

Health and Social Care Scrutiny Sub-Committee **AGENDA**

DATE: Thursday 19 April 2012

TIME: 7.30 pm

VENUE: Committee Room 5
Harrow Civic Centre

MEMBERSHIP (Quorum 3)

Chairman: Councillor Ann Gate

Councillors:

Jerry Miles
Sachin Shah

Mrs Vina Mithani (VC)
Simon Williams

Advisers: Mr Julian Maw – Harrow LINK
Dr Nicholas Robinson – Harrow Local Medical Committee

Reserve Members:

1. Ben Wealthy
2. David Gawn
3. Krishna James

1. Barry Macleod-Cullinane
2. Mrs Lurline Champagne OBE

Contact: Alison Atherton Senior Professional Democratic Services
Tel: 020 8424 1266 E-mail: alison.atherton@harrow.gov.uk

AGENDA - PART I

1. ATTENDANCE BY RESERVE MEMBERS

To note the attendance at this meeting of any duly appointed Reserve Members.

Reserve Members may attend meetings:-

- (i) to take the place of an ordinary Member for whom they are a reserve;
- (ii) where the ordinary Member will be absent for the whole of the meeting; and
- (iii) the meeting notes at the start of the meeting at the item 'Reserves' that the Reserve Member is or will be attending as a reserve;
- (iv) if a Reserve Member whose intention to attend has been noted arrives after the commencement of the meeting, then that Reserve Member can only act as a Member from the start of the next item of business on the agenda after his/her arrival.

2. DECLARATIONS OF INTEREST

To receive declarations of personal or prejudicial interests, arising from business to be transacted at this meeting, from:

- (a) all Members of the Sub-Committee;
- (b) all other Members present in any part of the room or chamber.

3. MINUTES (Pages 1 - 12)

That the minutes of the meeting held on 6 December 2011 and of the Special meeting held on 7 February 2012 be taken as read and signed as correct records.

4. PUBLIC QUESTIONS

To receive questions (if any) from local residents/organisations under the provisions of Committee Procedure Rule 17 (Part 4B of the Constitution).

5. PETITIONS

To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Committee Procedure Rule 15 (Part 4B of the Constitution).

6. DEPUTATIONS

To receive deputations (if any) under the provisions of Committee Procedure Rule 16 (Part 4B) of the Constitution.

7. REFERENCES FROM COUNCIL AND OTHER COMMITTEES/PANELS

To receive any references from Council and/or other Committees or Panels.

8. FULL BUSINESS CASE FOR EALING HOSPITAL TRUST AND NORTH WEST LONDON HOSPITALS TRUST MERGER (Pages 13 - 14)

Letter from Ealing Hospital NHS Trust and North West London Hospitals NHS Trust

9. QUALITY ACCOUNT 2011-12 (Pages 15 - 44)

Report of North West London Hospitals NHS Trust

10. REVIEW OF PAEDIATRIC CONTRACTS (Pages 45 - 50)

Report of NHS Brent and Harrow

11. ADMIRAL NURSES SERVICE UPDATE (Pages 51 - 52)

Report of NHS Harrow

12. QUALITY ACCOUNT 2011-12 (Pages 53 - 120)

Report of Central North West London NHS Foundation Trust

**13. INFORMATION ITEM - JOINT OVERVIEW AND SCRUTINY COMMITTEE
(Pages 121 - 206)**

Report of the Divisional Director of Partnership Development and Performance considered by the Overview and Scrutiny Committee on 3 April 2012

14. ANY OTHER BUSINESS

Which the Chairman has decided is urgent and cannot otherwise be dealt with.

AGENDA - PART II

Nil

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HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE MINUTES

6 DECEMBER 2011

Chairman: * Councillor Ann Gate

Councillors: * Jerry Miles * Sachin Shah
* Mrs Vina Mithani * Simon Williams

* Denotes Member present

70. Attendance by Reserve Members

RESOLVED: To note that there were no Reserve Members in attendance at this meeting.

71. Declarations of Interest

Agenda Item: 8 Outline Business Case for Ealing Hospital Trust and North West London Hospital Trust Potential Merger; Agenda Item: 9. HealthWatch; Agenda Item: 10. Adult Social Care – Local Account

Councillor Ann Gate declared a personal interest on the above items in that she was employed by the Pinn Medical Centre. She would remain in the room whilst these matters were considered and voted upon.

Councillor Mrs Vina Mithani declared a personal interest in the above items in that she was employed by the Health Protection Agency. She would remain in the room whilst these matters were considered and voted upon.

Councillor Simon Williams declared a personal interest in the above items in that his wife was a Community Psychiatric Nurse for North West London Mental Health Trust. He would remain in the room whilst these matters were considered and voted upon.

72. Minutes

RESOLVED: That the minutes of the meeting held on 24 October 2011 be taken as read subject to:

The first line of Minute Item 66, paragraph two being amended to read: 'Mr Simon Crawford, Senior Responsible Officer for the Organisational Futures Programme for Ealing Hospital NHS Trust and the North West London Hospitals NHS Trust ...'

73. Public Questions, Petitions and Deputations

RESOLVED: To note that no public questions were put, or petitions or deputations received at this meeting.

74. References from Council and Other Committees/Panels

RESOLVED: To note that there were no references.

RESOLVED ITEMS

75. Outline Business Case for Ealing Hospital Trust and North West London Hospital Trust Potential Merger

Mr Simon Crawford, Senior Responsible Officer for the Organisational Futures Programme for Ealing Hospital NHS Trust and the North West London Hospitals NHS Trust introduced the Outline Business Case (OBC) for the Ealing Hospital Trust (EHT) and North West London Hospital Trust (NWLHT) potential merger. The OBC, titled 'STRONGER Together', put forward the case for the creation of a single trust by July 2012.

Mr Crawford stated that the OBC had been approved by both Trust Boards in November 2011 and contained four key chapters. Chapter 3 - Commissioning Strategy in North West London, provided an overview of the health needs of Brent, Ealing and Harrow, the three boroughs served by the Trusts. It examined the priorities of the Commissioners, the financial challenges and the potential impact on services. He added that the Commissioning Strategy had been formed with input from GPs and community groups, seeking to place a greater emphasis on shifting care from hospitals into the community.

Chapter 4 - Implications for EHT and the NWLHT, investigated the implications for each hospital should it remain independent, and outlined the visions of both Trusts to deliver the highest quality of care. It examined the latest guidance issued by bodies such as the National Institute for Clinical Excellence and the Care Quality Commission (CQC), for example. The chapter concluded that reasons such as the increased availability of appropriate staff and services would serve to demonstrate why a merger would be beneficial to patients.

Chapter 6 - Clinical Vision for a Combined Organisation, discussed how the potential merger would make better use of equipment and resources. It provided the clinical vision to deliver the benefits of an integrated healthcare service through increased partnership with GPs and social care sector, for example. The chapter also included an appendix which was devised with input from senior clinicians and GPs within the Trusts to highlight scenarios in response to the future commissioner's plans for services.

Chapter 7 - Financial Evaluation, inspected the historical performance of both Trusts. Responses to the financial challenge had been developed through a Finance Working Group.

In response to a question by a Member relating to how many redundancies would result from the merger, Mr Crawford advised that there would be employment implications for roles associated across the merged organisations. Mr Peter Coles, Interim Chief Executive of North West London Hospitals Trust, added that there were no detailed workforce plans at this stage, and stated that efficiencies would be sought from non-clinical staff to protect patient service delivery.

A Member queried the reduction in the physical footprint of the hospitals involved in the potential merger. Mr Crawford advised that the intention was to place a greater emphasis on providing services in the community, and added that work with GPs and those from the community sector would be continued to help develop outreach services. Estates planning exercises would be conducted as part of the Full Business Case (FBC), which was under construction.

In response to a question by a Member relating to the private patient strategy, Mr Crawford advised that to prevent the underutilisation of hospitals, private funding was being explored to make better use of available space. Professor Rory Shaw, Medical Director, North West London Hospitals NHS Trust, added that advances in medicine and evolution in technology had served to drastically reduce the length of hospital stays for patients. It was essential to reflect this reduction in stay time in the better use of available ward space and resources.

A Member sought assurances that patients were being discharged as a result of receiving the best possible care, and not simply to save money. Mr Coles responded that there was no evidence that NWL Hospital's discharge rates were too aggressive, adding that the Trusts were compliant with national targets in this area.

A Member requested ways in which the Authority could offer further support. Dr Alfa Sa'adu, Medical Director Ealing Hospital Trust, responded that Health and Wellbeing Boards could prove useful by helping to inform the public of the advantages of a merger. He added that the close relationship elected Members had with their constituents could also assist with spreading that message. Mr Coles added that the vision of the merger could only work with joint effort and a shared focus. Mr Crawford stated that there was currently no formal means of communication between the Authority and the team

co-ordinating the potential merger. The possibility of establishing a formal means of co-ordination would be explored.

A Member sought clarification on how much the OBC had cost to compile. Mr Crawford advised the Sub-Committee that the OBC had cost approximately £1.4 million to date and the merger in total should amount to £3 million.

Information was sought by a Member in what was perceived as a potential disadvantage of the merger. Mr Crawford advised that implementing such a large scale operation whilst continuing with patient services carried a degree of risk, adding that the risk was outweighed by the benefits which would include a more unified trust bringing together the already existing Brent, Ealing and Harrow Integrated Care Organisation. The merger would also provide the opportunity to deal with the underlying debt of NWLH and meet the challenges faced by Ealing Hospital Trust as a stand alone organisation. Dr Sa'adu reiterated this sentiment by emphasising that the individual hospitals would be unlikely to meet future challenges on their own.

A Member questioned how staff associated with the merger were being engaged. Mr Crawford responded that approximately forty staff sessions had been conducted where staff were given the opportunity to pose direct questions. Regular emails and bulletins were also sent to members of staff. In response to a question by a Member regarding the moral of staff, Mr Coles stated that staff had been fully informed at every stage of the process. This reduced the period of uncertainty and aimed to prevent rumours from spreading.

In response to a point made by a Member that the issue of transport should be explored with TfL early on, Mr Crawford advised that potential issues surrounding transportation between hospitals had been considered. The possibility of providing transport services would be investigated.

RESOLVED: That the report be noted.

76. HealthWatch

The Sub-Committee received a presentation of the Assistant Chief Executive which outlined the establishment of local HealthWatch by October 2012, subject to the Health and Social Care Bill. The officer advised that:

- HealthWatch would be the local consumer champion across health and social care;
- Local HealthWatch would not be a network but a 'body corporate', independent of the Authority. 'Body corporate' would include companies with limited or unlimited liability, companies limited by guarantee, charter companies and bodies created by statute;

- Overseeing HealthWatch would be HealthWatch England, the national independent champion for health and social care consumers. HealthWatch England would sit within the Care Quality Commission (CQC) to provide support to local HealthWatch organisations.

In response to a question by a Member regarding the accountability of HealthWatch, the officer advised that an option was for the Management Group, which included representatives from Adult Complaints and the voluntary and community sector, to become more robust to help scrutinise performance and an options paper will be put together to address this. An adviser to the Sub-Committee suggested that as HealthWatch was independent, it would operate outside of Council scrutiny system. The officer asserted that it will be even more important to build a more robust management group to monitor performance as HealthWatch would have a great deal of responsibility. This was acknowledged by Members.

A Member queried the percentage of income that would be awarded to HealthWatch. The officer responded that the money awarded would be dependant on the services HealthWatch were expected to deliver. The officer added that HealthWatch would be shaped through intensive consultation exercises within the community. A rigorous tendering exercise, similar to that conducted when founding LINK, would ensure the establishment of a prosperous Local HealthWatch.

RESOLVED: That the presentation be noted.

77. Adult Social Care - Local Account

The Corporate Director for Adults and Housing introduced a report which set out the Directorate's historical approach to Quality Assurance and how this had led to the development of a Local Account for Adult Social Care.

The officer advised that the importance of robust quality assurance remained as the Care Quality Commission (CQC), the regulator of home care and residential inspections, had ceased assessing all local authorities work with vulnerable people. Harrow's Quality Assurance framework, which had received national acclaim, had been developed around four key areas:

1. Independent Challenge;
2. Consumer/Citizen Challenge;
3. Provider Challenge;
4. Professional Challenge.

All quadrants were continually being monitored to ensure the best performance from a variety of perspectives.

In response to a question by a Member, the officer advised that user views were essential. Those using the services had the opportunity to provide direct feedback on how services should work and improvements they would like to see implemented.

In relation to a question by a Member relating to the potential merger, that officer stated that the Ealing Hospital Trust and North West London Hospital Trust potential merger had not had an impact on services. The situation surrounding the potential merger would be monitored.

In response to a question by a Member regarding personal budgets, the officer advised that it was hoped the Council would commit to all eligible residents in the borough receiving personal budgets, although choice was at its heart and personal budgets were by no means mandatory. Consideration would be given to utilising Local HealthWatch to help interpret the Adult Social Care Local Account.

A Member queried how the Local Account would be made more accessible. An officer advised that more digestible versions would be available once the document had been transferred to Easy-Read. In addition, in response to consultation, a DVD had also been produced to make the Local Account accessible to all areas of the community. The officer added that continuous dialogue with customers and regular meetings with service users ensured that management were kept fully engaged with what was happening in the community.

RESOLVED: That the report be noted.

(Note: The meeting, having commenced at 7.30 pm, closed at 9.35 pm).

(Signed) COUNCILLOR ANN GATE
Chairman

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE (SPECIAL) MINUTES

7 FEBRUARY 2012

Chairman: * Councillor Ann Gate

Councillors: * Jerry Miles * Sachin Shah
* Mrs Vina Mithani * Simon Williams

* Denotes Member present

78. Attendance by Reserve Members

RESOLVED: To note that there were no Reserve Members in attendance.

79. Declarations of Interest

Agenda Item 4 - NHS North West London, Commissioning Strategy Plan 2012-15; Agenda Item 5 - NHS Harrow Budget Position and Savings Plan with Reference to the Implications on NWLH; Agenda Item 6 - NWLH Budget Position and Savings Plan with Reference to the Implications on NHS Harrow; Agenda Item 7 - Temporary closure of Central Middlesex Hospital A&E; Agenda Item 8 - Safeguarding Children

Councillor Ann Gate declared a personal interest on the above items in that she was employed by the Pinn Medical Centre. She would remain in the room whilst these matters were considered and voted upon.

Councillor Mrs Vina Mithani declared a personal interest in the above items in that she was employed by the Health Protection Agency. She would remain in the room whilst these matters were considered and voted upon.

Councillor Sachin Shah declared a personal interest in the above items in that he was employed by Parkinson's UK. He would remain in the room whilst these matters were considered and voted upon.

Councillor Simon Williams declared a personal interest in the above items in that his wife was a Community Psychiatric Nurse for North West London Mental Health Trust. He would remain in the room whilst these matters were considered and voted upon.

80. Deputations

RESOLVED: To note that no deputations were received at this meeting.

RESOLVED ITEMS

81. NHS North West London, Commissioning Strategy Plan 2012-15

Mr Elkeles, Director of Strategy for North West London Cluster, provided Members with a presentation, 'Shaping a Healthier Future'. He advised that the programme pledged to provide the support needed for two million people in North West London to look after themselves, grant easy access to primary care clinicians and promote well co-ordinated access to specialists and up-to-date hospital facilities.

The timeline for the programme would allow for a minimum of 12 weeks public consultation, with a preferred option being anticipated to be available by April 2012. Two engagement events were being held on 15 February and 23 March 2012 to discuss the programme and grant the opportunity for local patient representatives and clinicians the opportunity to influence the development of the proposals.

It is anticipated that a Joint Health Overview and Scrutiny Committee (JHOSC) would be established to provide external scrutiny and enable the eight different boroughs within North West London the opportunity to shape the proposals of the programme.

In response to a question by a Member regarding the size of the hospitals in North West London and accessibility to A & E, Mr Elkeles advised that more money was spent on hospitals than any other part of the service which needed to be redressed. Spending more on hospitals resulted in less available money for front line care. The programme aims to tackle this by creating better primary and community services, by developing a robust out of hospital model of care through joined up working with GPs, the community and Social Services whilst reducing the number of hospitals.

In response to a question by a Member regarding the size of the hospitals in North West London, Mr Elkeles advised that more money was spent on hospitals than any other part of the service which needed to be redressed. Spending more on hospitals resulted in less available money for front line care. The Programme aimed to tackle this by creating better primary and Community services, through the development of a robust out of hospital model through joint-up working with General Practitioners (GP), the community and Social Services whilst reducing the number of hospitals.

As Public Health is due to become the responsibility of local authorities subject to the passing of the Health and Social Care Bill, a Member questioned how the authority could play a greater role in the delivery of the healthcare proposals. Dr Kelshiker advised that newly formed relationships as part of Health and Wellbeing Boards could provide a means of considering community care packages as a whole, and encourage closer working between the authority and healthcare professionals. Professor Shaw, Medical Director of North West London Hospitals NHS Trust, reiterated that as finances were diverted to areas of greatest need, closer working with the authority will become more important. Identifying problems earlier by anticipating care needs was paramount. Ms Sehgal, Borough Director of NHS Harrow, added that by co-ordinating care and identifying delays jointly, better outcomes for patients would be realised.

A Member queried the communication plan for the programme. Mr Elkeles advised that lots had been invested in the communication strategy, with a clear and transparent patient facing document being developed. In response to a question by a Member regarding public assurance, Mr Elkeles stated that all existing contacts, such as GP's and those based within hospitals, were being fully utilised. The Programme was supported by GPs and hospitals who agreed that the proposals would serve to benefit patients within North West London, a message which would be echoed throughout the consultation phase.

A member queried the timeline for the consultation on the proposals which was planned for June to September 2012, which would also coincide with the golden jubilee, the Olympics and members time off. Mr Elkeles explained that should a JHOSC be formed, a longer consultation period could be negotiated.

An Officer briefed Members on the views expressed by some of the other seven authorities that are being consulted on 'Shaping a Healthier Future' by NHS North West London. The officer requested the Sub-Committee's views on entering into a JHOSC to address the plans for 'shaping a Healthier Future'. The Sub-Committee agreed in principle that should a JHOSC be formed, Harrow would be part of it.

REOLVED: That the presentation be noted.

82. NHS Harrow Budget Position and Savings Plan with Reference to the Implications on NWLH

Ms Sehgal, Borough Director of NHS Harrow, presented a report which provided the NHS Harrow Budget position. Considerable improvement had been made in the achievement of capital resource limit, the under spend against resource limit and the achievement of cash limit.

The forecast outturn position in year was breakeven. This was made up of forecast overspends of £0.7 million on primary care, £0.3 million on prescribing and £0.8 million on acute commissioning. These overspends were offset by forecast under spends of £0.3 million on joint working, £1.1 million on community services and £0.4 million contingency.

The Quality Innovation Productivity and Prevention (QIPP) Programme included schemes designed to provide an expansion of rapid response and

home care, enhanced recovery and shorter stays in hospital, for example. The QIPP for 2012/13 had been risk assessed and approved by the cluster.

A Member requested scenarios of how money would be saved by less people attending hospital. Ms Sehgal advised that if a patient was displaying signs dementia for example, the case would be referred to a GP and then to hospital. By providing greater care in the community, tests could be conducted and the necessary care could be provided without the need for hospital admission, which would cost approximately £1,800 for two weeks care.

In response to a request by a Member for more in-depth analysis on the budget, Ms Sehgal advised that further information was available and would be sent to Members at their request.

Dr Kelshiker reiterated that proposals for greater community based care would not have the support of GP's, clinical specialists and the Clinical Commissioning Board (CCB) if they were designed solely to save money.

RESOLVED: That the report be noted.

83. NWLH Budget Position and Savings Plan with Reference to the Implications on NHS Harrow

Mr Kishamer Sidhu, Director of Finance for North West London Hospitals (NWLH), provided Members with the NWLH budget position and savings plan. He advised that the planned deficit of £9.7 million for 2011/12 had been approved by the Strategic Health Authority. The current model at the Central Middlesex Hospital was unsustainable, as greater activity was needed through the site.

Recruitment of staff on the middle grade had proven difficult, with the effect of the shortage being felt nationally. The recruitment and retention at a number of grades had also impacted on finances, with costs being offset by funding from Central Government.

In response to a question by a Member in relation to the increase in cash balances, Mr Sidhu advised that a transfer from capital to cash balances had been requested to reflect that capital had not been used.

RESOLVED: That the report be noted.

84. Temporary Closure of Central Middlesex Hospital A&E

Professor Shaw, Medical Director of North West London Hospitals NHS Trust, advised Members that the temporary closure of the Central Middlesex Hospital A&E department followed the establishment of the GP led Urgent Care Centre at the hospital. The Urgent Care Centre absorbed approximately 70% of the workload for the A&E department.

The A&E department was run exclusively on agency staff at a rate of approximately two patients per hour. Middle grade staff had been increasingly difficult to recruit and retain, with the situation reaching a climax

when a clinician did not arrive for work which resulted in a single doctor covering the department for 24 hours.

An action plan was being developed, with regular meetings with the sector being held. Advertisements for five new Consultants and a Clinical Director were due to be published in February 2012. In addition, a recruitment drive in partnership with Imperial College had been initiated to tackle recruitment issues with middle grade staff.

RESOLVED: That the report be noted.

85. Safeguarding Children

An Officer advised the Sub-Committee that concerns had been raised in relation to the Safeguarding of Children. It was intended to hold a scrutiny review. Issues were being investigated. Information on the matter would be circulated to Members once the scope has been signed off by the Overview and Scrutiny Committee.

RESOLVED: That the verbal report be noted.

(Note: The meeting, having commenced at 7.30 pm, closed at 9.45 pm).

(Signed) COUNCILLOR ANN GATE
Chairman

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Trust Headquarters

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Southall, Middlesex
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Tel: 020 8967 5492

Trust Headquarters

Northwick Park Hospital
Watford Road
Harrow, HA1 3UJ
Tel: 020 8869 2002

Thursday 5 April 2012

Chairman, Councillor Ann Gate
Health and Social Care Scrutiny Sub – Committee
Harrow Council
Civic Centre
PO Box 57, Station Road
Harrow HA1 2XF

Dear Councillor Gate

Re: Proposed merger of Ealing Hospital NHS Trust and The North West London Hospitals NHS Trust

We are writing to update you on the next steps with regards to the publication of the Full Business Case (FBC) for the proposed merger of our Trusts and provide you with a general update on the merger programme.

Full Business Case

As you will be aware from an email from Simon Crawford on 28 March, we submitted the FBC as planned to NHS London on 9 March and we were aiming to present the Business Case to both Trust Boards on the 29 March. However, due to the need to refine the financial elements of the FBC to ensure that it meets the requirements of NHS London we were not able to do so.

NHS London and indeed our Trusts' Boards remain committed to the merger process. As soon as we have a clearer picture of the timescales for publication we will let you know.

Given that we had hoped to present the FBC at your next committee meeting it would be useful to have a discussion with you as to the best way forward. Simon Crawford will be in contact with you after Easter to discuss.

Appointment of Transaction Director

We would like, however, to take this opportunity to formally welcome David McVittie. He has been appointed by NHS London as Transaction Director and will be leading the merger process working closely with ourselves and Senior Responsible Officer Simon Crawford. Many of you will know David as he was previously Chief Executive of Hillingdon Hospital NHS Trust. David has more than 21 years' experience at executive director level in the NHS and private sector. Before working in the NHS he worked for

PricewaterhouseCoopers and British Telecom. He was Chief Executive at Hillingdon Hospital for 11 years.

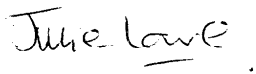
Name for the new organisation

We have started the process of deciding the name for the new organisation. In deciding the name, we are required to follow NHS Identity Guidelines, which are fairly prescriptive about the type of name that can be chosen, and that we consult with staff and neighbouring NHS organisations.

As part of our consultation with staff, we shared a shortlist of names and asked staff to vote on their preferred options via an online survey. Their preferred choice was **London North West Healthcare NHS Trust**. At a meeting of both Trust Boards on 29 March, this name was endorsed and it was agreed that we would now consult with neighbouring NHS Trusts. Final agreement on the name will be required from Department of Health.

Finally, can we take this opportunity to thank you for your ongoing interest and support, and apologise for any inconvenience the change in timetable regarding the FBC may have caused in the planning of your meetings. We hope this update was helpful. Please feel free to contact our offices if you would like to discuss any of the matters in this letter in more detail.

Yours sincerely,



Julie Lowe
Chief Executive
Ealing Hospital NHS Trust



Peter Coles
Chief Executive
The North West London Hospitals NHS Trust

Quality Account

2011 – 2012

**North West London Hospitals NHS Trust
Quality Account 2011 – 2012**

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Who we are

The North West London Hospitals NHS Trust (NWLHT) manages Northwick Park and St Mark's hospitals in Harrow and Central Middlesex Hospital in Brent.

We care for more than half a million people living in Brent and Harrow, as well as patients from all over the country and internationally at St Mark's, our specialist hospital for bowel diseases. This makes us one of the biggest and busiest NHS trusts in the capital.

We employ approximately 4,800 doctors, nurses, therapists, scientists and other health professionals as well as administrative and support staff, making us one of the largest employers locally.

We are a major centre for undergraduate and postgraduate education – teaching many nurses, doctors and other health professionals each year. Our principal partners are Imperial College London and Thames Valley University.

For more information visit www.nwlh.nhs.uk

Part 1 Chief Executive Statement

Narrative to be inserted on completion by CEO

Safeguarding Vulnerable Adults (SVA)

Narrative to be inserted quality related action and performance during 2011/12

Safeguarding children

Narrative to be inserted quality related action and performance during 2011/12

Maternity services

Narrative to be inserted quality related action and performance during 2011/12

Emergency Department (A&E)

Narrative to be inserted quality related action and performance during 2011/12

Part 2 Priorities for Improvement and Statements of Assurance

Report on Quality Priorities 2011/12

In our 2010/11 Quality Account we outlined key priorities for quality improvement in the organisation. These were:

- **Priority 1** Improve overall patient satisfaction
- **Priority 2** Reduce the number of falls (and the 'harm' they cause) amongst patients while they are in hospital
- **Priority 3** Increasing the number of patients discharged on a Chronic Obstructive Pulmonary disease (COPD) "discharge care bundle" following an admission with acute exacerbation of their COPD

We agreed ways in which to measure our progress against our priorities and the information below describes how we have performed.

Priority 1 Improve overall patient satisfaction

- Improve Trust performance for eliminating mixed sex accommodation
- Improve performance against key performance indicators related to patient experience

Eliminating mixed sex accommodation

The NHS Operating Framework for 2011/12 required all providers of NHS funded care to confirm they are compliant with the national definition *'to eliminate mixed sex accommodation except where it is in the overall best interests of the patient, or reflects their patient choice'*.

During 2009/10 the Trust had found it was struggling to meet the targets to meet this requirement challenging and reported to the following breaches:

- 147 breaches - December 2010
- 141 breaches – January 2011
- 184 breaches – February 2011

Hence this became a key priority for 2011/12.

2011/12 performance information under validation

Improving performance against patient experience indicators

This was a key improvement target during 2010/11 and whilst the Trust made progress in some areas this did not go far enough and it was, therefore, a key priority once again in 2011/12.

We particularly sought to make improvements on five core quality standard questions agreed as a standard across London and with our commissioners. These focused on responsiveness to the personal needs of patients and the questions were:

- Were you as involved as you wanted to be in decisions about your care and treatment?
- Did you find someone to talk to about worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Were you told about medication side effects to watch out for when you went home?
- Were you told who to contact if you were worried about your condition after you left hospital?

2011/12 performance information under validation

Priority 2 Reduce the number of falls (and the 'harm' they cause) amongst patients while they are in hospital by:

A patient falling is one of the most common patient safety incidents reported to the National Patient Safety Agency (NPSA) via its National Reporting and Learning Service (NRLS). It is a major problem in hospitals with approximately 152,000 reported in acute hospitals in England and Wales each year. Many of these falls can lead to serious harm and the NPSA estimates that there are over 530 patients every year who fracture a hip following a fall in hospital, and a further 440 patients who sustain other fractures.

Although the majority of falls result in no harm, even falls without injury can be upsetting and lead to loss of confidence, increased length of stay in hospital and increase the likelihood that someone will have to be discharged to a residential or nursing home care.

The Trust made this a key priority for 2011/12 aiming to achieve:

- A reduction in the total number of falls by the end of the year of 10%
- A reduction in the 'harm'* caused to the patient as a result of those falls

*Harm' here is defined as scoring 2 or above in the NPSA severity level table for falls. This includes categories of minor, moderate, major and catastrophic harm. More details can be found on the NPSA website: www.npsa.nhs.uk

2011/12 performance information under validation

Priority 3 Increasing the number of patients discharged on a Chronic Obstructive Pulmonary disease (COPD) “discharge care bundle” following an admission with acute exacerbation of their COPD.

COPD stands for chronic obstructive pulmonary disease and this is a term used for a number of conditions; including chronic bronchitis and emphysema. COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder to breathe. The word 'chronic' means that the problem is long-term.

The most common cause of COPD is smoking. Once you give up smoking, you gradually reduce the chances of getting COPD - and you slow down its progress if you already have it. Occupational factors, e.g. coal dust and some inherited problems can also cause COPD.

Symptoms of COPD vary depending on how bad it is, and how people have adapted to their problems. In mild cases, symptoms like a cough, phlegm and shortness of breath may only be present during the winter or after a cold. In more severe cases, you may be short of breath every day. Exacerbations are also known as flare-ups and are common in people with COPD, often leading to an admission to hospital.

During 2011/12 the Trust worked with partners in primary care to specifically improve the quality of care for patients admitted to hospital with an exacerbation of COPD.

The improvement target set was that, for a minimum of 75% of patients admitted with an acute exacerbation of COPD, during their admission / before their discharge, we completed our COPD Discharge Care Bundle.

We measured performance through two audits: one related to patients admitted in August 2011 and the other on patients admitted in February 2012.

The results of the August 2011 audit indicated a compliance rate of 76.6%.

AWAITING Validation of Feb 2012 results

Priorities for 2012/13

The Trust continues to make progress to embedding quality improvement within the culture of the organisation and discussions about quality are an integral part of the Trust Board and committee structure at all levels of the organisation.

To support this we continue to hear a “Patient Story” at the start of many Board meetings where Board members hear first hand from patients about their experience of using the services provided by NWLHT.

Additionally, we have taken into account feedback from our healthcare partners and taken account of the local Commissioning for Quality and Innovation (CQUIN) priorities and the national and regional picture. We have reviewed performance against our priorities for 2011/12 to decide if improvements and monitoring are sufficiently embedded and established within normal working.

Following review and discussions we have identified the following quality priorities for focus as we believe they significantly contribute to the safety, clinical effectiveness and patient experience agenda for 2012/13:

Priority 1 - Continued development and improvement of the patient journey and experience through accident and emergency (patient pathway):

Narrative to be inserted regarding 2012/13 quality related action and performance measures

Priority 2 Further improve the quality of care for our vulnerable adults with dementia

About 750,000 people in the UK have dementia – and this number is expected to double in the next thirty years. Dementia damages the structure of the brain and affects a person’s ability to think, use language, remember, understand and make judgments. It can change a person’s personality and make it difficult for them to control their emotions and behave appropriately in social situations.

Dementia usually affects people over the age of 60. It is very common, and one in every 20 people over the age of 65 has dementia, and one in five over the age of 80. In most cases, there is no cure for dementia, and symptoms get worse over time. Even so, it is important to get treatment so that a person can cope better with their symptoms and improve their quality of life. Getting help early can make a big difference to a person’s future because they have time to establish routines that could help them stay independent for longer.

The Trust therefore will make the assessment of dementia a key priority in 2012. Work will include:

- Identifying people with dementia – members of staff will ask members of the family or friends of a person admitted to hospital if the patient has suffered any problems with their memory in the last 12 months
- Asses people with dementia – if there is evidence to suggest a problem with their memory, that person will be given a dementia risk assessment
- Refer on for advice – a referral would be made for further support either to a liaison team, a memory clinic or a GP.

In measuring quality improvement the Trust will aim for 90% of admitted patients aged 75 and over, identified (through a mini mental state examination) as at risk of having dementia being referred for specialist diagnosis.

Priority 3 Improve access to emergency theatres for all specialities

On comparing the amount of emergency surgery from 2009/10 to the present day, the Trust has had a 24.8% increase in volume. This had resulted in a lack of time and space and does not allow patients to have their operative procedure within an optimum time. We therefore need to make a change to the way we do things to avoid our patients staying in hospital longer than they should, which is not only costly but disruptive to patients' lives, delaying their recovery.

Additionally this potential delay in getting into theatre is a poor patient experience and could possibly adversely affect patient outcomes and lead to an increase in post-operative complications further adding to length of stay in hospital.

It is therefore the Trust's intention that all our emergency patients should receive their surgery within 24 hours of the decision to operate and as a consequence improve our patient experience and outcomes, reduce length of stay and therefore the related expenditure on bed days.

Further narrative to be inserted regarding 2012/13 quality related action and performance measures

Statements of Assurance

During 2011/12 NWLHT provided and or sub contracted **XX** NHS services. The Trust has reviewed all the data available to them on the quality of care in **XX** of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents **XX** per cent of the total income generated from the provision of NHS services by NWLHT for 2011/12.

