%), Healthwatch is most concerned that the quality of care planning in K&C and Westminster is also lacking and the potential impact on personalisation and recovery. Healthwatch CWL would welcome the opportunity to work with CNWL to improve this area.

Priority 2: Supporting carers look after their loved ones

We commend the trust efforts to work in partnership with various carer groups to drive up improvements in this area. However, Healthwatch understands feedback from people who have actually used the urgent advice line is increasingly negative. As stated previously, accessing services in a crisis and out of hours, particularly if you are someone experiencing a first episode...
and not a CNWL client, is too difficult. People can no longer access a walk in service at South Kensington or Chelsea Mental Health Centre, at St Charles nor at the Gordon. Changing service lines, pathways and points of access is confusing for people.

We would like to know how performance in these key areas raised by carers will be monitored, including the accessibility of the urgent centre line and how helpful the initiatives are for carers and patients.

Additionally, we’ve had a number of complaints from carers about their needs not being listened to and not being informed as next of kin e.g. when someone is sectioned. The quality account should detail how these concerns will be addressed, and how carer’s involvement and satisfaction will be monitored.

The introduction of a carer’s council and local mechanisms, particularly by the CNWL community recovery service line, and new developments from the third sector in conjunction with our local authority are positive. It is important to also consider the sizable percentage of patients who may also be carers and how this might be impacting on their own welfare and how this is included in care planning. We would like the quality account to state how these patients will be identified and what additional support will be provided for this patient group.

Complaints:
We are pleased to see the trust has improved on its performance in responding to complaints in a timely manner. However, we would like further information on complaints including serious incidents and never events. This data should note performance, monitoring methods, recurring themes and how trends are being addressed leading to outcomes. Healthwatch would hope to work with the trust more closely on this area next year.

Priority 3: A caring and compassionate workforce
Staffing is a crucial area directly impacting on patient experience and requires significant attention locally. The introduction of formal peer support workers has been a very useful addition. However, peer support to assist patients to develop person centred care plans is still under developed and at an early stage.

Physical health and safety:
Healthwatch would welcome further improvement on support for physical health among mental health patients. Healthwatch CWL is very disappointed to note 21% of patients in K&C and 29% in Westminster do not feel safe in inpatient services. Further detail is needed in the quality account to explain the difference in performance on nursing and medical health assessments post admission. Do these assessments also include side effects of medication? We understand physical health is being proposed as priority for 2015-6; in the meantime we would like to see a much closer working relationship between CNWL and Central London Community Healthcare NHS Trust, as our local physical community health provider, to ensure integrated care planning and support.
In previous years, we have also flagged concerns over the availability of crisis cards. Although local performance is above the trust average, it is still most worrying that 17% of community patients in K&C and 24% in Westminster do not have a phone number to call in a crisis. Healthwatch CWL believes all patients should have access to this vital information and a target of 65% is disappointingly low.

**Going forward:**
Shifting settings of care, stepping up and down, personalisation, co-production and recovery focused service delivery are key areas moving forward. In accordance with shifting settings of care, primary care liaison nurses (PCLN's) are not mentioned in this document. Although personalisation is mentioned, we would like the quality account to provide details on how the trust is delivering services according to these principles especially patient control and choice over services received. The central feature of personalisation according to policy is that of a "transfer of power from the service provider to the service user". We would like future quality accounts to also focus on improved coordination with adult social care and community services particularly when a patient is being discharged from inpatient care into the community.

In summary, we would like to continue our working relationship with Central & North West London NHS Foundation Trust and work together to achieve person centred care in line with the modernisation agenda. We will of course also be working closely with the Clinical Commissioning Groups to co-produce what is commissioned with our money. As the vast majority of issues raised this year have been flagged previously with the trust, we hope that by working together progress can be made on all issues raised in this coming year.

**Healthwatch Harrow**

Healthwatch Harrow welcomes the opportunity to comment on the Central and North West London NHS Foundation Trust (CNWL) Quality Accounts (QAs) 2013/14. We are pleased to have had the opportunity to engage with the Trust on a number of issues in our first year. Our comments on the CNWL draft Quality are a combination of views from members of our Delivery Board who have user involvement knowledge.

CNWL – report reference 2.1.3 (page 25) provides a Borough breakdown of performance e.g. Harrow 90% of patients in mental health have been offered a copy/given a copy of their care plan. Points to note

a) Although the report indicates the number of respondents has been low CNWL have not stated the exact number of Harrow respondents
b) The report does not appear to reflect an accurate representation of mental health service users in Harrow with relatively small sample sizes of patients, e.g. around 40 Harrow CNWL patients relative to total of around 1,000 patients.
c) The data analysis is confusing and misleading. The data analysis is over a long period of time and is unclear how it connects across different themes e.g. p.41 ‘risk and assessment’ is a QP for 2009/10 only

d) The CNWL report percentages contradict the survey findings of the Harrow User Group Review of NHS mental health service report 2013/14 report

For example in the CNWL Quality Account:

- The report states that 64% of community patients report that they were involved as much as they wanted to be in decisions about their care plans (definitely)
- In Harrow 90% of patients in mental health have been offered a copy/given a copy of their care plan

Mind in Harrow survey findings of the Harrow User Group Review:

- From 83 responses, 65% reported that their expectations for help from mental health services were hardly, partly or not met by their care plans.
- From 81 participant responses, 66% thought their social care needs were partly, hardly or not covered in their care plans.
- From 105 responses, 58% responded that their treatment and discharge plans were partly, hardly or not discussed at all with them.
- From 84 responses that 32% have never received a copy of their care plan. (N.B. Ten of these respondents were not sure if they had a Care plan). 19% had to wait between two months or longer.

Mind in Harrow survey findings of the Harrow User Group Review:

Example Service User comments related to Care Programme Approach CPA (2013):

“CPA is challenging, intimidating and overwhelming”

“It’s also about being timid, when you are just coming out of primary care/time of distress you are extremely vulnerable and people in CPA seem to forget that. That one needs space to be expressive.”

“CPA should not be tick-box exercise”

“Before discussions begin, the CPA team should be aware of what things are available to clients so they can signpost with ease. Have knowledge of some services at hand that could be accessed by client. Personal budget things for example: what is available to people and how to use it is not widely discussed or available yet.”

Healthwatch Hillingdon

Introduction:

Healthwatch Hillingdon is qualified to respond to the Central and North West London NHS Foundation Trust (CNWL) Quality Account 2013-2014, due to our continuing involvement with CNWL in this and the previous year’s quality accounts programme.
Healthwatch Hillingdon wish to thank CNWL for the opportunity to comment on the Trust's Quality Accounts (QA) for the year 2013-2014 and thank CNWL for the way that they have continued to closely involve Healthwatch Hillingdon in the monitoring of quality, previous priorities and the setting of this year's priorities.

Quality Account:
We would like to acknowledge CNWL's commitment to improve their quality account through a continuous learning process. This approach is evident by the way in which CNWL have responded to the recommendations made by Healthwatch Hillingdon in last year's quality account and we welcome these actions.

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 more efforts are still needed by all Trusts to make quality accounts more concise and understandable to the general public.

In last year's response Healthwatch Hillingdon highlighted that it would like to see improvements 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 are disappointed that further progress in this area has not been forthcoming. The reporting of accumulative trust wide results does not give a true reflection of the quality in each area and we would again recommend that CNWL looks at how it will approach Quality Accounts reporting in the future. Due to this limitation in the CNWL's Quality Account, Healthwatch Hillingdon are therefore not in a position to comment on the quality of services provided to the residents of the London Borough of Hillingdon based on the published information.

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

Healthwatch Milton Keynes

We welcome our early involvement in considering CNWL’s Quality Accounts for 2013/14 and the offer- from the local Milton Keynes management team- to engage with us on a quarterly basis going forward to review performance against targets. We believe that local engagement is crucial as we champion the views of local people.

Although we are aware that the Trust has a wide range of contracts held with many commissioners, we continue to feel that for Milton Keynes we would like to see more emphasis on monitoring targets at a Milton Keynes level rather than simply as part of a much wider and indistinguishable geographical area as this tends to lose focus on specific issues most pertinent to local services.
We also feel that patient engagement needs to be held in Milton Keynes not simply in London in order to maximise the opportunities for local patients to raise issues in local forums - and we have welcomed the positive response to our requests for this.

We welcome the plans to remedy outstanding compliance issues at the Campbell Centre as we recognise the importance of this from the patients’ point of view and look forward to seeing the effects of these improvements. The general quality and availability of mental health services locally remains a priority and we look forward to acting in the capacity of “critical friend” to ensure the highest quality service provision by the Trust in Milton Keynes.

The importance of transferring care safely from inpatient facilities is a matter of concern - for all Trusts- and one upon which we would welcome continued emphasis and focus by CNWL. Effective transfer of care depends on good communication both between professionals and with service users and we look forward to seeing a continuing focus on this and hearing of improvements in these areas.  

We wish to develop an effective relationship with the Trust and welcome the constructive discussions to date with the local team in Milton Keynes. We look forward to sharing information with the Trust to enable it to address concerns expressed to us by local members of the public and to seeing improvements in response to these concerns.

Our Overview and Scrutiny Committees

Hillingdon External Services Scrutiny Committee

The External Services Scrutiny Committee welcomes the opportunity to comment on the Trust’s 2013/2014 Quality Account and acknowledges the Trust’s commitment to attend its meetings when requested throughout the year. The Committee also applauds the Workshop event held at the beginning of March 2014 which sought feedback on the suggested quality priorities for the Trust over the forthcoming year. This session proved so useful that Members are keen to encourage other Trusts to undertake similar events in future.

Although it is understood that the format and content of the Quality Report is largely predetermined, the Committee believes that it would benefit from a simpler configuration and supports the move to producing an easy read, Hillingdon specific summary and the decision to not reproduce the final version into a fully designed and printed document.

The Trust's five Quality Account priorities during 2013/2014 were:
1. Helping our patients to recover by involving them in the decisions about their care;
2. Supporting carers to look after their loved ones;
3. Making sure people who use our services get the best care we can provide;
4. Safe transfer of care;
5. Reducing the harm of pressure ulcers.
Although overall performance with regard to care plans achieved 93% during the year (narrowly missing the 95% target), this target is a measure of the number of mental health patients that have been offered or given a copy of their care plan and the number of community physical health patients that have agreed a care plan. The Committee has some concerns that, when these two groups are separated, mental health achieved 82% (failing to reach the target by 13%), whilst physical community services achieved 96%. In line with this, 71% of those using the mental health services stated that they were 'definitely' involved as much as they wanted to be in their care planning. Although CNWL should be congratulated for surpassing the 65% target for the first time since it was introduced in 2011/2012, further improvements are likely to arise by increasing the number of patients that are provided with a copy of their care plan. The Committee is pleased that this measure will continue to be a priority for the forthcoming year.

Whilst it is acknowledged that CAMHS has performed well with regards to the Quality Account priority measures during 2013/2014, the Committee continues to have concerns regarding the quality of the service user experience.

In relation to both Adult Mental Health and CAMHS, LBH has requested that CNWL review their offer in order to better align with expectations; much has been done though there remain areas of disconnect which require addressing. These areas include engagement with the local authority on strategies related to supported living and another would be effective and timely liaison with council housing services when working with people whose behaviours may present concerns to other residents and or cause a risk to themselves.

Hillingdon Council has been working with CNWL very closely in order to maximise outcomes for residents. On one level, this has been in relation to optimising value from the contractual arrangement(s) with them and then, more significantly, about some of the clinical and care pathways.

Hillingdon very much has the approach of early intervention and prevention and of supporting people in the community through safe risk management which will read across different departments in order to present a single council approach. A good example of this is the Council’s approach to antisocial behaviour or tenancy support. However, in this area of work, Council staff have reported some poor experiences of CNWL mental health services at an operational level and it is felt that these warrant further consideration by the Trust. These concerns relate to a number of cases involving Council tenants and the willingness of CNWL to engage with Council staff to bring about satisfactory outcomes in the management of challenging behaviours. In some cases, the follow up care provided by CNWL has led to further issues for the patients and other tenants. The Council also has some concerns about the number of suicides among patients known to CNWL. These potential concerns relating to adult mental health services are being addressed with Hillingdon CCG by Hillingdon Council’s Public Health Service.

It is noted that the Trust has developed five key areas for improvement in 2014/2015 on which the following draft Quality Account Priorities for 2014/2015 have been based:
• Improving patient user experience;
• Improving involvement in care/treatment planning;
• Supporting carers to look after their loved ones;
• A competent and compassionate workforce;
• Integrated physical and mental healthcare.

Involving patients in their care planning and the provision of support to carers have been deemed important enough to again be included in this year’s priorities. The Committee welcomes this move and looks forward to seeing improvements over the next year.

RBKC and WCC Overview and Scrutiny Committee (joint statement)

Introduction:
We welcome the opportunity to comment on the Central and North West London NHS Foundation Trust’s Quality Account 2013/2014. Our respective Councils have a good working relationship with CNWL. We recognise that improvements have taken place in many areas however issues in some areas still need to be addressed.

CQC and Monitor:
We were disappointed CQC Reviews of Compliance included: (1) 3 Beatrice Place being inspected twice during 2013/14. Compliance action and enforcement action was taken. (2) Compliance action was required at St Charles Mental Health Unit.

CQC have taken enforcement action against 3 Beatrice Place to protect the health, safety and welfare of people using this service

“Whilst there was good information about people’s life stories, the service had failed to use the information to ensure that people’s needs were appropriately met. We found examples where the failure in linking people’s early life experiences led to care that at times undermined people’s safety and wellbeing.

The provider failed to respond appropriately to an allegation of abuse both in terms of how it was investigated and how it failed to protect the person who made the disclosure. Sometimes people had to be restrained in order to deliver care or to keep them safe. We found that half of the clinical staff had not been trained to restrain people appropriately and safely. This put people at risk of harm. Strategies to de-escalate potentially violent situations were inadequate.

We saw that the provider had invested resources and implemented systems to improve the service. This included auditing people’s care arrangements and reviewing incidents in the service. However, we found that that these were not sufficiently robust to protect people from the risk of unsafe or inappropriate care and treatment.”¹

¹ Summary of CQC Inspection report (15 March 14): http://www.cqc.org.uk/directory/rv329
The Trust has a Monitor continuity of services rating of 4 and a governance rating of “issues identified”.2

Monitor are to investigate whether CNWL are in breach of licence conditions. They “will look into whether the concerns raised by CQC indicate wider problems with how the trust is run.... Monitor will examine whether the trust has robust and effective systems in place for identifying and rectifying any problems with the quality of care.”

**Increased responsibilities:**
We note Milton Keynes Community Health Services is now part of CNWL.3 The provision of services the Trust manages has broadened, from mental health to community services, and it is now over a wider geographical area. We are concerned that these developments might be a distraction from the Trust’s core work.

We note reporting on Milton Keynes in the Quality Account seems to have reduced the quantity of reporting about other parts of the business (e.g. Two fifths of the improvement priorities now relate to Milton Keynes). Also, the public are not able to make comparisons with previous years where CNWL results incorporate the results from Milton Keynes (e.g. table of data on patient experience page 59).

We are concerned that the Trust has expressed an intention to take on responsibility for further community service contracts and that might serve as a further distraction from addressing the improvement of its core health service provision.

**Longer-term plans:**
The financial outlook for NHS provider trusts 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.

**Quality Account Priorities 2013/14:**
Overall, CNWL achieved 9 out of the 14 quality indicators.

We are pleased to note:
- For mental health services 71% (Target 65%) for patients report being ‘definitely’ involved as much as they wanted to be in decisions about their care plan.
- The long list of actions the Trust has carried out to improve overall quality in safety, clinical effectiveness and patient experience in 2013/14.

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We are disappointed to note performance against the quality priorities 2013/14:

- Percentage of patients that have a ‘carer status’ identified in Kensington & Chelsea 66%. In Westminster 58%. Eating Disorder 57%. Target 70%

It is of high concern that many patients are still not offered or given a copy of their care plan (mental health):

- 82% (Target 95%) of patients have been offered or given a copy of their care plan (mental health). In Kensington & Chelsea 78%. Westminster 74%. Eating Disorders 83%. This was a problem in 2012/13. It should be kept as a priority.

The Trust sets out three proposed Quality Account Priorities for 2014-15: (1) Helping our patients to recover by involving them in their care or treatment; (2) Supporting carers to look after their loved ones; and, (3) A competent and compassionate workforce. CNWL should continue to report on the "record inpatient/community patients have been offered/given a copy of their care plan (mental health)" as part of priority 1. CNWL should continue to report on the "percentage of patients that have a ‘carer status’ identified" as part of priority 2.

National priorities and historical quality priorities:

We are disappointed to note the performance on a number of the National priorities and historical quality priorities in 2013/14:

- 92% of mental health inpatients have had a risk assessment completed and linked to their care plans (Target 95%)
- Surveying those who called the Urgent Advice Line number: 48% (Target 65%) of cases, patients report that they ‘definitely’ got the help that they wanted.
- 63% (Target 80%) of community mental health patients reported that they had been given/offered a copy of their care plan. The failure to meet this target is not reflected in the commentary on page 53.
- The percentage of mental health inpatients that have had a risk assessment completed and linked to their care plans: Westminster 80%. CAMHS 97%. Eating Disorder 90% (Target 95%)
- Mental health patients reported that they felt safe during their most recent inpatient stay: Westminster 71%. Eating Disorder 63% (Target 75%)
- Community mental health patients report that they have a phone number to call in a crisis. CAMHS 56% (Target 65%)
- Inpatients with physical health assessment after admission (Nursing). Kensington & Chelsea 88%. Westminster 83%. CAMHS 93% (Target 95%)
- The percentage of patients, who are on CPA, received a full CPA review within the last 12 months where appropriate. Learning Disability 86% (Target 95%)
- Mental health community patients report that they had been given/offered a copy of their care plan. Kensington & Chelsea 51%. Westminster 67%. CAMHS 22%. Eating Disorders 50%. Addictions 66% (Target 80%)
- Patients on CPA whose care plans contain at least one personal recovery goal: Westminster 65% (Target 75%)
We note the statement, "The scores that CNWL achieved in the 2013 national [patient experience] survey were universally poorer than in 2012. This has driven the Trust to pay even more attention to the practice of clinicians involving patients in developing their care packages." (page 63). A more radical initiative is required to address a very serious problem with patient experience.

**St Charles:**

<table>
<thead>
<tr>
<th>CQC Summary Inspection Report - St Charles Mental Health Centre – September 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>“We visited five wards which included an older people’s ward, three acute adult wards and the male Psychiatric Intensive Care Unit (PICU). We spoke with patients and staff on all the wards visited. We also looked at feedback from service user meeting minutes. Patients gave mixed feedback about the care and treatment received. The centre had policies on consent procedures. Staff had been trained in how to assess mental capacity and were aware of their responsibilities however, we did not see records of capacity assessments. We were told that by staff that patients had their rights explained to them. Patients confirmed that they had their rights explained to them, but we did not see records of this. Care plans and risk assessments were completed. However, the level of detail was not consistent in all wards visited. There were examples of practices which was not conducive to the care and welfare of patients. The Trust had appropriate policies in Safeguarding Adults and staff had received training in safeguarding. Staff in different wards gave explanations of the signs of abuse and provided examples of the various forms of abuse. However, we were given examples of incidents which had not been reported in line with the Trust policy in one ward. There were systems in place to monitor the quality of service people received. People were asked for their feedback through patient surveys and service user meetings. We saw evidence that feedback was acted upon.”</td>
</tr>
</tbody>
</table>

CNWL attended the Royal Borough’s Committee to discuss the issues at St Charles on 23 January 2014. The Westminster Committee would like to plan to assess provision at St Charles towards the end of 2014.

**Delayed discharges:**

We would have liked mention of issues around delayed discharges in mental health: Half due to lack of suitable community placements (both social and health care), and the remaining half due to a combination of family difficulties, benefit issues and properties requiring deep cleaning or to be refurbished before discharge is possible.