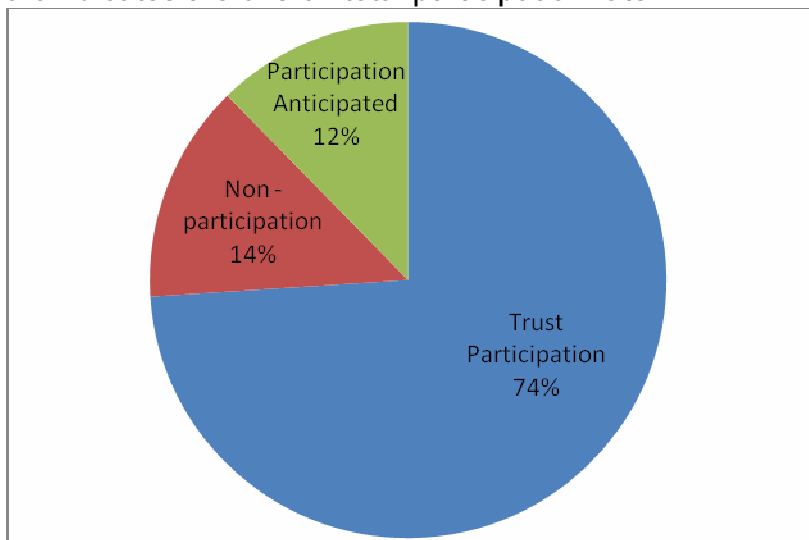
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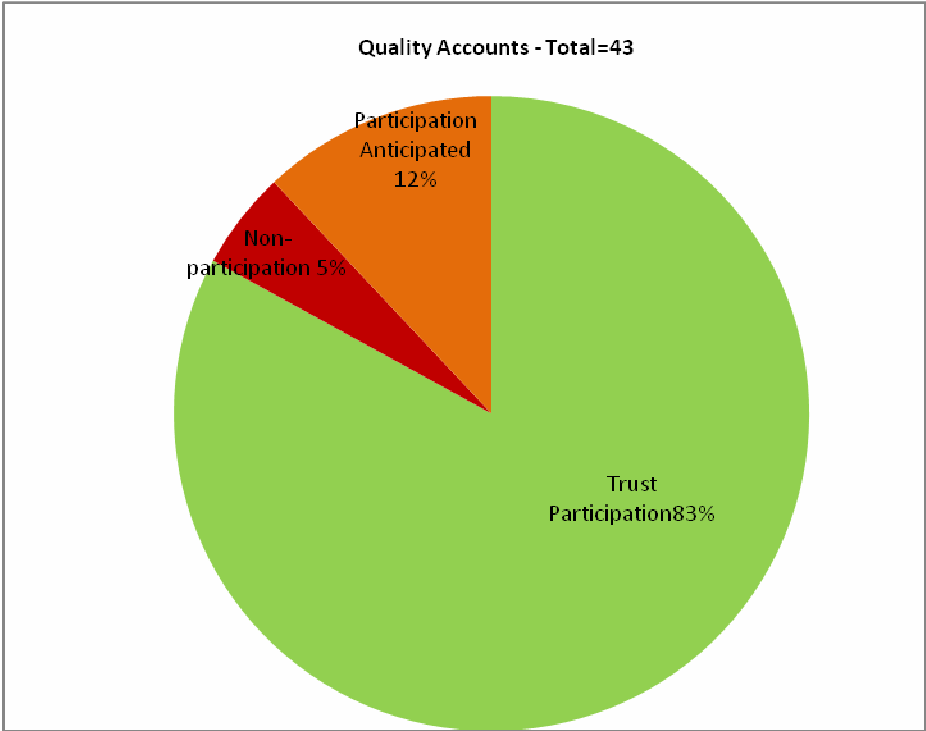
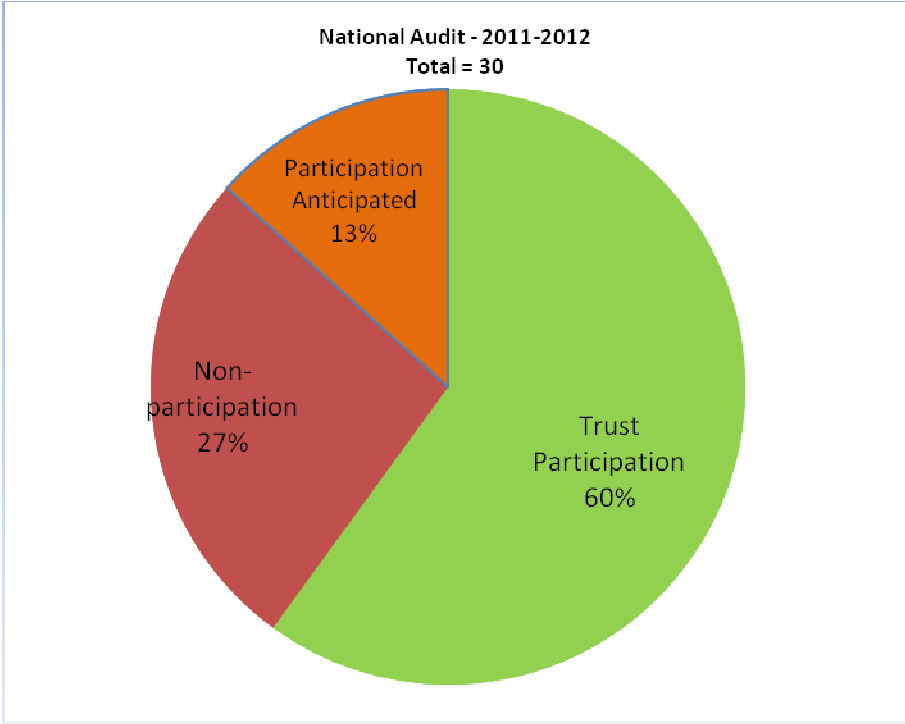
Clinical Audit

During 2011-12, there was a total of 86 National/Quality accounts Audits eligible to NHS Trusts. Of the 86, 73 National/Quality Accounts audits were applicable to this Trust as a relevant service is provided by NWLH

Total applicable to trust	N=73/86 [n/a 13 excluded from the calculation.]
Trust Participation	N= 54
Non – participation	N= 10
Participation Anticipated	N= 9

Of the 73 Audits, 43 were Quality accounts audits and 30 National Clinical Audits
Pie Chart indicates the overall total participation rate:





Name of Quality Account audits - 2011/2012	Participation
Perinatal mortality	✓
Neonatal intensive and special care	✓
Pain management	✓
Childhood epilepsy (Organisational)	✓
Childhood epilepsy (clinical)	✓
National Paediatric Diabetes Audit	✓
Emergency use of oxygen	✓
Adult community acquired pneumonia	✓
Non invasive ventilation - adults	✓
Pleural procedures	✓
Severe sepsis & septic shock	✓
Seizure management	✓
National Adult Diabetes Audit	✓
Heavy menstrual bleeding	✓
Ulcerative colitis & Crohn's disease (Clinical)	✓
Ulcerative colitis & Crohn's disease (organisational)	✓
IBD audit Biological	✓
National Parkinson's Audit	✓
Bronchiectasis	✓
Hip, knee and ankle replacements (National Joint Registry)	✓
Peripheral vascular surgery (Vascular Surgery Database)	✓
Carotid Intervention Audit	✓
National Lung Cancer Audit	✓
National Bowel Cancer Audit Programme	✓
Head & Neck Cancer	✓
National Oesophago-gastric Cancer Audit	✓
National Hip Fracture Database	✓
Severe trauma (Trauma Audit & Research Network)	✓
National Bedside transfusion	✓
National - Medical use of blood	✓
National Health Promotion in Hospitals Audit	✓
Care of dying in hospital	✓
Acute Myocardial Infarction & other ACS	✓
National Heart Failure Audit	✓
Acute stroke	✓
Cardiac arrhythmia /Cardiac Rhythm Management Audit	✓
Potential donor audit	✓
Adult critical care	Non - participation
Adult asthma	Non - participation
Paediatric pneumonia	Anticipated
Paediatric asthma	Anticipated
National Cardiac Arrest Audit	Anticipated
Elective surgery (National PROMs Programme)	Anticipated
Data Quality [MINAP]	Anticipated
Paediatric intensive care	N/A
Paediatric cardiac surgery /Congenital Heart Disease Audit	N/A
National Chronic Pain Audit	N/A

Intra-thoracic transplantation	N/A
Liver transplantation	N/A
Coronary angioplasty	N/A
CABG and valvular surgery	N/A
Renal replacement therapy (Renal Registry)	N/A
Renal transplantation	N/A
Prescribing in mental health services	N/A
National Schizophrenia Audit	N/A
Name of National Clinical Audits - 2011/2012	Participation
Human Recourses NICE National Audit (organisational questionnaire)	✓
National Diabetes Inpatient Audit – [bedside clinical information]	✓
2nd Multiple Sclerosis (organisational audit)	✓
Breast cancer Audit	✓
Urology Audit Section of Oncology: Complex operation audits: Prostatectomy; Cystectomy – for cancer; Nephrectomy (all performed whether for malignancies or not) – commenced January 2004.	✓
Abdominal Aortic Anurysm	✓
Limb Amputation audit (National Vascular Database)	✓
IUGA on-going audit	✓
Audit patient access to GUM clinics against national targets monthly. This goes to the Department of Health (DH)	✓
Survey of prevalent HIV infection- Health Protection Agency	✓
British Association for Sexual health and HIV 2012 Asymptomatic Screening re-audit	✓
Bisphosphonate Related Osteonecrosis of the Jaws	✓
Regional Audit of Implementation of NICE Guidelines for the removal of wisdom teeth	✓
Regional Audit Paediatric Network	✓
Consultant Sign off – [separate from the quality indicator reporting to DH]	✓
NHSP Data Quality Review (trends) NHSP Data Audit.	✓
Patient satisfaction relating to aetiological investigate-Review of parental satisfaction of children with long term hearing impairment	✓
Review of Asthma Deaths	✓
BAUS Section of Endourology: PCNL [prospective registry of all procedures]	Non - participation
BAUS Section of Endourology: PUJ obstruction – audit of management	Non - participation
BAUS Section of Endourology: Endoscopic treatment of UTCC	Non - participation
BAUS Section of Endourology: Urethroplasty	Non - participation
Section of Andrology and Genito-Urethral Surgery: Penile Curvature Surgery & Penile Prosthesis	Non - participation
Section of Female, neurological and urodynamic urology (FNUU):	Non - participation
Dementia Re-audit 2012	Non - participation
Theatre equipment national audit	Non - participation
British Society of Urogynaecology: Surgery for urinary incontinence submit audit data to specialist society database	Anticipated
Section of Female and Reconstructive Urology	Anticipated

Blood sampling/labelling information given to patients	Anticipated
COPD -discharge planning	Anticipated
Sudden Death audit	N/A

Confidential Enquiries [100% participation rate]

NCEPODs - 2011/2012	Report
Surgery in Children Report - 'Are We There Yet?'	Trust is currently reviewing the recommendations from the report
Peri-operative Care Report - 'Knowing the Risk'	
NCEPODs - 2011/2012 – Current Studies	Participation
Cardiac Arrest	✓
Alcohol Related Liver Disease	✓
Bariatric Surgery	N/A
Subarachnoid Haemorrhage	N/A

National Survey/ Regional study

2011/2012	Participation
Growth assessment on all children with food allergy in the U.K. (Great Ormond Street Hospital)	✓
National Survey London Paediatric Diabetes Survey	✓
Survey of IT re-survey lead by the NBTC on behalf of the CMO's National Blood Transfusion Committee	Non - participation

Participation in national clinical audit and local learning and improvement

Our Accident and Emergency Department took part in a national audit of 'Feverishness in children 2010/2011' The audit criteria was based on the clinical standards for managing feverish children developed by consensus from representatives of the College of Emergency Medicine. The audit was led by this professional body.

Audit results showed positive outcome in most of the elements audited, i.e. the trust was above the national average in measuring and documenting Vital signs. In addition to this, the audit also indicated that there were elements that required long term improvements. Subsequently the Trust has put in place dedicated actions to ensure that patients continue to receive high quality care

Example of planned actions to be carried out over the coming years:-

- Education/Training programmes
- Advanced IT system to in co-operate additional clinical data to be collected for improving patient care.
- Develop local protocols to further improve the service across the Trust.

NWLHT continues to participate in National audits as a means to continue to improve its high quality care.

Research

NHS clinical research is now monitored at a national level and the performance of the Trust is now available in a new format. The new Trust research activity league tables are available on the Guardian website <http://www.guardian.co.uk/healthcare-network-nihr-clinical-research-zone/trust-research-activity-league-tables> and indicate the numbers of studies open and the numbers of patients recruited into those studies.

The Trust has 65 studies open, recruiting 1,006 patients. We are therefore position 63 out of 396 for the number of studies opened and position 127 out of 396 for the numbers of patients recruited placing us as a mean in the top 25% of Trusts.

Participation in clinical research demonstrates NWLHT's commitment to improving the health and wellbeing and care we can offer to patients, while making a significant contribution to wider health improvement. Some examples of work undertaken in 2011/12 and the improvement for patients are shown below:

Genito-Urinary Medicine

Dr. Gary Brook's research work won him the first Trust R&D award for best research, based on the introduction of Electronic Patient Records into the GUM clinic, making us first in the country to go completely paperless,. The results of research show large increases in efficiency around patient recall if they have a Sexually Transmitted Infection. This shows that patients are treated on average 11 days sooner, generating big potential public health impacts and reduction in clinical complications. This work was also chosen by the journal Sexually Transmitted Infections for a press release and received international recognition after publication. A subsequent paper on the use of EPR to improve audit processes and record data has been published.

Regional Rehabilitation Unit

Research within the Regional Rehabilitation Unit has continued to be pivotal to the implementation of the National Service Framework for long term neurological conditions - in particular the demonstration of cost-efficiency of rehabilitation for highly dependent patients who offset the additional cost of long lengths of stay in rehabilitation through large savings in the costs of continuing care; and our work to evaluate and describe the needs of carers who look after adults with acquired brain injury.

The tools that we have developed to assess patients' needs for care and nursing in hospital and community settings (Northwick Park Nursing and Therapy Dependency Scores, the UK FIM+FAM, the Rehabilitation Complexity Scale) have been subjected to rigorous psychometric evaluation and are now widely taken up in clinical practice both in the UK and abroad.

Radiology

The Radiology Department have been promoting changes in service delivery through research. An example is the recent publication of "The CT Colonography Standards" which has allowed standardised practice, patient care and pathway implementation in CT Colonography to be circulated throughout the imaging community, which in turn will improve service delivery and patient experience.

Haematology

Over the last year, based on research within the Haematology Department investigators have represented the Trust at several international and European meetings in the management of patients with Myeloma and Waldenstrom's lymphoplasmacytic lymphoma. The expertise provided in patient management and guideline development at the Trust are extensive in particular, international guidelines on Kyphoplasty and management of spine disease in patients with Multiple Myeloma are being developed as a direct result of patient care guidelines locally at NWLHT and research done at NWLHT in conjunction with the Spine team at Royal National Orthopaedic Hospital, leading to improved quality of care for patients recognised at an international level. These guidelines will feed into NICE guidance.

Sickle Cell

Support for investigators involved in Sickle Cell Disease has led to psychological interventions including cognitive behavioural therapy and neuropsychological screening, which have been incorporated in recent national standards and guidelines for care in both children and adults. The need for these interventions were highlighted in previous research carried out within the Trust with Department of Health and Roald Dahl's Marvellous Children's Charity funding.

Pathology

Paul Tadrous's research into automated screening for acid-fast bacilli can reduce the costly consultant time requirements and may improve detection rates. In the Pathology Department there were 470 requests for ZN staining in 1 year. Given 15 minutes of consultant time to screen each slide, almost 120 hours of direct clinical care time (15 full working days) could be saved (in addition to the benefits to population health). The technology may also help improve Cervical and Bowel Cancer Screening as detailed in the publication. Tadrous PJ. Computer-assisted screening of ZN-stained tissue for mycobacteria: algorithm design and preliminary studies on 2000 images. *Am J Clin Pathol.* 2010 Jun;133(6):849–858.

Clinical Genetics

The Ehlers-Danlos Syndrome (EDS) diagnostic service, based at the North West Thames Regional Genetic Service (Kennedy-Galton Centre), provides a nationally funded source of clinical and scientific expertise for patients with hereditary disorders of connective tissue. The service is led by Professor Pope who has an international reputation in the field with multiple high impact peer reviewed publications, patient liaison (EDS support group UK) and expertise gained over 40 years of work with these patients. Through collaboration with colleagues at the Hammersmith Hospital, the EDS service plans use next generation sequencing technology to investigate the underlying genetic basis in patients with EDS, and other related conditions, in whom the molecular basis is currently unknown. This research is part of a wider study ('New sequencing technologies for investigation of genetic disease'), lead by Professor Tim Aitman for which research ethics approval is currently being sought. It is anticipated that this collaboration will translate into:

- Improved surveillance, management and outcomes for patients at risk of early onset stroke and bowel rupture;
- Expansion of the role of molecular genetic testing in general medicine (mainstreaming), increased diagnostic speed and subsequent management;
- Deeper understanding of the role of genetic predisposition to chronic pain and arthralgia, autonomic dysfunction and osteoporosis.

CQUINS (Commissioning for Quality & Innovation Scheme) for 2011/12

The trust's CQUIN scheme comes from the government's commitment to support a continued shift in the NHS towards quality and to help produce a system which actively encourages a focus on quality improvement and innovation in its commissioning of services.

For 2011/12 the trust's scheme consisted of a total of six work streams (referred to as goals). Two of the work streams were national: that is they were mandatory and applied to ALL acute trusts providing services. Four of the work streams were local: that is they applied to the trust only and had been agreed between the trust and its local commissioners.

The work streams have required significant changes in the way staff work and in the way that services to patients are delivered. They have covered the following areas:

National goals:

- assessing adults admitted to our trust for their risk of forming a blood clot while in hospital or as a result of their stay in hospital
- capturing information on the experience of those who are admitted to our trust

Local goals:

- patients being reviewed by a consultant within 12 hours of their being admitted to the trust
- providing those admitted to the trust with an acute episode of their chronic obstructive pulmonary disease (COPD), with information to improve or continue their care once they have been discharged
- improving the 'end of life' care for patients admitted to the trust by implementing standards of care from the Department of Health's, National End of Life Care Strategy
- taking steps to reduce the number of falls (or at least the harm caused by the fall) by patients during their admission to the trust

For 2012/13 the Trust will again be involved in another CQUIN scheme. Full details are yet to be agreed but what is known is that there will be an additional two mandatory, national goals. These goals will involve work around:

- screening and identifying signs of dementia for patients admitted to the trust who are 75 years of age and over
- collecting information from patients admitted to the trust with regard to areas such as pressure ulcers, falls and urinary tract infections – this will allow the

same information to be collected (and then compared and shared) across the country

Care Quality Commission

NWLHT is required to register with the Care Quality Commission (CQC). Our current registration status is fully registered, at all locations, without compliance conditions. The CQC has not taken enforcement action against the Trust during 2010/11.

Since the Dignity and Nutrition inspection of March 2011, reported in our last Quality Account, the Trust has been subject to the following CQC inspections and the findings have been as follows:-

1. Full Review of Compliance – Central Middlesex

CQC Finding - Central Middlesex Hospital was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

Improvements suggested: Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

Risk assessments of premises were conducted on a regular basis. Premises were generally suitable to work in and safe and accessible to patients and visitors. However, on the wards there was the potential for water from the shower area to splash and create a slippery toilet floor thus putting some patients at risk of falls.

2. Full Review of Compliance - Northwick Park Hospital

CQC Finding - Northwick Park Hospital was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

Improvements suggested: Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Generally care and treatment were explained to people in a way in which they understood and suitable arrangements were in place for obtaining valid consent. However, in some instances documentation in relation to decisions not to attempt resuscitation of patients was incomplete. It was not clear whether patients or their relatives had been consulted on the decision taken.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Patients were provided with information on the medication prescribed for them. Generally patients were protected against the risks associated with the unsafe use and management of medicines. However, not all medication had been stored safely in paediatrics. Expired medication was found in a drugs fridge and fridge temperatures were not monitored consistently on all wards. As a result patients could have been put at risk of receiving ineffective medication.

3. Full Review of Compliance – Maternity Services- Northwick Park Hospital

CQC Finding - Northwick Park Hospital was meeting all the essential standards of quality and safety.

4. Inspection of A&E services – Northwick Park Hospital

The CQC carried out this review because concerns were identified in relation to:

- Outcome 04 - Care and welfare of people who use services
- Outcome 13 - Staffing

CQC Finding - Northwick Park Hospital was meeting all the essential standards of quality and safety.

5. Full review of Compliance – St Marks Hospital

CQC Finding - St Mark's Hospital was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

Improvements suggested:

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

There were procedures in place for obtaining consent and acting in accordance with the wishes of the patient. However, in respect of Do Not Attempt Resuscitation orders an incomplete form may indicate that patient involvement had not taken place when the decision was made.

Overall we found that St Mark's Hospital was meeting this essential standard but, in order to maintain this, we suggested that some improvements were made.

6 Inspection of services related to Termination of Pregnancy.

Info for insertion when report received from CQC

Data Quality

Good quality information underpins the effective delivery of patient care; therefore improving data quality will support improvements in patient care and value for money.

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

Which included the patients valid NHS number was –

(APR _ DEC)

- o 94% for admitted patient care
- o 96.7% for outpatient care
- o 84.3% for accident and emergency care

****TO BE CONFIRMED FULL YEAR** Data validation in progress**

Which included the patient's valid General Medical Practice was –

(APR _ DEC)

- o 96% for admitted patient care
- o 95% for outpatient care

- XX% for accident and emergency care

****TO BE CONFIRMED FULL YEAR** Data validation in progress**

Information Toolkit Attainment levels

NWLHTs Information Governance Assessment Report score overall score for 2011/12 was **XX% and was graded XXXXXXXX** using the Information Governance Toolkit grading scheme.

The Trust continues to work against its action plan for improving scoring against the requirements of the Information Governance toolkit.

Data validation in progress

Clinical Coding Error rate

Clinical coding is a mechanism by which medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is one indicator of the accuracy of patients records.

During 2011/12 NWLHT the error rates reported for that period for diagnoses and treatment coding (clinical coding) were

Admitted patients clinically coded data

	2009/10 PbR		2010/11 PbR		2011/12 Audit scheduled for 20/2/12.	
	% correct	% incorrect	% correct	% incorrect	% correct	% incorrect
Primary diagnosis	98.1	1.9	94.8	5.2	Results will not be available until March / April 2012	
Secondary diagnosis	89.2	10.8	91	9		
Primary Procedure	92.1	7.9	94	6		
Secondary Procedure	89.2	10.8	91.5	8.5		

Data validation in progress

Part 3 Quality Overview

Performance against selected metrics

In selecting the metrics for our Trust we have chosen to measure our performance against indicators for patient safety, clinical effectiveness and patient experience. Staff experience indicators are also included in recognition of the important role our staff plays in delivering the quality and patient safety agenda.

Safety and Clinical Effectiveness Indicators

Clinical Quality- CQUINS	Exec Lead	RAG Status	Proxy target	YTD Target	YTD Actual	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
National																	
% of patients who had a VTE Assessment on admission	RS	G	90%	90%		63.1%	62.1%	63.1%	74.5%	75.1%	82.4%	84.2%	87.3%	89.9%	90.8%	91.8%	
Local																	
Rate of Inpatient Falls	CF	R	<3.00	<3.32	3.41	2.74	2.78	3.50	3.27	2.74	3.42	4.33	4.71	3.50	3.12		
Clinical Safety	Exec Lead	RAG Status	Proxy target	YTD Target	YTD Actual	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Mortality Rate																	
Summary Hospital-level Mortality Indicator (SHMI)	RS	N/A			59.1	60.1	56.6	57.2	56.8	59.6	64.6	59.2	62.5				
36 Continuity of Care - Environment Scores																	
Central Midx Hospital - Very high risk Area	GM	G	98.0%	98.0%	98.6%	98.5%	98.6%	98.6%	98.6%	98.6%	98.6%	98.5%	98.6%	98.6%	98.8%	98.7%	
Northwick Hospital - Very high risk Area	GM	G	98.0%	98.0%	98.9%	98.9%	98.8%	98.9%	98.8%	98.7%	98.7%	98.7%	98.8%	98.8%	98.8%	98.9%	
Central Midx Hospital - High risk Area	GM	G	95.0%	95.0%	97.6%	97.7%	97.5%	97.6%	97.5%	97.6%	97.7%	97.7%	97.4%	97.6%	97.8%	97.7%	
Northwick Hospital - High risk Area	GM	G	95.0%	95.0%	98.0%	97.9%	98.0%	98.2%	98.4%	97.9%	97.6%	97.9%	97.8%	97.9%	97.7%	97.9%	
Central Midx Hospital - Significant risk Area	GM	G	90.0%	90.0%	97.8%	n/a	97.8%	97.5%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Northwick Hospital - Significant risk Area	GM	G	90.0%	90.0%	95.9%	95.6%	95.6%	96.1%	96.2%	97.6%	96.0%	95.9%	n/a	n/a	n/a	96.5%	
Central Midx Hospital - Low risk Area	GM	G	85.0%	85.0%	97.1%	n/a	97.1%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Northwick Hospital - Low risk Area	GM	G	85.0%	85.0%	91.4%	n/a	92.4%	n/a	n/a	90.0%	90.0%	n/a	n/a	n/a	n/a	n/a	
Schedule 3 Indicators	Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Infection																	
MRSA bacteraemia reduction of incidences	FC	R	3	2	5	1	1	0	2	0	0	0	0	1	0	0	
C Diff reduction of incidences	FC	R	29	27	43	7	1	6	4	5	5	5	2	4	1	3	
Women & Children's																	
Caesarean sections rate in line with agreed trajectory	RS	R	27%	27%	28.4%	32.6%	27.1%	30.5%	30.6%	30.8%	30.8%	31.2%	29.4%	27.7%	26.3%	15.3%	
No of women experiencing a 3rd degree tear, consistent with best clinical practice	RS	G	< 4%	< 4%	2.5%		3.0%	2.5%	1.9%	2.4%	2.6%	2.2%	3.5%	1.3%	2.1%	3.1%	
No of PP Haemorrhages, consistent with best clinical practice agreed	RS	N/A	Minimum	Minimum	2.9%	n/a	n/a	1.6%	3.3%	3.1%	3.5%	2.9%	3.0%	2.7%	4.0%	2.7%	

37

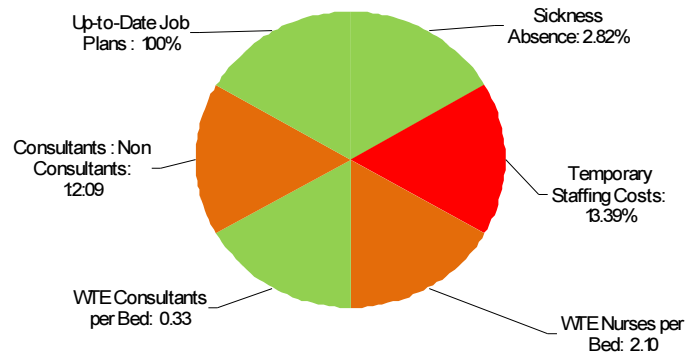
Acute Trust Performance Indicators	Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	
A&E Clinical Quality Indicators- Core																		
Unplanned re-attendance rate- CMH	RS / CF	R	<5%	<5%	5.59%	4.71%	6.37%	5.70%	6.08%	6.84%	8.02%	5.46%	6.00%	4.85%	3.76%	4.74%		
Unplanned re-attendance rate- NPH	RS / CF	R	<5%	<5%	8.95%	6.78%	6.95%	8.62%	11.20%	10.65%	8.88%	8.45%	9.96%	7.98%	9.27%	9.31%		
Total Time spend in A&E Department- Median- Admitted- CMH	RS / CF				3.45	3.42	3.42	3.41	3.39	3.47	3.48	3.49	3.45	3.44	3.47	3.50		
Total Time spend in A&E Department- Median- Non-Admitted- CMH	RS / CF				1.13	2.32	2.24	2.31	2.27	2.46	2.56	1.22	1.21	2.34	1.15	1.29		
Total Time spend in A&E Department- Median- Admitted- NPH	RS / CF				3.36	2.51	3.24	3.31	3.31	3.35	3.30	3.40	3.44	3.41	3.42	3.46		
Total Time spend in A&E Department- Median- Non-Admitted- NPH	RS / CF				1.33	2.04	2.16	2.19	2.23	2.31	2.33	1.42	1.45	2.48	1.40	1.29		
Total Time spend in A&E Department- 95th Percentile- Admitted- CMH	RS / CF	R	<=4hours	<=4hours	06:26	06:53	05:14	06:33	05:09	06:34	07:04	07:43	04:32	04:00	05:25	07:32		
Total Time spend in A&E Department- 95th Percentile- Non-Admitted- CMH	RS / CF	G	<=4hours	<=4hours	03:42	03:34	03:36	03:45	03:52	03:45	03:59	03:47	03:44	03:28	03:37	03:46		
Total Time spend in A&E Department- 95th Percentile- Admitted- NPH	RS / CF	R	<=4hours	<=4hours	09:39	09:34	08:48	09:31	09:48	07:38	07:35	11:24	10:42	09:15	09:10	11:22		
Total Time spend in A&E Department- 95th Percentile- Non-Admitted- NPH	RS / CF	G	<=4hours	<=4hours	03:57	03:53	03:51	03:52	03:52	03:55	03:54	03:57	03:58	03:59	03:58	04:43		
Total Time spend in A&E Department- Longest Wait- Admitted- CMH	RS / CF				21.35	11.31	15.08	15.19	16.02	19.43	20.08	18.06	14.38	11.25	15.02	21.35		
Total Time spend in A&E Department- Longest Wait- Non- Admitted- CMH	RS / CF				18.24	5.28	15.23	14.08	11.02	8.14	13.54	14.17	12.09	6.51	7.44	16.26		
Total Time spend in A&E Department- Longest Wait- Admitted- NPH	RS / CF				23.31	17.41	19.48	22.10	23.09	21.12	21.29	23.31	22.09	20.41	21.04	23.24		
Total Time spend in A&E Department- Longest Wait- Non- Admitted- NPH	RS / CF				22.56	14.50	16.17	18.05	15.47	16.03	17.27	22.03	18.31	18.17	22.56	20.45		
Left without being seen- CMH	RS / CF	G	<5%	<5%	3.96%	3.43%	3.86%	4.80%	5.01%	3.17%	4.63%	3.97%	3.84%	2.89%	3.39%	4.47%		
Left without being seen- NPH	RS / CF	G	<5%	<5%	3.21%	3.03%	2.50%	2.53%	3.43%	3.00%	3.04%	3.51%	3.77%	3.33%	3.08%	3.65%		
Time to Initial Assessment- Median- CMH	RS / CF				0.08	0.02	0.03	0.03	0.08	0.09	0.08	0.09	0.08	0.09	0.09	0.09		
Time to Initial Assessment- Median- NPH	RS / CF				0.12	0.05	0.05	0.06	0.09	0.10	0.12	0.14	0.16	0.16	0.15	0.18		
Time to Initial Assessment- 95th Percentile- CMH	RS / CF	R	<15min	<15min	00:44	00:25	00:30	00:31	00:50	00:43	00:43	00:52	00:41	00:39	00:45	00:45		
Time to Initial Assessment- 95th Percentile- NPH	RS / CF	R	<15min	<15min	01:06	00:49	00:45	00:45	00:48	00:47	01:03	01:11	01:23	01:14	01:28	01:27		
Time to Initial Assessment- Longest Wait- CMH	RS / CF				12.15	1.25	12.15	1.09	3.37	2.05	2.01	4.01	4.06	2.26	2.22	2.54		
Time to Initial Assessment- Longest Wait- NPH	RS / CF				21.34	8.56	21.34	8.14	3.36	3.56	4.58	11.21			6.03	11.18		
Time to Treatment- Median- CMH	RS / CF	R	<60min	<60min	01:01	00:56	00:55	00:43	01:03	01:21	01:27	01:09	01:02	00:46	00:45	01:00		
Time to Treatment- Median- NPH	RS / CF	R	<60min	<60min	01:23	01:17	01:06	01:16	01:14	01:13	01:24	01:24	01:33	01:32	01:36	01:38		
Time to Treatment- 95th Percentile- CMH	RS / CF				3.39	3.54	3.53	3.48	3.18	3.29	3.21	3.28	3.02	2.16	2.39	2.31		
Time to Treatment- 95th Percentile- NPH	RS / CF				3.29	3.26	3.27	3.30	3.27	3.00	3.25	3.31	3.39	3.44	3.35	3.42		
A&E Clinical Quality Indicators- Core																		
Ambulatory Care- Cellulites and DVT- CMH	RS/ CF																	
Ambulatory Care- Cellulites and DVT- NPH	RS/ CF																	
Service Experience for A&E Services- CMH	RS/ CF																	
Service Experience for A&E Services- NPH	RS/ CF																	
Consultant Sign Off- CMH	RS/ CF																	
Consultant Sign Off- NPH	RS/ CF																	
Stroke Care																		
Patients that have spent more than 90% of their stay on a stroke unit	RS	G	80.0%	80.0%	97.5%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	92.1%	98.9%	96.0%	94.0%			

Patient Experience indicators

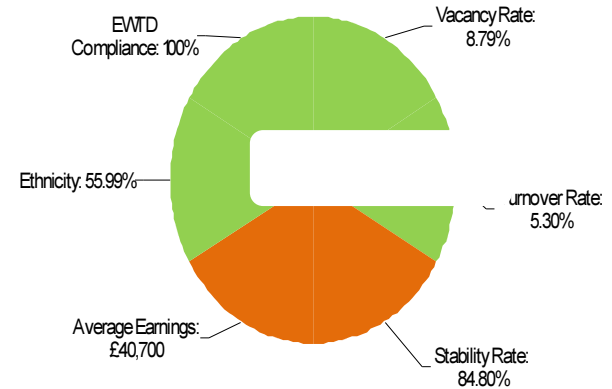
Clinical Quality- Patient Experience		Exec Lead	2010	2009	2008													
Patient Experience Questions- Comparison with other Trusts																		
The A&E Department	CF		The Same	The Same	The Same													
Waiting Lists and Planned Admissions	CF		The Same	The Same	The Same													
Waiting to be admitted to a ward bed	CF		The Same	The Same	The Same													
The hospital and ward	CF		The Same	The Same	Worse													
Doctors	CF		The Same	Worse	The Same													
Nurses	CF		Worse	Worse	Worse													
Care and Treatment	CF		Worse	Worse	Worse													
Operations and Procedures	CF		Worse	Worse	The Same													
Leaving Hospital	CF		The Same	The Same	The Same													
Overall views and Experiences	CF		The Same	Worse	Worse													
Patient Experience Questions- CQUINN Performance																		
Were you involved as much as you wanted to be in decisions about your care and treatment	CF	R	62.1	65.3														
Did you find someone on the hospital staff to talk to about your worries and concerns?	CF	G	51.8	49.3														
Were you given enough privacy when discussing your condition and treatment?	CF	R	76.5	78.8														
Did a member of staff tell you about medication side effects to watch for when you went home?	CF	G	40.4	38.3														
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital?	CF	R	66.9	69														
Aggregate Score	CF	R	59.5	60.1														
Clinical Quality- Patient Experience		Exec Lead	RAG Status	Proxy target	YTD Target	YTD Actual	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Meridian Patient Experience Trackers																		
I found that there were members of the hospital staff that I could talk to about my worries and concerns	CF		TBC	TBC											92.86		78.65	
I was given enough privacy when discussing my condition and treatment	CF		TBC	TBC											87.50		86.98	
A member of staff told me about medication side effects to watch for when I went home	CF		TBC	TBC											86.61		74.48	
I was involved as much as I wanted to be in decisions about my care and treatment	CF		TBC	TBC											85.71		80.21	
I was told who to contact if I was worried about my condition or treatment after left Hospital	CF		TBC	TBC											82.14		76.04	
Clinical Quality		Exec Lead	RAG Status	Proxy target	YTD Target	YTD Actual	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Complaints																		
% of complaints acknowledged within 3 days of receipt	CF	G	90.0%	90.0%	91.3%	79.0%	96.0%	95.0%	92.0%	90.0%	91.0%	92.0%	93.0%	97.0%	99.0%			
% of complaints responded to within the agreed first target	CF	R	75.0%	75.0%	51.0%	52.0%	54.0%	55.0%	53.0%	59.0%	48.0%	42.0%	50.0%	50.0%	49.0%			

Staff experience indicators

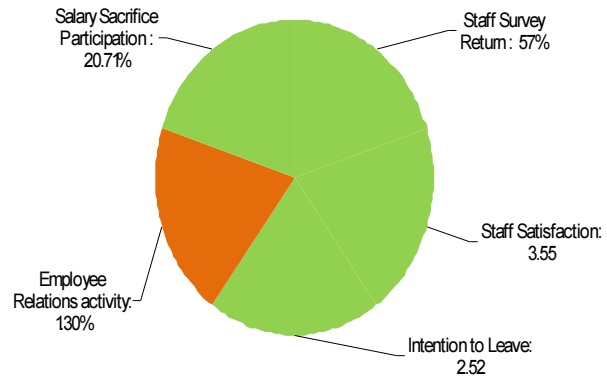
Model Employer



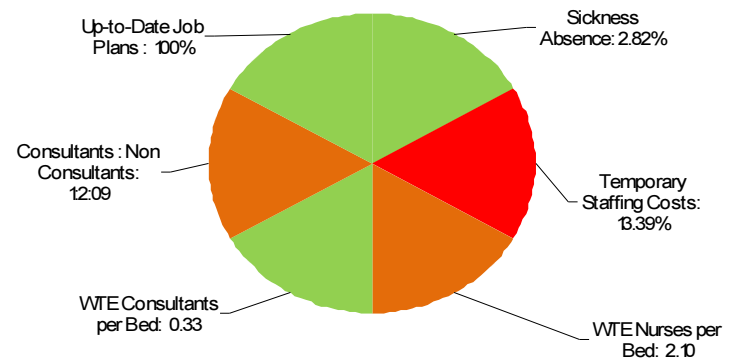
Model Career



Staff Engagement



Productivity



Trust Performance - Benchmarking data

Data validation in progress – benchmark data to be inserted when available

Part 4 Annex – Stakeholder Statements

Response of the Harrow Link

Response of the Brent Local Involvement Network

Brent Council's Health Partnerships Overview and Scrutiny Committee response to the North West London Hospitals NHS Trust Quality Account

Response on behalf of the Health Social Care Scrutiny Sub-Committee Harrow Council

COMMENTS FROM THE HEALTH AND ADULT SOCIAL SERVICES STANDING SCRUTINY PANEL, EALING COUNCIL

Glossary Acronyms?

NBOCAP	National Bowel Cancer Audit Project
HQIP	Healthcare Quality Improvement Partnership
DAHNO	Data for Head and Neck Oncology
NLCA	National Lung cancer Audit
NNAP	National Neonatal Audit Plan
BCIS	British Cardiac Intervention Society
MINAP	Myocardial Infarction National Audit Project
BASO	British Association of Surgery and Oncology
TARN	Trauma Audit Research Network
BAUS	British Association of Urological Surgeons
SINAP	Stroke Improvement National Audit Programme
AAA	Abdominal Aortic Aneurysm
IUGA	International Uro-gynaecological Association
SOPHID	Survey of Prevalent HIV Infections Diagnosed
BHIVA	British Human Immunodeficiency Virus Association
BASHH	British Association of Sexual health and HIV
QRT	Quality Rating Tool.
BRONJ	Bisphosphonate related osteonecrosis of the jaws)
NASH	national audit of seizure management in hospitals)
NIV	Non Invasive Ventilation
COPD	Chronic Obstructive Pulmonary Disease
NHSP	Newborn Hearing Screening Programme
BOS	British Orthodontics Society
QET	Quality Enhancement Tool.
HR NICE	Human Resources – National Institute of Clinical Excellence
(NaDIA)	National Diabetes Inpatient Audit

NHS Harrow

Review of Paediatrics Contracts

Background

As part of the contract negotiations for 12/13 NHS Harrow has reviewed its contracts for paediatric services. This has involved updating service specifications, refreshing key performance indicators and developing quality incentives (CQUIN). Many of these services have been commissioned without clear specifications in the past and this has in some cases hindered the potential to develop and adapt the services to meet local needs.