**Health Service Journal:**

We are pleased to note:

- Claire Murdoch was named as one of HSJ Top Chief Executives 2014.

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5 CNWL presented the report: [A4 CNWL Report 1](http://www.cqc.org.uk/node/315994)

6 As reported in: [Quality Account Half Year Review: CNWL](http://www.cqc.org.uk/node/315994)

• The Placement Efficiency Project team was shortlisted for three HSJ Efficiency Awards.  

Conclusion:
While progress has been made by the Trust, we would look to see a heightened focus on the number of areas of concern noted in our response, particularly care plans. We are interested to find out how the priorities outlined in the Quality Account are implemented over the course of 2014/15.

We were disappointed that the CQC needed to ask for action to be taken at 3 Beatrice Place and St Charles Mental Health Unit. We trust the Monitor investigation is swift and thorough.

We look forward to continuing our strong working relationship with Central and North West London NHS Foundation Trust in 2014/15. We look forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2014/15.

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8 CNWL shortlisted for three HSJ Efficiency Awards | My NHS Alerts (June 13)
http://www.mynhsalerts.london.nhs.uk/2013/06/cnwl-shortlisted-for-three-hsj-efficiency-awards/?source=email&uid=98&pid=10752
Annex 3 – 2013-14 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 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 NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2013 to 27 May 2014;
  - Papers relating to Quality reported to the board over the period April 2013 to 27 May 2014;
  - Feedback from the commissioners dated 5 May 2014 (closing date of the Quality Account 30-day consultation);
  - Feedback from governors dated 5 May 2014 (closing date of the Quality Account 30-day consultation);
  - Feedback from Local Healthwatch organisations dated 5 May 2014 (closing date of the Quality Account 30-day consultation);
  - The trust’s Annual Complaints Report (2013-14) published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
  - The latest national patient survey dated 2013;
  - The latest national staff survey dated 2013;
  - The Head of Internal Audit’s annual opinion over the trust’s control environment dated XX May 2014;
  - CQC quality and risk profiles dated to May 2014;
- the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board
Finance report for the 12 months to 31 March 2014
– FOR APPROVAL

Board of Directors

14 May 2014

This Report enables the Trust Board of Directors to be assured that the Trust is meeting its objective of:

• Providing a financial base that is robust for the future development of the Trust and to provide economic and efficient services
Position Overview

**EBITDA**
- The Trust’s EBITDA for the year was £15.7m (3.6%), the same level as at Month 11. This is £4.0m behind the Monitor plan. The adverse performance is predominantly driven by under-achievement of CIPs and high levels of agency usage.

**Surplus**
- The Trust has delivered a surplus, excluding restructuring costs, of £4.7m. When exceptional costs, relating to the restructure (£4.3m) are included this gives a total surplus of £0.4m, as reported in Appendix 1.

**Cash**
- Overall, the Trust had cash and short term investments of £20.9m at the end of March ’14 against a plan figure of £39.6m.

**Monitor rating**
- The Trust’s financial risk rating for the month is scored at 2.55. This is behind plan expectation of achieving a score of 3.70.
- The Trust is now also assessed against the Continuity of Service rating. The capital servicing capacity ratio improved to a 4 in Month 12 as previously forecast as a result of the improved surplus.

**CIP and contract reductions delivery**
- The Trust had a savings target of £30.1m for 2013/14, which included savings required due to reduction in contract values and QIPP, as well as internally generated efficiency requirements, and any unachieved or non recurrent CIP from 12/13;
- CIPs to the value of £20.1m (66%) were identified. £2.4m of this was identified but not deliverable due to slippage in implementing QIPP schemes agreed during 2013/14 contracting;
- The emphasis is now on delivery of savings plans for 14/15 and the following years, although significant further CIPs have been identified in month 12, as unachieved CIP is carried forward into 2014/15, so the overall target for the service lines across the 2 years does not change;
- For comparison purposes the (risk-rated) gap at Month 12 in 2012/13 was £5.8m (28%).
Monitor Risk rating

The Trust’s capital servicing capacity ratio has increased to a 4 due to the improvement in the surplus in Month 12.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>M12 YTD</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital servicing capacity</td>
<td>Revenue available is sufficient to meet committed debt costs</td>
<td>2.66 times</td>
<td>4</td>
</tr>
<tr>
<td>Liquidity ratio</td>
<td>There is sufficient cash available to meet short term operating liabilities</td>
<td>3.5 days</td>
<td>4</td>
</tr>
</tbody>
</table>

The Trust’s overall risk rating is scored at a 2.55 for the year to date, which is below the plan of 3.70.

CUMULATIVE MONITOR RISK RATING

### METRIC

<table>
<thead>
<tr>
<th>13/14 Mth 12</th>
<th>Rating</th>
<th>Weight</th>
<th>Weighted score</th>
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<th>Lower score</th>
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</thead>
<tbody>
<tr>
<td>EBITDA Margin</td>
<td>Target</td>
<td>4.87%</td>
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<td>25%</td>
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<tr>
<td>EBITDA Achieved</td>
<td>Actual</td>
<td>3.55%</td>
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<td>25%</td>
<td>0.50</td>
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<tr>
<td>Return on Assets</td>
<td>Target</td>
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<td>5</td>
<td>20%</td>
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<tr>
<td>I&amp;E Surplus Margin</td>
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<tr>
<td>Liquidity Ratio (Days)</td>
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<tr>
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<td>Actual</td>
<td>3.70</td>
<td>3</td>
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</table>

Targets taken from Monitor 2013-14 Plan.

### Additional risk indicators

Monitor previously required Foundation Trusts to report on ten risk indicators that give an indication of the level of financial risks facing individual organisations. These indicators were reported on an exception basis. Further detail can be found on page 7.

<table>
<thead>
<tr>
<th>Risk indicator</th>
<th>Actual</th>
<th>Actual</th>
<th>Actual</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Indicator 4:</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Debtors &gt; 90 days past due account for more than 5% of total debtors balances</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Risk Indicator 5:</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
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<tr>
<td>Creditors &gt; 90 days past due account for more than 5% of total creditor balances</td>
<td>✗</td>
<td>✗</td>
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</tbody>
</table>
Statement of comprehensive income – 12 months to 31st March 2014

Income

• Income (£439.5m) is ahead of plan (£415.0m) by £24.4m. This is slightly ahead of the trend in months 1-11.
• In Month 11 £2.4m was billed to CCGs to recognise the value taken out of contracts for QIPPs that have not been implemented out of the Trust's control. This continues to be provided for awaiting resolution. The provision is recognised within non-pay expenditure.
• During Month 12 invoices were issued for space in estate transferred from Camden and Hillingdon PCTs to CNWL and partly occupied by other tenants. This was £0.5m ahead of the expected value.
• Additional GUM income of £2.0m has been generated compared to budget, primarily as a result of additional volume with the London Borough of Camden.
• Income from subcontracting of acute beds to other Trusts, including SLAM, St George’s and BEH has generated £1.0m of additional income.
• Budgets were set prior to contracts being agreed with commissioners, therefore much of the variance is driven by better than expected contract outcomes.

Pay expenditure

• Pay expenditure is £14.3m above plan. This is predominantly driven by temporary staff spend in the year of £27.5m. The budget for agency and locum spend for the year was £4.0m. Month 12 agency spend was £3.1m, the highest month of the year. Further detail is provided at Appendix 5.

Non-pay expenditure

• £2.4m of the variance relate to the doubtful debt provision for unachieved QIPP invoicing referred to in income above.
• During Month 12 £0.4m of unexpected estate costs were received. These related to services received at St Pancras Hospital, of which £0.2m related to 2012/13 and earlier years. There was also a significant increase in backlog maintenance in the final two months of the year due to a time lag in recording in earlier months. In total backlog maintenance was £1.2m overspent in 2013/14.
• The restructuring costs include the costs of Milton Keynes special measures (£0.9m YTD) and IT costs (£2.5m YTD).
• CIP targets are held in non-pay, therefore the unidentified CIP drives the remainder of the overspend. The CIP report is attached at Appendix 6.
• The EBITDA plan would have been 5.2% had the exceptional items budget been in the plan below the line.
## Statement of financial position as at 31 March

<table>
<thead>
<tr>
<th></th>
<th>2013-14 PLAN</th>
<th>2013-14 ACTUAL</th>
<th>2013-14 VARIANCE</th>
</tr>
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<tr>
<td></td>
<td>Qtr4</td>
<td>Qtr4</td>
<td>M12 Variance from plan</td>
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<td>Intangible Assets, Net</td>
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<td>216,264 (M12</td>
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<td>NHS Trade Receivables, Non-Current, Gross</td>
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<td>0</td>
</tr>
<tr>
<td>Impairment of Receivables, Non-Current (for bad &amp; doubtful debts)</td>
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<tr>
<td>Non Current Assets</td>
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<td>234,910</td>
<td>(5,401)</td>
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<tr>
<td>Inventories</td>
<td>171 (M12</td>
<td>391 (M12</td>
<td>(220)</td>
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<td>Current Tax Receivables</td>
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<td>210 (M12</td>
<td>1,191</td>
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<td>NHS Trade Receivables, Current, Gross</td>
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<td>35,255</td>
<td>(14,307)</td>
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<td>Impairment of Receivables, Current (for bad &amp; doubtful debts)</td>
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<td>(4,435)</td>
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<td>Accrued Income</td>
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<td>8,176 (M12</td>
<td>161</td>
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<td>Prepayments, Current, non-PFI related</td>
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<td>1,821</td>
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<td>PDC dividend overpayment receivable</td>
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<td>489</td>
<td>(489)</td>
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<tr>
<td>Non NHS Trade Receivables, Current, Gross</td>
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<td>9,823</td>
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<td>Other Receivables, Current, Gross</td>
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<td>369</td>
<td>55</td>
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<td>Current Asset Investments</td>
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<td>0</td>
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<td>Cash with Commercial banks and in hand</td>
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<td>112</td>
<td>1,114</td>
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<tr>
<td>Cash with Government Banking Service</td>
<td>38,459</td>
<td>20,747</td>
<td>17,712</td>
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<td>Current assets</td>
<td>77,440</td>
<td>72,957</td>
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<td>Current Tax Payables</td>
<td>(5,340) (M12</td>
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<td>Deferred Income, Current</td>
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<td>(7,340) (M12</td>
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<td>Payments on Account</td>
<td>(3,838) (M12</td>
<td>(4,023) (M12</td>
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<td>PDC dividend payable</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Provisions, Current</td>
<td>(3,581) (M12</td>
<td>(1,247) (M12</td>
<td>(2,334)</td>
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<td>Other Payables, Current</td>
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<td>(4,419)</td>
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<tr>
<td>Trade Payables, Current</td>
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<td>Capital Payables, Current</td>
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<td>(684)</td>
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<td>Current liabilities</td>
<td>(64,688)</td>
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<td>Provisions, Non-Current</td>
<td>(1,956) (M12</td>
<td>(1,975) (M12</td>
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<td>Other Creditors, Non-Current</td>
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<td>Finance Leases, Non-current</td>
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<tr>
<td>Non Current liabilities</td>
<td>(3,230)</td>
<td>(3,297)</td>
<td>66</td>
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<td>Net Assets Employed</td>
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<td>Public dividend capital</td>
<td>151,283</td>
<td>135,539</td>
<td>15,744</td>
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<tr>
<td>Retained Earnings (Accumulated Losses)</td>
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<td>45,921</td>
<td>(12,742)</td>
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<tr>
<td>Revaluation Reserve</td>
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<td>54,541</td>
<td>52</td>
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<tr>
<td>Total taxpayer’s equity</td>
<td>239,051</td>
<td>236,002</td>
<td>3,049</td>
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</tbody>
</table>

### Summary

Non current assets stand at £234.9m. This places the non-current assets at £5.4m ahead of plan.

- NHS trade receivables stand at £35.2m (plan £20.9m);
- Accrued Income stands at £8.1m (plan £8.3m);
- Current Accruals stand at £29.7m (plan £21.6m);
- Trade Payables stand at £15.0m (plan £19.4m).

Cash and short term investment balances are at £20.9m against a plan of £39.6m. The negative variance of £18.8m has been mainly due to:-

- (£5.4)m Increase in Non Current Assets Expenditure;
- (£14.3)m Increase in NHS Trade receivables;
- (£5.5)m Increase in Non NHS Trade Receivables;
- £8.1m Increase in Current Accruals;
- (£4.3)m Decrease in Trade Payables.

The overall impact on the Taxpayers’ equity has been a net decrease of £3.0m.
Capital Expenditure

Summary: M12
Cumulative spend to date on capital projects to 31st Mar 2014 stood at £23.87m (PPE £13.56m and Intangibles £10.31m) against an original approved budget for the year to date of £25.4m (full year £25.4m).

Of the £10.31m spent on Intangibles, £1.96m went on Intangible assets and £8.35m were included in Assets Under Construction for the IT Capital program. £1.6m of Intangible Assets under Construction was transfer to Intangible additions in M12.

Cumulative depreciation for PPE totals £4.3m, whilst cumulative amortization costs for Intangibles total £1.0m. The total depreciation/amortizations costs of £5.3m is a 28.3% increase when compared to the same period last year.

Detail: Month 12
At project level, the key trends in the Trust’s YTD capital expenditure (£23.87m) are set out below:
- £10.54m was spent on IT (Including Intangibles);
- Margaret Pyke Centre & St Pancras - South Wing Internal Improvements works - £2.11m;
- Hillingdon Project work has cost the trust £2.55m;
- Legal Fees & Contingency costs amount to £0.52m;
- Various upgrades and improvements costs to the SK&C & St Charles sites total £0.68m;
- Park Royal project work costs total £1.03m;
- The external & internal decoration programmes have cost the Trust £1.76m;
- Milton Keynes Contingency & Enabling costs and work at Cherry wood total £0.82m;
- Other Capital works at Milton Keynes total £0.95m;
- Other additions to date total £0.94m;
- Harrow Learning & Resource Ctr Costs total £0.64m.

A detailed capital expenditure report is attached in Appendix 3 of this report.
Debtors & Payments

Debt Summary

- Total debt was £45.1m at the end of March ‘14.
- In March’14 the Trust’s 90+ days debtor performance was 11% (£4.3m of debtors net of provided for debt) against the Trust’s target of 5% (£2.1m).
- The trust has a bad debt provision of £1.6m to reflect its ageing bad debt over 90 days.

Aged Debt

The graphs opposite show the overdue debt ageing profile and the type of debt. The key debts that were more than 90 days overdue as at 31 March were as follows:

- Hertfordshire PCT £1.8m – Back to back liabilities settlement – payment provisionally agreed with DoH in April ’14;
- Central London CCG £693k – £634k overseas visitors – legacy payment of £848k to be allocated against this in April ’14;
- Bedford Hospital NHS Trust £532k – Recharge of provisions for Milton Keynes CHS under dispute – escalated to CEO.

Payments

In March’14 the Trust’s 90+ days creditor performance was 8% (£1.9m) against target of 5% (£1.2m), compared to 5% last month.

The key credit balances that were more than 90 days overdue and under dispute as at 31 March were:

- NHS Property Services £304k – Invoices to be credited;
- Community Health Partnerships £213k – Invoices to be credited;
- Imperial College NHS Trust £115k – Disputed dementia invoices.

Performance against Better Payment Practice Code

NHS – The Trust paid 56% (56% last month) of total transactions by number, and 78% (78% last month) of total transactions by value, within 30 days.
Non NHS – The Trust paid 67% (66% last month) of total transactions by number, and 62% (66% last month) of total transactions by value, within 30 days.

A report will be presented to the Exec Board illustrating underlying performance improvements which are masked by the payment of backlog invoices. The move to SBS is forcing a review and improvement of all existing processes.
### Risks

**The Commissioning Environment - Clinical Commissioning Groups, Commissioning Support Units, NHS England and Local Authorities**

Contract negotiations have proved very challenging for 14/15, with NWL negotiations complicated by the unhelpful interventions of the CSU. There still remains a challenging QIPP demand from North West London although Milton Keynes has now been agreed, and regular meetings are taking place between Directors from the Trust and CCGs to try and resolve this. The Trust continues to refuse to take the risk on unspecified QIPP plans.

**Activity Information**

The Trust published local PbR prices on 27th February 2014. Commissioners have not yet commented on them. NWL have indicated that they expect to use the prices in shadow form in 2014/15, and the Trust will be working with the clustering information to support the development of 'shifting settings of care' QIPP plans with commissioners.

**Financial Environment - Funding allocations**

The NHS Director of Finance has recently confirmed that HCAS will no longer feature as a separate funding stream in 14/15. This assumption was included as part of the budget setting process for 14/15, but is still a disappointing outcome. It is being played into contract negotiations with NWL. Whilst overseas visitors has been paid in 13/14, it is likely to be up for debate again in 14/15 against the background of political pressure regarding 'health tourism'.

**Accounts Receivable - cash flow issues**

The issue of cash flow and outstanding debt is increasing in importance as the Trust's failure to achieve its financial plan has reduced the working capital position in this financial year. Uncertainty in the commissioning environment has made it difficult to track who is responsible for outstanding PCT debt, and local authorities are questioning the basis of billing for sexual health services. The Accounts Receivable department has reviewed its escalation procedures and referring an increasing number of outstanding debts to a debt collection agency.

---

<table>
<thead>
<tr>
<th>The Commissioning Environment - Clinical Commissioning Groups, Commissioning Support Units, NHS England and Local Authorities</th>
<th>5x4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract negotiations have proved very challenging for 14/15, with NWL negotiations complicated by the unhelpful interventions of the CSU. There still remains a challenging QIPP demand from North West London although Milton Keynes has now been agreed, and regular meetings are taking place between Directors from the Trust and CCGs to try and resolve this. The Trust continues to refuse to take the risk on unspecified QIPP plans.</td>
<td>5x4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity Information</th>
<th>3 x 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust published local PbR prices on 27th February 2014. Commissioners have not yet commented on them. NWL have indicated that they expect to use the prices in shadow form in 2014/15, and the Trust will be working with the clustering information to support the development of 'shifting settings of care' QIPP plans with commissioners.</td>
<td>3 x 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Environment - Funding allocations</th>
<th>3 x 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NHS Director of Finance has recently confirmed that HCAS will no longer feature as a separate funding stream in 14/15. This assumption was included as part of the budget setting process for 14/15, but is still a disappointing outcome. It is being played into contract negotiations with NWL. Whilst overseas visitors has been paid in 13/14, it is likely to be up for debate again in 14/15 against the background of political pressure regarding 'health tourism'.</td>
<td>3 x 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accounts Receivable - cash flow issues</th>
<th>3 x 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>The issue of cash flow and outstanding debt is increasing in importance as the Trust's failure to achieve its financial plan has reduced the working capital position in this financial year. Uncertainty in the commissioning environment has made it difficult to track who is responsible for outstanding PCT debt, and local authorities are questioning the basis of billing for sexual health services. The Accounts Receivable department has reviewed its escalation procedures and referring an increasing number of outstanding debts to a debt collection agency.</td>
<td>3 x 4</td>
</tr>
</tbody>
</table>
### Appendix 1 – Rolling 12 month statement of comprehensive income forecast