The objective of this work has been to ensure that all paediatric services are clearly specified and deliver agreed measurable outcomes for patients. Clear specifications and outcome measures are an essential mechanism for maintaining ongoing dialogue between commissioners and providers. This dialogue is going to be increasingly important as Harrow strives to meet financial challenges while at the same time retaining a focus on improving quality of care to provide a cost effective and sustainable local health economy

Scope of the review

The contract review covered paediatric services delivered by North West London Hospital Trust (NWLHT) and the Ealing Integrated Care Organisation (ICO). These are namely:

- Health Visiting
- School Nursing
- Paediatric Community Nursing
- Paediatric Therapies
- Community Child Health Consultant Clinics

Although the initial contract review phase has been completed there are a number of in year developments planned which are outlined in the report.

Strategic context

The emerging NHS Harrow Out of Hospital Strategy provides the overarching strategic context for all 12/13 commissioning intentions. This sets out plans to strengthen proactive and preventative community based services to deliver care which is integrated across organisational boundaries and focussed on the individual care needs of patients.

For children's services, this translates to providing universal preventative services to all Harrow children, ensuring that targeted services are available to vulnerable children and their families, ensuring that children with complex or enduring health conditions are supported in a way which minimises the risk of complications and unplanned hospital care.

Financial context

NHS Harrow is facing an unprecedented level of financial challenge with an underlying financial deficit of £50million. There is a requirement nationally for CCGs to take over balanced budgets in April 2013 which has created significant pressure to clear underlying debt within a short time period.

NHS Harrow has achieved £14 million savings in 11/12 through a comprehensive Quality, Innovation, Productivity and Prevention (QIPP) Programme. Another £14million savings are set out in detailed QIPP plans for 12/13 and will be delivered through comprehensive service redesign aimed at reducing avoidable hospital activity and reviewing the cost and value of contracting arrangements to improve overall value for money.

QIPP savings plans related to the paediatric contracts listed above total £592k against a funding total of £5.75million. These plans are based on improved productivity and there is no proposal to reduce current service levels. Contracts have still to be signed at this point so achievement of these savings is yet to be determined.

Health Visiting

NHS Brent, NHS Ealing and NHS Harrow have worked jointly to develop a tri-borough core service specification for Health Visiting (appendix 1). This is based on the concept of progressive universalism set out in national guidance and sets out expectations for delivery of the universal Healthy Child Programme and targeted services for vulnerable children and families. There is additional focus transferring health visitor record keeping fully onto the (RiO) electronic record keeping system. Safeguarding requirements have been more clearly stated in specifications and reporting and monitoring arrangements defined in the activity schedule of the community contract.

The Health Visiting service is currently involved in a comprehensive re-design process which is being led by the Assistant Director for Community Nursing and the Health Visiting managers and team leads. Interim proposals for the re-designed services were presented to Harrow commissioners in January and to the NHS London peer review team in March 2012. The outcome of the external review was positive and the objectives of the re-design and progress made to date were commended.

Community contracts include an incentive (CQUIN) scheme which is worth 2.5% of the total contract value. As part of the overall scheme NHS Harrow commissioners have developed a Health Visiting CQUIN, which incentivises case finding and follow up of vulnerable children through regular monthly reviews with GPs. Regular high quality communication between GPs and Health Visitors is seen as a key lever for improving integration between community based children's services and ensuring that GPs are more involved and linked into local children centre provision.

Although concerns have been raised locally about caseload, health visitor numbers in Harrow are currently at and slightly above the targets set out by NHS London in line with national guidance on the future enhanced health visiting role. Productivity levels within the service have been sub-optimal and a key focus of the review is caseload management, integration of specialist leads into the health visiting teams and matching teams more closely to the varying level of need across different parts of the Borough.

School Nursing

NHS Brent, NHS Ealing and NHS Harrow have worked jointly to develop a tri-borough core service specification for School Nursing (appendix 2) including robust KPIs. Safeguarding requirements have been more clearly stated in specifications and reporting and monitoring arrangements defined in the activity schedule of the community contract

The Ealing ICO is planning to carry out a comprehensive review of School Nursing services early in 12/13. This will be an opportunity to address some of the current challenges of the service and look at opportunities for re-investing productivity savings to commission 'core plus' school nursing services in response to specific Harrow requirements. This will tie in with a current review of nursing support to special schools in Harrow currently provided by the school nursing service and community paediatric community nursing team.

Paediatric Community Nursing

A draft service specification has been developed for Paediatric Community Nursing in conjunction with NWLH including robust KPIs and a service improvement plan to record all activity data electronically.

As a result of the current review of nursing support for special schools, a new requirement for the paediatric nurses is to take responsibility for leading the nursing requirements for special schools. The team is being asked to support the school in establishing up to date policies and procedures for managing health needs within the school environment, that the school has information on the health needs of new children in the school, that the school has a management plan for each child with known health needs and that all parties involved with the child have appropriate access to management plans and appropriate training to support health needs in the school environment.

A number of issues were raised relating to the clinical governance arrangements between NWLH and Ealing ICO delivering care within the school environment and the additional resources required to provide the service as NWLH views this as a request for a new service provision. NHS Harrow accepts that further work needs to be undertaken to align the support delivered to special schools and agreed to provide further clarity to NWLH.

A signal to provide 365 day nursing was included as part of the core service requirement however this is not part of the current service provision. NWLH agreed to provide the commissioners with the number of admissions taking place at weekends to gain a better understanding of what the weekend requirements for the service may be. Ealing and Brent are in similar discussions about a possible move to a 365 day service and it was agreed that Harrow providers would be part of this process to look at opportunities for providing weekend cover across the three boroughs.

Paediatric Therapies

NHS Harrow commissions Speech & Language Therapy (SLT), Occupational Therapy and Physiotherapy services for 0-18years of age. Services are delivered in a variety of acute and community settings including children centres, pre-schools and schools and will continue to commission services at the current level.

Draft service specifications for all therapy services have been developed in conjunction with NWLH with clear outcome measures.

The Local Authority also commissions SLT for Children & Young People (CYP) with statements of special educational needs and has done so since the Harrow Case (1996). Harrow has a higher overall proportion of children with special educational needs (21.2%) than the national average for primary schools (19.9%). Currently 1,700 CYP access the service.

Although both organisations commission this service separately it was agreed that a better understanding of what is being commissioned by each organisation was necessary to support an integrated and sustainable service model. It has been recognised that the demand for SLT service has continued to increase across the age groups and there is a need to review service provisions.

NHS Harrow is actively working with the Local Authority, NWLH and representative head teachers to clarify commissioning arrangements and address how to collectively use resources to meet the needs of children with SLCN.

The Occupational Therapy service has seen an increased demand from school aged children with ASD. Clinical evidence indicates that OT is more effective if provided in the early years and consequently services have been targeted at primary aged CYP. However CYP with physical disability or long term health conditions continue to access the service until 18 years of age when they are transitioned to adult services.

Child Health Consultants

NHS Harrow needs to ensure that the Child Health service is providing proactive planned care for children with complex health needs to keep them

stable and reduce their need for unscheduled hospital based care whilst delivering best value for money.

The numbers of new and follow-up appointments in the consultant's clinics were benchmarked against the guidelines set out in the British Association for Community Child Health (BACCH) and the number of children seen in the clinics was well below the recommended guidelines. The analysis also highlighted that productivity within the service is sub-optimal with high numbers of DNA and cancelled clinics. It further suggests that the savings can be released from the overall Child Health budget which includes consultant and the administrative funding as the overall cost appears to be high for the level of service provided.

The impending Ealing ICO merger offers the Trust a unique opportunity to realign resources across three boroughs and deliver more cost effective services in line with objectives set out in the Trust's own merger business case.

NHS Harrow has taken on board the on-going concerns raised by NWLH regarding the CAMHS pathway. Commissioners are working to resolve these problems and to strengthen the pathway and we welcome the involvement of the Child Health consultants in this objective.

Conclusion

The recent merger of community health teams within the ICO has created both opportunities and challenges. The further proposed merger of the Ealing ICO with NWLHT means that this situation will continue for a further year. It is essential that commissioners continue an ongoing dialogue with service leads over the next year as all parties undergo this transition. Governance and assurance systems are key to ensuring the quality of services for patients while at the same time making the most of this period to recognise opportunities to deliver services in a more integrated and joined up way across the larger organisation.

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Admiral Nursing Service Update

The Admiral Nursing service was originally commissioned via Harrow Local Authority and was viewed as a valuable local resource for patients with dementia, their families and carers. The intention was to sustain funding in 2011/12 as a tri-partite arrangement between NHS Harrow, Central & North West London NHS Foundation Trust and Harrow Local Authority, however, this was not implemented as the organisations involved wanted to take the opportunity to establish and implement a robust care pathway facilitated through the work of the joint Mental Health Modernisation Board and ensure funding security for the delivery of the future service model

There has been substantial lobbying by Harrow residents led by Mr Neville Hughes to re-establish the Admiral Nursing service since the funding was withdrawn in March 2011. NHS Harrow and the Harrow Local Authority have met with Mr Hughes and have taken the opportunity to hear and discuss his concerns and anxieties regarding the decommissioning of the service. The two organisations are committed to develop an integrated approach to dementia care. Mr Hughes has been invited to participate in the development and shaping of local dementia services and he has requested a further meeting with NHS Harrow to discuss this, which is currently being arranged.

Dementia

Harrow Local Authority and NHS Harrow have committed to the development of an integrated Harrow Dementia strategy and the delivery of an effective care pathway. Work has begun and an action plan is being developed for agreement at the next Dementia sub group. It has been acknowledged that local stakeholder engagement is vital to ensure that the provision meets local needs and the representation by key individuals has been identified on task and finish groups. Part of this work will involve reviewing the requirement for Admiral Nurses to deliver elements of specialist care.

There has as yet been no commitment to creating an Admiral Nurse post/service as it is vital that there is an overview of the entire service which will identify future provision requirements and the way in which these will best meet the needs of the population of Harrow.

NHS Harrow is taking the opportunity to review the current Memory Assessment and Older Peoples Day Hospital services in line with the Mental Health modernisation agenda and the development of the Dementia strategy.

**NHS Support for Social Care: Provision of support for memory services
(Section 256 funding)**

The announcement by the Department of Health that there will be £10m funding support to Social Care via Primary Care Trusts for memory service provision has resulted in a local recurrent funding investment of £41,737. This financial resource has been identified to provide support, advice and information to carers of people with dementia. NHS Harrow and Harrow Local Authority have agreed on an integrated approach to the delivery of this service, which will be via Re-ablement and an integrated provision within the Memory Assessment service delivered by CNWL.

5th April 2012

Quality Directorate
Stephenson House
Hampstead Road
London
NW1 2PL
Tel: 020 3214 5700
Fax: 020 3214 5892

Dear Colleagues,

Re. Consultation with Overview and Scrutiny Committees (OSC) on CNWL DRAFT Quality Account 2011-12

Firstly, we would like to take this opportunity to thank those that have contributed and helped us shape our draft Quality Account this year.

Please find attached to this letter CNWL's draft Quality Account 2011-12 for 30-day consultation.

As you will be aware, all NHS providers have had a legal duty to publish an annual Quality Account since June 2010, and are required to publish the *draft* version for a 30-day formal consultation to various groups. This marks the start of that 30-day consultation, which runs from **Thurs, 5 April – Sat, 5 May 2012**.

OSCs have a role in the external assurance of Quality Accounts through formal consultation. We have included in this letter (embedded below) guidance for OSCs published by the Department of Health which sets out what your role is in assuring our Quality Account.



Roles of
Commissioning PCTs 1

To this end we welcome and encourage your feedback on our *draft* Quality Account 2011-12.

There are some point to note when reviewing this document:

- In Part 1, KPMG still need to publish their statement of assurance based on audit findings
- Where possible we have published quarter 4 or year end data, but in some cases this data was not available at the time of the start of this consultation, and will be updated in the final version
- Borough by borough data breakdown of data is available for the performance on the current Quality Priorities
- There are comments made throughout the document highlighting where further updates are to be made
- An EASYREAD version of the Quality Account will be produced once the final Quality Account has been signed off

We would be grateful if you would send your responses to the draft Quality Account 2011-12 back to us using the consultation response form embedded below.

Please note that the word limit for response statements is 1000 words as set out in the NHS (Quality Accounts) Amendment Regulations 2011.



QA FEEDBACK FORM
for Commissioners.do

Deadline for responses: Sat, 5 May 2012

Responses to: matt.malherbe@nhs.net

Please do not hesitate to contact us if you have any queries that we can help with on the following email address: ela.pathak-sen@nhs.net.

Yours sincerely,

Ela Pathak-Sen
Associate Director for Quality & Service Improvement

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CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST

QUALITY ACCOUNT

2011/2012

DRAFT
FOR PUBLIC CONSULTATION

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- Statement on quality from our Chief Executive
- Statements from our auditors (*to be included at later date*)

PART 2: PRIORITIES FOR IMPROVEMENT

- Delivering quality services
- Summary of our performance against our 2011/12 quality priorities
- Mental health and allied specialties performance against our 2011/2012 quality priorities
- Hillingdon Community Health performance against our 2011/2012 quality priorities
- Camden Provider Services performance against our 2011/2012 quality priorities
- Our quality priorities for 2012/13
- How we agreed our quality priorities for 2012/2013
- Mental health and allied specialties quality priorities for 2012/13
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- Camden Provider Services community service quality priorities for 2012/13
- Monitoring and sharing how we perform
- Statements relating to the quality of NHS services provided

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- Our performance against national and local indicators
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ANNEX 1

- Statements from primary care trusts, Local Involvement Networks, Overview and Scrutiny Committees and our commissioners (*to be included at a later date*)

ANNEX 2

- Glossary of Terms

ANNEX 3

- Statement of director's responsibilities in respect of the quality account *(to be included at later date)*

PART 1

CHIEF EXECUTIVES STATEMENT

Welcome to Central and North West London NHS Foundation Trust's (CNWL) annual Quality Account for 2011/12. This Quality Account forms part of our Annual Report for the same period. Delivering safe, clinically effective services that our patients value is at the core of what we do, and this account gives us an opportunity to share with you our on-going commitment to achieve better outcomes for our service users and carers. We will state what our quality priorities are for 2012/13 and explain how we have worked with our stakeholders to agree these.

This Quality Account also provides a summary of our wider approach to quality improvement, and how we are doing against the priorities that we set ourselves for 2010/11. We will tell you about some of the wider work that we have done, and will continue to do, to deliver quality services across the Trust.

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

This last year has been one of major change for the Trust. We added to our portfolio of services to include community provider services across Hillingdon and Camden and also undertook major restructuring of our mental health and allied specialties into service lines to ensure consistency of care across the whole patient pathway. It is a credit to all our staff across the Trust that throughout this process we have continued to deliver high quality services to our service users and carers. It is also encouraging to see that throughout these changes to our organisation, our staff satisfaction levels have remained high as reflected in our staff satisfaction survey this year.

We believe that providing the breadth of services that we do, across a wide geography, provides us with a great opportunity to identify any gaps in the wider health and social system that supports our service users. We might not be in a position to provide services to fill these gaps, but we absolutely can and will feed this information into the right conversations locally about health and social care provision.

There is a great deal of focus nationally and locally about looking at health and social care together, and ensuring that healthcare (both physical and mental) and social care form a part of all conversations. As service users, patients and carers we know that you want this to be the case and we are committed to achieving this. We are already working with our commissioners and other providers across Central and North West London in Integrated Care Pilots to further develop health and social care teams working together to deliver high quality care across all parts of health and social care agenda, that ultimately delivers better outcomes for our service

users. We are also keeping physical healthcare as a quality priority area as we know that we need to be more ambitious in this area, and there is more we can do to help deliver better outcomes for our service users and to achieve a joined up approach to healthcare.

Our quality priorities for 2012/13 broadly reflect the same themes from last year, and we think that this is appropriate as this is in line with the feedback from our stakeholders and reflects that our drive to deliver high quality services is on-going. Last year we heard from our stakeholders that recovery should be included as a quality priority, and whilst we were unable to include this last year we did continue to work on focussing on recovery with a key achievement being setting up our Recovery College. This year we heard again that recovery should be a quality priority and we are pleased to say that we have included recovery and involvement as one of the priority areas we will focus on in 2012/13, and will continue to build on the excellent foundations in place from the work undertaken to date.

We would like to thank all of you that have talked with us throughout the year, and in particular as part of the Quality Account process. It really is so important to us to hear from you, and what we hear really does influence the work we do and shapes what we commit to delivering as our quality priorities over the upcoming year. This Quality Account represents our commitment to ensuring that we continue to embed quality improvement at the heart of our organisation. We look forward to working with all of you to make this happen.

To the best of our knowledge and belief, this Quality Account is true and accurate. It will be audited by KPMG by 30 June 2012 in accordance with Monitor's audit guidelines.

Claire Murdoch

Chief Executive

STATEMENTS FROM OUR AUDITORS

[To be included at a later date]

PART 2 – PRIORITIES FOR IMPROVEMENT

DELIVERING QUALITY SERVICES

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

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

SUMMARY OF OUR PERFORMANCE AGAINST OUR 2011/12 QUALITY PRIORITIES

For 2011/12 we had 12 quality priorities across CNWL, including Hillingdon Community Healthcare and Camden Provider Services. Each of these quality priorities had one or more measure, and over the course of the year we tracked our performance against these measures.

In total there were 29 measures, and the chart below shows for what proportion of measures we achieved the target, we nearly achieved the target (within 20% of the target), and where we did not achieve the target.



The detail about how we performed for each of these quality priorities and measures is included in the following pages.

We know that feedback from our staff and service users is absolutely vital in understanding how well we are performing so we have also included some information about our staff and patient survey results, and our response to complaints.

MENTAL HEALTH & ALLIED SPECIALTIES PERFORMANCE AGAINST OUR 2011/12 QUALITY PRIORITIES

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

This year has been very challenging for us as we have implemented our new service line structures. We recognise that this has been a significant change that has impacted on our staff, and may also have impacted on our service users and carers. We have been working to prepare for this change over the last three years and do believe that the new service line structure is important, and will result in a longer term positive impact across the whole organisation for our service users, carers and staff.

As a Trust, we look to measure our performance in terms of patient reported experience and outcome measures, as well as via process measures. The NHS White Paper, Equity and

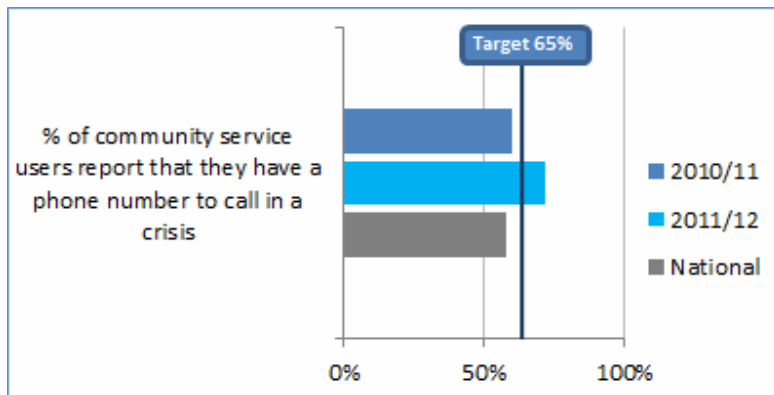
Excellence: Liberating the NHS, 2010, demonstrated the commitment to put patients at the heart of the NHS – and improve their experience of the NHS and the quality of care they receive. We recognise how important patient experience and feedback is in informing what we do, and how we do it. Over the next year we will look to improve the way that we monitor and report on our performance; we will be more innovative in the ways that we measure patient experience and seek to capture patient feedback so that we can understand the reasons for responses. This will help us to highlight specific areas that we need to focus on, and enable us to be more responsive and act quicker to make necessary changes.

This year we have monitored the performance of our mental health and allied specialities services against four quality priority areas as set out in last year’s quality account. In this section we will show how we performed for each of the measures against these four quality priorities, and will also explain what we have done to achieve this performance.

ACCESS TO SERVICES WHEN IN A CRISIS –HELPING SERVICE USERS WHEN THEY NEED IT MOST

Measure A: percentage of community service users report that they have a phone number to call in a crisis

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

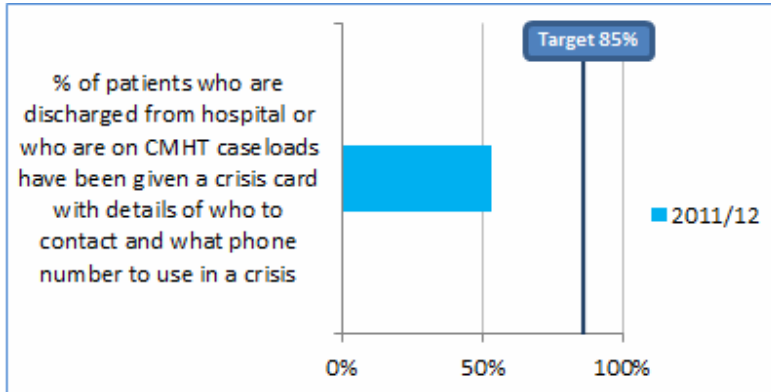


External source: CQC National Community Service User Survey 2011

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

Measure B: percentage of patients who are discharged from hospital or who are on a community mental health team case load have been given a crisis card with details of who to contact and what phone number to use in a crisis.

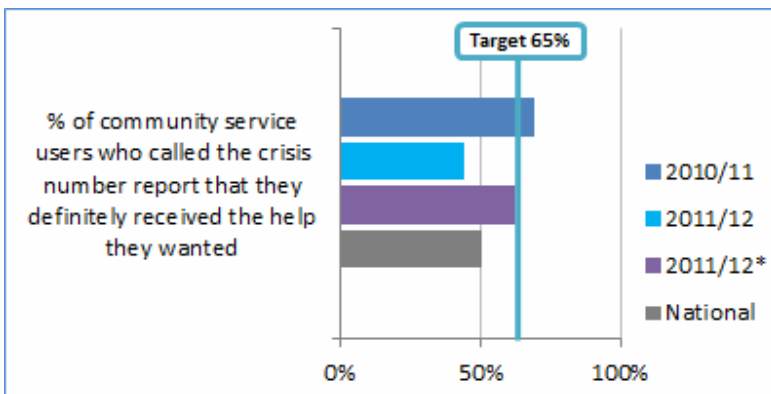
This measure looks at how well we are doing at providing our service users with a crisis card including details of how to contact our services when in an emergency or crisis. These cards let our service users know who to contact when they are in a crisis and most in need of our services. Based on feedback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



There has been a Trust-wide drive to distribute these new cards, however this has not been reflected in the feedback from service users. We recognise that we need to embed the process of crisis card distribution as these new cards were only introduced in the second half of the year. Our approach has been to provide crisis cards to our users when we see them; for inpatients this is done at discharge, and for community service users this is as part of their standard reviews/appointments. We will continue to roll these out over the following year and expect our performance against this measure will improve and will monitor this through our quality dashboard.

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

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



External source: CQC National Community Service User Survey 2011

**This includes responses 'definitely' and 'to some extent'*

Our aspirations in this area are ambitious and, based on feedback from service users, we chose to set ourselves the rigorous standard of measuring whether or not they 'definitely' got the help they wanted. Based on this, our performance falls some way below our target of 65% , however, when we also include those service users who say they got the help they wanted to 'some extent,' our performance rises to 64%.

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


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


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

FOCUS ON CRISIS CARDS FOR SERVICE USERS

This year we have designed, in conjunction with service users and carers, crisis cards and distributed these to our service users. These cards let service users know how to access services out of hours when in an emergency, and have helped facilitate discussions between staff and service users on the most appropriate support service users may require.


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



Central and North West London 
NHS Foundation Trust

Have you been given your crisis card?

A crisis card tells you who to phone and what to do in an emergency or a crisis

Central and North West London 
NHS Foundation Trust

Crisis Card

CRISIS LINE

WHAT TO DO IF YOU ARE HAVING A CRISIS

If you haven't, please ask a member of staff for one

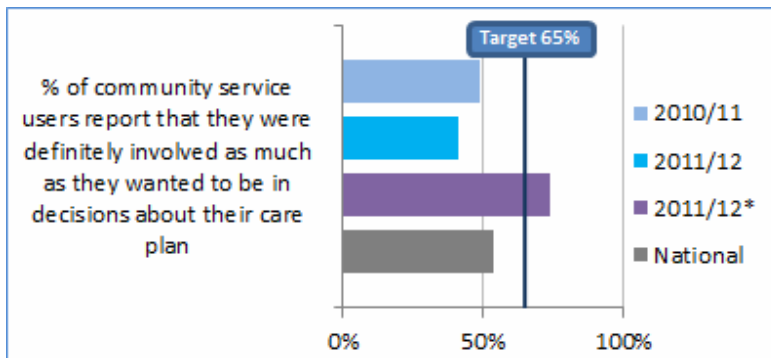
We have also added crisis cards to the discharge checklist as a reminder for staff when a patient is discharged from inpatient care.

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

RESPECT AND INVOLVEMENT – RESPECTING AND INVOLVING PEOPLE WHO USE OUR SERVICES

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

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



External source: CQC National Community Service User Survey 2011

*This includes responses 'definitely' and 'to some extent'

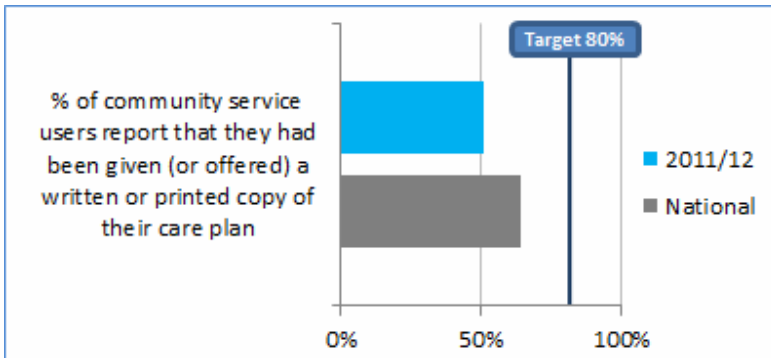
Note that the exact wording for the national measure differs slightly from the CNWL measure. National survey asks: 'Do you think that your views were taken into account when deciding what was in your NHS care plan'?

This year we set ourselves the challenge of ensuring that we got this right for both service users on Care Programme Approach (CPA) and those on Lead Professional Care (LPC). We are pleased that when we look at the number of service users who responded 'definitely' or 'to some extent' when asked if they were involved as much as they wanted to be in decisions about their care plan, we achieved 74% in Q4. We recognise that we need to do more to ensure that service users are definitely involved as much as they want to be, as our performance here was below our target.

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

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

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

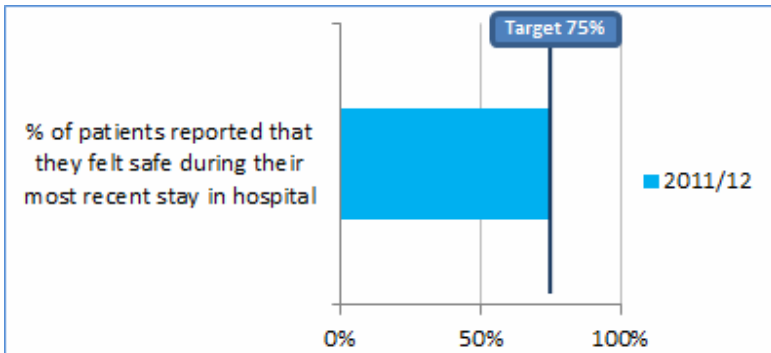


External source: CQC National Community Service User Survey 2011

Again we set ourselves a challenging target of 80% to include service users on CPA and LPC. Analysis of performance in this area indicates that we need to focus more on ensuring service users on LPC are aware of their care plan.

Measure C: percentage of patients reported that they felt safe during their most recent inpatient stay in hospital

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



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

FOCUS ON INVOLVEMENT IN CARE PLANNING

We are continuing our work to enhance the benefits of the Care Programme Approach for service users. At the core of this is ensuring joint care planning that absolutely involves service users, and embeds

a recovery focus through an approach that is more flexible and adaptable to their needs.

Care planning should not be just a snapshot from the result of one large meeting, but something that the service user is actively a part of over time and that brings together the services and support that meet service user needs, and this is what our new approach seeks to achieve.

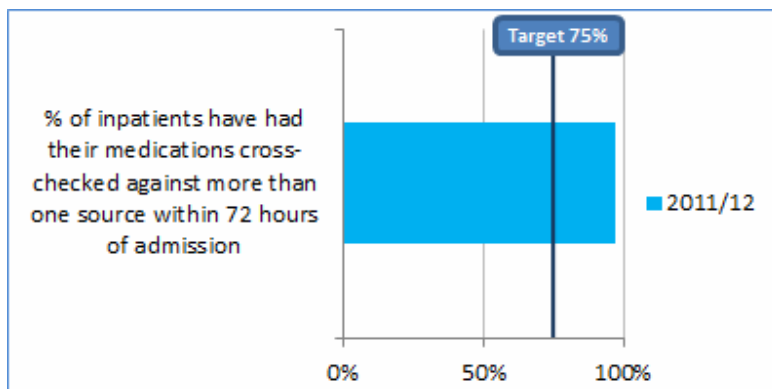
We have continued to deliver training to our staff on the implementation of CPA, Recovery and Personalisation, with recovery at the heart of the service model. This has already had an impact on our service user experience, and will help to ensure that our focus on recovery and collaborative care planning continue going forward.

We have also recently introduced a new care plan format that is more service user focussed in both the structure and language used. We are introducing a new assessment format which integrates CPA and social care budget arrangements, streamlining the process for service users, carers and staff, and reducing duplication. This will continue to be rolled out across the Trust this year.

PHYSICAL HEALTH - TAKING CARE OF PHYSICAL HEALTH AS WELL AS MENTAL HEALTH

Measure A: percentage of patients have had their medications cross-checked against more than one source of within 72 hours of admission

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



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

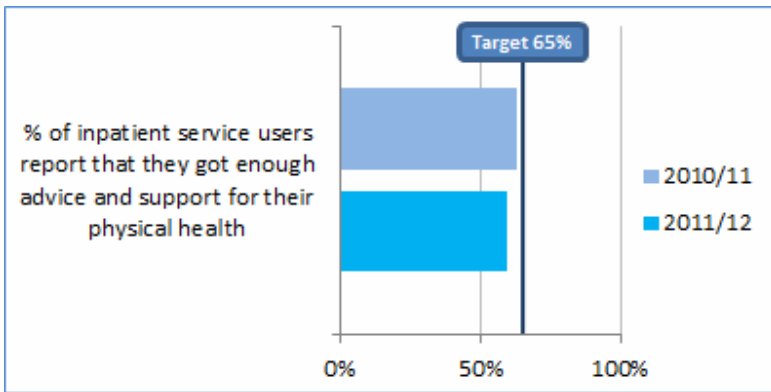
We will work to maintain our high performance in this area, and will continue to monitor via our quality dashboard.

Measure B: percentage of inpatient service users report that they got enough advice and support for their physical health

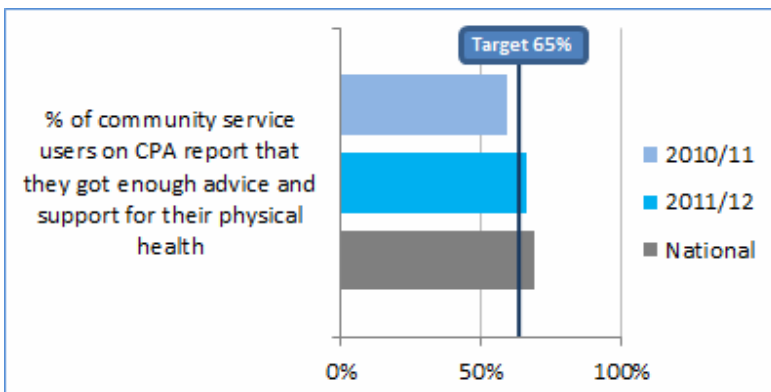
Measure C: percentage of community service users on CPA report that they got enough advice and support for their physical health

Measures B and C relate to the advice and support we give our inpatient service users (measure B) and community service users on CPA (measure C) for their physical health needs.

Measure B



Measure C



External source: CQC National Community Service User Survey 2011

This year we raised our targets to 65% for both inpatients and community service users. We have seen a good performance for inpatients, exceeding our target in quarter 2 (69%) and quarter 3 (68%) but in Q4 we achieved 59%, slightly below our target. We are pleased that for community service users on CPA we have slightly exceeded our target, achieving 66% in quarter 4.

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

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

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

FOCUS ON PHYSICAL HEALTH

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

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

CARER INVOLVEMENT – WORKING IN PARTNERSHIP WITH CARERS AND PROMOTING CARER INVOLVEMENT

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

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

We conducted a baseline audits during quarter 2 that showed 55% of service users had a carer identified, or no carer involvement stated. In quarter 4 we completed an audit that showed an improvement from our baseline with 78% of service users having a carer identified, or no carer involvement statement. We will continue to monitor our performance against this measure on our quality dashboard.

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

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

In quarter 2 and 3 we reviewed Local Authority RAP data (this looks at referrals, assessments and provision for carers) and established a baseline of 35.5% based on the average of these reviews.

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

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

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

We undertook a survey in quarter 3 and were pleased that 67% of carers reported that they felt involved in crisis care planning for the person they cared for. We have taken this figure as our baseline.

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

FOCUS ON CARERS

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

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

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

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

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

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

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

Mother

BOROUGH BREAKDOWN – A REVIEW OF OUR PERFORMANCE IN 2011/12 AGAINST LAST YEAR’S MENTAL HEALTH AND ALLIED SPECIALTIES PRIORITIES

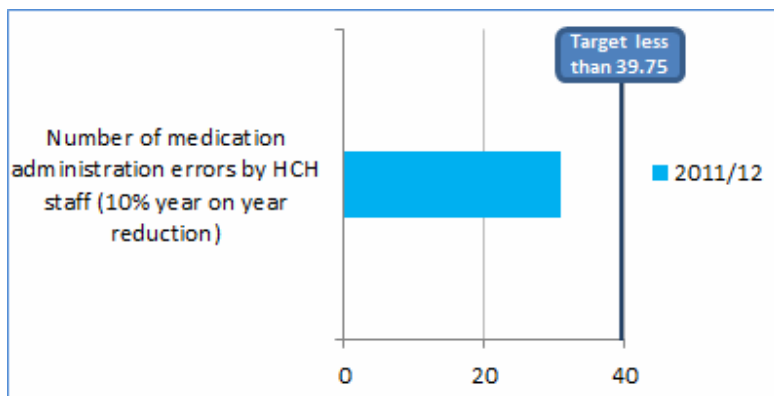
Quality Area	Ref	Quality Priorities 2011-12	Period	Target	Adult Service					Older Adult					Overall Trust Position
					Brent	Harrow	Hillingdon	K&C	Westminster	Brent	Harrow	Hillingdon	K&C	Westminster	
ACCESS IN A CRISIS	1A	Community service users report that they have a phone number to call in a crisis	Q4	= 65%	82%	73%	71%	88%	75%	71%	43%	36%	50%	83%	72%
	1B	Discharged patients or those on a community caseload report being given a crisis card	Q4	> 85%	69%	56%	55%	56%	54%	44%	13%	25%	8%	38%	53%
	1C	Community service users who called the crisis number report that they definitely got the help they wanted	Q4	> 65%	20%	44%	67%	33%	67%	25%	-	0%	0%	-	44%
RESPECT & INVOLVEMENT	2A	Community service users report that they were definitely involved as much as they wanted to be in decisions about their care plan	Q4	> 65%	56%	47%	24%	48%	58%	12%	53%	14%	40%	83%	41%
	2B	Community service users report that they had been given (or offered) a written/ printed copy of their care plan	Q4	> 80%	69%	46%	50%	55%	65%	41%	36%	36%	30%	0%	51%
	2C	Patients reported that they felt safe during their most recent inpatient stay	Q4	> 75%	73%	70%	71%	60%	83%	100%	100%	100%	100%	100%	75%
PHYSICAL HEALTHCARE	3A	Inpatients who have had their medication cross-checked against more than one source within 72hours of admission	Q4	> 75%	96%	93%	100%	98%	93%	100%	100%	100%	90%	-	96%
	3B	Inpatient service users report that they got enough advice or support for their physical health	Q4	> 65%	25%	67%	44%	90%	50%	100%	-	100%	0%	-	59%
	3C	Community service users report that they got enough advice or support for their physical health	Q4	> 65%	63%	50%	56%	74%	85%	100%	100%	-	-	50%	66%
CARER INVOLVEMENT	4A	Establish a baseline for the percentage of service users that have a carer identified	Q4	> 55%	82%	69%	90%	75%	80%	50%	100%	80%	57%	67%	78%
	4B	Establish a baseline for the percentage of carers recorded as having been offered a carers assessment	Q4	> 40%	tba	tba	tba	tba	tba	tba	tba	tba	tba	tba	tba
	4C	Establish a baseline for the percentage of carers that report feeling supported in looking after the person they care for	Q4	tba	tba	tba	tba	tba	tba	tba	tba	tba	tba	tba	tba
Key	Not applicable		YTD Data represents 'year to date' positions												
	Data not available by Directorate/ Data not collected in the quarter		Q4 Quarter 4 data												
	Note: Some data for Quarter 4 is not available at this point and will be included in the final published Quality Account														

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HILLINGDON COMMUNITY HEALTHCARE PERFORMANCE AGAINST OUR CURRENT QUALITY PRIORITIES

[Please note that all of the data included to Hillingdon Community Health staff reflects our performance at Month 11. It will be updated with Month 12 data when this is available (during April).]

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



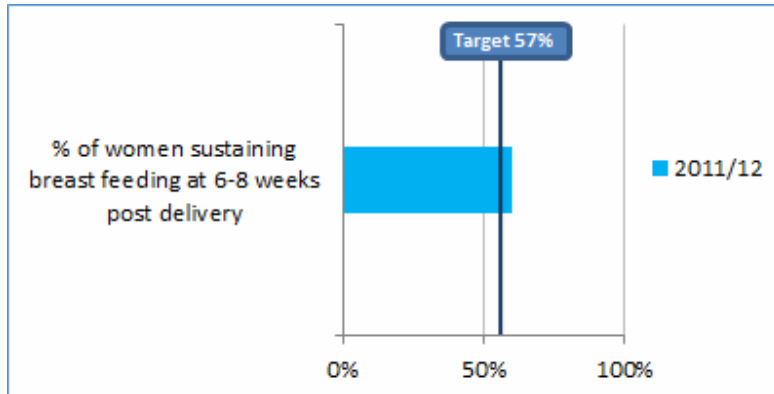
The organisation on a year-to-date basis has reduced medication administration errors and has managed to remain below monthly target in most months. The target was for us to achieve a 10% reduction from last year, which meant our target was to have less than 39.75 errors. We are pleased to report that we have achieved this target with only 31 medication administration errors by HCH staff were recorded, significantly exceeding our 10% reduction target.

We achieved this performance through a number of means, including the planning and implementation of a Medicines Management Programme, which allows clinical staff to access awareness or training sessions. All new staff attend an Induction Training Day and for clinical staff medicines management is included in this programme. For other staff there is a compulsory half day medicines management training programme which includes completing a competency framework and mandatory drug calculations. This will continue to be mandatory for all nursing staff as a 3 yearly update. These are new programmes for the year and attendance and compliance will continue to be monitored in the future, under mandatory training compliance.

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

The Pharmacist reports incident reviews through the Quality Governance Group and the information is cascaded via the Heads of Services for Adults, Children’s and Dental Services. The information is also monitored centrally in the Trust.

2) Increasing the number of women who sustain breastfeeding at 6-8 weeks post delivery



The organisation data shows year to date the target has been achieved and the Breast Feed Co-ordinator has continued to work with the community engagement team. The Breast Feeding Steering Group has met throughout the year to monitor and report on activity in this area.

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

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

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

FEEDBACK FROM SERVICE USERS:

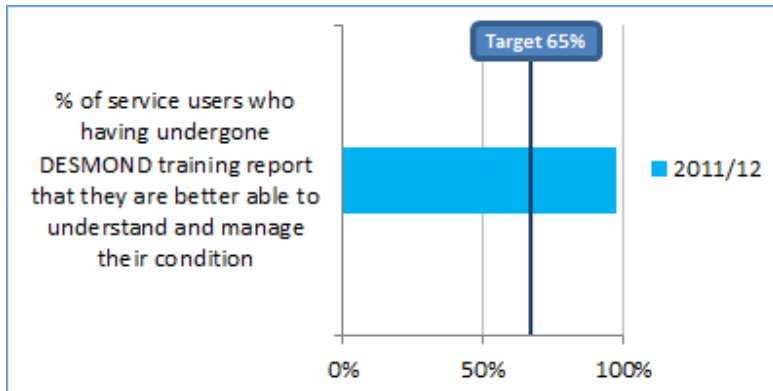
“Started at hospital today, and just had the most wonderful time there, I learnt so much (from the Infant Feeding Coordinator), it was great to finally get that much needed practical hands on approach with the new mums. Can’t wait to get back there on Monday. I almost didn’t want to go home!!!”

Jo, Volunteer following her first shift on the maternity unit (usually volunteers in a Children’s Centre)

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

From breastfeeding support – delivered within the children’s centre settings

3) Supporting service users with diabetes to better understand and manage their condition (through DESMOND training)



The year to date compliance has shown very good results. 98% of service users have undergone specific training, which would indicate that measure A has been successfully addressed.

Good attendance at the training has indicated that service users now feel more able to manage and understand their conditions, which need to be continued to be followed up within the service.

As part of the initiative related to training of carers the Team continues to consider training for carers as a piece of work.

FEEDBACK FROM SERVICE USERS:

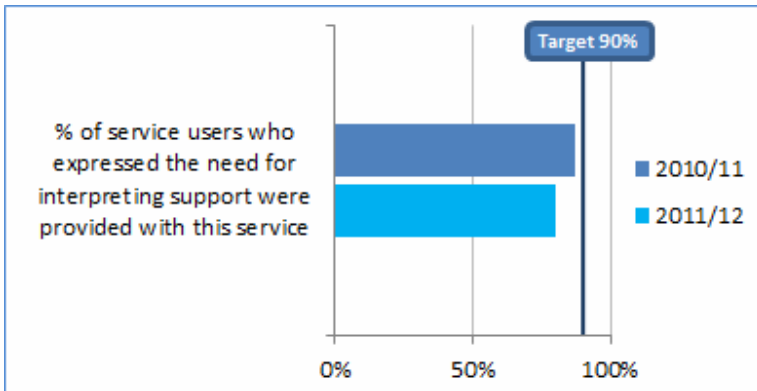
“It was a very informative useful day. I wasn’t too sure about going on the course, but found it helpful. The course leaders were very friendly and encouraging and you didn’t feel silly voicing concerns”

Anonymous feedback

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

Anonymous feedback

4) Offering and providing interpreting support to service users when they express a need for it



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

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

Reviewing the data showed that there has been no negative feedback through the PALS Service and use of the service by those who require it, whilst not achieving the 90% target, the service has been available for the majority of those who require it. It was agreed that in the future the information could be monitored as part of other quality initiatives rather than being set as an individual quality priority.

CAMDEN PROVIDER SERVICES PERFORMANCE AGAINST OUR CURRENT QUALITY PRIORITIES

Priority 1 Improving telephone access

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

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

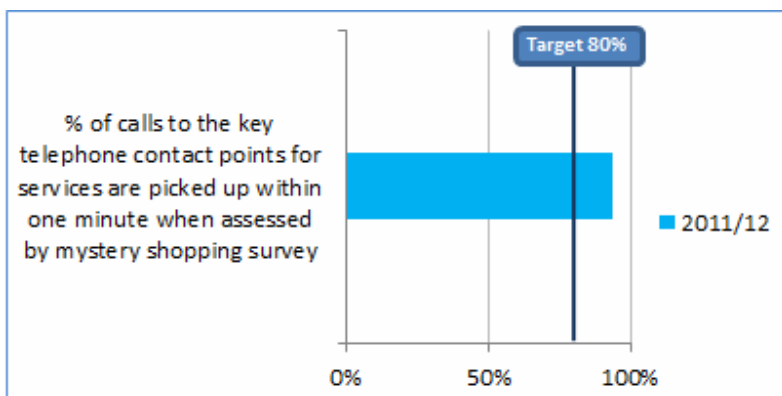
Surveys were undertaken in adult community services, health visiting, school nursing services and podiatry. The results from the School Nursing survey highlighted that there were some issues that need to be addressed. A link to School websites was introduced and School Heads were surveyed further. An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

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

Adult Community Services	94.7%
Health Visiting	95.0%
School Nursing Services	61.0%
Podiatry	78.0%

below:

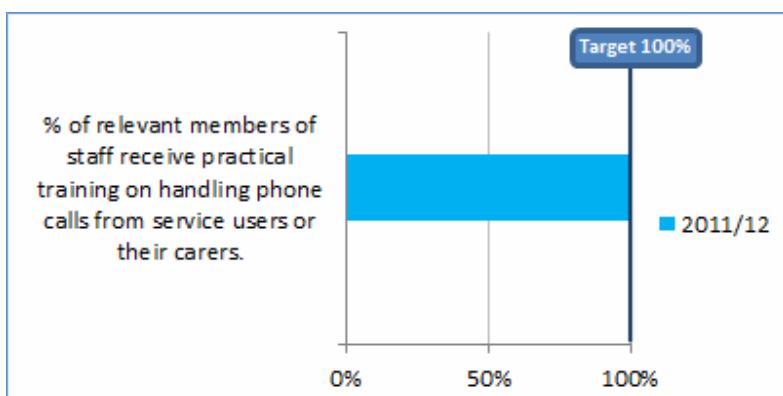
Measure B: percentage of calls to the key telephone contact points for services are picked up within one minute when assessed by mystery shopping survey



We conducted two telephone surveys across all services. The first, undertaken in November 2011, involved a total of 35 calls of which 34 were answered within one minute. Of these 4 calls went on to a message leaving service and 2 calls were put through to a message informing the caller that the clinic was closed and provided details of opening times.

The second audit, undertaken in February 2012, involved a total of 33 calls of which 30 were answered within one minute.

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



All (31) relevant members of staff have attended practical training on telephone customer care.

Priority 2 Introducing safer ambulatory syringe drivers

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

Measure	Target 2011/12	2011/12	2010/11
A. To have completed all actions required in response to the patient safety alert before the first deadline of the 16 December 2011	Complete all actions	Achieved	N/a
B. To identify a preferred new model of ambulatory syringe driver to be used in CPS services (device selection to be undertaken in conjunction with the North Central London Palliative and Supportive Care Network) and an end date to complete the transition between existing ambulatory syringe drivers and ambulatory syringe drivers with additional safety features (CPS will be seeking to complete the transition to safer syringe drivers as soon as possible and within a time period shorter than the five year maximum specified by the NPSA)	Identify preferred new model and agreed end date	On track	N/a
C. To revise the syringe driver policy, training programme and competency assessments to support the safe operation of all designs of ambulatory syringe driver in use during the transitional period.	Revise policy	Not achieved this year	N/a

Measure A

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

Measure B

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

Measure C

These actions will be undertaken this year as part of the implementation planning for introducing the new device.

Priority 3 To provide intensive stroke rehabilitation in accordance with NICE quality standards

To select and measure performance against some of the standards set in the NICE guidance for intensive stroke rehabilitation.

Measure	Target 2011/12	2011/12	2010/11
A. Patients with stroke are assessed and managed by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days (adapted from NICE Quality Statement 5)	N/a	94%	N/a
B. Patients with stroke are offered a min of 45 minutes of each active therapy that is required, for a min of 5 days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it (NICE Quality Statement 7)	N/a	90%	N/a
C. Patients with stroke who have continued loss of bladder control two weeks after diagnosis are reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers (NICE Quality Statement 8)	N/a	Pilot assessment tool	N/a
D. All patients after stroke are screened within six weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment (NICE Quality Statement 9)	100%	94%	N/a
E. All patients discharged from hospital who have residual stroke-related problems are followed up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management (NICE Quality Statement 10).	100%	94%	N/a

[Note that these figures quotes are as per end of Q3 and will be updated following 3rd week in April]

Measure A

Targets are being achieved for patients being seen within 72 hours. Patients are being screened within 24 hours with documented goals.

Measure B

90% of patients received 45 minutes of appropriate therapy 5 days a week for the first 2 weeks of discharge.

Measure C

The project concerning the assessment of bladder function and continence care plans has been focussed on our complex care and neurology-nursing teams. The team have developed an assessment tool that is currently being piloted. The assessment tool is an on-going method of assessing and planning the care, and enables the team to map the patients' journey in relation to this. It is designed to involve patients and families where it is achievable to do so. Depending on the outcome of the pilot, we continue to use the assessment tool for all patients with bladder or bowel dysfunction, and it will be kept under review by the multi-disciplinary team.

Measure D

The screening targets are being met. The REACH Team has also arranged for training from their Improving access to Psychological Therapies link person.

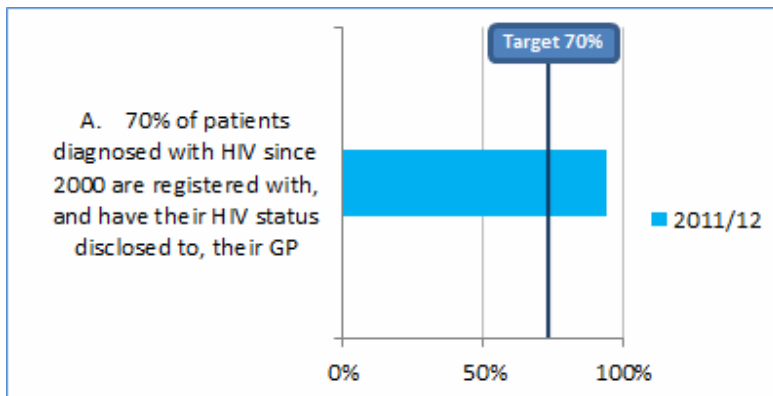
Measure E

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

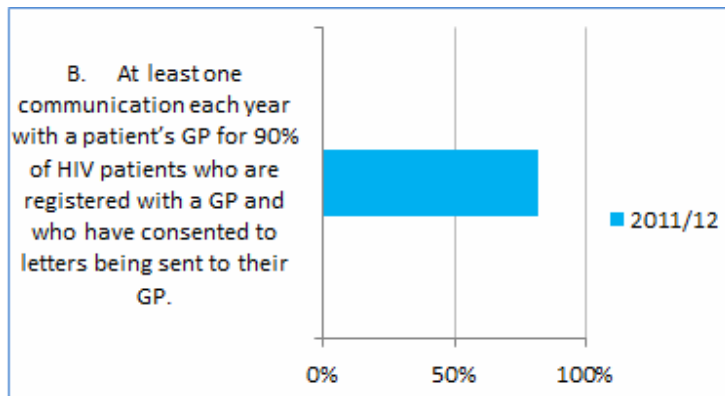
Priority 4 Communication with GPs about the care of HIV patients

To achieve effective two way communication with GPs concerning the medication prescribed for HIV patients to reduce the risk of contra-indications.

Measure A: *percentage of patients diagnosed with HIV since 2000 are registered with, and have their HIV status disclosed to, their GP*



Measure B: at least one communication each year with a patient’s GP for 90% of HIV patients who are registered with a GP and who have consented to letters being sent to their GP



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

OUR QUALITY PRIORITIES FOR 2012/13

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

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

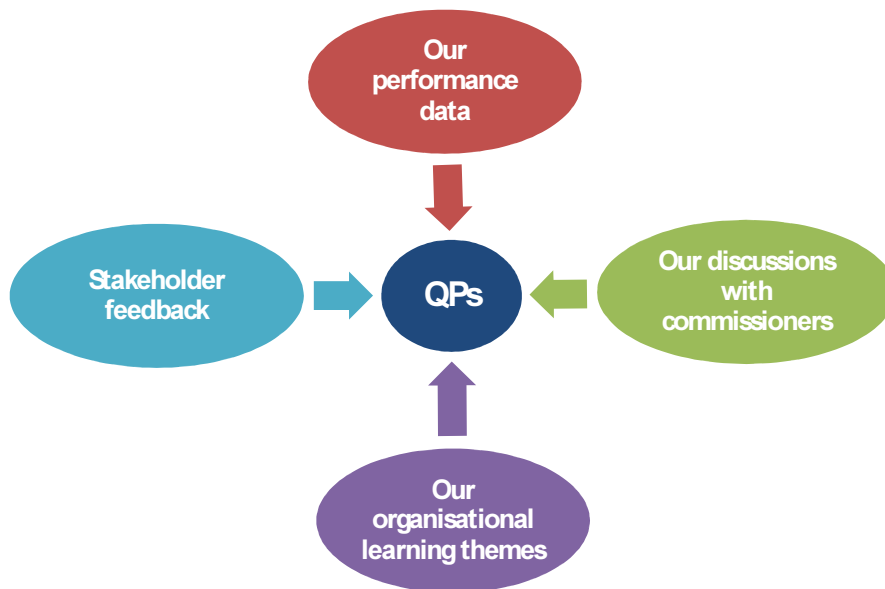
For each quality priority we have identified indicators and targets to measure our performance in this area. These indicators help us to check how we are performing throughout the year and will be used to report on our performance in next year’s quality account. However, we are keen to emphasise that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

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

HOW WE AGREED OUR QUALITY PRIORITIES FOR 2012/13

In agreeing our quality priorities for 2012/13 we looked at a wide range of information available to us.

QPs = Quality Priorities



OUR QUALITY DATA

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

On a quarterly basis we look at all our quality indicators and publish our quality dashboard and quality governance reports. The Quality and Performance Committee, chaired by one of our non –executive directors, oversees our progress in this area and provides assurance to our Board that we are working towards meeting standards.

ORGANISATIONAL LEARNING THEMES

We also take stock of what we hear across the Trust to develop our Organisational Learning Themes. These are key areas of focus for the Trust for our quality and improvement activities. Organisational Learning Themes are based on information received from complaints, claims, incidents, serious untoward incidents, PALS data, staff and patient surveys, and clinical audits.

CONSULTATION WITH STAKEHOLDERS

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

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



The feedback from our large stakeholder event helped to inform the final quality priorities for 2012/13 as shown over the next few pages.

MENTAL HEALTH AND ALLIED SPECIALITIES QUALITY PRIORITIES FOR 2012/2013

RECOVERY AND INVOLVEMENT

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

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

Our measures for this year are:

Measure	Target 2012/2013	Target 2011/12	Measure is a CQUIN this year	New measure this year	Measure same as last year but sample extended
A. Percentage of community patients report that they were involved as much as they wanted to be in decisions about their care plan	65%	65%			★
B. Percentage of service users on CPA whose care plans contain at least one personal recovery goal	50%		★	★	

Why we have set these targets?

This year we are extending, where possible, the sample for measure A to all applicable service lines. This is based on consultation feedback and as requested by our Board. This remains a very important user experience measure for us and we are keen to remain focussed on our performance here. Our performance in quarter 4 of 2011/2012 was challenging as we chose to look at whether or not service users felt they were definitely involved in decisions about their care. We believe that keeping our target at 65% is ambitious and appropriate for us for 2012/2013.

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

How are we going to achieve them?

We will continue our work to review use of the new care plan, and ensure recovery focussed practice really is adopted across the organisation. This will be through staff supervision and training, and the Recovery College will be crucial to achieving this.

We have begun to introduce new assessment tools that are service user focussed. They are being introduced on a borough by borough basis, as each borough has a different approach to social care personalisation. These have been introduced in Westminster, and we will continue to roll out wider across the Trust over the next year and beyond.

FOCUS ON THE CNWL RECOVERY COLLEGE

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

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

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

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

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

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

Waldo Roeg, Peer Recovery Trainer

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

Joss Fleming, Student

PHYSICAL HEALTH

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

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

Our measures for this year are:

Measure	Target 2012/2013	Target 2011/12	Measure is a CQUIN this year	New measure this year	Measure same as last year but sample extended
A. Percentage of service users with dementia prescribed anti-psychotic medication that have 3-monthly reviews, and output sent to GPs and families/patients within 2 weeks	90%		★	★	
B: % of service users on CPA report that they got enough advice and support for their physical health	65%	65%			★

Why we have set these targets?

Measure A focuses on our Older Adult service line, and in particular those service users with dementia. It is an important safety measure and communications with GPs will promote good practice on this issue across the wider health system.

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

How are we going to achieve them?

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

CARER INVOLVEMENT

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

Our measures for this year are:

Measure	Target 2012/2013	Target 2011/12	Measure is a CQUIN this year	New measure this year	Measure same as last year but sample extended
A. Percentage of carers who report feeling supported by CNWL staff	Baseline		★	★	
B. Percentage of carers that report having information that tells them how to access services in a crisis	Baseline		★	★	

Why we have set these targets:

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

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

How are we going to achieve them?

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

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

SERVICE PATHWAY & ACCESS TO SERVICES WHEN IN A CRISIS

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

Our measures for this year are:

Measure	Target 2012/2013	Target 2011/12	Measure is a CQUIN this year	New measure this year	Measure same as last year but sample extended
A. Develop protocols to support safe discharge from secondary care and to support a simplified access pathway back into secondary care for discharged service users	Baseline		★	★	
B. Percentage of individuals reporting that they received the help they wanted from CNWL crisis contact points when they contacted them in a crisis	65%	65%			★

Why we have set these targets?

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

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

How are we going to achieve them?

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

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

FOCUS ON DEVELOPING A SINGLE TELEPHONE NUMBER TO ACCESS OUR SERVICES OUT OF HOURS IN A CRISIS

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

In order to achieve this we are reviewing how we manage out of hours access at present and are looking to develop a CNWL triage facility that links to all these services, across all of our boroughs, to provide a smooth and efficient service for our users.

HILLINGDON COMMUNITY HEALTH SERVICES: QUALITY PRIORITIES FOR 2012/2013

USE OF CARE PLANS

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

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

Our measures for this year are:

Measure	Target 2012/2013	Target 2011/12	Measure is a CQUIN this year	New measure this year	Measure same as last year but sample extended
A. Percentage of End of Life Care Patients on District Nursing Caseload with Advance Care Plan	65%		★	★	
B. Percentage of patients with learning disability conditions using HCH services who have personalised care plans	25%		★	★	

Why we have set these targets?

Measure A will build on work from 2011/12, and we believe that 65% is an ambitious target for us to work to achieve.

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

How are we going to achieve them?

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

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

We will build on our work to date that has focused on the identification of individuals with a learning disability, the introduction of a training package for staff and the evolvement of specific care planning. Monitoring will be take place centrally on a monthly basis. The category of patients with Learning Disabilities is now recorded on their electronic record and therefore a personalised care plan will be attached to that record.

REDUCING THE NUMBER OF AVOIDABLE GRADE 2/3/4 PRESSURE ULCERS

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

Our measures for this year are:

Measure	Target 2012/2013	Target 2011/12	Measure is a CQUIN this year	New measure this year	Measure same as last year but sample extended
A. Number of avoidable grade 2/3/4 pressure ulcers	10% year on year reduction		★	★	

Why we have set these targets?

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

How are we going to achieve them?

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

We will also review the involvement of the Tissue Viability Team in providing expert advice and assist with the management of patients with pressure ulcers

IMPROVING STAFF AWARENESS IN RELATION TO CARERS

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

Our measures for this year are:

Measure	Target 2012/2013	Target 2011/12	Measure is a CQUIN this year	New measure this year	Measure same as last year but sample extended
A. Develop localised guidelines for all HCH staff to enable more effective support for carers which will include development & delivery of a training package for staff in conjunction with 3rd sector partners	Baseline			★	
B. Ensure at least 80% of all new referrals to the wheelchair service are given specific information for their carers about using a wheelchair and, where requested, provide additional training	80%			★	

Why we have set these targets?

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

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

How are we going to achieve them?

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

We will continue to build on the foundations laid by the wheelchair services, and deliver further training to wheelchair users' carers as proved beneficial through the pilot exercise.

CAMDENQUALITY PRIORITIES FOR 2012/2013

CLINICAL QUALITY IN OUR HIV SERVICES

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

Our measures for this year are:

Measure	Target 2012/2013	Target 2011/12	Measure is a CQUIN this year	New measure this year	Measure same as last year but sample extended
A. Percentage of HIV patients whose immune systems are maintained at a CD4 count greater than 200	95%			★	
B. Percentage of patients with a viral load less than 50 copies / ml within one year	95%			★	

Why we have set these targets?

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

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

How are we going to achieve them?

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

PATIENT EXPERIENCE

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

Our measures for this year are:

Measure	Target 2012/2013	Target 2011/12	Measure is a CQUIN this year	New measure this year	Measure same as last year but sample extended
Percentage of patients with an appointment with sexual health services, who arrive on time, that are seen within 30mins of the appointment time	80%			★	
Number of responses stating poor responsiveness to call bells on inpatient wing of St Pancras hospital	0			★	

Why we have set these targets?

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

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

How are we going to achieve them?

We will continually monitor waiting times through our recently introduced electronic booking system, identifying busy periods and matching staff to workload as closely as possible. In addition we will look at working practices to continue to improve the patient journey through the clinic. Quarterly reports will be produced for the Quarterly Governance Report to monitor progress at Executive level.

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

MONITORING AND SHARING HOW WE PERFORM

RECORD OUR PERFORMANCE

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

MEASURE OUR PERFORMANCE

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

MONITOR OUR PERFORMANCE

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

BENCHMARKING

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

REPORT OUR PERFORMANCE

We report on our performance in this annual quality account, however we also share a public facing dashboard with our stakeholders every quarter that is broken down by borough. We have presented our performance at the Trust level in the body of our Quality Account to keep the flow of the document and not to overload our readers with too much detail, however you will be able to find borough level data on pages .

STATEMENTS RELATING TO QUALITY OF NHS SERVICES PROVIDED

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

SERVICES

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

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

The income generated by the NHS services reviewed in 2011/2012 represents [98% LAST YEAR] per cent of the total income generated from the provision of NHS services by CNWL for 2011/2012.

PARTICIPATION IN CLINICAL AUDIT

During 2011/12, 4 national clinical audits and 2 national confidential enquiries covered NHS services that CNWL provides.

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

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

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

The national clinical audits and national confidential enquiries that CNWL participated in during 2011/12 are as follows:

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

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

National Confidential Enquiry / National Audit	Cases submitted
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	96.92% (for period January 2005 to January 2011)
National Confidential Enquiry into the Patient Outcome and Death - Cardiac Arrest Study	No cases requiring submission during 2011/12
National Parkinson's Audit	35% (7/20). Due to the limited number of patients seen by the team only 7 cases were submitted rather than the requested 20
National Schizophrenia Audit	93 cases submitted - minimum sample of 80 required
Care of Dying in hospital	38 cases submitted. No number specified as it depended on the number of patients in a given period
Prescribing in mental health services (POMH) <ul style="list-style-type: none"> • Assessment of the side effects of depot antipsychotics • Monitoring of patients prescribed lithium • Use of antipsychotic medication in CAMHS 	<ul style="list-style-type: none"> • 183 cases submitted • 92 cases submitted • 54 cases submitted (No set number required - audit sample determined by Trust)

The reports of 6 national clinical audits were reviewed by the provider in 2010/2011 and CNWL intends to take the following actions to improve the quality of healthcare provided.

- National Falls and Bone Health in Older People (Hillingdon Community Health): Using 'Patient Safety First -the 'How to' guide for reducing harm from falls 09/2009' and in involving members of the multi disciplinary team, the necessary documentation and risk assessment tools were devised. The audits were carried out on a monthly basis. The aim of the audit was to assess if staff were completing all the necessary falls documentation and risk assessments. These audits continue bi-monthly.
- National Falls and Bone Health in Older People (Camden Provider Services): The report of the national audit of falls and bone health (2010-11) was reviewed locally and the following progress was noted since participation in the previous round of this audit:

- Improved screening, specialist falls management and introduction of a validated home hazard assessment tool.
- Increased screening for falls by health care professionals working in the community.
- Assessment of clients placed on falls management pathway using a Multi Factorial Falls Risk assessment
- Use of validated Home hazard assessment (Home Fast) – used on all clients identified to have the environmental risk for fall
- Improved structures and increased staffing: Falls Coordinator in post, Camden Falls Steering Group formed
- Effective joint working with Care Homes: All Local Authority in-house operated care homes have falls registers, an agreed protocol for risk identification and protocols to manage residents who have fallen.
- Training: Provided for a range of different health care professionals in the community re: risk identification and referral processes.

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

- Designated consultant time for the falls service.
- Consider whether Camden Provider Services needs or could have access to a fracture liaison nurse/service and a specialist pharmacist with a specific remit for falls and bone health
- Interventions for osteoporosis – prescribing advice, protocol to promote routine offer of calcium and vitamin D for patients who are housebound and in care homes
- Arrangements for referrals to syncope services or tilt table testing
- Local audits on prescription of calcium, vitamin D and other bone sparing agents in high risk groups
- Parkinson's UK National Audit: The REACH Neuro team submitted data for its occupational therapy provision to Parkinson's patients. There was no cause for concern or urgent improvement identified. The results of the audit will be used in the future to assist in shaping services.
- National Care of the Dying Audit: On reviewing the report from this national audit the Palliative Care Team has identified the need to improve documentation of communication after death with relatives and GPs. This could be addressed by stronger links with wards and bereavement office to ensure the contribution of the bereavement office is reflected within the LCP.
- Physical healthcare monitoring of patients receiving treatment by depot injection (POMH). The results of the audit have been presented to the Medicines Management Group, and communicated to participating teams. This was the third iteration of this audit. The Trust has made significant improvements in the areas of side effect recording; the use of a checklist to assess side effects and assessment of EPS, BMI/weight and sexual side effects.
- Lithium treatment (POMH). This report has been discussed by the Physical Health Steering group and will also go to the Medicines Management Group for further discussion about the action to be taken.
- Use of antipsychotic medicine in children and adolescents (POMH). The report was received from POMH towards the end of March and will be discussed at the Medicines

Management Group and disseminated to the relevant teams involved. This is the second iteration of this audit and CNWL has seen improvements in all standards.

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

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

- Insulin Administration and Documentation Audit

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

- Pain Scales Audit carried out by Podiatry.

Action: Teams will be supported to complete pain scales at entry and end of care package to ensure that we have a record of measurable patient outcomes.

- Improvements in Physical Activity Outcome measurements in Pulmonary Rehabilitation carried out by REACH Pulmonary Rehabilitation team

Action: Develop a system for telephone follow up of Pulmonary Rehabilitation patients to try and retain the benefits achieved and to improve recruitment back into the program at one year.

- Multi-Agency Child In Need Case File Audit carried out by Health Visiting and School Nursing

Action: To hold specific training/workshops on the skills of providing evidence of decision making using the Common Assessment Framework when compiling a report for child protection case conferences. To hold generic training to address quality of report writing. Child protection supervision sessions to include oversight and analysis of case conference reports with a focus on barriers to information sharing with parents/carers/children.

- Audit of physical health examination on admission to a mental health ward

Action: Training for teams to increase the percentage of completion of physical health assessments

- Shared Care Prescribing Audit

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

- Audit of Prolactin Monitoring in patients on antipsychotics

Action: Costings for prolactin testing to be investigated to clarify whether it would be feasible to test prolactin of all patients.

- Crisis Cards Audit

Action: Posters placed on the back of consultation room doors in the community mental health team reminding staff to check they have a crisis card. Another setoff posters has been displayed to prompt patients to ask for one, placed at reception and the main entrance

RESEARCH

Please note that the figures quoted below are up until February 2012. Full year end figures will be available in early April and provided in the final quality account.

The number of patients receiving NHS services provided or sub-contracted by Central and North West London NHS Foundation Trust in 2011/2012 that were recruited during that period to participate in research approved by a research ethics committee was 966.

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

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

GOALS AGREED WITH COMMISSIONERS

USE OF THE CQUIN PAYMENT FRAMEWORK

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

Further details of the agreed goals for 2011/12 and for the following 12month period are available electronically at[[note: insert web link when updated and available](#)].

WHAT OTHERS SAY ABOUT THE PROVIDER

STATEMENTS FROM THE CARE QUALITY COMMISSION

CNWL is required to register with the Care Quality Commission and its current registration status is unconditional registration. CNWL has the following conditions on registration – none.

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

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

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

CNWL has made the following progress by 31st March 2012 in taking such action (see table below for details of the Trust progress against the action plans).

CQC Reviews of Compliance		
Location	Outcome of Review	Progress with actions
3 Beatrice Place (older adult inpatient)	Re-inspected to assess improvements as specified in the action plan submitted post the CQC's first inspection in January 2011.	No further action required. All concerns were lifted and Beatrice Place is deemed fully compliant with the CQC standards.
Butterworth Centre (older adult inpatient)	Re-inspected to assess improvements as specified in the action plan post the CQC's first inspection in April 2011.	No further action required. All concerns were lifted and Butterworth Centre is deemed fully compliant with CQC standards.
Northwick Park Hospital (adult and older adult inpatient)	Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns with Outcomes 4: Care and welfare of people who use services, and Outcome 10: Safety and suitability of premises.	An action plan has been devised and a report on progress with the actions has been submitted to the CQC.
Feltham HMYOP (young offenders prison)	Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns around Outcomes 2: Consent to care and treatment, 8: Cleanliness and infection control, and 10: Safety and suitability of premises, and one suggestion for improvement for Outcome 1: Respecting and involving people.	An action plan has been devised and a report on progress with the actions has been submitted to the CQC.
7a Woodfield Road (adult	Compliant with CQC Standards. However the CQC identified	An action plan has been devised and a report on

inpatient/rehabilitation)	improvement action as follows: Minor concerns around Outcome 4: Care and welfare of people.	progress with the actions has been submitted to the CQC.
Trust Headquarters (all services provided in the community)	Fully compliant with the CQC Essential Standards assessed.	None required
Kingswood Learning Disability Service	Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns with Outcomes 4: Care and welfare of people who use services, and Outcome 7: Safeguarding.	An action plan has been devised and a report on progress with the actions has been submitted to the CQC.
Seacole Centre Learning Disability Service	Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns with Outcomes 4: Care and welfare of people who use services, and Outcome 7: Safeguarding.	An action plan has been devised and progress will be reported back to the CQC by April 10 th 2012.
Park Royal Centre for Mental Health (adult and older adult inpatient)	Compliant with CQC Standards. However the CQC identified improvement action as follows: Minor concerns Outcome 2: Consent to care and treatment and Outcomes 4: Care and welfare of people who use services. No concerns were identified with Outcome 1 (respect and involvement) but improvement action was required.	An action plan has been devised and a report on progress with the actions has been submitted to the CQC.

DATA QUALITY

STATEMENT ON RELEVANCE OF DATA QUALITY AND YOUR ACTIONS TO IMPROVE

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

- Undertake a review of all our information systems to ensure we meet the new challenges of reporting by service line and the inclusion of community services while maintaining and improving data quality
- To continue to examine the market for new products which will support data quality.
- Review the Information Assurance Framework on a quarterly basis. This has been developed to identify any gaps in data capture or processes across all service lines, including community services

- In association with this, we will continue the development and testing of our monthly Community Information Data Set (CIDS) to examine and improve data quality in community services
- Continue with the distribution of weekly data quality reports with patient level data to identify any breach areas and ensure that systems are in place to capture and record information on a timely way
- To expand the provision of the weekly QIS reports to mental health services, which provide front line data on KPIs and data quality
- Audits are developed in line with the standards set out in the Data Quality Policy and all staff are made aware of the importance of data quality and the need to keep accurate records
- Review and monitoring of benchmarking data (both internal and external) to ensure that CNWL compares favourably with other leading mental health organizations
- Monthly red/amber/green (RAG) rating on the accuracy of all activity reports for every team down to staff member level – and moving to weekly reports as above
- Internal audits to measure compliance of KPI reporting against clinical notes

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

NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

CNWL submitted records during 2011-12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number at quarter three of 2011-12 was:

- 92.3% for admitted patient care;
- 98.5% for out patient care; and
- N/A for accident and emergency care.”

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

- 100% for admitted patient care;
- 100% for out patient care; and
- N/A for accident and emergency care.”

INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVELS

CNWL Information Governance Assessment Report score overall score for 2011/ 12 was 84% and was graded green.

CLINICAL CODING ERROR RATE

CNWL was not subject to the Payment by Results clinical coding audit during 2010-11 by the Audit Commission.

PART 3 – OTHER INFORMATION

OUR PERFORMANCE AGAINST NATIONAL AND LOCAL INDICATORS

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

The quality indicators are grouped in to the quality dimensions set out in Lord Darzi's High Quality Care for All report. These dimensions are Safety, Effectiveness and Experience.

SERVICE USER SAFETY

Measure	Target	2011/2012	2010/11	2009/10	Benchmark (where available)	
1. CPA 7-day follow-up	95%	95.5%	96%	97%	96% ¹	
2. Risk assessment and management	95%	90%	92%	95%	Not available	
3. Infection control	a. The number of cases of MRSA (MRSA infection) annually	0	0***	3***	9***	Not available
	b. The number of cases of MRSA (MRSA bacteraemia) annually	0	0	1	0***	Not available
	c. The number of outbreaks of Clostridium Difficile annually	9	7	11	0***	Not available
4. Crisis/ contingency plans	90%	92%	97%	-	Not available	
5. HCH Falls	10% decrease in number of falls at Northwood & Pinner Community Unit on 2009/10 performance**	TBC		No change	Not available	Not available
6. HCH medication errors	Number of serious / red medication incidents or errors**	0	3	1	Not available	Not available
7. HCH incident reporting	Percentage compliance with online incident reporting**	95%		100%	Not available	Not available
8. HCH hand hygiene	Percentage of patients happy with their HCP's attention to hand hygiene**	90%	85	87%	Not available	Not available

* This was a QP for 2009/10

** This was a QP for 2010/11

*** This figure is for CNWL Mental Health and Allied Specialities services only

¹Source: CQC National Priorities Indicator Benchmarking 2009/10 (Regional average)

Measure 1: This is important as we want to ensure our service users remain safe when they are discharged from hospital into community care. In 95.5% of cases we completed a follow-up within 7 days for service users discharged from hospital on CPA. This is slightly above our target of 95%.