#### Rolling 12 month statement of comprehensive income forecast

<table>
<thead>
<tr>
<th></th>
<th>M1</th>
<th>M2</th>
<th>M3</th>
<th>M4</th>
<th>M5</th>
<th>M6</th>
<th>M7</th>
<th>M8</th>
<th>M9</th>
<th>M10</th>
<th>M11</th>
<th>M12</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education, Training &amp; Research</strong></td>
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<td>1,698</td>
<td>1,698</td>
<td>1,698</td>
<td>1,698</td>
<td>1,698</td>
<td>1,698</td>
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<td>1,698</td>
<td>1,698</td>
<td>1,698</td>
<td>1,698</td>
<td>20,388</td>
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<tr>
<td><strong>Misc income</strong></td>
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<td>1,589</td>
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<td>1,589</td>
<td>1,589</td>
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<td>1,589</td>
<td>1,589</td>
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<tr>
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<td>(24,573)</td>
<td>(24,573)</td>
<td>(24,408)</td>
<td>(24,408)</td>
<td>(24,408)</td>
<td>(24,408)</td>
<td>(24,444)</td>
<td>(24,444)</td>
<td>(293,888)</td>
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<td><strong>Non-pay</strong></td>
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<td>(5,468)</td>
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<td>(9,153)</td>
<td>(9,153)</td>
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<td>(8,525)</td>
<td>(8,525)</td>
<td>(8,525)</td>
<td>(167,966)</td>
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<td>(32,768)</td>
<td>(401,844)</td>
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<td>1,683</td>
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<td>2,641</td>
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<td><strong>EBITDA %</strong></td>
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<td>4.8%</td>
<td>4.8%</td>
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<td>6.1%</td>
<td>7.5%</td>
<td>7.5%</td>
<td>7.7%</td>
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<td>(710)</td>
<td>(710)</td>
<td>(710)</td>
<td>(710)</td>
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<td>(710)</td>
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<td>(710)</td>
<td>(710)</td>
<td>(8,516)</td>
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<td><strong>Interest income</strong></td>
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<td>(238)</td>
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<td>(238)</td>
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<td><strong>Redundancy</strong></td>
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<tr>
<td><strong>Fixed asset impairment</strong></td>
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<tr>
<td><strong>Dividends, Interest, other</strong></td>
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<td>(508)</td>
<td>(508)</td>
<td>(508)</td>
<td>(508)</td>
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<td>227</td>
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<td><strong>IBE Surplus %</strong></td>
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<td>1.3%</td>
<td>1.3%</td>
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<td>2.6%</td>
<td>4.0%</td>
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## Appendix 2 – Cash flow forecast

### Central and North West London

**Finance Update**

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</tr>
<tr>
<td>2015-16</td>
<td>2016-17</td>
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<td>2017-18</td>
<td>2018-19</td>
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### Cash Flow Report as at 31 March 2014

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<tr>
<th>Cash Inflow:</th>
<th>Operating:</th>
<th>Non-Operating:</th>
<th>Total Cash Inflow</th>
<th>Cash Outflow:</th>
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</thead>
<tbody>
<tr>
<td><strong>Payments in Advance</strong></td>
<td><strong>Receipts from HMRC for VAT Reclaims</strong></td>
<td><strong>Payments to HMRC for VAT Reclaims</strong></td>
<td>** Payments to HMRC for VAT Reclaims**</td>
<td><strong>Payments to HMRC for VAT Reclaims</strong></td>
</tr>
<tr>
<td><strong>Payments in Advance</strong></td>
<td><strong>Payments to HMRC for VAT Reclaims</strong></td>
<td><strong>Payments to HMRC for VAT Reclaims</strong></td>
<td><strong>Payments to HMRC for VAT Reclaims</strong></td>
<td><strong>Payments to HMRC for VAT Reclaims</strong></td>
</tr>
</tbody>
</table>

### Financial Highlights

- **2013-14 Actual**
- **2014-15 Forecast**
- **2015-16 Forecast**
- **2016-17 Forecast**
- **2017-18 Forecast**
- **2018-19 Forecast**

### Key Figures

- **Total Cash Inflow**
- **Total Cash Outflow**

### Notes

- **Cash Inflow** includes payments from HMRC for VAT reclaims and other activities.
- **Cash Outflow** covers staff salaries, payments to HMRC for VAT reclaims, and other expenses.

### Data Table

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Cash Inflow</th>
<th>Total Cash Outflow</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>2014-15</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>2015-16</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>2016-17</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>2017-18</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>2018-19</td>
<td>£m</td>
<td>£m</td>
</tr>
</tbody>
</table>

### Additional Information

- **M01**
- **M02**
- **M03**
- **M04**
- **M05**
- **M06**
- **M07**
- **M08**
- **M09**
- **M10**
- **M11**
- **M12**

### Analysis

- **Cash Inflow** shows a steady increase from year to year.
- **Cash Outflow** shows a decreasing trend from year to year.

---

**Page 422 of 449**
This report is to advise the Board of Directors of the financial position of the trust as at the end of April 2014.
Financial Report for one month to 30\textsuperscript{th} April 2014

1. The more detailed report will go to the Business and Finance Committee on 29\textsuperscript{th} May 2014.

2. The Trust is after one month in deficit by £1.5m which is £1.25m worse than plan.

3. The key areas leading to this position are:
   
   a. Acute MH overspend £0.6m  
   b. Community MH Services £0.2m  
   c. MK Services £0.1m  
   d. Unallocated QIPP £1.0m  

4. There has been an element of prudence concerning the extent that additional funds agreed and under discussion in contracts are recognised, especially given some areas of increased income will also result in increased expenditure.

5. The NWL MH Contract value is the main outstanding agreement for 14/15. Detailed discussions are still on-going to protect the 13/14 level of funding plus some specific developments

6. The current position has been discussed at the Operations board (9\textsuperscript{th} May) at a headline level and more detailed work is underway, both on managing the expenditure and identifying and delivering the savings required.

Trevor Shipman  
Director of Finance  
9\textsuperscript{th} May 2014
### Central and North West London NHS Foundation Trust

#### Month 1
2014/15

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity income</strong></td>
<td>32.14</td>
<td>32.11</td>
<td>(0.03)</td>
</tr>
<tr>
<td><strong>Education &amp; R&amp;D</strong></td>
<td>1.70</td>
<td>1.70</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Other Income</strong></td>
<td>1.57</td>
<td>1.57</td>
<td>(0.00)</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>35.41</td>
<td>35.38</td>
<td>(0.03)</td>
</tr>
<tr>
<td><strong>Pay Expenditure</strong></td>
<td>(24.98)</td>
<td>(26.49)</td>
<td>(1.52)</td>
</tr>
<tr>
<td><strong>Non-Pay Expenditure</strong></td>
<td>(9.23)</td>
<td>(9.02)</td>
<td>0.21</td>
</tr>
<tr>
<td><strong>Total Trust Expenditure</strong></td>
<td>(34.21)</td>
<td>(35.51)</td>
<td>(1.31)</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>1.20</td>
<td>(0.13)</td>
<td>(1.33)</td>
</tr>
<tr>
<td><strong>EBITDA %</strong></td>
<td>3.40%</td>
<td>-0.37%</td>
<td>3.77%</td>
</tr>
<tr>
<td><strong>Depreciation</strong></td>
<td>(0.71)</td>
<td>(0.77)</td>
<td>(0.06)</td>
</tr>
<tr>
<td><strong>Interest income</strong></td>
<td>0.01</td>
<td>0.00</td>
<td>(0.01)</td>
</tr>
<tr>
<td><strong>Restructuring costs</strong></td>
<td>(0.24)</td>
<td>(0.11)</td>
<td>0.13</td>
</tr>
<tr>
<td><strong>capital coded to revenue</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>exceptional items</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Dividends and other</strong></td>
<td>(0.51)</td>
<td>(0.51)</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Retained Surplus</strong></td>
<td>(0.24)</td>
<td>(1.51)</td>
<td>(1.27)</td>
</tr>
<tr>
<td><strong>I&amp;E Surplus % (EXCLU Restructure)</strong></td>
<td>-0.02%</td>
<td>-3.97%</td>
<td>-3.95%</td>
</tr>
</tbody>
</table>
Board of Directors

Report of the Business and Finance Committee
14 May 2014

Objective:
The Board is asked to note this report which highlights issues from the March and April meetings of the Committee and which it is felt should be drawn to the Board’s attention. Details of other considerations are contained in the minutes of the meetings attached to this report.

The Board is asked to:
• Note the report

Executive summary:

Forward Plan
The Committee held a detailed discussion of the financial detail of the forward plan in March, in particular in relation to the CIP target and plans to achieve them. The Committee noted that achievement of the target would be difficult but that there were significant plans developed which would deliver a significant proportion of the target and there were other workstreams being developed which it was anticipated should deliver the remaining gap. The Committee have requested that a detailed report tracking progress against these different CIP areas be provided on a monthly basis.

The Committee also considered the other financial information provided and that the Trust was targeting a Continuity of Service rating (the new Monitor financial risk rating metric from 2014/15) of 4. The Committee raised some queries against some of the figures and held detailed discussions, and following this, agreed to the plan for submission to the Board for final signoff.

Finance
The Committee has continued to review the Trust’s finance position and CIPs position. It was noted that the Trust was on target for a Monitor risk rating of 4. The Trust has also achieved 96% of its CQUIN target this year.

The Committee has requested that the breakdown by month of anticipated cash flow be extended to cover two years, with a quarterly breakdown thereafter. The Finance
report structure and content will also be reviewed to ensure it remains focussed on the key concerns for the Trust.

**Contracting / CQUIN**
The Committee were updated on the current position of the contracting negotiations. Discussions are progressing with commissioners, however contracts still need to be finalised with NHS England and the North West London CCGs. It was also noted that CQUIN achievement would be even more challenging this year, and targets continue to be negotiated.

**Capital Programme**
The Committee received and considered the proposed Capital Programme for 2014/15, and recommended it to the Board for approval.

Bhavana Desai
Non-Executive Director
Objective:
The objective of this report is to:
- Respond to the Board’s request for a paper on strategic planning
- To provide a draft self assessment of CNWL’s strategic capacity as recommended by Monitor (Table 1). While the self-assessment is not submitted, it is necessary to confirm that the Board has been involved in the self-assessment and the proposal is to have a document that can be shared with Monitor if required

The Board is asked to:
- Consider the self-assessment

Executive summary:
When reviewing the Operational Plan in February, the Board asked for a paper on strategic planning. The document sets out the current position, an analysis of our capacity using the Monitor template, and a refreshed LEAN strategic planning process.

The analysis show that CNWL has adequate resource around strategic planning – corporately and in the service lines. The development of the Programme Management Office (PMO) is a key contribution to effective planning and monitoring, which can inform our strategic approach and replace work currently done to develop and monitor the plan through the service lines.

John Vaughan
7th May 2014
1. **Background:**

The Board, reviewing the Annual Plan, on 12th February 2014, asked for a paper on our strategic planning processes.

Monitor requires us to undertake a self-assessment of our strategic capacity.

This paper brings together these two requirements, for the consideration of the Board:

1.1. **Strategic Planning processes**

- CNWL need to be able to respond to a challenging and changing environment. This includes financial challenges, CQC issues and Whole Systems. The Board needs a strategic process which makes it clear where there is duplication or gaps. Also, the Board must be able to make decisions about the direction of the organisation, based on solid data and criteria which are part of an agreed plan.

1.2. **Self Assessment**

- In its guidance for the Annual Planning Review published in December 2013, Monitor identified a need for improved strategic planning in Foundation Trusts. A draft self-assessment of strategic capacity has been undertaken for the consideration of the Board. It has been triangulated against Monitor’s ‘hallmarks’ of successful strategic planning – provided at Appendix 1.

2. **Current process for the Strategic Plan document:**

The current expression of strategy is contained in the Annual Plan Review (APR) submitted to Monitor each year. This year the plan has been redesigned in line with a review of strategic capacity in FTs by PWC, and separated into an Operational and Strategic Plan.

The strategic direction as expressed in the APR each year is the product of a refresh of the programmes planned by each service line in their business planning each year, combined with a review of the internal and external environment and corporate priorities. Core to the plan is delivering quality services which improve the experience of people using our services, and meeting financial requirements. All of this data is then drawn together into a set of priorities – usually 5 or 6 - which are consistent with our vision, values and key objectives.
The report consists of a narrative and a financial section. The narrative sets out our key programmes as above; and the financial plan is over the same period. Monitor looks for consistency between, for example, what programmes we identify to achieve CIPs in the narrative, and our CIPs in the financial template.

3. The Case for Change:
Change is now needed and possible.

- The business plans at service line level are now 3-4 years old and work programmes needed have changed along with the environment. The service lines are anyway changing so many of those plans will need to be rewritten.
- The reporting process via the quarterly reviews is also likely to be modified within the new Divisions
- CNWL has a set of Challenge Workstreams which will frame the organisation’s direction over the next 2-3 years.
- These are supported by a Programme Management Office (PMO) to oversee delivery. Our Operational Plan, submitted at the end of March, was built around the Challenge Workstreams, and reporting on progress to the Board will involve the PMO.
- The PMO cannot and should not, however, gather or cover all aspects of intelligence gathering. There is a strategic role to ensure that we marshall key information to monitor our achievement of our strategy and to scan the horizon for threats and opportunities in a LEAN way. Further to discussion with the Executive Board, it is proposed that this process be led by a virtual strategic planning team derived from a review of strategic posts across the Trust and improving consistency of feedback to a central point. This resource would work closely with the Business Development Unit and PMO, Finance, Information, Human Resources and the Divisions – with other areas of Trust business being involved as needed. The current implementation of monitoring via the quarterly reviews will be reviewed with the establishment of Divisions (Appendix 1)

The opportunity is here to introduce a LEAN and effective strategic planning process.

4. Self Assessment – Draft Response:
In their recommendations to Monitor, PWC have set out what they would expect to see in robust strategic planning as a minimum:

- A robust planning process including engagement with all partners in the LHE – this is underway
- Assessment of risk to sustainability of high quality services – drawing on accurate inputs that have been analysed and presented correctly. Again, to be developed with key stakeholders and the LHE – we have analysis but need more. This is also under development
- Assessment of options with risks and why each option has been chosen (with LHE as above) – this relies on the analysis above
- Definition of a vision for sustainability and the key initiatives which underpin this. Our initiatives have been identified to meet the demands of the LHE but will need refreshing each year as a minimum.
• Plan for delivery – including financial projections which are internally consistent and credible – this is a focus for the Challenge Programme

Based on this, Monitor has provided a self-assessment tool for the Board and a set of ‘hallmarks’ of an organisation with good strategic planning (Appendix 1). The self-assessment tool response has been drafted in the next section.
### Table 1: Self Assessment – Draft Response

<table>
<thead>
<tr>
<th>Step</th>
<th>Questions from Monitor</th>
<th>CNWL response</th>
<th>Further work identified</th>
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</thead>
</table>
| **Step 1: Evaluation of Planning process:** To show that the Trust has a strategic planning process in place that makes sure its board and executive team take the necessary planning actions at the right times, a provider must be able to answer ‘yes’ to the following questions | Has the organisation put in place a structured strategic planning process to guarantee that the board and executive team regularly spend time discussing strategic issues? | Yes: There are 6 Board Workshops each year for discussion of strategic issues. These cover, for example, growth, planning and new policy. The Board has a minimum of two sessions on the development of the plan each year.  
There is an annual strategic day for key leaders in the Trust  
The annual refresh of strategic planning is subject to a planned timetable of work each year. The plan in progress is discussed with the Board and Executive, also with our Council of Members, as it develops. A sub-group of the Council of Governors meets 2-3 times for each section of the Plan (Operational and Strategic)  
The Business and Finance Committee oversees the development and monitoring of the APR.  
aspect of the plan. Each plan is presented at least once to the full Council of Governors for discussion | Improved reporting to Board on progress against the strategic plan – LEAN quarterly report including data from PMO and other sources.  
Monitor recommends a standing strategy and planning committee. In CNWL, this is led by the B&F Committee. Reporting to B&F to be reviewed. |
| Do the board and executive team have strategic planning background and skills? | CNWL’s Non-Executive Directors include a number who have held senior positions in public and private sector organisations. They have experience of strategic planning around commercial and health or related areas  
There is a Director of Strategic Planning and Partnerships and a Director of Commercial Development | The plan will contain a full description of the process around the commercial reviews which incorporate much of this data. |
<table>
<thead>
<tr>
<th>Step</th>
<th>Questions from Monitor</th>
<th>CNWL response</th>
<th>Further work identified</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Decisions around strategic options and business developments are supported by an analysis of the environment and CNWL’s capacity – in terms of the markets, business intelligence and commissioning / political directions. Proposals are scrutinised by the Business and Finance Committee and agreed by the Board. These are reflected in our strategic planning documents – including the business development strategy. These are refreshed each year. The Board has regular meetings with external bodies to support improved understanding of CNWL’s position and potential. An example is a two-day Executive and Board session with KPMG to establish the Challenge Workstreams. Do the board and executive team have an identified, responsible and skilled supporting staff to draw on when they carry out strategic planning?</td>
<td>Yes. Monitor recommends that there are at least 2 WTE staff dedicated to strategic planning and business development. CNWL meets this recommendation: As well as the Directors identified above, there are Strategy Leads in community services and in Milton Keynes, an Associate Director working to the Director of Strategy and a Head of Business Development. The Business Development Unit has three staff members, and hosts the PMO. There is an AD for Business Intelligence. There are skilled staff within the Trust to provide support around analysis and local knowledge at corporate and service line level. All support staff report directly to board and executive directors and have contact on an ad hoc basis with all service lines and have a formal quarterly process through the annual planning.</td>
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</tbody>
</table>

The resource needs review with a view to bringing together a LEAN strategic process to deliver what is needed across the Trust in a consistent and transparent way, making maximum use of the information available.
<table>
<thead>
<tr>
<th>Step</th>
<th>Questions from Monitor</th>
<th>CNWL response</th>
<th>Further work identified</th>
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<tbody>
<tr>
<td></td>
<td>Do the board and executive team have regular strategy discussions with a range of local health economy stakeholders (e.g. commissioners and other providers) and understand their perspectives?</td>
<td>Yes. There are ongoing strategy discussions through individual leads. These include: The CEO attends the Mental Health Programme Board of lead GPs across the 8 CCGs, and the Whole Systems Programme Board Executive, as two examples. There is regular attendance at Overview and Scrutiny Committees across CNWL, usually led by the COO. The Board requires all CNWL officers to proactively engage with external organisations and stakeholders – for example, attending any meetings of OSCs, Health and Wellbeing Boards, local commissioning meetings, clinical sessions, development of whole systems as requested. There is work to do with commissioners to improve this – for example, involving CNWL in discussions around the BCF. The divisions, each headed up by a Divisional Director, are designed to streamline and intensify this engagement and address any gaps in stakeholder experience of working with CNWL in terms of openness and productivity.</td>
<td>The new Communications Director is reviewing and developing processes to ensure senior debate across the Trusts around policy issues 2-4 times a year. The Executive has agreed for an annual event similar to the Quality Assurance Framework event to discuss the strategy with all stakeholders in June 2014 and each year thereafter. We are reviewing processes to feedback information from meetings attended throughout the Trust with key stakeholders and in key areas. CRM tool to be used.</td>
</tr>
</tbody>
</table>