Measure 2: This measure assesses whether a risk assessment has been completed, and how risks identified will be incorporated into the care plan to be effectively managed. Our performance has fallen slightly from last year and remains below our target of 95%. We will continue our efforts to improve our performance and ensure we achieve our target in the future.

Measure 3: Reducing healthcare acquired infections is a priority for all Trusts. We have a duty to ensure our patients do not get any healthcare acquired infections whilst they in our care and / or in contact with any of our services. We are very pleased to report that at the end of Q3 we are on track to meet our targets for both MRSA and Clostridium Difficile. [Update as necessary when Q4 data available].

Measure 4: This measure shows if our service users have a documented plan in their notes of what to do in a crisis. We are pleased to report that 92% of our service users do have crisis / contingency plans as part of their CPA.

Measure 5: This measure looks at the number of falls of our patients in Hillingdon Community Healthcare Northwood and Pinner Community Unit. [insert relevant text when target is known].

Measure 6: This measure looks at medication errors and incidents in Hillingdon Community Healthcare and is an important patient safety measure. [insert relevant text when current performance known].

Measure 7: This assesses how compliant Hillingdon Community Healthcare are with online incident reporting. . [insert relevant text when current performance known].

Measure 8: It has been well documented that good hand hygiene is an effective way to prevent transmission of infection. This measure assesses what percentage of our patients were happy with our healthcare professionals (HCP) hand hygiene. A recent patient survey recorded that 85% of patients were happy with our HCP hand hygiene, which is below the target of 90% that we set ourselves.

CLINICAL EFFECTIVENESS

Measure	Target	2011/2012	2010/11	2009/10	Benchmark (where available)	
1. Re-admission rates	What percentage of service users were re-admitted to hospital within 28 days of leaving?	<11%	4.2%	5%	5.7%	Not available
2. Outcome measures –	Patients on CPA who have been assessed using HoNOS, who have had at least two events which require scoring whose scores have been paired*	60%	72%	Adults: 23/25; Older Adults: 24/25; CAMHS: 13/13	All targets met	Not available
3. Crisis Resolution Team gate keeping	The percentage of service users admitted to acute adult inpatient beds who were assessed as to their eligibility for home treatment prior to admission?	90%	98%	95%	94.5%	95.1% ²
4. Crisis Resolution home treatment episodes	Did we achieve the commitments (set by commissioners) to deliver new crisis resolution home treatment episodes?	5	4/5	5/5	Not measured	Not available
5. Early Intervention Teams	Did our Early Intervention Teams meet the commitments (set by commissioners) to serve new psychosis cases?	95%	100%	100%	Not measured	Not available
6. Mental Health Minimum Data Set (data completeness)	a. Identifiers	99%	99%	99%	99.6%	99.51% ²
	b. Outcomes	50%	97%	87.5%	59.6%	52.47% ²
7. Physical health checks	a. Inpatient service users with physical health assessment after admission (either nursing or medical)**	95%	98%	99%	Not measured	Not available
	b. Inpatient service users with physical health assessment after admission (Nursing)**	95%	94%	95%	Not measured	Not available
	c. Inpatient service users with physical health assessment after admission (Medical)**	95%	79%	89%	Not measured	Not available
8. HCH Edinburgh Post Natal Mood Assessment	Percentage of new mothers receiving an Edinburgh Post Natal Mood Assessment within four to six weeks of birth**	90%	90%	90%	78%	Not available
9. HCH wheelchair initial assessment waiting time	Waiting time for initial assessment in District Wheelchair Service (weeks)**	13	11	11	Not measured	Not available
10. HCH Ambulatory wound care services	Number of patients accessing the Ambulatory Wound Care Services**	TBC		>2000	Not measured	Not available

* This was a QP for 2009/10
** This was a QP for 2010/11

²Source: CQC National Priorities Indicator Benchmarking 2009/10 (Regional average)

Measure 1: Some service users may get re-admitted to hospital shortly after leaving and this is important for us to measure and monitor as high re-admission rates may indicate that service users were discharged too soon or not given the appropriate support in the community. We are very pleased that our readmission rates within 28 days of discharge a significantly below target, 4.2% against a target of 11%.

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

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

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

Measure 5: This indicator assesses whether we have met our commitments, set by our commissioners, to serve new cases of First Episode Psychosis. We are proud of our 100% performance against this measure, against our target of 95%.

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

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

Measure 8: Offering HCH mothers Edinburgh Postnatal Depression Scale screening is important as it is recognised the post natal depression is undiagnosed and can have a significant impact on women and their families. Our performance in month 11 showed that we met our target of 90%.

Measure 9: This measure shows the average waiting time for wheelchair assessment in HCH, and is important as it ensures we provide a more effective service to a vulnerable group of service users. Our year to date performance is in line with our target, 11 weeks.

Measure 10: This measure looks at how many HCH patients use our ambulatory wound management service, to help service users get better quality of care closer to their homes. .
[insert relevant text when current performance known].

SERVICE USER EXPERIENCE

Measure		Target	2011/2012	2010/11	2009/10	Benchmark (where available)
1. Delayed transfers of care	On average, what percentage of hospital beds are being used by service users who should have been discharged?	7.5%	2.9%	2.8%	4.4%	3.15% ³
2. CPA 12 month review	What percentage of our service users who are on CPA received a full CPA review within the last 12 months where appropriate?*	95%	95%	95%	99% (Jan-Mar 2010 audit)	Not available
3. Copy of care plan	What percentage of our service users have been offered a copy of their care plan?	95%	84%	88%	90%	64% ⁴
4. Access for people with a learning disability	Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	7/7	7/7	6/6	Not measured	Not available
5. Understanding what is in care plan	The % of community service on CPA who say they definitely understand what is in their care plan**	75%	48%	63%	Not measured	35% ⁴
6. Referral to Treatment	The referral to treatment waiting times: non-admitted (HCH and CPS only)	95%	99.9%	100% (HCH only)	99.8% (HCH only)	Not available
7. HCH service users know how to provide feedback	Percentage of service users who knew how to compliment or complain about a service**	60%		62%	TBC	Not available
8. HCH phlebotomy service	Number of patients accessing the community phlebotomy service**	TBC		3233	Not measured	Not available

* This was a QP for 2009/10
** This was a QP for 2010/11

³Source: CQC National Priorities Indicator Benchmarking 2009/10 (Regional average)

⁴Source: CQC National Community Service User Survey 2011

Measure 1: This indicator assesses what percentage of hospital beds are being used by those who should have been discharged. This is an important measure to monitor because inpatient beds should be kept free for those who need them most and also because service users should be treated in the most appropriate setting. We are proud that once again we have seen very good performance in this area.

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

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

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

Measure 5: This indicator is about making sure that our service users on the Care Programme Approach definitely understand what the plans are for their care. The figure reported is for those who 'definitely' understand, but if we include those who said that 'to some extent' they understand what is in their care plan we have achieved 79%, which is encouraging.

Measure 6: This is a nationally set target for consultant led services to ensure that patients are seen within an agreed timeframe from point of referral. This is an important indicator in ensuring that patients are not kept waiting for a long time before starting treatment. We are very pleased that our performance of 99.9% exceeds the national target of 95%.

Measure 7: This looks at whether HCH service users know how they can make a compliment or complaint about an HCH service. This is important as this feedback helps to inform future service delivery and developing. . [insert relevant text when current performance known].

Measure 8: This measure looks at the number of patients that access HCH domiciliary phlebotomy service. . [insert relevant text when current performance known].

BOROUGH BREAKDOWN – REVIEW OF PERFORMANCE AGAINST NATIONAL PRIORITIES AND HISTORICAL QUALITY PRIORITIES

[Please note that a borough breakdown of our performance against national priorities and historical quality priorities will be available as part of the final Quality Account.]

OTHER INDICATORS OF QUALITY

STAFF SATISFACTION

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

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

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

Whilst it is good to know what we do well at, it is important to look at where we can improve and implement action plans to address any findings. This year's staff survey highlighted that we were below the national average for the following areas: percentage of staff saying hand washing materials are always available, percentage of staff believing that the trust provides equal opportunities for career progression or promotion, and percentage of staff experiencing discrimination at work in the last 12 months.

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

[Please note that the figures included below are for CNWL mental health and allied specialties services only. The 2011/2012 figures will be updated to reflect a Trust wide performance when the data is available in mid-April.]

Measure	Target	2011/12	2010/11	2009/10
Staff turnover The number of staff leaving as a percentage of total staff	Year on year improvement	12.4%	12.6%	11.1%
Average sickness per employee The time lost to sickness per employee as a percentage of total time available	Year on year improvement	3.8%	3.8%	3.6%

PATIENT EXPERIENCE

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

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

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

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

The results from all surveys are reviewed at service level and Board level, and are used to inform decisions regarding improvement plans, and in deciding the quality priorities.

COMPLAINTS

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

296 formal complaints were made to CNWL. Most were graded as moderate or low and 6 were related to a serious incident. At the end of March we had responded to 218, 17% of which were fully upheld. The remainder have a response which is being finalised, or remains under investigation. A review group to consider learning from complaints, PALS and claims issues has been convened, the first meeting of which took place in January 2012.

ANNEX 1: ANY STATEMENTS PROVIDED BY OUR COMMISSIONERS, LINKS OR OSCS

[Include an explanation of any changes made to the final version of QA after receiving these statements from our 30 day consultation period.]

ANNEX 2: GLOSSARY OF TERMS

ABBREVIATIONS

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

EXPLANATION OF TERMS USED

Care Programme Approach (CPA)

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

CPA Assessment

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

CPA Care Co-ordinator

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

CPA Care Plan

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

Clinical/Specialist Care Plans

Clinical/specialist care plans give the detailed procedure for each service identified as being appropriate to support the service user within their overall CPA care plan.

Crisis Plan

A crisis plan is included within the CPA care plan. It sets out the action to be taken if the service user becomes ill or their mental health deteriorates.

Contingency Plan

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

CPA Review

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

Carer

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

Lead Professional

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

Local Involvement Networks (LINKs)

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

Patient Advice and Liaison Service (PALS)

PALS offers help, support, advice and information to service users, carers, family or friends.

Service User

The term "service user" refers to those people receiving treatment and care.

ANNEX 3: STATEMENT OF DIRECTOR'S RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

[To be inserted following public consultation]

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**REPORT FOR: OVERVIEW AND
SCRUTINY COMMITTEE**

Date:	3 April 2012
Subject:	'Shaping a Healthier future for North West London' – Preparing for a Joint Overview and Scrutiny Committee
Responsible Officer:	Alex Dewsnap, Divisional Director Partnership Development and Performance
Scrutiny Lead Member area:	Councillor Ann Gate Lead Member - Health and Social Care
	Councillor Vina Mithani Lead Member - Health and Social Care
Exempt:	No
Enclosures:	Shaping a Healthier Future – Case for Change

Section 1 – Summary and Recommendations

This report outlines issues for consideration by the Overview and Scrutiny Committee to recommend to Council that Harrow will participate in a Joint Overview and Scrutiny Committee. The Joint Overview and Scrutiny Committee will be formed to consider NHS North West London's programme to improve care for North West London and the consultation process.

Recommendations:

Councillors are recommended to:

- I. Consider the summary of the '*Shaping a Healthier Future*' programme

- II. Consider the relative merits of Harrow taking part in the JOSC
- III. Ask that full Council agree Harrow's involvement in the establishment of the JOSC and delegate authority to the Overview and Scrutiny Committee to appoint the Harrow representative(s) to the JOSC and to determine membership and issues related to the JOSC.

Section 2 – Report

Background

Shaping a healthier future is a programme that has been set up by NHS North West London (NWL) to respond to the challenge of trying to provide high quality healthcare for North West London. The NHS NWL cluster is amongst the largest in England with a budget of £3.4 billion and covers 8 London boroughs including Harrow, Hillingdon, Brent, Ealing, Kensington and Chelsea, Westminster, Hammersmith and Fulham and Hounslow. The programme has also been developed with the 8 Primary Care Trusts (PCTs)/Clinical Commissioning Groups serving a population of 1.9 million people. Amongst the 8 boroughs there are 14 hospital sites and 423 GP practices.

The Shaping a healthier future programme has been set up by clinicians following recognition that changes need to be made to the way services are delivered because of pressure on the services. Some of the key challenges and changes include:

- the ageing population
- current lifestyle is creating an epidemic of obesity, diabetes, cancer, heart disease and stroke
- the numbers of patients living with chronic disease are increasing
- science and technology offer new ways of tackling old problems
- internet, mobile communications and telehealth are opening up new channels for delivering care and providing health information, increasingly supporting patients to care for themselves

The programme is also being developed in order to address the growing challenges which lie in the way primary care and out-of-hospital care has been organised in the past which will not meet future needs. In some parts of north west London, patients cannot get a basic appointment with their GP or access services easily. Amongst six of the eight boroughs in north west London patient satisfaction has also been recorded as being in the bottom 10% nationally (*NHS NWL, The Case for Change, February 2012*). The programme also aims to bring more proportionality to health care spending and increase spending and investment in community and local services.

With all this NHS costs are on the rise whilst there is less funding available. Some changes have been made over the past few years including:

- changes in community, primary and hospital care increasing localisation of services

- co-ordination and integration of care across the boundaries of providers has been improved reducing non-elective admissions for diabetic and elderly patient groups
- some specialist services have been centralised into single networked centres, improving clinical outcomes

However, there is also recognition that far more still has to be done.

North west London has also got a vast amount of hospital space per head per population in comparison to other part of the country, the aim will be to have senior, specialised teams available 7 days a week, 24 hours a day with health services delivered locally when they can.

Out of Hospital Care

The work being carried out on out-of-hospital care presently is a big part of the '*Shaping a healthier future plan*' CCG's. The work is being lead by CCG's in north west London, PCT borough directors, director from each local authority and provider out of hospital care leads.

The programme is focused on developing high-quality cost-effective care outside of hospitals in order to support the changes in other parts of the health economy.

Quality standards have been developed to support the changes in out-of- hospital care which include:

1. Individual empowerment and care - provision of information to aid people when making decision about their care
2. Access, convenience and responsiveness - ensure that out-of-hospital care operates as a seven day a week service with community and health care services responding to local needs
3. Care planning and multi-disciplinary care delivery - co-ordinated and seamless integrated service using evidence pathways and care planning to support individuals.
4. Information and communication - following individual consent, health and social care records will be shared between care providers to identify changing needs so that care plans can be reviewed and updated. By 2015, it is hoped all patients will have access to their health records.

Joint Overview and Scrutiny Committees (JOSC)

Under the 2001 Health and Social Care Act, 2002 Regulations and 2003 Directions and Guidance) requires that where a local NHS body consults more than one Overview and Scrutiny Committee on a proposal it has under consideration for a substantial development of the health service or a substantial variation in the provision of service, the Overview and Scrutiny Committees of the local authority shall appoint a JOSC for

the purpose of consultation. Only the JOSC has the statutory power to request information relating to the issue being consulted upon.

The JOSC will:

- make comments on the proposal consulted on by NHS NWL
- Require NHS NWL to provide information about the proposals
- require NHS NWL to attend and answer questions in relation to the proposals

Informal JOSC meeting

The first informal meeting of the JOSC will be held on 4 April 2012 and will only include Councillors and Officers in the first part of the meeting where membership options, the terms of reference, timescales and meetings dates and administration of the JOSC will be considered.

Membership Options

At the first informal JOSC meeting Members will be invited to consider the advantages and disadvantages of the options outlined below:

Option 1: one nominated scrutiny member & one substitute member from each council participating in the JOSC.

Advantages

- (a) It is envisaged that the nominated representative in each borough will attend all meetings thereby ensuring a consistent and broad level of understanding from all participating members which can be drawn on in agreeing recommendations and the final report.
- (b) Where the nominated representative is unable to attend, the attendance of a substitute representative will ensure that all participating councils remain fully involved and have a voice in the work of the JOSC.

Disadvantages

- (a) The majority of the workload (which could involve significant time commitments) will fall to one member including the need to attend all meetings of the joint committee and acting as the link back to the local scrutiny panel. This could prove difficult depending on other time commitments.
- (b) Substitute members standing in for the nominated representative may find it more difficult to put evidence into a complete context if attending isolated meetings.

Option 2: two nominated scrutiny members from each council participating in the JOSC.

Advantages

- (a) It is envisaged that the nominated representatives in each borough will attend all meetings thereby ensuring a consistent and broad level of understanding from all participating members which can be drawn on in agreeing recommendations and the final report.

- (b) Where one of the nominated representatives is unable to attend the other representative would be able to represent the participating council and have a full understanding of all issues highlighted in evidence to date.
- (c) Members in each local authority may find it helpful to discuss proposals with another local councillor sitting on the JOSC, especially where that proposal impacts on their authority in a distinct way.
- (d) This option will allow a wider pool of member experience and knowledge to inform the work of the JOSC.

Disadvantages

- (a) It may be more difficult to find meeting times/dates that are suitable for all members.
- (b) There may be a lack of interest/capacity in boroughs to committing this level of member resource.

Proposed terms of reference

The proposed draft terms of reference will be redrafted and circulated in time for sign off at the first formal meeting of the JOSC. Proposed terms of reference are as follow:

1. Consider the '*Shaping a Healthier Future*' consultation arrangements - including the formulation of options for change, and whether the formal consultation process is inclusive and comprehensive.
2. Consider and respond to proposals set out in the '*Shaping a Healthier Future*' (**) consultation with reference to any related impact assessments or other documents issued by or on behalf of NHS North West London in connection with the consultation;
3. Consider whether the '*Shaping a Healthier Future*' proposals affecting acute and out of hospital care are in the interests of the health of local people and will deliver better healthcare for the people in North West London and people travelling across the GLA boundary, having due regard to cross-border issues;

(**) or whatever the exact title of the awaited consultation document turns out to be.

Harrow nomination to the JOSC

Having agreed to take part in the JOSC in principle, it should be noted that the committee cannot agree a formal nomination from the council until the next full Council meeting, which will be on 24 May 2012 until it is agreed that harrow participate and due to possible changes in membership of committees. The options which are chosen by the current members of the informal JOSC (option 1 or 2 detailed above) will also have implications on membership.

Members agree that representative(s) waiting to be formally appointed to the JOSC are able to participate in any meetings during the pre-consultation phase, in the same way as those that have been appointed.

The current chair and Vice-Chair of the Health and Social Care Scrutiny Sub-Committee who are also the Adult Health and Social Care lead members will be in attendance at the informal meeting on 4 April.

In view of any changes that may arise, it is also recommended that Council give the Overview and Scrutiny Committee the power to decide on any key decisions in terms of the membership and issues related to the JOSOC.

Timescales, meeting dates and current status

NHS NWL are currently in pre-consultation phase on their proposals and this began in January 2012 and will run till May 2012. The main focus of the pre-consultation phase to date has been two public consultation events held in February and March 2012 involving patients, local authorities, patient groups, GP's, other clinicians and the public. According to current timescales, the formal consultation period is expected to run from the beginning of June to September 2012.

At the first two informal briefing sessions delivered for scrutiny members by NHS North West London, members raised concern about the timing of the consultation which coincides with the summer holiday period, the Olympics and the Diamond Jubilee. *Members should note that NHS North West London has stated that the JOSOC is able to comment on the suitability of the length of the consultation period.*

In addition to the meetings needed to take evidence from suggested witnesses, members will need to have at least a further two meetings to carry out the following tasks:

- Agree terms of reference, rules of procedure, elect chair(s). This can be done at the start of the first meeting during the formal consultation period, which will also be taking evidence.
- Agree the committee's consultation response
- (After the consultation ends) Review NHS North West London's response to the JOSOC's consultation response.

Members will receive an updated timetable once meetings dates for the JOSOC are agreed.

Local engagement activity that takes place with individual boroughs has not been included. Members may find it helpful to keep each other notified of any engagement carried out at a local borough level, so the JOSOC retains an overview of engagement activity across all 8 boroughs.

Jan – May Pre-consultation engagement activity with JOSOC

16th Jan Informal briefing on case for change

29th Feb Informal briefing on clinical standards, service models and

	process and timeline for Joint Committee engagement & formation.
4 th Apr	Members give views and give informal agreement to some of the practical arrangements of the JOSOC.
	Members give views on the draft short list of options to go in the consultation document and the benefits framework.
19 April	Information item to Health and Social Care Scrutiny Sub-Committee
w/c 30 th Apr	Members give views on short list of options, draft consultation plan and out of hospital strategies.
w/c 14 th May	Members give views on consultation options, draft consultation document and plan.
24 May	Full Council
Jun* – Aug	JOSOC takes evidence from identified witnesses
June (date tbc)	First meeting of the JHOSOC in formal consultation period to agree chair(s), rules of procedure, terms of reference & take evidence
	Dates of further witness sessions tbc
Sep*	JOSOC agree final response and submit to NHS NWL.
1 st -14 th Sep	Officers draft report
15 th – 30 th Sep	Members give comments on draft and finalise their response. Date(s) of meeting tbc
Oct	JOSOC receive formal response to recommendations from NHS NWL Date of meeting tbc

Resourcing Needs

It is envisaged that the following tasks will need to be undertaken in order to support the JOSOC:

- preparing and sending out the agendas for meetings;
- arranging witnesses for the JOSOC meetings;
- organising venues for the JOSOC meetings;
- providing procedural advice to the JOSOC;
- drafting correspondence on behalf of the JOSOC;
- communicating with NHS NWL
- organising press and PR activity on behalf of the JOSOC;

- minuting the meetings;
- drafting the final report and recommendations for the JOSC;
- support to the Chairman.

Members should be aware that there is no financial funding available to the JOSC. Regardless of whether support arrangements are met through Option A or Option B as outlined below, it is proposed that the participating authorities take it in turn to host meetings in their respective boroughs. There will therefore be a need to rely on the good will of participating boroughs for minute taking, nameplates and additional copies

Option A

At the time of writing, scrutiny chairs across the 8 boroughs were in the process of writing to NHS North West London to request financial assistance to allow them to procure administrative and policy support to assist the work of the JOSC. In particular, this support would be responsible for producing the final report (and recommendations) of the JOSC.

It is important to note that support would not come from an NHS employee, but would be procured from an independent source so as to ensure that the independence of the JOSC is not compromised.

Where this request is met, it is suggested that the person(s) providing the support should be able to demonstrate:

- Their experience of working with scrutiny members in a Joint Committee structure considering complex, potentially contentious and high profile issues such as health provision.
- A good understanding of health commissioning and provider arrangements across the NW London sector.
- That they are well respected and known by officers and members working in the London scrutiny committee.

Option B

Where a request for support as outlined in Option A is not met, all support to this JOSC will need to be drawn from the participating authorities and the workload shared between existing scrutiny resource within these authorities.

The Centre for Public Scrutiny will remain available to the Committee to provide advice and answer general queries on an informal basis.

Financial Implications

There are no financial implications associated with this report.

Performance Issues

There are no specific performance issues associated with this report.

Environmental Impact

There are no specific environmental implications associated with this report.

Risk Management Implications

There are no specific risk management implications associated with this report.

Corporate Priorities

The council has a priority to 'support and protect people who are most in need' and to develop a 'united and involved communities: a Council that listens and leads'. The content of this report is relevant to both these priorities and the need to safeguard the interests of residents.

Section 3 - Statutory Officer Clearance

Not required for this report.

Section 4 - Contact Details and Background Papers

Contact: Fola Irikefe, Scrutiny Officer, 0208 420 9389

Background Papers: Presentation by NHS North West London – Shaping a Healthier Future – this can be viewed on the Council's website.

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North West London

*A programme to improve healthcare
for two million people in North West
London*

March 2012



North West London

Welcome

Anne Rainsberry



North West London

Gavin Grey

Agenda for this afternoon

13:30	Welcome	Anne Rainsberry and Gavin Grey
13:35	Review of feedback from last event	Daniel Elkeles
13:45	Out-of-hospital progress update	Dr Tim Spicer
14:10	Introduction to feedback system	Gavin Grey
14:15	Options development	Dr Mark Spencer
14:40	Round table discussions	
14:55	<i>Break</i>	
15:10	Introduction to the criteria used to get from medium list to short list	Dr Mark Spencer
15:20	Breakout on detail of short-listing criteria	Gallery walk
16:15	Feedback	Gavin Grey
16:30	Q&A	Dr Mark Spencer, Dr Susan LaBrooy, Dr Tim Spicer
16:45	Next steps	Dr Mark Spencer



North West London

*Review of feedback from
15 February event*

Daniel Elkeles

Attendees at the event

- Patients, patient representatives and the public:
 - Representatives from all eight LINKs patient groups from across North West London
 - Representatives from all eight local authorities in North West London, including elected councillors
 - Patient groups including Age UK, Mencap, MIND and the Patients Association
- Local Clinicians:
 - GPs from across North West London including those from the new Commissioning Consortia in each borough
 - Clinicians representing every NHS NWL service provider, including hospitals and community health services

What was discussed at the event

- The case for change
- Our proposals for improving out of hospital care
- Our proposals for improving hospital care
- The evaluation criteria we might use to assess options for change in the way we provide hospital care
- There was also a Q&A session with programme leaders

How we are addressing the concerns raised about out of hospital care

You said:

- Current out-of-hospital services **inconsistent and uncoordinated**
- Patients are not able to **see one GP on a consistent or regular basis**
- **Communication** between patients and clinicians, between clinicians and between systems **is a key area for improvement;**
- Healthcare should be better coordinated and the **patient placed at the centre.**
- **Integrated IT systems** are essential to facilitate joint working
- **Access** needs to improve - particularly ease with which a patient can get an appointment or speak to a healthcare professional.

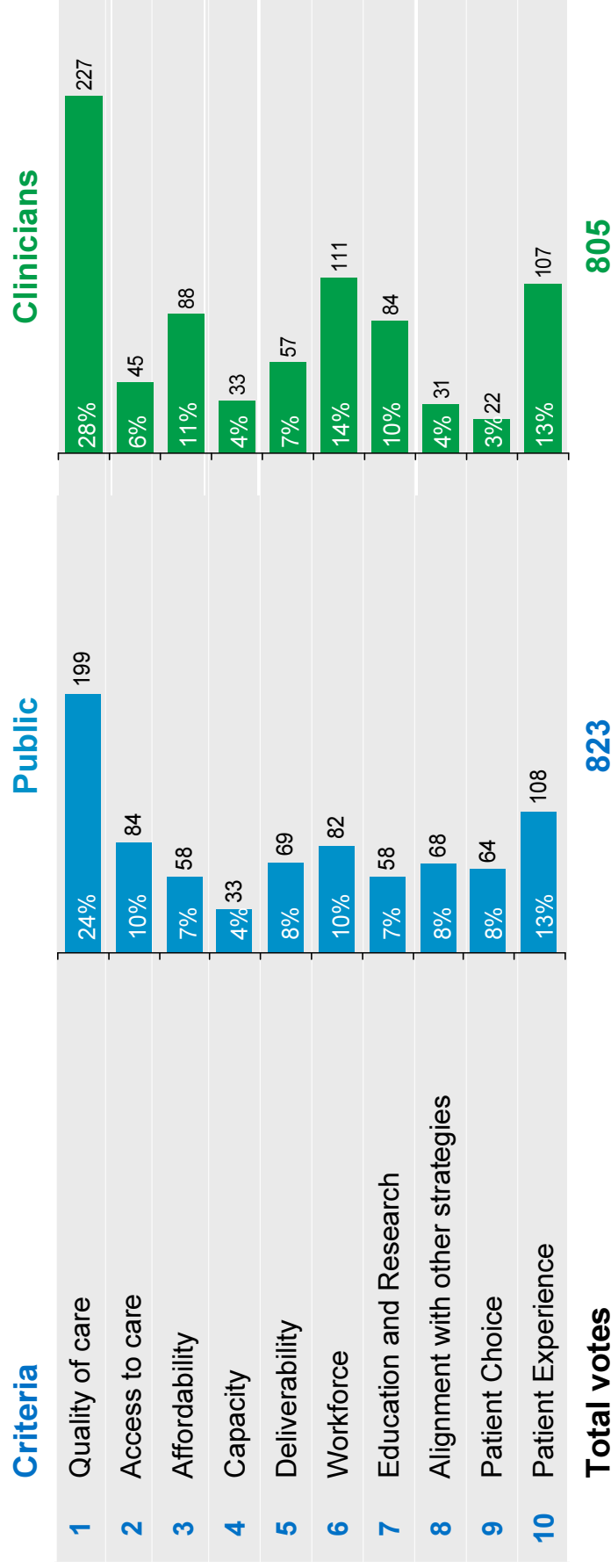
We have incorporated into our Out of Hospital Standards

A copy of the latest standards is in your pack



Participants at the last engagement event ranked the criteria that were most important to them

Count of 'votes' as indicated by stickers



Additional criteria suggested during the event included...

From the patients, patient representatives and the public

	Votes
Integration	18
Equalities (in health choice)	15
Supporting preventative care and patient self-management	9
Additional - operates 24/7 basis	5
Patient user consultation before change	5

From clinicians

	Votes
Impact on other co-dependent services	7
Self-treatment, independence and self-force/ patient education	6
Integrated care – collaborate	5
Full range of services	5
Flexibility across pathway	4

Suggested criteria have been reviewed and included where appropriate

FOR EXAMPLE:

Suggested criteria	Where this has been included
● Risk to existing services	● Deliverability criteria
● Impact on other co-dependent services	● Deliverability criteria
● Career experience	● Quality criteria
● Expertise – who, where is this	● Workforce criteria
● Distribution of services meets local needs	● Access criteria
● Flexibility across pathway	● Patient choice criteria

Some criteria were not included because they would not differentiate between different options

Examples of suggestions	Reasons why these were not included
<ul style="list-style-type: none"> ● Integration of services 	<ul style="list-style-type: none"> ● Out of Hospital strategy
<ul style="list-style-type: none"> ● Health equality across NWL 	<ul style="list-style-type: none"> ● Out of Hospital strategy. ● Equalities impact analysis on the shortlisted options and identify actions to address any adverse impacts on specific groups.
<ul style="list-style-type: none"> ● Support for preventative care and help for patients to manage their own conditions, encouraging independence 	<ul style="list-style-type: none"> ● Out of Hospital strategy

Other feedback and how we have responded

- Tell us more about how and when **transformation of out-of-hospital services** will be achieved
- Important that patients, and their relatives and friends **can easily get to the services** and sites that they need
- **Integration of health and social care** will need committed joint-working and better sharing of resources. Programme should be integrated with other aspects of care (e.g., mental health, cancer, end-of-life)
- The programme is **ambitious in its scale** – any changes need to be carefully considered

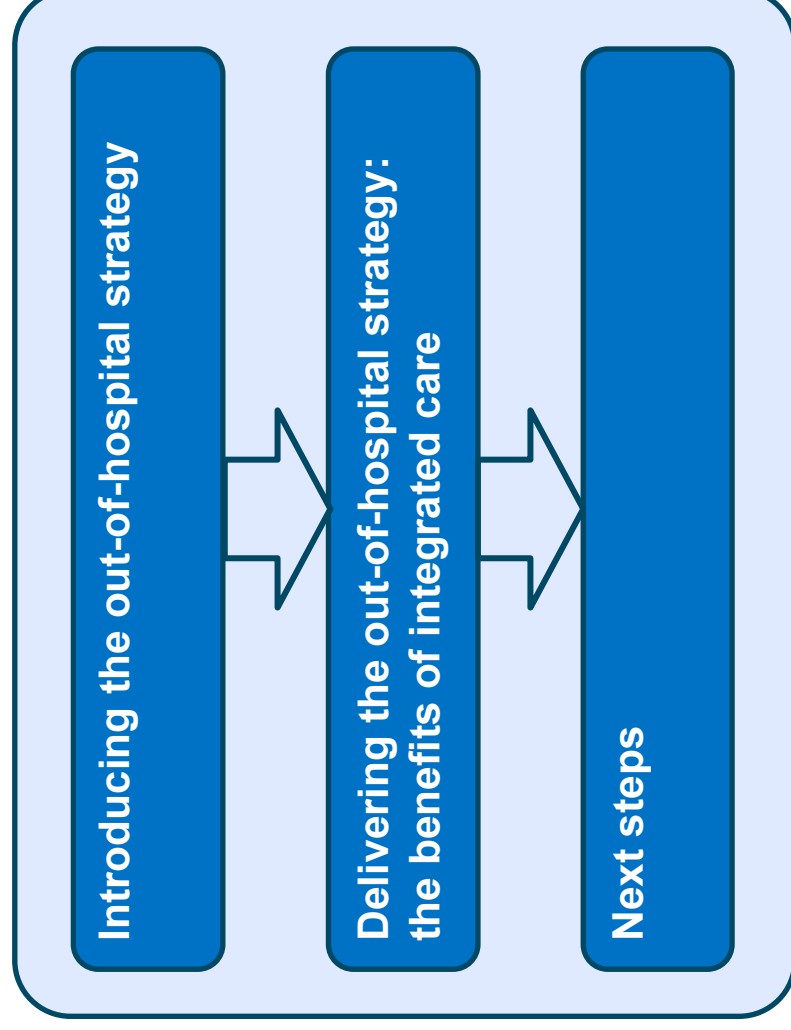


North West London

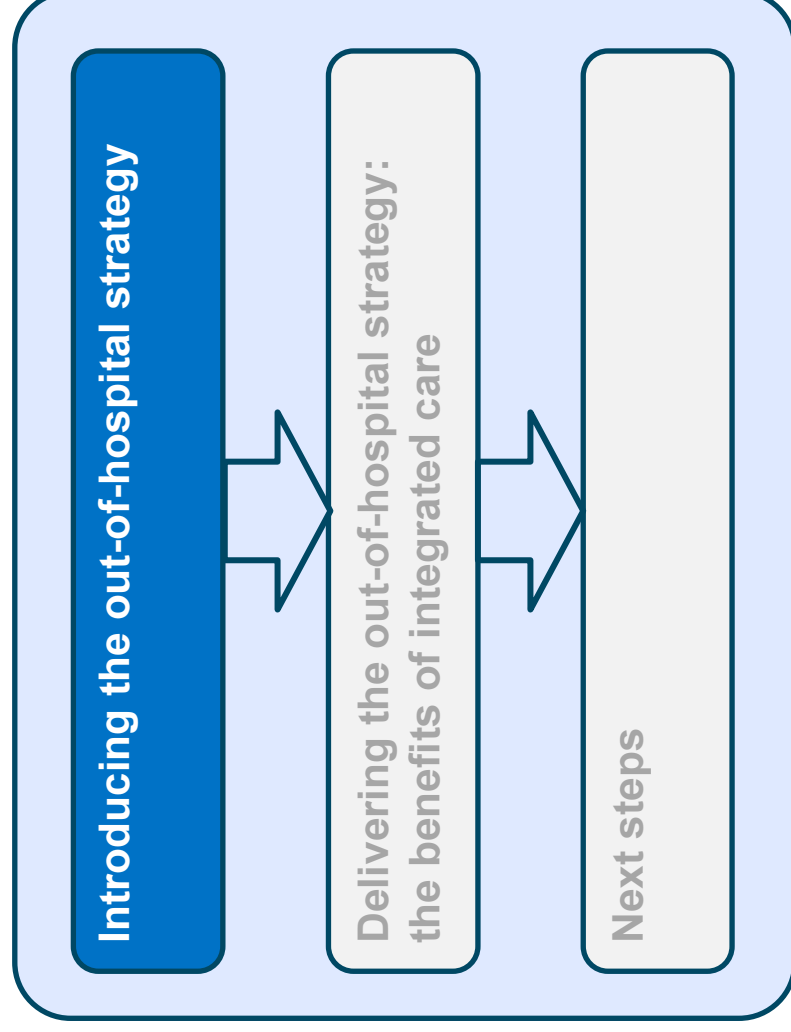
Out-of-hospital progress update

Dr Tim Spicer

Delivering the out-of-hospital strategy



Delivering the out-of-hospital strategy



Why do we need an out-of-hospital strategy?

Changing needs; improving patient experience; improving quality; affordability



The residents of North West London have **changing health needs**, as people live longer and live with more chronic and lifestyle diseases - putting pressure on social and community care

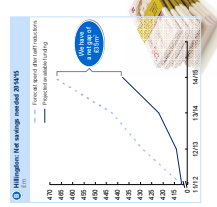
When my mother, who is elderly, needed care recently, she seemed to fall through the cracks. I had to call multiple services to find who should be helping her at home. This was a stark contrast to my experience elsewhere in the UK, where they have joined up services, and specialist plans in place for patients with long-term conditions. My mother should have had a single place to call from where all the services and animals have been owned and coordinated.

Workshop participant, Hillingdon

Our healthcare provision is **fragmented** and people have **very different experiences** in different locations; in other words, we sometimes fail our patients



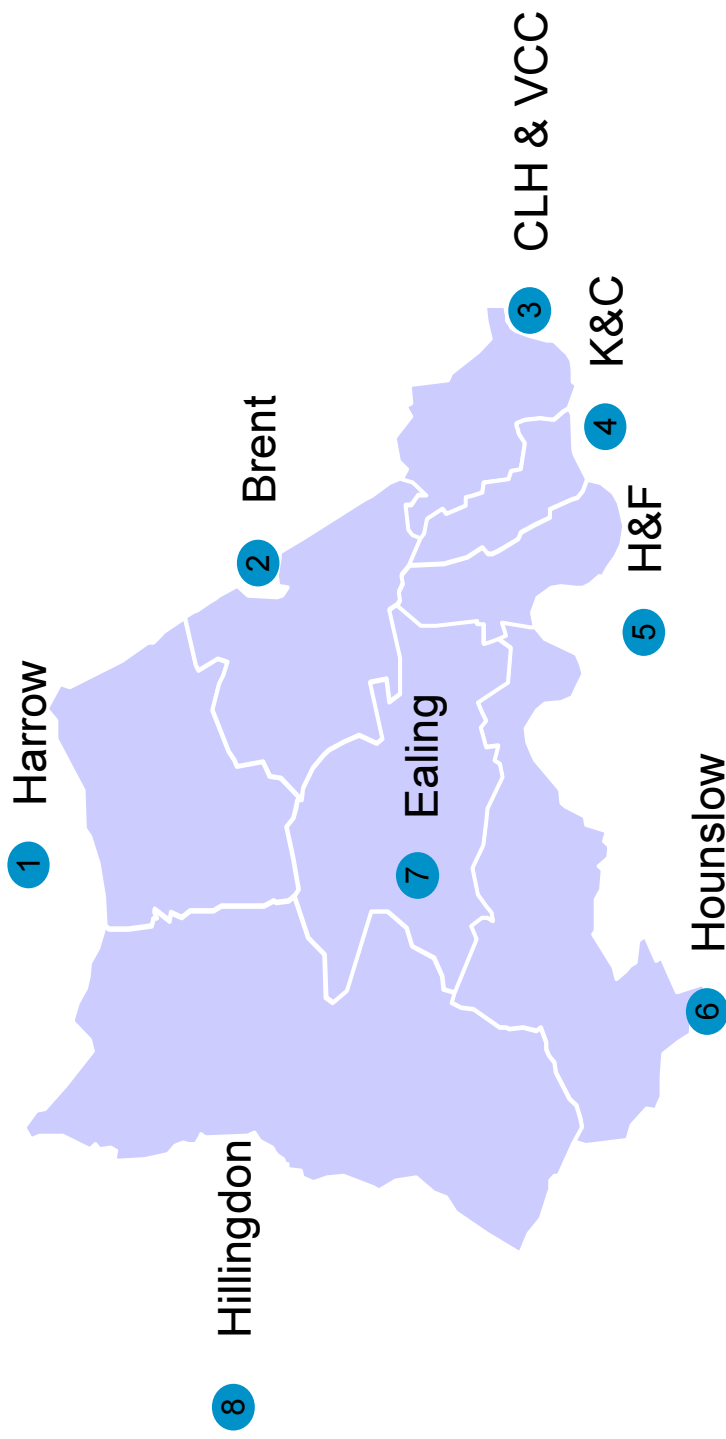
Across the UK we know that care can be delivered out of hospital with better outcomes for the patient and at lower cost. We are highly reliant on **hospital care**



We will have to adhere to the national imperative to provide **high-quality care more affordably**

All 8 CCGs have been developing an out-of-hospital strategy

A real plan describing the care that is needed, who does it and where it will take place

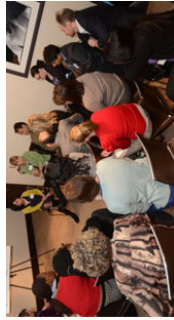


CCGs have been investing time to think strategically about what is needed over the next 3 years

All 8 CCGs have been developing an out-of-hospital strategy

A real plan describing the care that is needed, who does it and where it will take place

Vision beyond 12/13- Agreed goal, key themes, initiatives



15+ CCG Workshops - to develop and engage

Hillingdon

2

Brent

New initiatives to get there – rapid response, MDTs, redesign of pathways, telehealth

We have already started thinking about our **vision** for care closer to home....

We are committed to deliver care at the **right time across integrated care pathways**, which **coordinate** the health, social, community and voluntary sectors. We will put our **patients** at the centre and develop a system that delivers **recovery-focused patient outcomes**

Engaging providers & stakeholders – Out-of-hospital working group

Organising care – how to coordinate care around the patient



Key enablers – Described the governance, IT, incentives needed to drive change

6 Hounslow

Quantifying investment – What workforce is needed, what estates

We will calculate high-level planning assumptions to give direction to the system over a 5 year period

Area	Assumptions	Implications
Community care	• 10-22% increase in demand	• Increased demand for community care services
Primary care	• 10-22% increase in demand	• Increased demand for primary care services
Secondary care	• 10-22% increase in demand	• Increased demand for secondary care services
Healthcare support workers	• 10-22% increase in demand	• Increased demand for healthcare support workers
Healthcare professionals	• 10-22% increase in demand	• Increased demand for healthcare professionals
Healthcare facilities	• 10-22% increase in demand	• Increased demand for healthcare facilities
Healthcare equipment	• 10-22% increase in demand	• Increased demand for healthcare equipment
Healthcare information systems	• 10-22% increase in demand	• Increased demand for healthcare information systems
Healthcare research and development	• 10-22% increase in demand	• Increased demand for healthcare research and development
Healthcare education and training	• 10-22% increase in demand	• Increased demand for healthcare education and training
Healthcare management	• 10-22% increase in demand	• Increased demand for healthcare management
Healthcare finance	• 10-22% increase in demand	• Increased demand for healthcare finance
Healthcare legal and compliance	• 10-22% increase in demand	• Increased demand for healthcare legal and compliance
Healthcare risk management	• 10-22% increase in demand	• Increased demand for healthcare risk management
Healthcare quality improvement	• 10-22% increase in demand	• Increased demand for healthcare quality improvement
Healthcare patient experience	• 10-22% increase in demand	• Increased demand for healthcare patient experience
Healthcare sustainability	• 10-22% increase in demand	• Increased demand for healthcare sustainability
Healthcare innovation	• 10-22% increase in demand	• Increased demand for healthcare innovation
Healthcare digital transformation	• 10-22% increase in demand	• Increased demand for healthcare digital transformation
Healthcare cybersecurity	• 10-22% increase in demand	• Increased demand for healthcare cybersecurity
Healthcare data management	• 10-22% increase in demand	• Increased demand for healthcare data management
Healthcare analytics	• 10-22% increase in demand	• Increased demand for healthcare analytics
Healthcare artificial intelligence	• 10-22% increase in demand	• Increased demand for healthcare artificial intelligence
Healthcare blockchain	• 10-22% increase in demand	• Increased demand for healthcare blockchain
Healthcare quantum computing	• 10-22% increase in demand	• Increased demand for healthcare quantum computing
Healthcare nanotechnology	• 10-22% increase in demand	• Increased demand for healthcare nanotechnology
Healthcare biotechnology	• 10-22% increase in demand	• Increased demand for healthcare biotechnology
Healthcare space exploration	• 10-22% increase in demand	• Increased demand for healthcare space exploration
Healthcare deep-sea exploration	• 10-22% increase in demand	• Increased demand for healthcare deep-sea exploration
Healthcare underwater exploration	• 10-22% increase in demand	• Increased demand for healthcare underwater exploration
Healthcare high-altitude exploration	• 10-22% increase in demand	• Increased demand for healthcare high-altitude exploration
Healthcare extreme environment exploration	• 10-22% increase in demand	• Increased demand for healthcare extreme environment exploration
Healthcare space-based exploration	• 10-22% increase in demand	• Increased demand for healthcare space-based exploration
Healthcare lunar exploration	• 10-22% increase in demand	• Increased demand for healthcare lunar exploration
Healthcare Mars exploration	• 10-22% increase in demand	• Increased demand for healthcare Mars exploration
Healthcare Venus exploration	• 10-22% increase in demand	• Increased demand for healthcare Venus exploration
Healthcare Jupiter exploration	• 10-22% increase in demand	• Increased demand for healthcare Jupiter exploration
Healthcare Saturn exploration	• 10-22% increase in demand	• Increased demand for healthcare Saturn exploration
Healthcare Uranus exploration	• 10-22% increase in demand	• Increased demand for healthcare Uranus exploration
Healthcare Neptune exploration	• 10-22% increase in demand	• Increased demand for healthcare Neptune exploration
Healthcare Pluto exploration	• 10-22% increase in demand	• Increased demand for healthcare Pluto exploration
Healthcare dwarf planet exploration	• 10-22% increase in demand	• Increased demand for healthcare dwarf planet exploration
Healthcare interstellar exploration	• 10-22% increase in demand	• Increased demand for healthcare interstellar exploration
Healthcare galactic exploration	• 10-22% increase in demand	• Increased demand for healthcare galactic exploration
Healthcare cosmic exploration	• 10-22% increase in demand	• Increased demand for healthcare cosmic exploration
Healthcare universe exploration	• 10-22% increase in demand	• Increased demand for healthcare universe exploration

New ways of working – Smarter working not more of the same, new roles (Care co-ordinators, hybrid workers)

Set standards – Commitment to higher standards of care



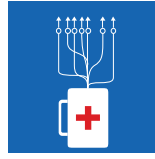
North West London

What stage are we at now?

Key themes are emerging from each CCG's out-of-hospital strategy



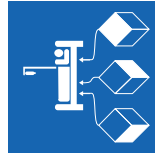
Easy access to high quality, responsive care to make out of hospital care first point of call for people



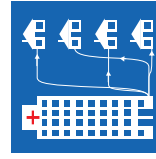
Clearly understood planned care pathways that ensure out-of-hospital care is not delivered in a hospital setting



Rapid response to urgent needs so fewer people need to access hospital emergency care



Providers working together, with the patient at the centre to proactively manage LTCs, the elderly and end of life care out-of-hospital



Appropriate time in hospital when admitted, with **early supported discharge** into well organised community care

Out-of-hospital quality standards

The quality standards underpin each of the five themes

Individual Empowerment & Self Care

Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing

Access, Convenience & Responsiveness

Out-of-hospital care operates as a seven day a week service. Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.

Care Planning & Multi-Disciplinary Care Delivery

Individuals using community health and care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions

Information & Communication

With an individual's consent, relevant parts of their health and social care record will be shared between care providers. Monitoring will identify any changing needs so that care plans can be reviewed and updated by agreement. By 2015, all patients will have online access to their health records

What opportunities are there to improve integrated working?

A year in the life...

Date	Type	GP	Contact from	Notes
18/11/2010	Letter	GP 5	Haematology	OP letter - vomiting - on lots of meds? Rv 4/12
22/11/2010	Phone	GP 6	Patient	Med req - for visit
01/12/2010	Home visit	GP 5	Patient	No reply re-booked for 08.12.11
08/12/2010	Home visit	GP 3	Patient	Pain control - bloods taken
09/12/2010	Letter	GP 3	Patient	tcj for bloods and flu jab
15/12/2010	Home Visit	GP 3	Patient	Neusex, metoprolol changed to compendone
22/12/2010	IPhone	GP 6	Patient	Pain control - increase tramadol
17/02/2011	Consultation	GP 2	Patient	Dosset box has old dose of tramadol
16/03/2011	Phone	GP 6	Acute	OGD report - gastritis
18/03/2011	Letter	GP 2	Acute	CT head report - nil new
21/03/2011	IPhone	GP 1	Discharge Team	Request discharge summary
21/03/2011	Letter	GP 2	Patient	Med request; meds not as per discharge
23/03/2011	ifax	GP 4	Patient	Medication clarification
05/04/2011	IPhone	GP 1	Care Agency	Unable to contact patient
12/04/2011	Phone	GP 5	Acute	Discharge summary, 30.03-11.04 - abdo pain N&V
14/04/2011	Letter	GP 5	Acute	correct dose prednisolone
30/04/2011	Letter	GP 4	Patient	re medication review
09/05/2011	Letter	GP 4	A&E	Abdo pain
12/05/2011	Letter	GP 4	CARS	Hx mechanical falls - assess safe mobility
16/06/2011	IPhone	GP 1	Patient	Gastritis - increase omeprazole
22/06/2011	Home visit	GP 2	Patient	advice re N&V management
26/06/2011	Home visit	GP 2	Patient	ongoing stomach problems
28/06/2011	Letter	GP 4	Patient	re carer's credit
06/07/2011	Letter	GP 1	Rehab	referred 11.05.11 assessed 11.06.11 discharged 17.06.07
09/08/2011	Phone	GP 6	Social Care	returning carer from support worker - no answer - no
17/08/2011	Letter	GP 6	Patient	Flu letter invitation
11/09/2011	Letter	GP 5	A&E	Fall
12/09/2011	Letter	GP 3	Patient	Medication request
13/10/2011	Phone	GP 3	Patient	phonecall attempted
14/10/2011	Home visit	GP 1	Patient	constipation - abdo pain - ? Uti
14/10/2011	Phone	GP 3	Social Care	Dysuria - req home visit
16/10/2011	Letter	GP 6	A&E	attended with abdo pain
16/10/2011	Home visit	GP 6	Patient	Abdo pain ? Prostatitis
19/10/2011	Letter	GP 3	DN	constipation - urgent referral
19/10/2011	Phone	GP 3	Patient	constipation
31/10/2011	Home visit	GP 2	Patient	Abdo pain (phone 1 week)
03/11/2011	Letter	GP 4	Haematology	req review
07/11/2011	Letter	GP 6	Social Care	report of referral from DN to H@H - constipation
17/08/2011	Letter	GP 6	Patient	Flu letter invitation
11/09/2011	Letter	GP 5	A&E	Fall
12/09/2011	Letter	GP 3	Patient	Medication request
13/10/2011	Phone	GP 3	Patient	phonecall attempted
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31/10/2011	Home visit	GP 2	Patient	Abdo pain (phone 1 week)
03/11/2011	Letter	GP 4	Haematology	req review
07/11/2011	Letter	GP 4	H@H	report of referral from DN to H@H - constipation
07/11/2011	Letter	GP 1	DN	flu immunisation notification
07/11/2011	IPhone	GP 5	H@H	Concerns re med compliance
07/11/2011	Phone	GP 4	H@H	patient not heard from DNs - (will chase)
09/11/2011	Consultation	GP 2	H@H	Medication review
11/11/2011	Letter	GP 4	Rehab	Discharge from community rehab - patient unwell
14/11/2011	Phone	GP 3	H@H	Fall-accidental at night
14/11/2011	Phone	GP 6	Patient	Attempted - no reply
15/11/2011	IPhone	GP 2	H@H	Pt admitted CXH - abdo pain

16/03/2011	Acute	OGD report - gastritis
18/03/2011	Acute	CT head report - nil new
21/03/2011	Discharge Team	Request discharge summary
21/03/2011	Patient	Med request; meds not as per discharge
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19/10/2011	DN	constipation - urgent referral
19/10/2011	Patient	constipation
31/10/2011	Patient	Abdo pain (phone 1 week)
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07/11/2011	H@H	report of referral from DN to H@H - constipation
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14/11/2011	Patient	Attempted - no reply
15/11/2011	H@H	Pt admitted CXH - abdo pain

What opportunities are there to improve integrated working?

A year in the life...

What are the opportunities?

- There were **9 different agencies** involved in the patient's care
- **Information flow was poor**; better information might have prevented the first admission
- **A delay in service provision** led to the second admission
- There were 6 different GPs involved, but **no care plan**
- **Lack of patient empowerment** throughout

Relevant quality standards

Information & Communications

Access, Convenience & Responsiveness

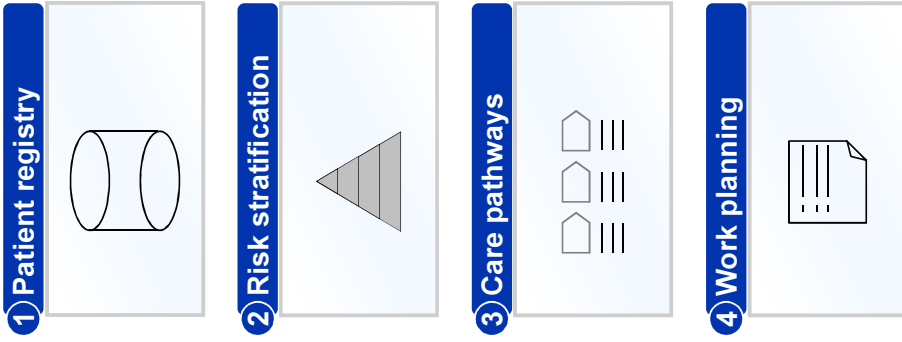
Care Planning & Multi-Disciplinary Care Delivery

Individual Empowerment & Self Care

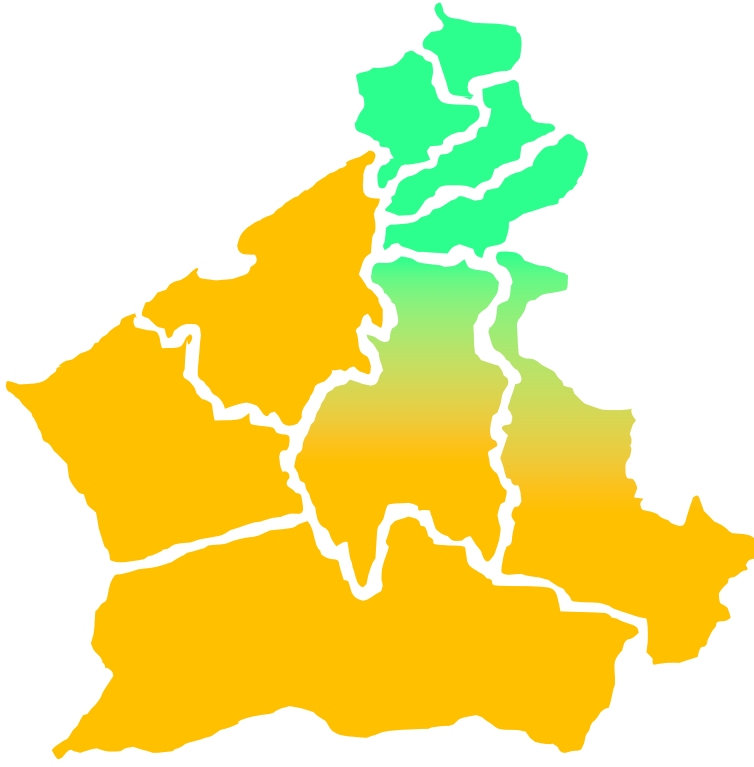
Responding to the challenge

The integrated care pilot is an important first step towards improving out of hospital care

The ICP changes the way that healthcare is provided in an out of hospital setting

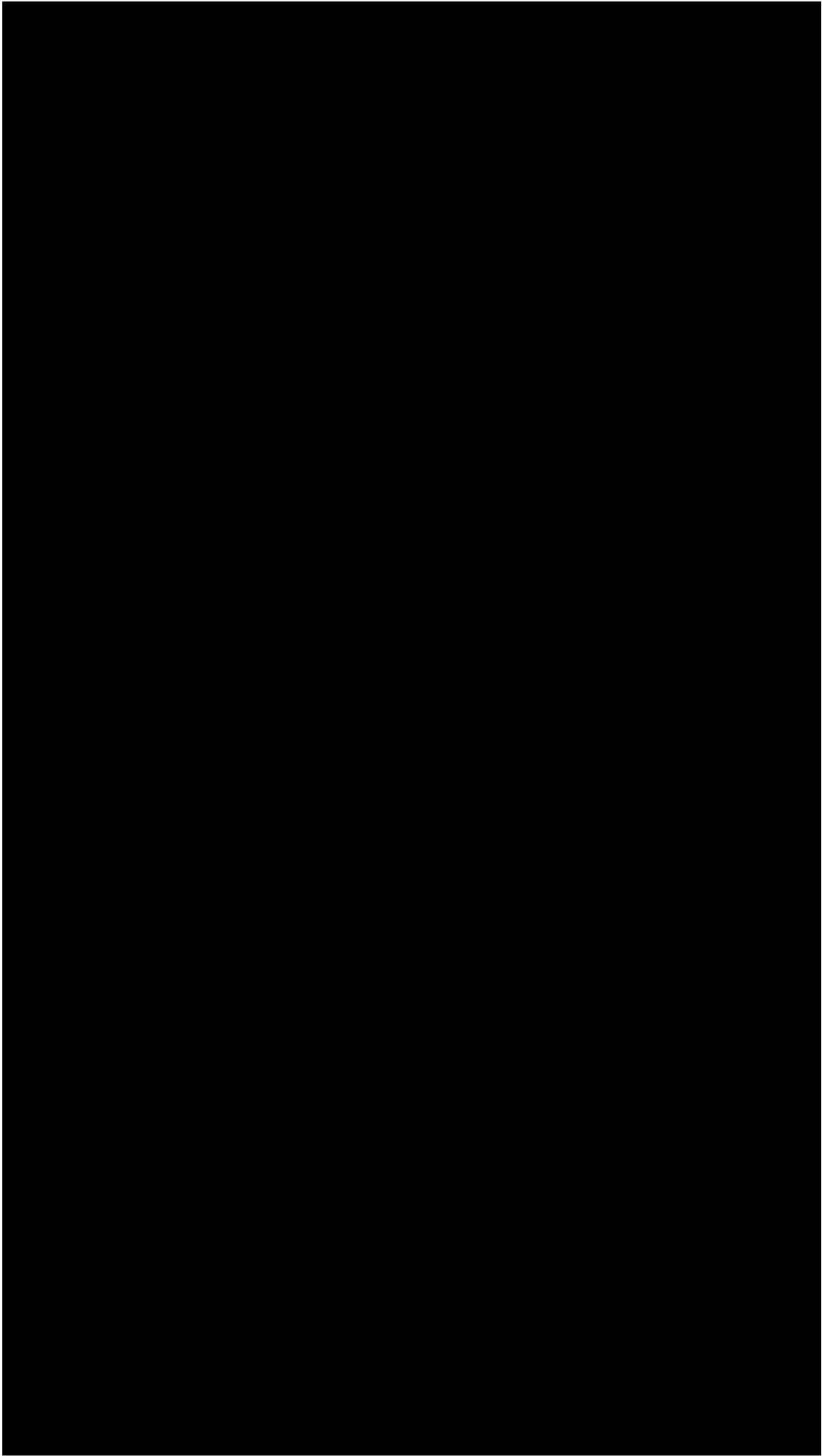


Inner NWL ICP is already operational; Outer NWL is due to commence soon



Responding to the challenge

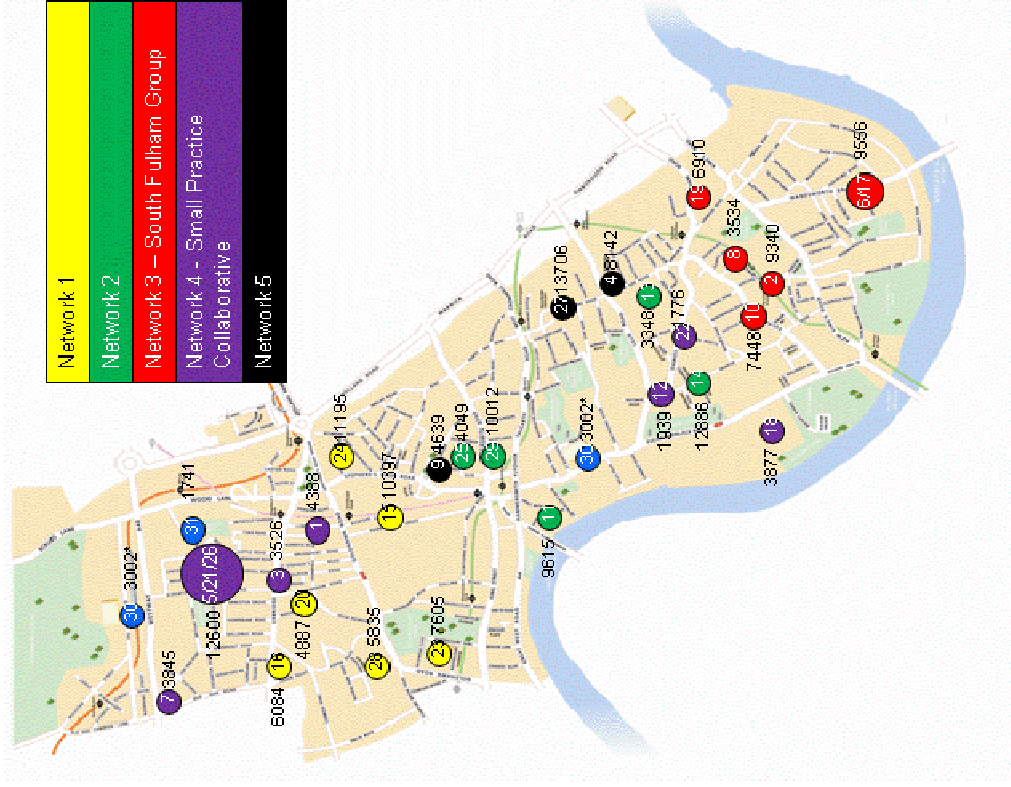
The integrated care pilot is an important first step towards improving out-of-hospital care



‘Whole systems’ integrated care

Provider networks offer a new way of organising out-of-hospital care

Primary Care networks are already a reality in many parts of NWL

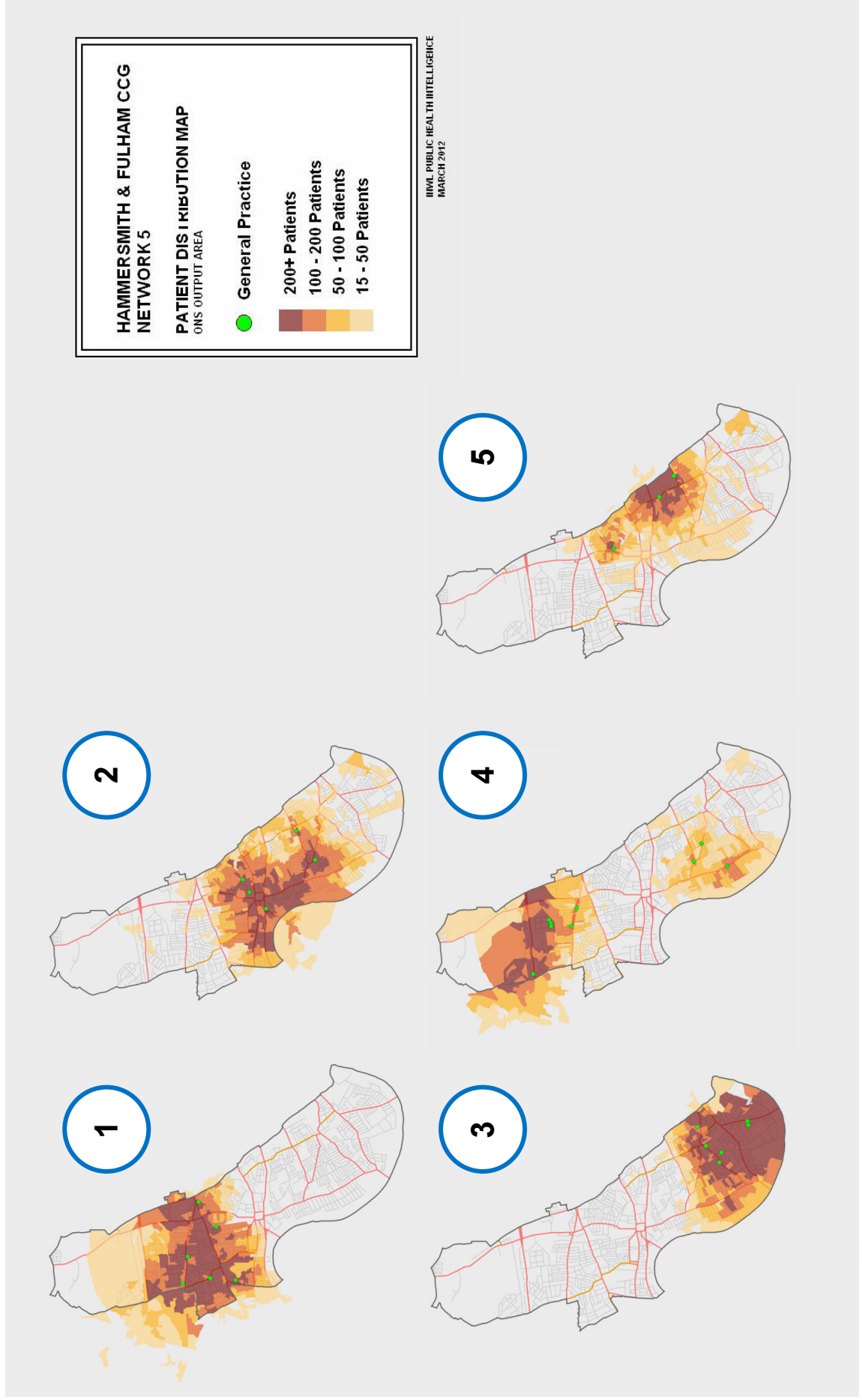


- Integrated care will be delivered within networks of practices, serving patient populations
- 5 networks
- Networks will have a role in both **commissioning** and **provision** of care
- Each network will have one integrated health and social care team aligned to network
- These teams will be physically based in a ‘centralised’ network location

'Whole systems' integrated care

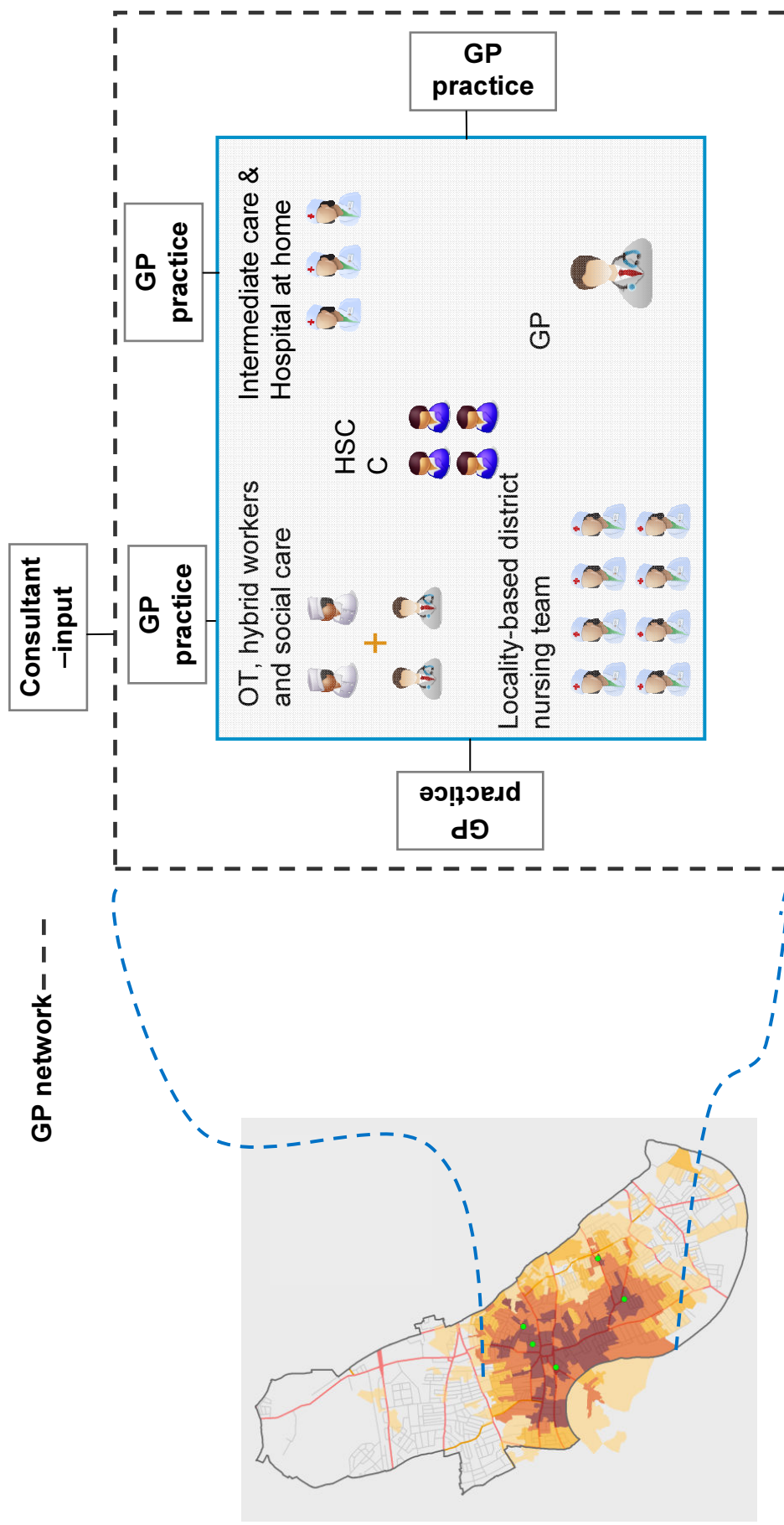
Provider networks offer a new way of organising out-of-hospital care

Networks support patients in a locality by coordinating their care more effectively

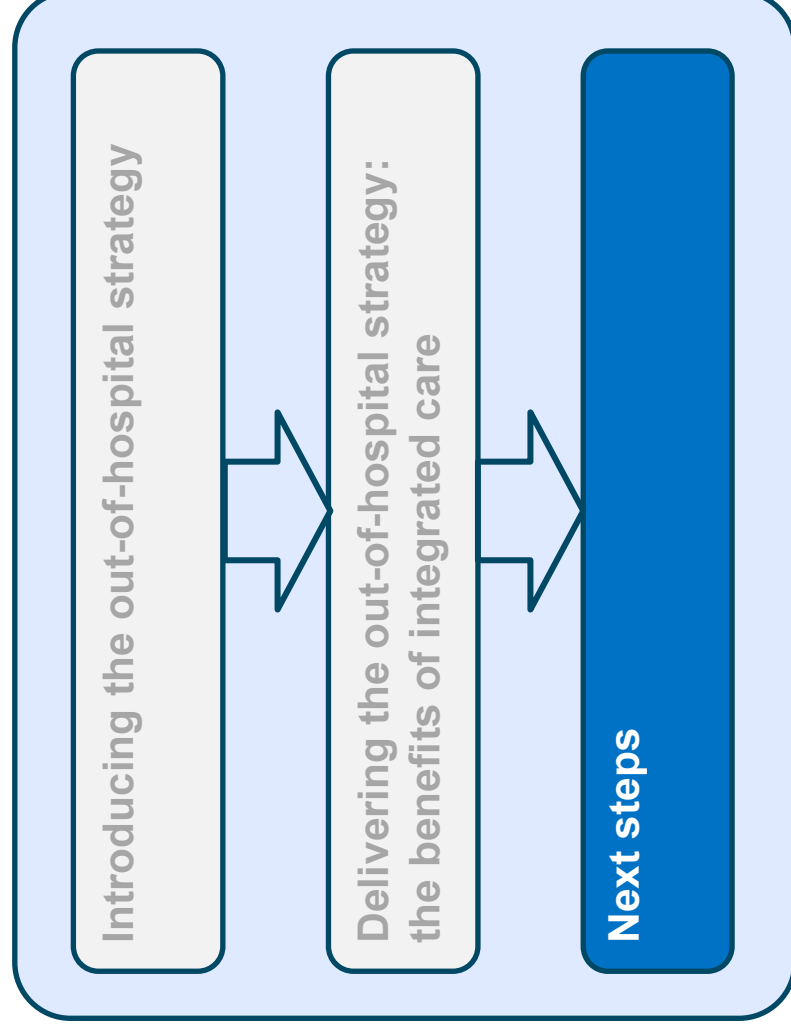


A 'whole systems' approach to integrated care in networks

Community services will be reorganised to work directly with networks



Delivering the out-of-hospital strategy



All 8 CCGs will complete their out-of-hospital strategies in April

Vision beyond 12/13- Agreed goal, key themes, initiatives



Ongoing engagement plans

We have already started thinking about our **vision** for care closer to home....