**Step 2: Evaluation of Plan Content.** To show that Trust has developed and refreshed a five to ten year strategic forward plan self-assessment.
<table>
<thead>
<tr>
<th>Step</th>
<th>Questions from Monitor</th>
<th>CNWL response</th>
<th>Further work identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>plan with content based on accurate and correctly analysed inputs, a provider must be able to answer ‘yes’ to the following questions</td>
<td>developed transformation plans by drawing on accurate inputs, including internal performance information and external market data, which it has analysed and presented correctly?</td>
<td>There is now a piece of work to be done to use our available resource to improve accuracy of forecasting in other areas. This development will be supported by the skilled Business Development Unit and Information Team, the clarity provided through the Challenge Workstreams and PMO. Also, the advance of CNWL’s ICT strategy and availability of live data from the front line which is now in place in key areas. CNWL has robust processes to obtain and use feedback from service users and carers and other stakeholders. A source for assurance in this area is the Quality Account. These findings are regularly reviewed and updated, but most importantly responded to. The monthly meeting of the Quality and Performance Committee oversees this process and reports to the Board</td>
<td>being promoted again</td>
</tr>
<tr>
<td></td>
<td>Can the board and executive team declare that their</td>
<td>Quantitative and qualitative data is reported in several locations, including through the monthly and quarterly reports to the Quality and Performance Committee. This includes an integrated dashboard which provides transparency around performance and identifies exceptions. Data is benchmarked where available – internally and externally. CNWL is a member of the NHS benchmarking club.</td>
<td>There is a gap around capacity in the Information Team to produce ad hoc analysis of data or to undertake work on the environment and wider impacts, that is more usually associated with public health professionals. There is an identified need for statistical analysis which has been discussed with the Executive.</td>
</tr>
<tr>
<td></td>
<td>Yes. CNWL’s Auditors have certified that the organisation is a going concern over the next 12 months. Our current financial rating with Monitor is 4. Both of these indicate stability.</td>
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<tr>
<td>Step</td>
<td>Questions from Monitor</td>
<td>CNWL response</td>
<td>Further work identified</td>
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<td></td>
<td>organisation will be financially and clinically sustainable according to current regulatory standards in one, three, five and ten years, if it keeps its current configuration and service profile?</td>
<td>The Board and Executive Team receive monthly reports on CNWL’s financial support and sustainability based on established criteria and CIPs. These plans are overseen by the Business and Finance Committee. These reports are regularly reviewed and adjusted to the needs of the organisation – for example, the establishment of the Divisions is changing the processes so that they remain ‘fit for purpose’</td>
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<td>There are impact assessments against all CIPs</td>
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<td>The assessment is based in current regulatory standards such as Monitor’s risk assessment framework</td>
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<tr>
<td></td>
<td></td>
<td>The plans are currently being developed over 5 years for submission as part of our return to Monitor in June. These plans are underpinned by realistic work programmes and supporting processes</td>
<td></td>
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<tr>
<td></td>
<td>Has the organisation identified a vision that establishes why and how the organisation should change or transform, if necessary, in order to deliver high-</td>
<td>Yes. In 2013-14, in response to an analysis of CNWL’s sustainability, based on financial and quality measures, the organisation established a set of workstreams to transform the organisation. These are the Challenge Workstreams. They will reduce our cost base to achieve CIPs, necessary to our longer term financial viability and will. This includes the impact of changes such as tenders over the next year. These workstreams are the framework for our operational plan over 2 years and will be reflected in our strategic plan over 5 years.</td>
<td></td>
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<td>We must show options for what we have considered and why dismissed or taken forward. This will be part of writing the strategic plan, working with parts of the Trust including service lines/divisional directors.</td>
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<td></td>
<td></td>
<td>We must demonstrate</td>
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<tr>
<td>Step</td>
<td>Questions from Monitor</td>
<td>CNWL response</td>
<td>Further work identified</td>
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<tr>
<td></td>
<td>quality and efficient patient care and address any sustainability gap identified?</td>
<td>years. The 5 year strategic plan will set out where there is a plan to fill the gap or, if necessary, what further action is needed in order for that plan to be in place. The plan involves an analysis of commissioner intentions and national policy objectives. Commissioner objectives are developing constantly – particularly in NWL with a range of initiatives so this work will be iterative. The vision for transformation will include in each case the qualitative impact on patients – with metrics where appropriate. Consideration of quality issues is prioritised by the Board in all areas over financial consideration.</td>
<td>contact with commissioners across the patch. This is complex work as there are many layers of governance – CCG, CSU, Whole Systems structures and so forth. A single public event will be arranged from 2014 onwards, as with the Quality Account. In future years, Strategic Plan and QAS to be linked in visits to OSCs and other public processes.</td>
</tr>
<tr>
<td></td>
<td>Is that vision supported by plans for initiatives that can be shown to address any sustainability gap identified?</td>
<td>Yes. The operational plan sets out what projects are needed to meet our CIP and quality requirements. This is in some detail over 2 years (backed up more detailed plans which underpin these). This includes, where available, financial and clinical impact. The 5 year plan will provide the longer vision as we understand it from this perspective. The annual refresh of the Operational Plan will ensure that the detail of the Strategic Plan comes into focus and is examined against the current reality, each year. The establishment of a PMO will provide the framework for</td>
<td>This is a challenging area for us – to show clinical (activity) and workforce benchmarks against our plans. Further work is underway with the Business Development Unit and Information Team.</td>
</tr>
<tr>
<td>Step</td>
<td>Questions from Monitor</td>
<td>CNWL response</td>
<td>Further work identified</td>
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<td>identifying gaps in planning and delivery transparently and efficiently.</td>
<td>The initiatives in the strategic plan must align with existing plans in the PMO or other areas.</td>
</tr>
<tr>
<td>Step 3: Evaluation of Plan Delivery. To show that Trust monitors delivery of their strategic initiatives, a provider must be able to answer ‘yes’ to the follow questions</td>
<td>Does the organization have detailed delivery plans for each of its strategic initiatives that lay out milestones, resource requirements, dependencies and risk mitigations?</td>
<td>Yes. Each initiative within the Plan will have a delivery plan and milestones with an executive lead for each Strategic Priority area. The PMO will provide a robust framework for monitoring progress, together with a risk log and dependencies. Progress including the risk log will be reported each month to the Executive Board. A single report on progress against the strategic plan will be provided to the Board each quarter – bringing together analysis of implementation by the PMO and strategy team.</td>
<td>There is a requirement from Monitor that the resource level for each initiative is expressed. Also that there be a stakeholder maps around each to analyse input needed from stakeholders and which need to be engaged.</td>
</tr>
<tr>
<td></td>
<td>Does the trust have skilled staff to draw on to implement those delivery plans?</td>
<td>Yes. Planning for each initiative includes an assessment of workforce requirements which is also part of the Challenge Workstream on Workforce. Changes at initiative and corporate level will be reviewed as part of the implementation report exceptions will be reported to the Executive Board as part of PMO reporting, and to the Board as part of the quarterly review of the strategic plan.</td>
<td>The Trust has people with project management skills but they are in different locations and management teams. Consideration could be given to consolidation of this group under the PMO or similar.</td>
</tr>
<tr>
<td></td>
<td>Are trust staff, patients and other stakeholders able to explain the</td>
<td>Developmental: There is work underway through the Communications Team to simplify key messages within CNWL as a complex organisation.</td>
<td>Our plans are very complex – we need to have accessible versions of our operational and strategic plans. Monitor</td>
</tr>
<tr>
<td>Step</td>
<td>Questions from Monitor</td>
<td>CNWL response</td>
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<td></td>
<td>ambition and initiatives of the provider when asked, and do they know what they must do to deliver both?</td>
<td>The Challenge Workstreams have been established in 2013-14 and the communication programme around them is underway. The key points of the Operational Plan have been communicated as part of a developing programme with staff. This will be supported, as will understanding of how the work will be delivered, through the Divisional structure in 2014-15 and a communication strategy. The strategic plan will be discussed with each CCG and Local Authority through individual meetings and existing fora such as the Transformation Board and Care Quality Group, if this is accepted to the agenda by the CSU. Each initiative based in the service lines is the responsibility of local management to communicate and place in objectives at team and staff level. Delivery of these objectives will then be part of annual development planning and linked to pay awards.</td>
<td>requires a short accessible version of the strategic plan as well as the full one to be submitted The Challenge Board and key initiatives, for example. The Communications Director is undertaking this work. Monitor recommends incentivising delivery of initiatives with achievement targets built into objectives As above, a public event is proposed along the lines of the Quality Account Session. An external communication strategy needs to be in place to provide information on objectives of the plan.</td>
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<tr>
<td></td>
<td>Are strategic plans reviewed and updated years to keep them relevant</td>
<td>Yes The annual plan is currently updated each year and this will be strengthened through the measures and proposals set out above.</td>
<td>Reporting will be improved as discussed earlier</td>
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Yes The annual plan is currently updated each year and this will be strengthened through the measures and proposals set out above.

Reporting will be improved as discussed earlier.
Appendix 1: Hallmarks against which to check our response

Step 1 – Questions and Hallmarks

1. Has the organisation put in place a structured strategic planning process to guarantee that the board and executive team regularly spend time discussing strategic issues at the correct point in the trust calendar?

Relevant hallmarks of high-quality strategic planning

- The board and the executive team are involved in planning, developing and drafting the 5-10 year strategic plan for the organisation and the annual updates required as part of Monitor’s APR process.

- The organisation has a planning calendar showing (a) the trust’s medium and long-term strategy development milestones (e.g., dates for developing and refreshing five and ten-year strategic plans), (b) annual milestones (e.g., dates for developing annual plan and refreshing strategic plan) and (c) regular milestones (e.g., dates for strategic discussions at board and executive meetings, dates for engagement sessions with strategic partners).

- The board has a standing strategy and planning committee, and the executive team has a strategy and planning committee or other relevant forum.

- The board and relevant executive committees have regular slots at public and private meetings to discuss strategic issues and to monitor progress against the strategic plan. Board minutes show the extent of the strategic discussion held and also show that actions resulting from those discussions are taken within agreed time limits.

- The board and executive team hold strategic planning sessions of at least half a day and at least twice a year to identify medium- and long-term challenges to their plans and to discuss market developments.

- The organisation keeps a log of high priority and highly challenging risks to sustainability, which the board and relevant executive committees review regularly.
### Step 1

#### 2. Do the board and executive team have strategic planning backgrounds and skills?

**Relevant hallmarks of high-quality strategic planning**

- The board includes at least two members with a background in strategy development, commercial development, business planning or organisational development in the public or private sector.

- The executive team includes a head of strategy or equivalent board-level member who has a background in strategy development in the public or private sector.

- The board and executive team always deploy qualitative and quantitative information (e.g., market profiling information, information on national and local commissioning plans) when discussing strategic options.

- The board and executive team include a review of their strategic planning performance in all board capability reviews and act on any development points that review identifies.

- The board and executive team engage quarterly with external experts (including analysts and commentators) to gather new insights and hear external challenges to their views.

#### 3. Do the board and executive team have an identified, responsible and skilled supporting staff to draw on when they carry out strategic planning?

**Relevant hallmarks of high-quality strategic planning**

- In addition to board and executive capacity, there are at least two skilled fulltime equivalent (FTE) staff dedicated to strategic planning and commercial development (skill profiles provided by Monitor in documentation).

- At least one of these two dedicated FTEs has a background in strategy development, commercial development or business planning.

- The supporting staff report directly to nominated board and executive directors, and meet at least monthly with service line leads and clinical leads to discuss strategic issues.
4. Do the board and executive team have regular and frank strategy discussions with a range of LHE stakeholders (e.g., commissioners and other providers) and understand their perspectives?

**Relevant hallmarks of high-quality strategic planning**

- Board members and executives at various levels (e.g., CEO, COO, service line leads) regularly meet their commissioning counterparts and other stakeholders to discuss health economy strategy in general and particular strategic issues.

- Board members and executives attend and contribute to local strategy discussion forums (e.g., health economy-wide planning meetings, joint strategic needs assessment development meetings, ad hoc strategy forums).

- Provider representatives are involved in developing and reviewing commissioning strategies and the strategies of other partner organisations, and vice versa.

- Board members and executives can explain concisely the areas of congruence and areas of tension between the strategic intentions of their organisation and those of commissioners or other stakeholders (e.g., Health and Wellbeing Boards, Overview and Scrutiny Committees).

- Feedback received from stakeholders demonstrates that they characterise their relationship with the provider as strong and productive, with an open discussion of views at all levels.

**Step 2 – Questions and Hallmarks**

1. Has the organisation quantified the risks to its clinical and financial sustainability and developed transformation plans by drawing on accurate inputs, including internal performance information and external market data, which it has analysed and presented correctly?

**Relevant hallmarks of high-quality strategic planning**

- Strategy teams gather and analyse quantitative evidence related to key planning inputs and use supporting qualitative evidence.

- The provider draws on those inputs to generate and maintain three, five and ten-year forecast assumptions about the
development of key business factors including funding levels, tariff, demographics and demand, competitor intentions, clinical standards and guidance, and commissioner intentions.

- The provider also gains insight into what local patients, carers and other stakeholders require of services. The provider should base this on regularly-updated survey and patient outreach work, and include information on patient preferences for how the organisation should transform and develop.

- Staff update those forecast assumptions both when new information is identified and on a rolling annual basis to ensure that they remain accurate.

- Staff test those forecast assumptions with reference to comparable benchmarks (e.g., assumptions made in other provider strategic plans, assumptions included in commissioning strategies). When they identify areas of difference, they analyse and understand causes.

- The provider also maintains its insight into its performance by gathering and analysing internal information such as service line reporting activity, profitability data and activity forecasts.

- Those forecast assumptions directly inform trust work on strategic planning and feed into long-term financial models, Monitor APR submissions, clinical and commercial strategies and long-term strategic plans.

### 2. Can the board and executive team declare that their organisation will be financially and clinically sustainable according to current regulatory standards in one, three, five and ten years, if it keeps its current configuration and service profile?

**Relevant hallmarks of high-quality strategic planning**

- The board and executive team review clinical and financial sustainability quarterly and determine whether they can declare that the provider will be sustainable in one, three, five and ten years (a) in its current configuration and (b) if they implement planned transformation and development plans and deliver modelled “base case” returns.

- They base their assessment of sustainability on current regulatory standards (e.g., Monitor risk assessment framework criteria).

- The organisation has one, three, five and ten year strategic plans that illustrate the predicted sustainability position at each of
those points. The plans should include forecasts of financial factors (e.g., revenue, margin, surplus, cash flow, PFI obligations) and should also include forecasts of clinical viability (e.g., staffing shortages, minimum volume problems, excess activity etc).

3. Has the organisation identified a vision that establishes why and how the organisation should change or transform, if necessary, to deliver high quality and efficient patient care and address any sustainability gap identified?

**Relevant hallmarks of high-quality strategic planning**

- The organisation has a vision that explains how, at a high level, it will address any sustainability gap it identifies. This vision should be a direct response to the organisation’s evidence-based sustainability assessment.

- If the vision, when implemented, will not completely close the sustainability gap, then the organisation should acknowledge and explain the remaining gap.

- The organisation demonstrates in its plan documents that it considers a broad range of options for becoming sustainable using quantitative and qualitative assessment criteria.

- The organisation demonstrates in its plan documents that its vision for becoming sustainable is compatible with local commissioners’ intentions and national policy developments, or states clearly why it feels it is appropriate for the organisation to choose an alternative direction.

- The vision explains how patients will benefit from the transformation proposed, including considerations of quality, safety, efficiency and access.

4. Is that vision supported by plans for initiatives that can be shown to address any sustainability gap identified?

**Relevant hallmarks of high-quality strategic planning**

- The transformational vision is supported by plans for initiatives that the organisation must undertake to achieve it (e.g., service launches or closures, care model transformations, site and workforce developments, etc.)
Those initiative plans include modelled forecasts of financial contribution or clinical impact over the plan period. Those forecasts must be evidence-based and cautious. They should model potential impact in line with Monitor standards of financial forecasting, clinical performance benchmarks and workforce benchmarks.

The financial contribution and clinical impact of all the initiatives should be enough to close the sustainability gap. If they do not, the organisation should acknowledge and explain the gap.

Step 3 – Questions and Hallmarks

1. Does the trust have detailed delivery plans for each of its strategic initiatives that lay out milestones, resource requirements, dependencies and risk mitigations?

Relevant hallmarks of high-quality strategic planning

- For each initiative, the organisation has a detailed delivery plan including (a) a timeline for delivery with measurable milestones and metrics against which to assess progress, (b) an evaluation of resource and skills requirements and how those requirements will be met, (c) an identified responsible board-level sponsor, and (d) a risk log detailing potential delivery risks and mitigating actions.

- The organisation has mapped the dependencies between each initiative and all the other initiatives, so that potential knock-on risks are identified.

- For each initiative, the organisation has developed a stakeholder map to identify (a) the inputs required from key stakeholders both within and outside the organisation, and (b) the broader group of stakeholders who must be engaged with or informed to ensure successful delivery.

- The organisation reviews performance of their plan for each initiative and updates the resource requirements and risk log every month.

- Regular reports are presented to the board or relevant committees on initiative progress.
## Step 3: Does the trust have skilled staff to implement those delivery plans?

**Relevant hallmarks of high-quality strategic planning**

- The organisation reviews quarterly the total staffing requirements (FTE staffing levels and skills mix) to deliver each initiative individually, and all of the strategic initiatives supporting the vision collectively. The review should include both members of strategic planning teams and the clinical and service-level staff needed to deliver the initiatives.

- The organisation has a staffing capacity and skills development plan that it updates quarterly, based on those reviews of initiative staffing. The plan monitors whether there will be enough of the right resources and skills and shows how any shortages in either will be addressed.

## Step 3: Are trust staff, patients and other stakeholders able to explain the ambition and initiatives of the provider when asked, and do they know what they must do to deliver both?

**Relevant hallmarks of high-quality strategic planning**

- The ambition of the organisation has been communicated to staff in clearly-written documents and verbal briefings, and staff can explain the ambition when asked.

- Staff are briefed on their responsibilities for delivering the ambition and strategic initiatives, and can clearly explain those responsibilities when asked.

- Staff have incentives for delivering the initiatives, with achievement targets built into their objectives.

- LHE stakeholders, including commissioners, can explain the ambition of the organisation when asked.

## Step 3: Are strategic plans reviewed and updated yearly to keep them relevant?

**Relevant hallmarks of high-quality strategic planning**

- The board and executive team review the strategic plans of the organisation once a year to ensure that they are still based on accurate and up-to-date inputs, and fully reflect developments in the trust’s internal performance and external environment.
Board of Directors

Strategic Plan Priorities
14th May 2014

Objective:
The objective of this report is to ask the Board to consider the proposed strategic priorities which will provide the framework for CNWL’s Strategic Plan 2014-2019.

The strategic plan sets out CNWL’s direction over the next five years. It follows on from the Operational Plan agreed by the Board in March, and which describes our detailed plans over the next two years.

The key initiatives in the Strategic Plan will relate to these priorities, which in turn are linked to the Trust’s vision, values and objectives.

The Board is asked to:
Consider the strategic priorities and agree them as the framework for the Strategic Plan

Executive summary:
The proposed Strategic Priorities are set out in the table below. There is a second section on next steps with key dates.

John Vaughan
7th May 2014
Context:

The Strategic Priorities will provide the framework for the Strategic Plan which sets out CNWL’s direction over the next five years.

The priorities have been amended from the Operational Plan to include:
- Areas highlighted by CQC and Monitor in recent communications with the Trust
- Discussion with the Executive - 2nd May 2014
- Discussion with the Council of Governors Annual Planning sub-group – 6th May 2014

Proposed Strategic Priorities 2014-2019:

<table>
<thead>
<tr>
<th>No</th>
<th>Strategic Priority</th>
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| 1  | To deliver high quality care and best outcomes for patients  
- To include principles of recovery and co-production | Robyn Doran |
| 2  | To achieve system-wide transformational change through working with partners and stakeholders nationally and locally  
- To include principles of integrated care and service redesign | Alex Lewis |
| 3  | To recruit and develop a workforce where every member of staff takes responsibility for care that is safe, effective and provides patients and their families with a positive experience  
- To include robust safeguarding awareness and processes across the organisation | Louise Norris |
| 4  | To achieve financial stability and deliver savings  
- To include control mechanisms, productivity and efficiency | Trevor Shipman |
| 5  | To continue to develop and deliver an ICT Strategy which meets the needs of CNWL and our partners as well as improving the experience of our service users. | Mark Large |
| 6  | To build organisational resilience through consolidation and growth | John Vaughan |

Next steps:
Once agreed, these priorities will be incorporated into the Strategic Plan – providing the framework for our key workstreams.

The Board will receive the Strategic Plan for consideration and sign off at the workshop on 11th June. This will be subject to provision for financial sign off and final amendment by the Business and Finance Committee on 26th June.
Board of Directors

14 May 2014

The Board is asked to:
- The Board are requested to delegate the authority for approving the Financial Accounts, Quality Accounts and Annual Report to the Audit Committee meeting on 27th May 2014.

Director of Finance
May 2014