We are committed to deliver care at the **right time across integrated care pathways**, which **coordinate** the health, **social, community** and voluntary sectors. We will put our **patients** at the **centre** and **develop a** system that delivers **recovery-focused patient outcomes**

Hillingdon

2 Brent

Plans to deliver new initiatives

Engaging providers to realise delivery



Organising care – how to coordinate providers around the patient

Key enablers – Described the governance, IT, incentives needed to drive change

6 Hounslow

Quantifying investment – What workforce is needed, what estates

We will calculate high-level planning assumptions to give direction to the system over a period of 5 years

ILLUSTRATIVE

Area	Assumptions	Implications
Community care	• 10-22% increase in demand • 10-22% increase in demand • 10-22% increase in demand	• 10-22% increase in demand • 10-22% increase in demand • 10-22% increase in demand
Primary care	• 10-22% increase in demand • 10-22% increase in demand • 10-22% increase in demand	• 10-22% increase in demand • 10-22% increase in demand • 10-22% increase in demand
Secondary care	• 10-22% increase in demand • 10-22% increase in demand • 10-22% increase in demand	• 10-22% increase in demand • 10-22% increase in demand • 10-22% increase in demand
Healthcare support	• 10-22% increase in demand • 10-22% increase in demand • 10-22% increase in demand	• 10-22% increase in demand • 10-22% increase in demand • 10-22% increase in demand

New ways of working – Smarter working not more of the same, new roles (Care co-ordinators, hybrid workers)

Set standards – Commitment to higher standards of care





North West London

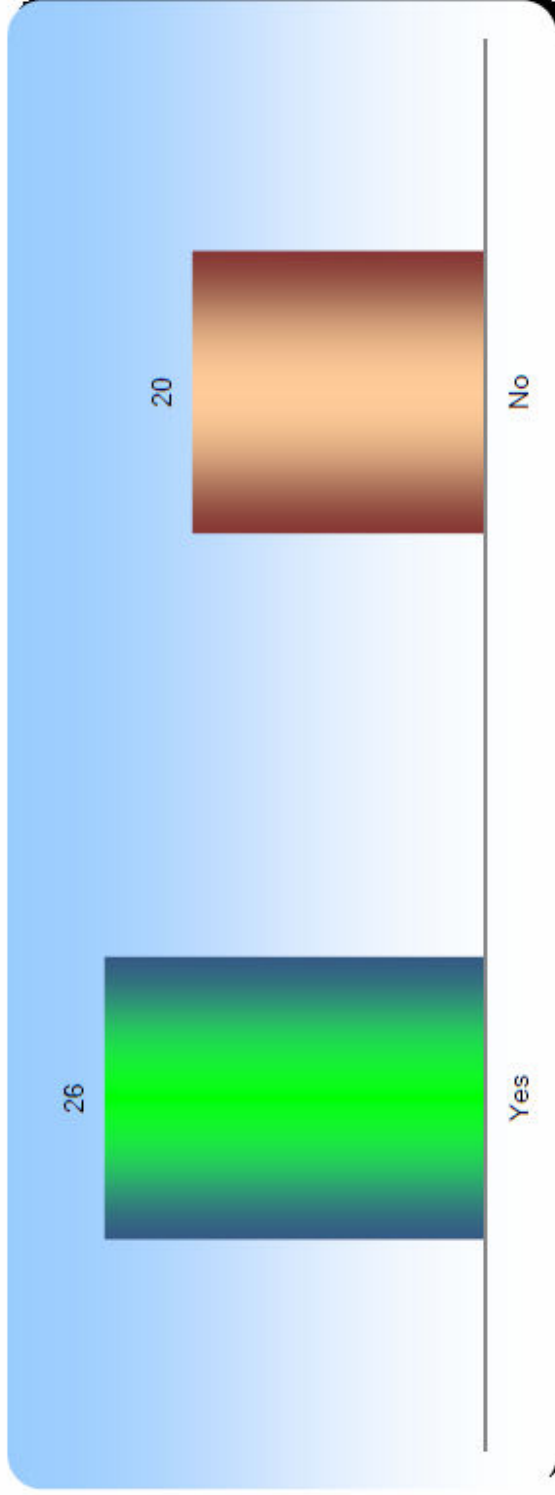
Introduction to feedback system

Gavin Grey

Introduction to feedback voting system – test question

Did you use public transport to get here today?

	Count	Percent
Q1. Did you use public transport to get here today?		
Yes	26	56.52%
No	20	43.48%
	46	100.00%



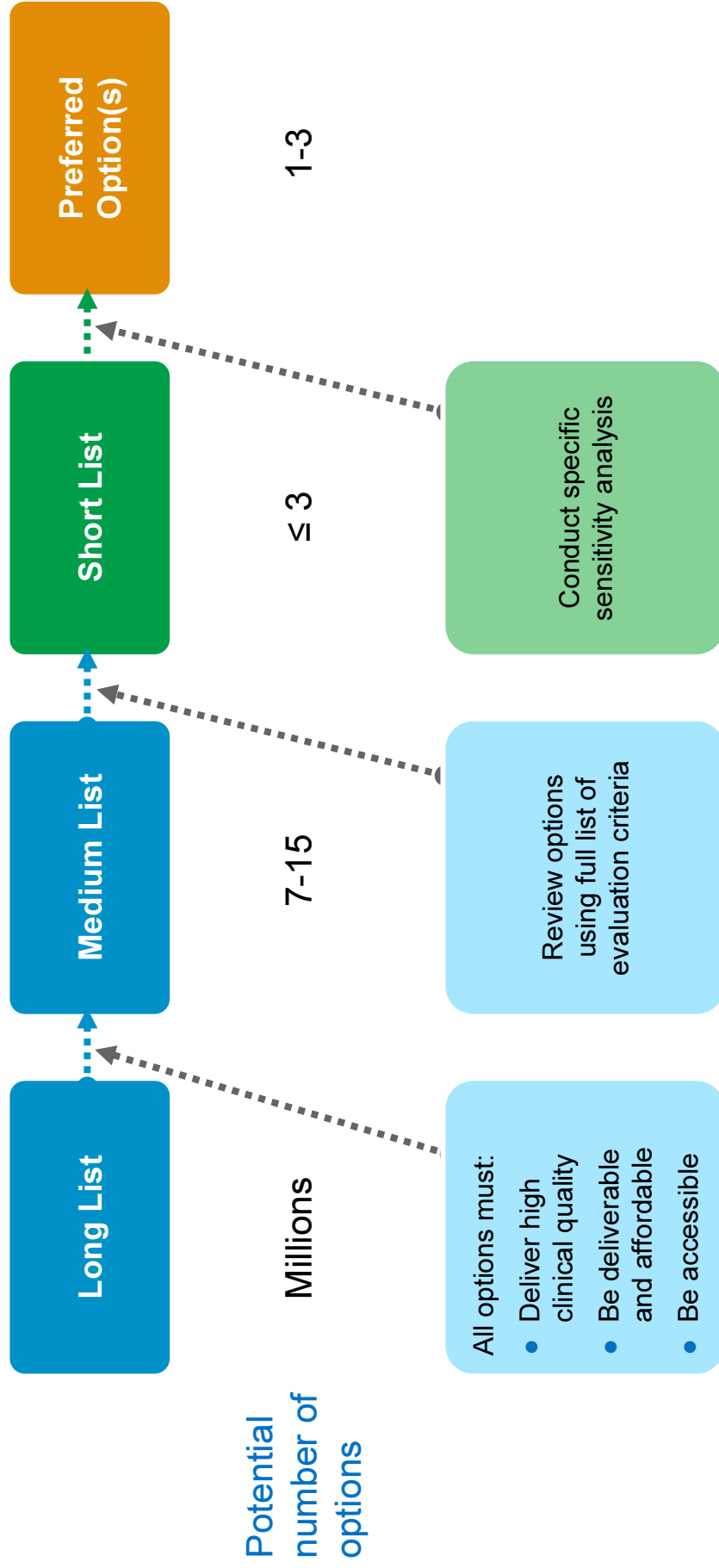


North West London

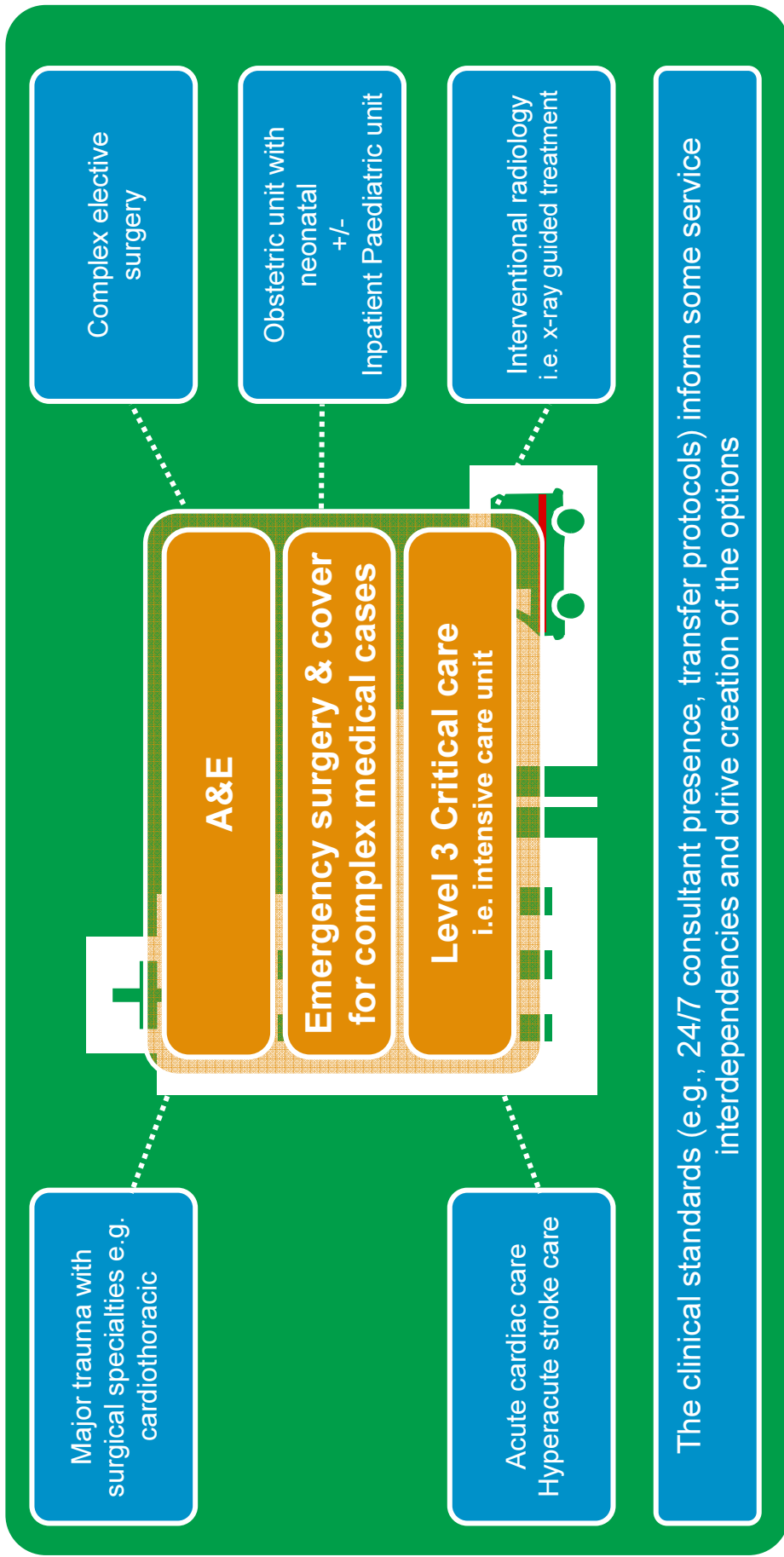
Options development

Dr Mark Spencer

Evaluation process for options



Some services rely on others...



■ Driver of service model

■ Adjacent services requiring access to emergency surgery and/or ICU, level 3

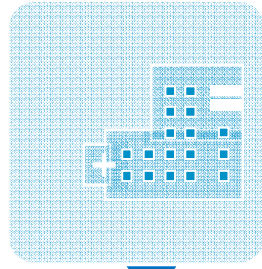
The range of services offered at each type of care centre is different

Local Hospital (SDM1)



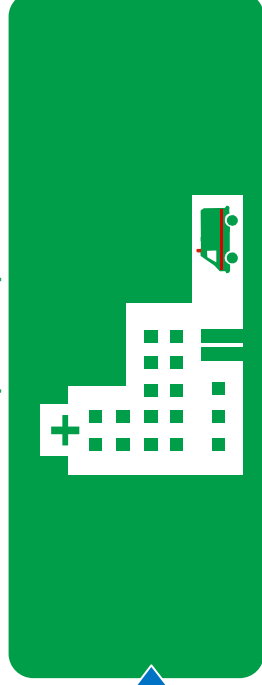
UCC
Outpatients & Diagnostics
Rehabilitation
Minor trauma
Midwifery unit
Minor procedures
GP beds

Transition State



UCC/MAU
Outpatients & diagnostics
Urgent medicine
ICU, level 2 +
Obstetrics/ Midwifery unit
NICU level 1/2

Major Hospital (SDM3)



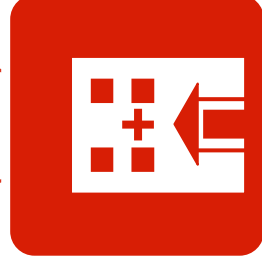
24/7 A&E	Complex surgery
UCC	Major Trauma Centre
Outpatients & diagnostics	Inpatient paediatric
Urgent surgery	Obstetrics & Midwifery unit
Urgent/complex medicine	Interventional radiology
ICU, level 3	HASU
Psychiatric Liaison Service	Acute Cardiac Services
Trauma unit	NICU level 2/3

Elective Hospital (SDM4)



Elective surgery (including day case)
Elective medicine
Outpatients & diagnostics
Rehabilitation
ITU/HDU
UCC

Specialist Hospital (SDM5)

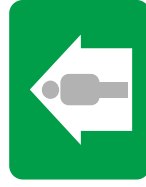


Examples:
Cardiothoracic
Cancer
Orthopaedics

■ Essential service ■ Optional service



We need to review Major Hospital (SDM3) sites to identify a proposed 'medium list' of reconfiguration options on which to do more detailed analysis, but...



- Out-of-hospital services will be expanded and improved in all areas



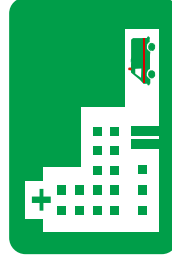
- All 9 current sites will retain Local Hospital (SDM1) services, providing c. 75% of all current activity (excluding specialist activity)



- All Specialist Hospitals (SDM5) will remain



- The care provided at Elective Hospitals (SDM4) will continue on the Central Middlesex site



- This presentation is about Major Hospital (SDM3) services

Clinical Board Rationale 1 for selection of medium list

Number of options

1

- A major hospital is required to ensure high quality care

Millions

Clinical Board Rationale 2 for selection of medium list

		Number of options
1	<ul style="list-style-type: none">A major hospital is required to ensure high quality care	Millions
2	<ul style="list-style-type: none">Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital	Millions

Clinical Board Rationale 3 for selection of medium list

1

- A major hospital is required to ensure high quality care

2

- Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital

3

- There should be **three to five major hospitals in NW London** to support the population of 1.9m. This is based on; available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas.

Number of options

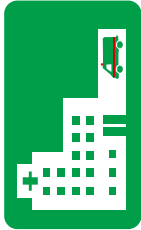
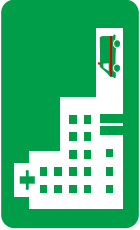



Millions

Millions

336

Rationale 3 supporting example

The Programme and Clinical Boards recommend that only options with three to five Major Hospitals should be considered

	Min. required emergency surgeons for rota cover	Implied catchment
 x 9 current	▪ 45 current	▪ 238,000
 x 6	▪ c. 62 WTE	▪ 317,000
 x 5	▪ c. 50 WTE	▪ 380,000
 x 4	▪ c. 40 WTE	▪ 475,000
 x 3	▪ c.30 WTE	▪ 630,000

"National shortages of some clinical staff groups, such as paediatricians, midwives, radiologists and pathologists, due to the numbers of individuals currently entering training, are expected to continue in the future.

Even if there were more suitably trained staff in place, they would quickly begin to lose their skills as they would not be seeing sufficient volumes of patients."

- Case for Change

Rationale 3 supporting example

Several sites have low levels of emergency surgeons and not all are able to conduct laparoscopic procedures

	Total number of emergency surgeons	% laparoscopic trained
Northwick Park	12	83%
Chelsea and Westminster	9	89%
*	7	100%
*	6	100%
*	6	33%
*	5	100%
NWL Total (Average)	45 (7.5)	84%

Clinical Board Rationale 4 for selection of medium list

		Number of options
1	<ul style="list-style-type: none"> A major hospital is required to ensure high quality care 	Millions
2	<ul style="list-style-type: none"> Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital 	Millions
3	<ul style="list-style-type: none"> There should be three to five major hospitals in NW London to support the population of 1.9m. This is based on: available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas. 	336
4	<ul style="list-style-type: none"> Only options that have five major hospitals are viable in the medium term. Moving to three or four sites would cause major disruption to existing services which could affect the consistent delivery of high quality services. It would also require transferring a large number of services simultaneously across the region increasing the likelihood of: <ul style="list-style-type: none"> A long implementation timeframe (~7+ years) and period of change A large investment to develop infrastructure on some sites during a period when access to capital investment is severely constrained 	126

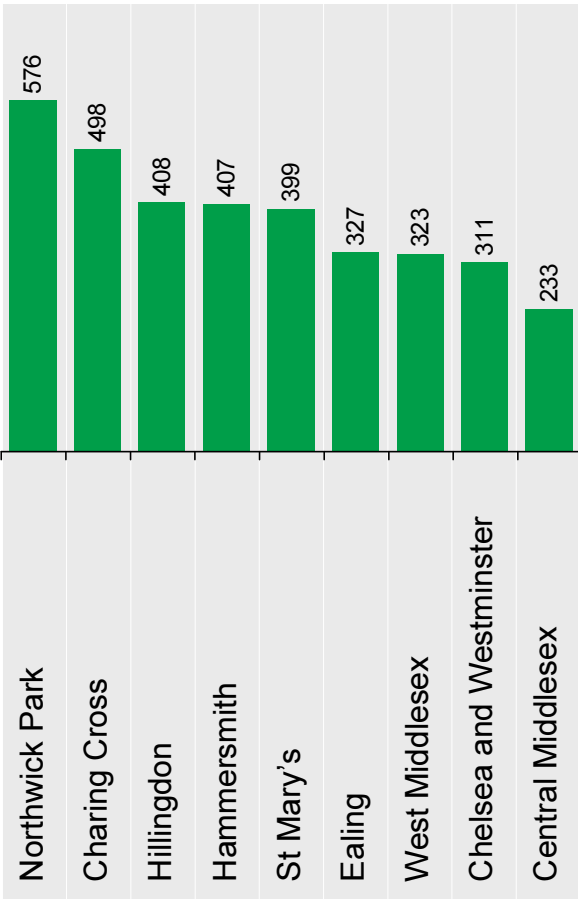
Rationale 4 supporting example

No sites currently have the capacity to deliver the volume of activity needed in a model with less than five major hospitals

No. of beds needed per major hospital if there are five or less in the area:

Three major hospitals	~ 800-1000
Four major hospitals	~ 600-700
Five major hospitals	~ 500-600

Current Bed Capacity, No. of beds



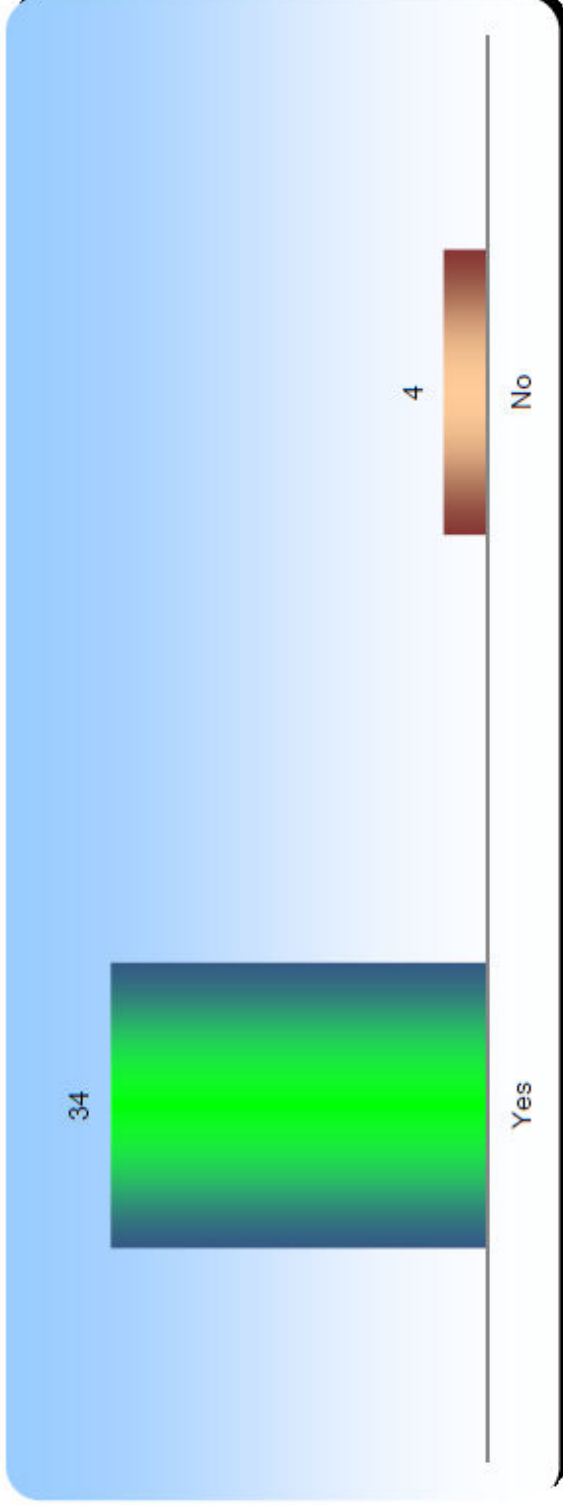
Note: There may also be SDM5 (specialist) and SDM4 (elective) sites so therefore the change in total bed base across the sector cannot be calculated using only these numbers



FEEDBACK

Have you understood the process we have described so far?

Q2. Have you understood the process we have described so far?		
Yes	34	89.47%
No	4	10.53%
	38	100.00%

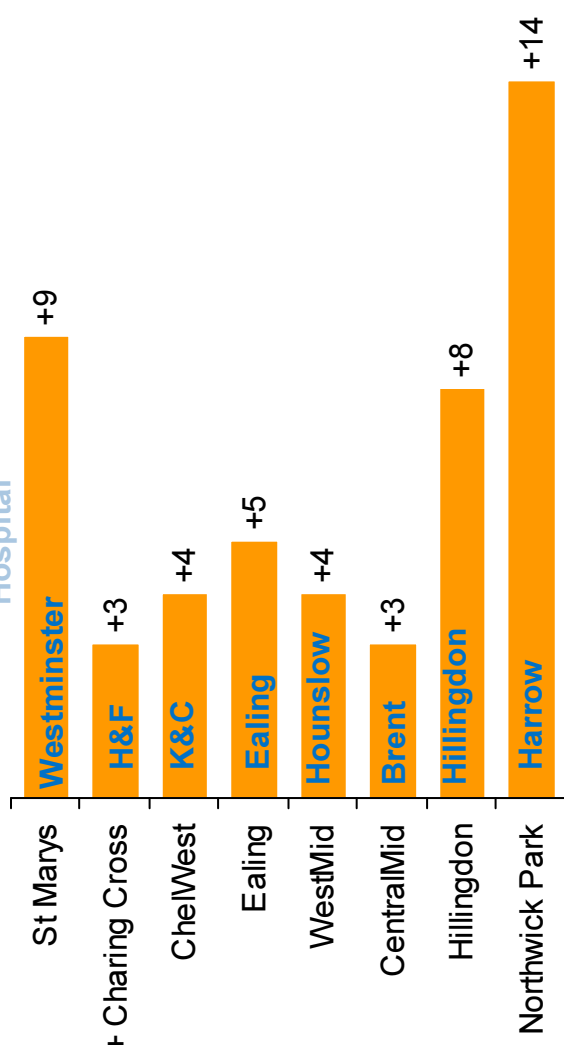
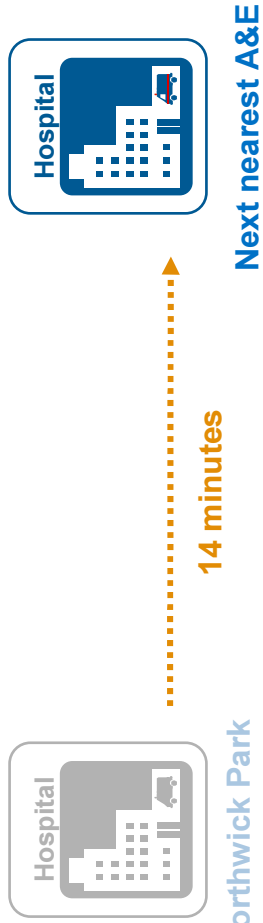
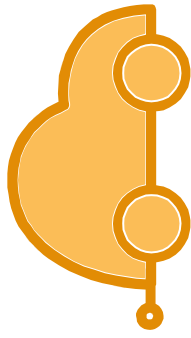


Clinical Board Rationale 5 for selection of medium list

		Number of options
1	<ul style="list-style-type: none"> A major hospital is required to ensure high quality care 	Millions
2	<ul style="list-style-type: none"> Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital 	Millions
3	<ul style="list-style-type: none"> There should be three to five major hospitals in NW London to support the population of 1.9m. This is based on; available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas. 	336
4	<ul style="list-style-type: none"> Only options that have five major hospitals are viable in the medium term. Moving to three or four sites would cause major disruption to existing services which could affect the consistent delivery of high quality services. It would also require transferring a large number of services simultaneously across the region increasing the likelihood of: A long implementation timeframe (~7+ years) and period of change A large investment to develop infrastructure on some sites during a period when access to capital investment is severely constrained 	126
5	<ul style="list-style-type: none"> To minimise impact on access, the Clinical Board proposes that Northwick Park and Hillingdon should be major hospitals in all options because they are geographically remote 	35

Rationale 5 supporting example

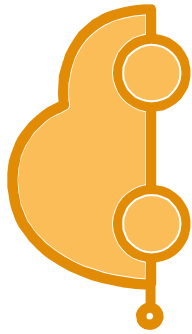
Impact on average borough car travel times (peak) when A&E destination is changed



Minutes added to car journey travelling to next nearest hospital

Rationale 5 supporting example

Impact on maximum borough car travel times (peak) when A&E destination is changed



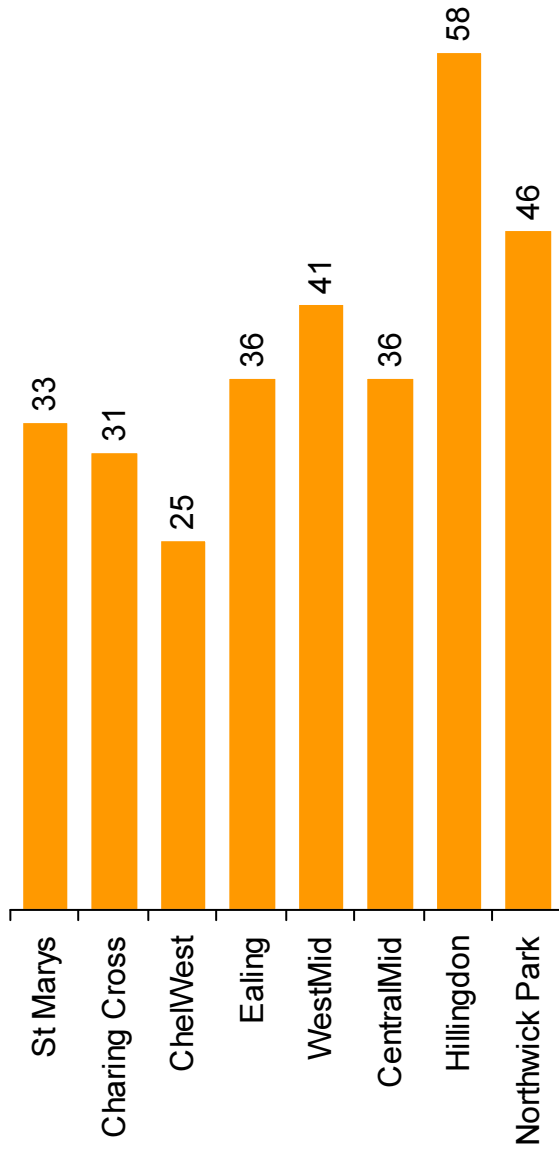
Hillingdon Hospital



Next nearest hospital



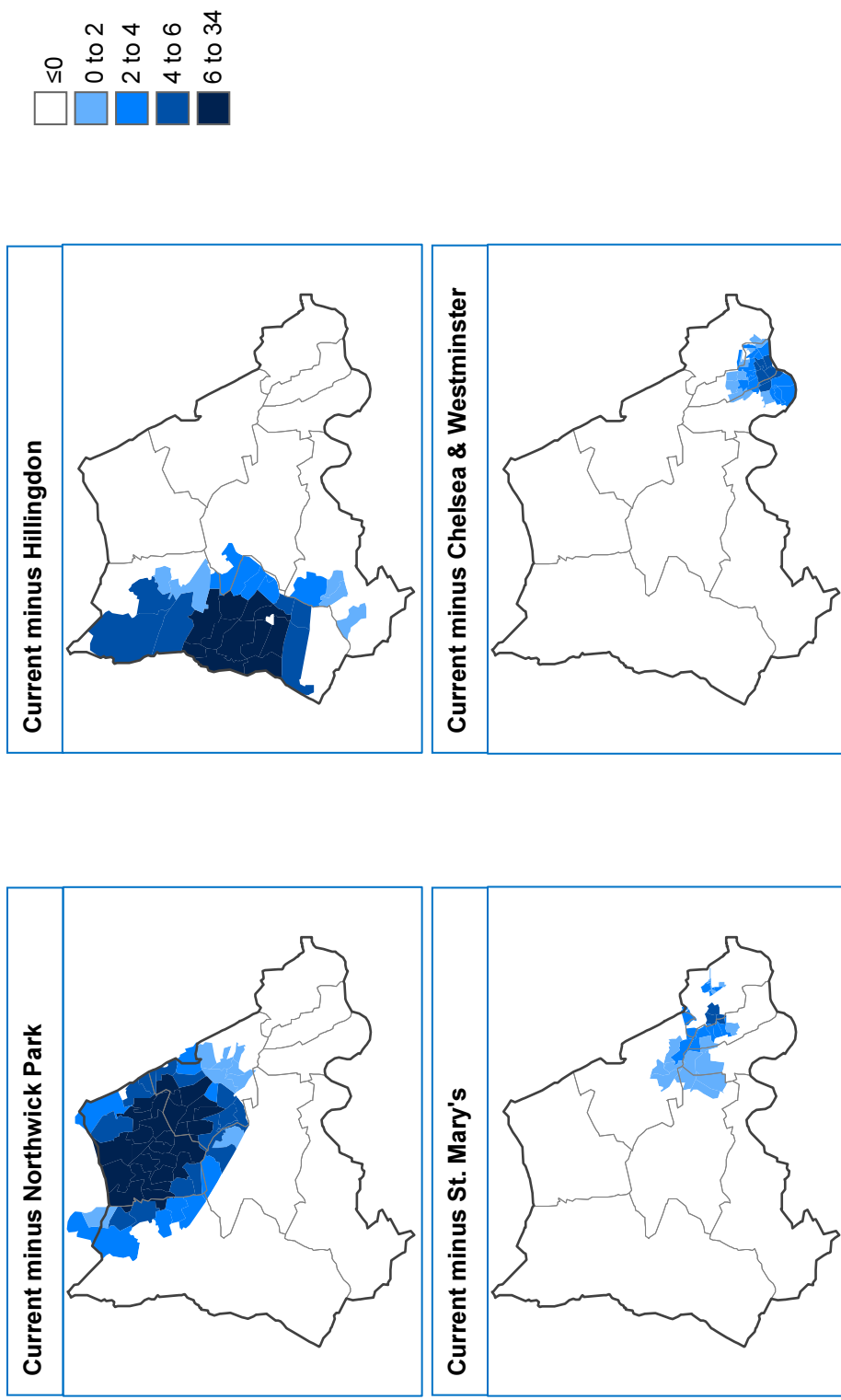
58 minutes



Maximum car journey time travelling to next nearest hospital

Rationale 5 supporting example

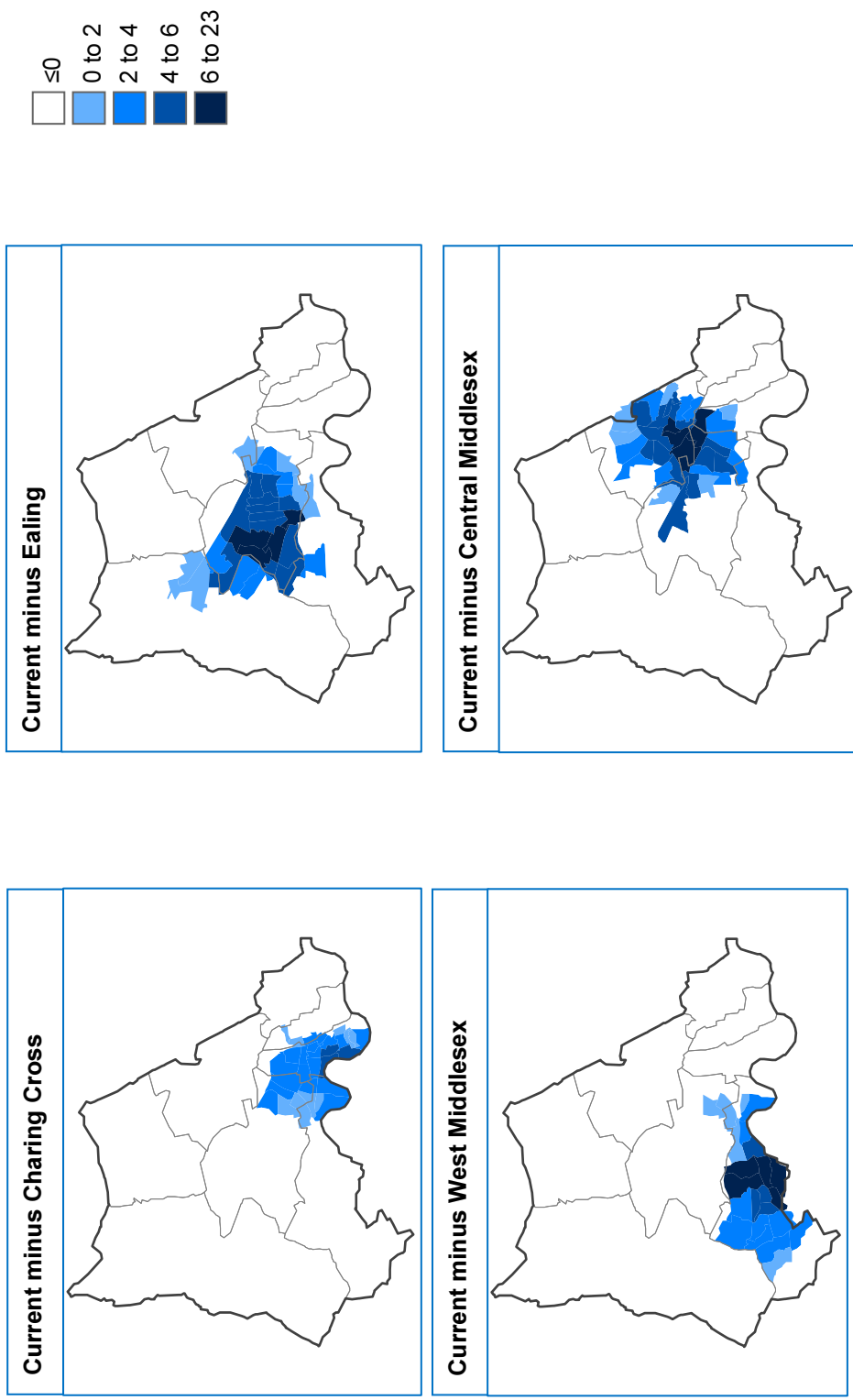
Impact on blue light travel times in each borough when A&E destination is changed



Absolute change in Blue Light travel time vs. current configuration (mins)

Rationale 5 supporting example

Impact on blue light travel times in each borough when A&E destination is changed

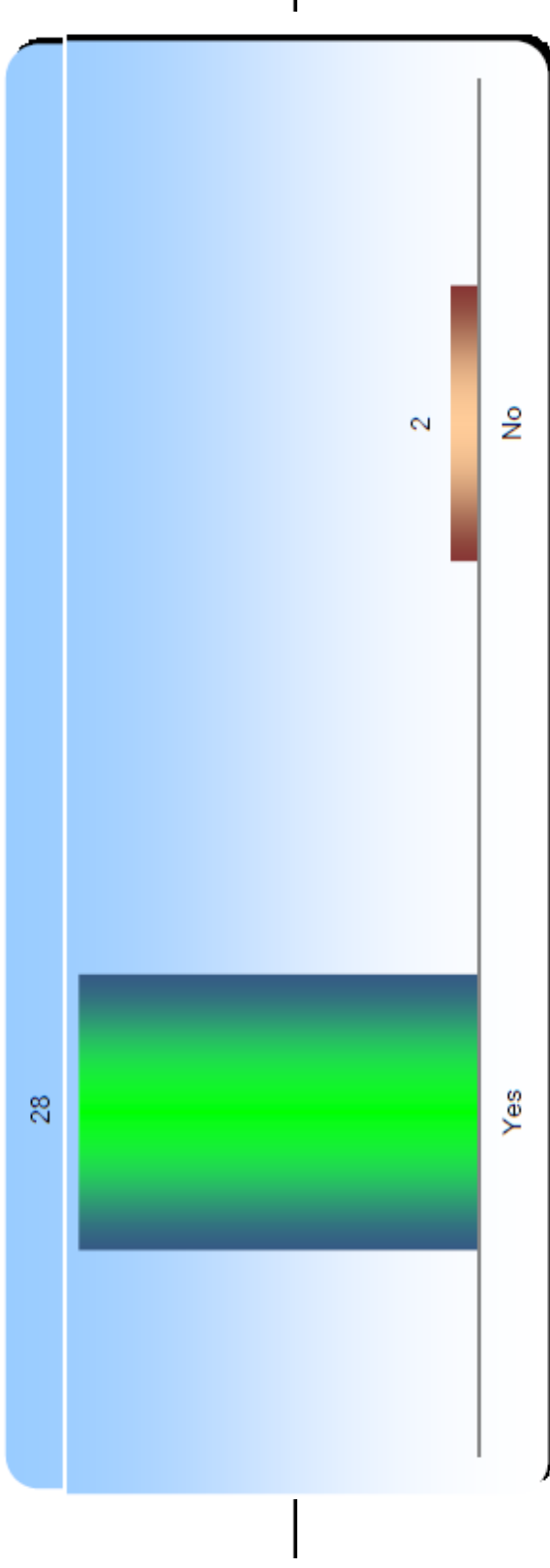


Absolute change in Blue Light travel time vs. current configuration (mins)

FEEDBACK

Have you understood the process we have described so far?

Q3. Have you understood the process we have described so far?		
Yes	28	93.33%
No	2	6.67%
	30	100.00%



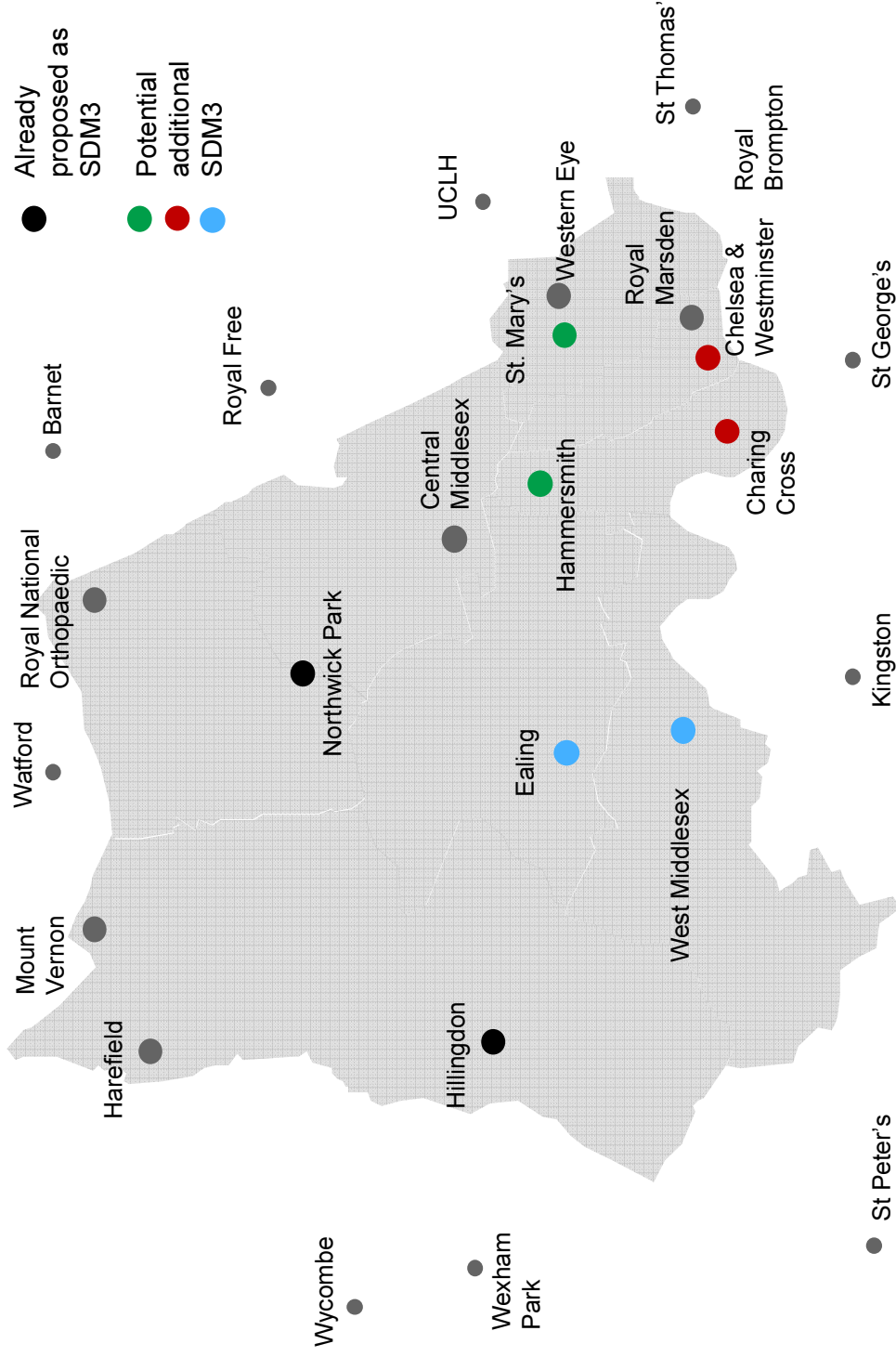
Clinical Board Rationale 6 for selection of medium list

		Number of options
1	<ul style="list-style-type: none"> A major hospital is required to ensure high quality care 	Millions
2	<ul style="list-style-type: none"> Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital 	Millions
3	<ul style="list-style-type: none"> There should be three to five major hospitals in NW London to support the population of 1.9m. This is based on; available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas. 	336
4	<ul style="list-style-type: none"> Only options that have five major hospitals are viable in the medium term. Moving to three or four sites would cause major disruption to existing services which could affect the consistent delivery of high quality services. It would also require transferring a large number of services simultaneously across the region increasing the likelihood of: A long implementation timeframe (~7+ years) and period of change A large investment to develop infrastructure on some sites during a period when access to capital investment is severely constrained 	126
5	<ul style="list-style-type: none"> To minimise impact on access, the Clinical Board proposes that Northwick Park and Hillingdon should be major hospitals in all options because they are geographically remote 	35
6	<ul style="list-style-type: none"> Central Middlesex should not be considered for a major hospital site because several services that would be required are already not delivered there and it would require the largest expansion of any site as it is the smallest of the nine acute sites in NW London 	20

Clinical Board Rationale 7 for selection of medium list

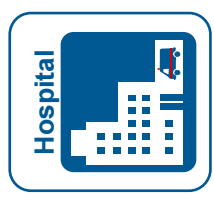
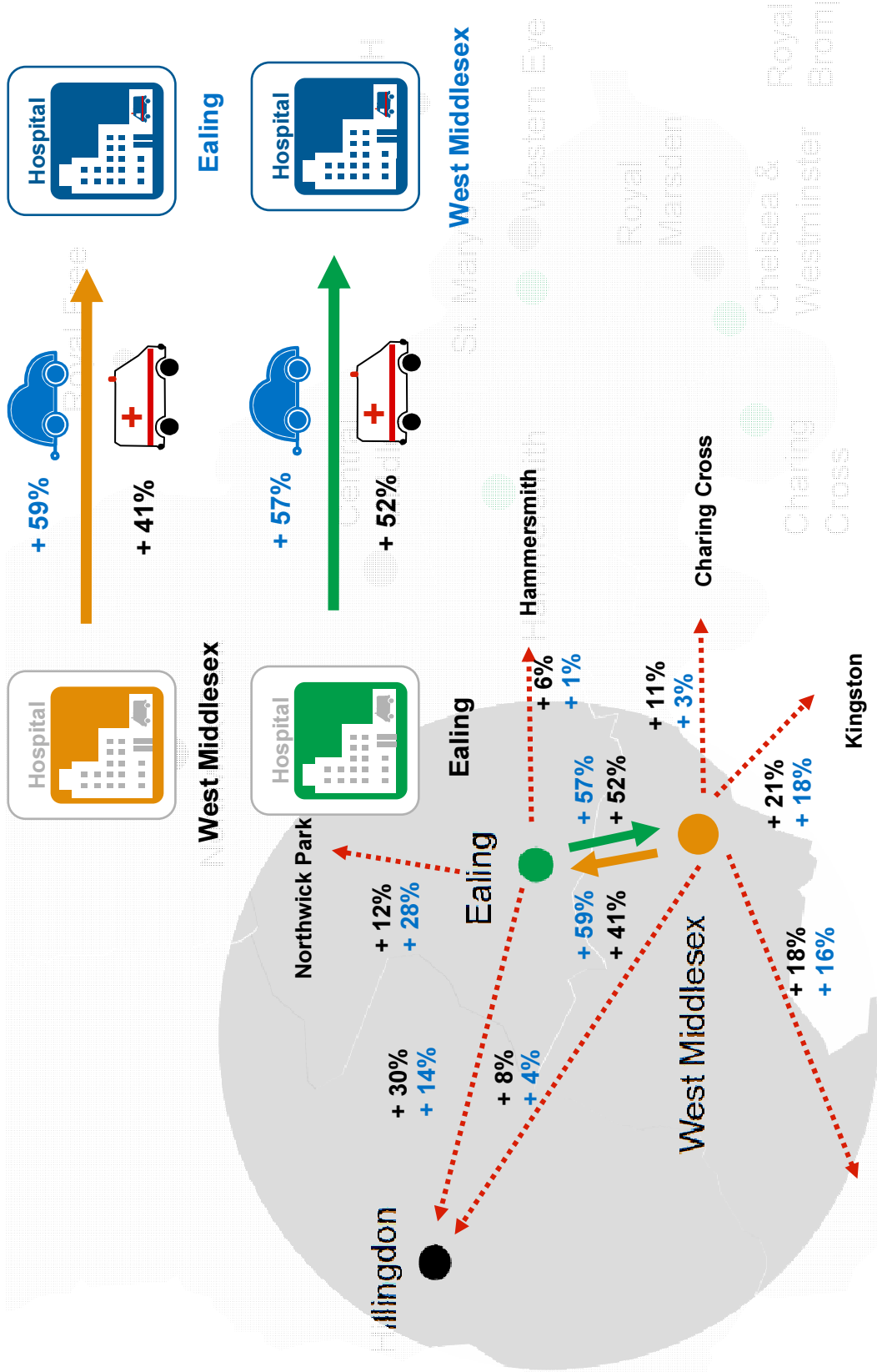
		Number of options
1	<ul style="list-style-type: none"> A major hospital is required to ensure high quality care 	Millions
2	<ul style="list-style-type: none"> Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital 	Millions
3	<ul style="list-style-type: none"> There should be three to five major hospitals in NW London to support the population of 1.9m. This is based on: available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas. 	336
4	<ul style="list-style-type: none"> Only options that have five major hospitals are viable in the medium term. Moving to three or four sites would cause major disruption to existing services which could affect the consistent delivery of high quality services. It would also require transferring a large number of services simultaneously across the region increasing the likelihood of: A long implementation timeframe (~7+ years) and period of change A large investment to develop infrastructure on some sites during a period when access to capital investment is severely constrained 	126
5	<ul style="list-style-type: none"> To minimise impact on access, the Clinical Board proposes that Northwick Park and Hillinadon should be major hospitals, in all 	35
6	<ul style="list-style-type: none"> The Clinical Board proposes geographic distribution of the remaining three major hospitals to minimise the impact of changes on local borough residents. <ul style="list-style-type: none"> – Either Hammersmith or St Mary’s – Either Ealing or West Middlesex – Either Charing Cross or Chelsea & Westminster 	
7		8

Rationale 7 supporting example



Rationale 7 supporting example

Patient/ travel flows between key hospitals



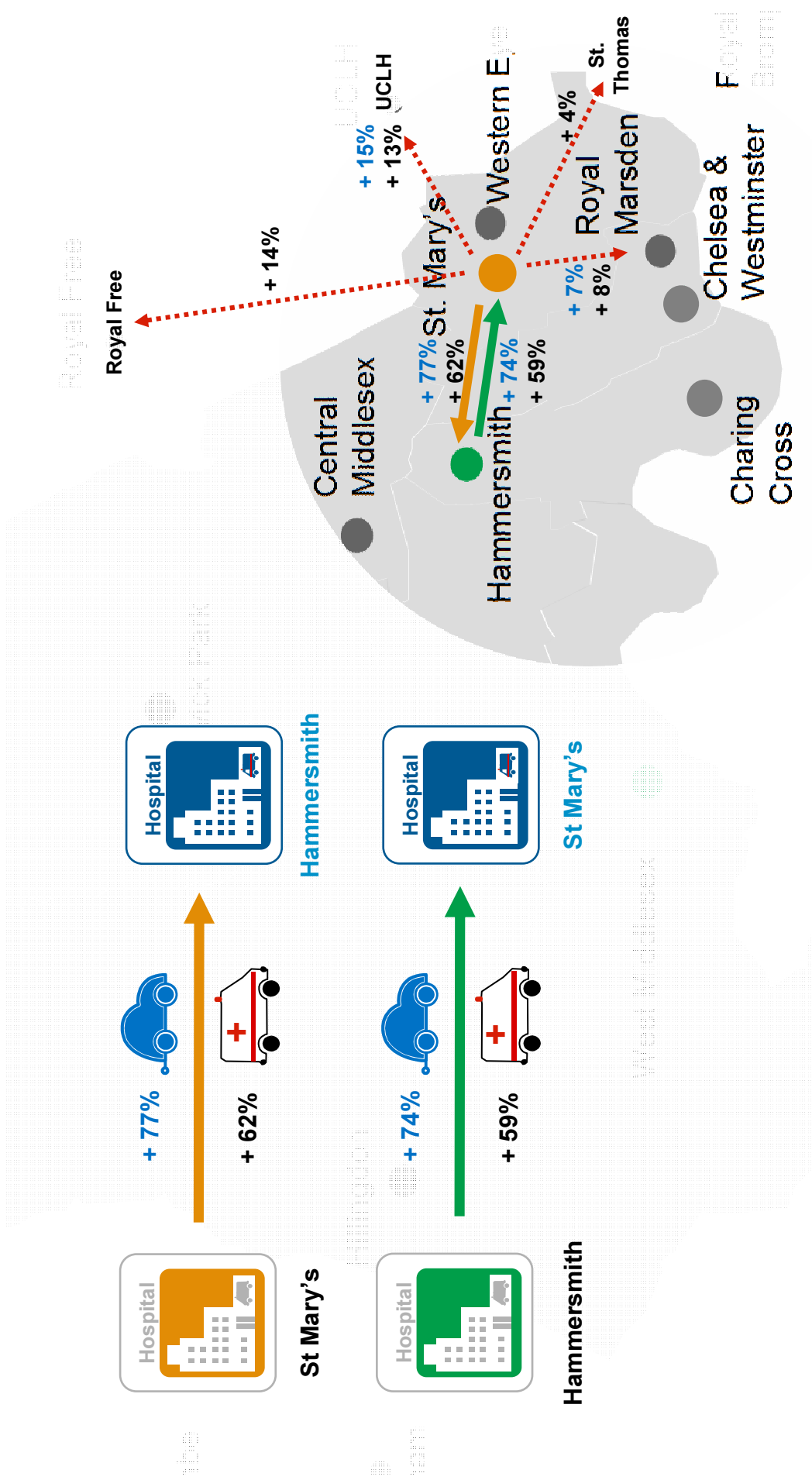
Ealing



West Middlesex

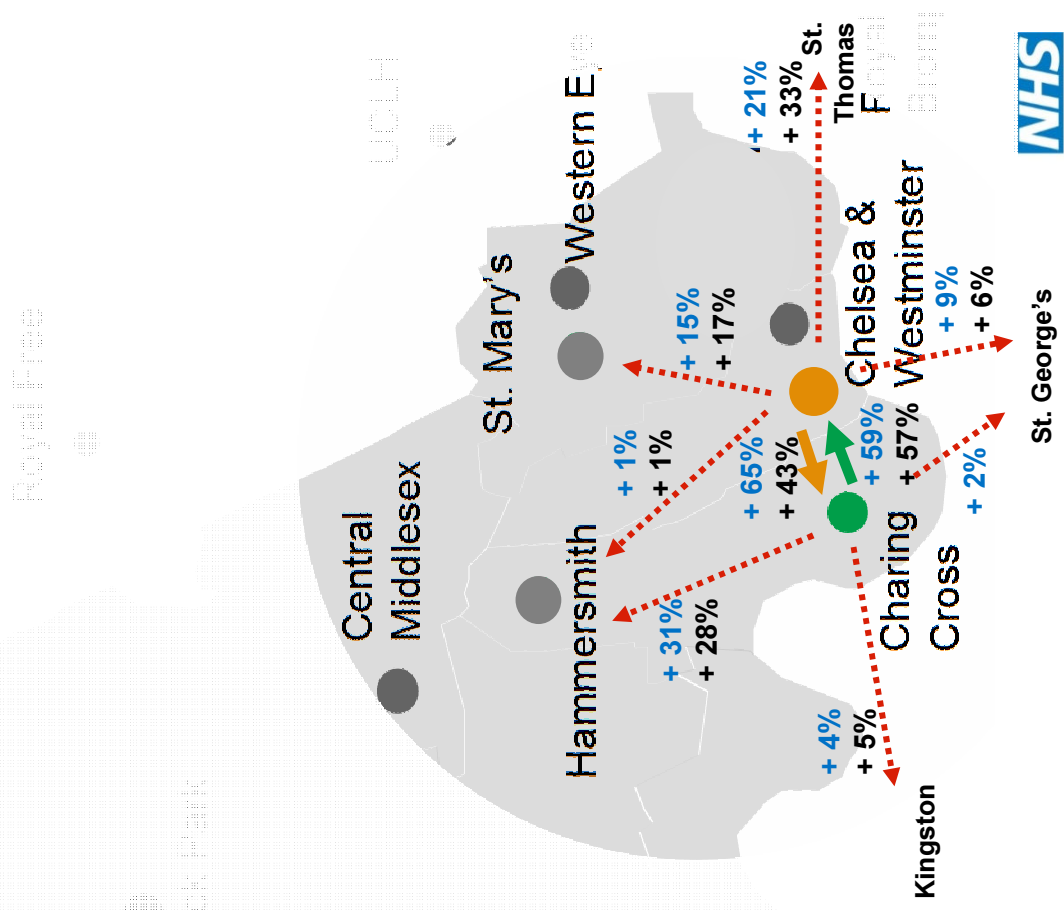
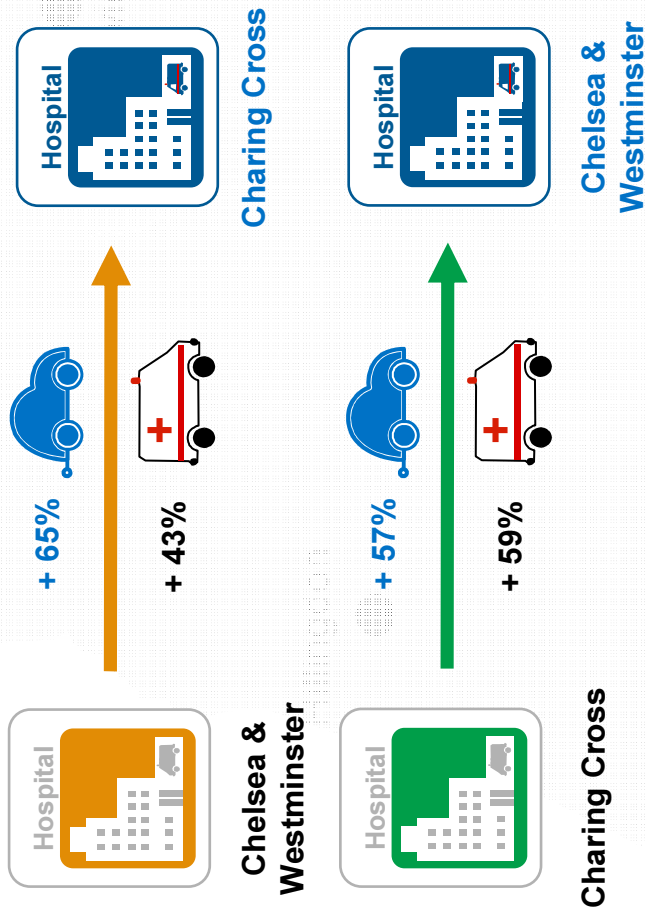
Rationale 7 supporting example

Patient/ travel flows between key hospitals



Rationale 7 supporting example

Patient/ travel flows between key hospitals



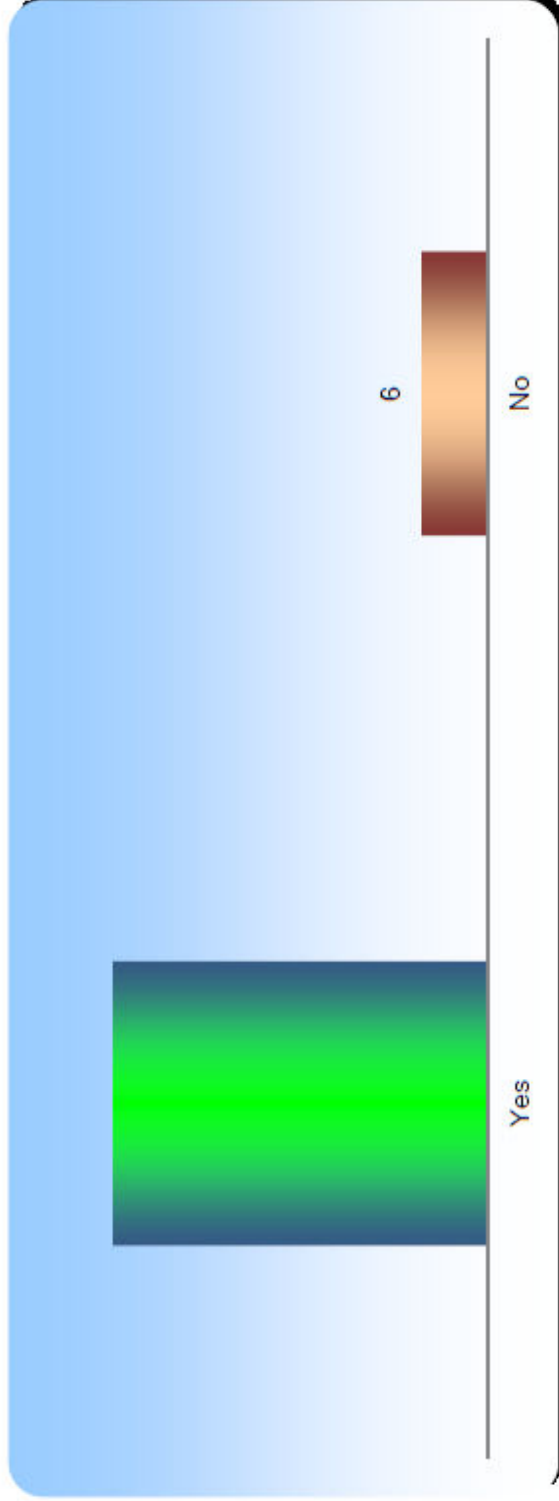
Clinical Board Rationale for selection of medium list

		Number of options
1	<ul style="list-style-type: none"> A acute hospital is required to ensure high quality care 	Millions
2	<ul style="list-style-type: none"> Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital 	Millions
3	<ul style="list-style-type: none"> There should be three to five major hospitals in NW London to support the population of 1.9m. This is based on; available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas. 	336
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6	<ul style="list-style-type: none"> Central Middlesex should not be considered for a major hospital site because several services that would be required are already not delivered there and it would require the largest expansion of any site as it is the smallest of the nine acute sites in NW London 	20
7	<ul style="list-style-type: none"> The Clinical Board proposes geographic distribution of the remaining three major hospitals to minimise the impact of changes on local borough residents. <ul style="list-style-type: none"> Either Hammersmith or St Mary's Either Ealing or West Middlesex Either Charing Cross or Chelsea & Westminster 	8

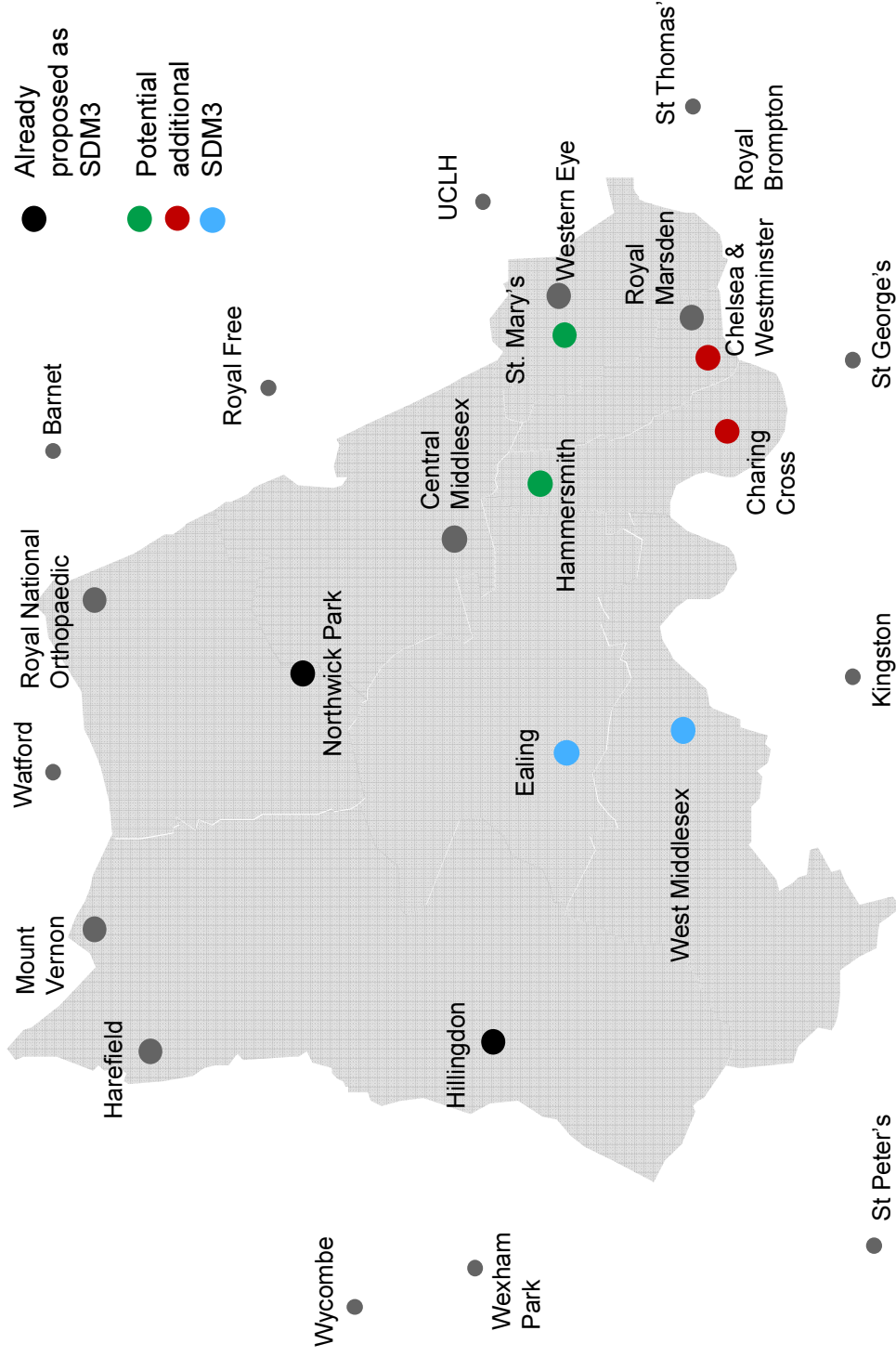
FEEDBACK

Have you understood the process we have described to get from the long to medium list?

Q4. Have you understood the process we have described to get from the long to medium list?			
Yes	34	85.00%	
No	6	15.00%	
	40	100.00%	



Medium list of options



After the break we will look at the criteria used to get from the medium list to the short list for public consultation



North West London

Round table work



North West London

Break

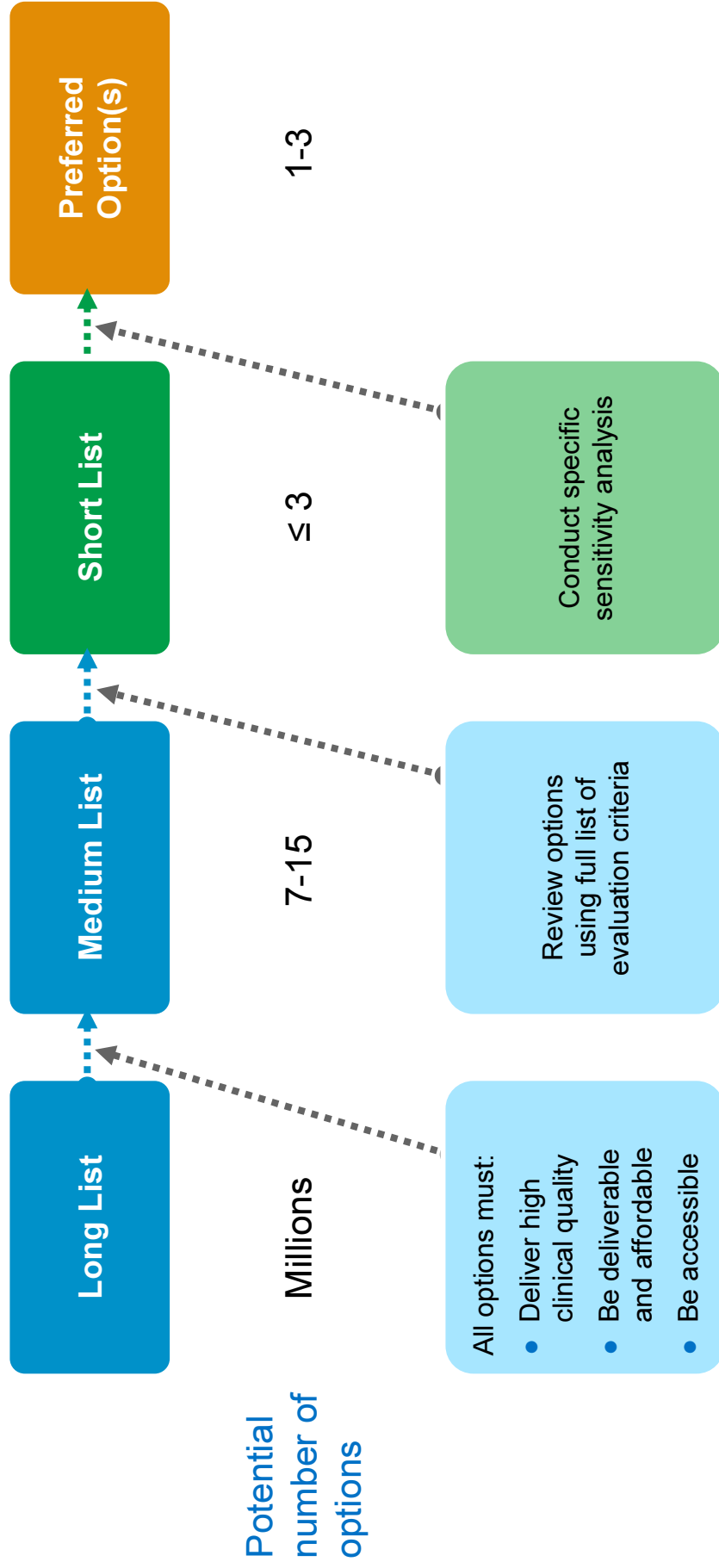


North West London

*Introduction to the criteria used to
get from medium list to short-list*

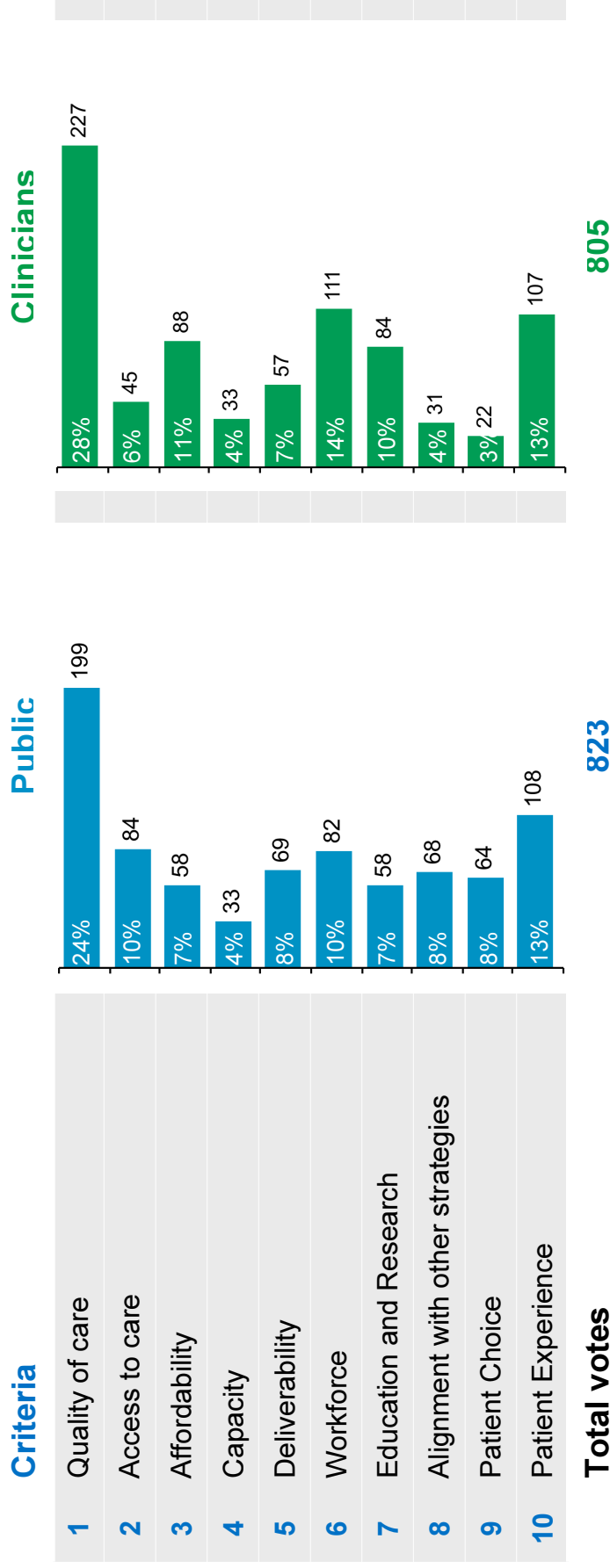
Dr Mark Spencer

Evaluation process for options



Participants at the last engagement event ranked the criteria that were most important to them

Count of 'votes' as indicated by stickers



Additional criteria suggested during the event included...

From the patients, patient representatives and the public

	Votes
Integration	18
Equalities (in health choice)	15
Supporting preventative care and patient self-management	9
Additional - operates 24/7 basis	5
Patient user consultation before change	5

From clinicians

	Votes
Impact on other co-dependent services	7
Self-treatment, independence and self-force/ patient education	6
Integrated care – collaborate	5
Full range of services	5
Flexibility across pathway	4

Suggested criteria have been reviewed and included where appropriate

FOR EXAMPLE:

Suggested criteria	Where this has been included
<ul style="list-style-type: none"> Risk to existing services 	<ul style="list-style-type: none"> Incorporated into deliverability evaluation criteria
<ul style="list-style-type: none"> Impact on other co-dependent services 	<ul style="list-style-type: none"> Part of deliverability criteria
<ul style="list-style-type: none"> Career experience 	<ul style="list-style-type: none"> Included in quality criteria
<ul style="list-style-type: none"> Expertise – who, where is this 	<ul style="list-style-type: none"> Addressed partially through the clinical standards and through workforce evaluation
<ul style="list-style-type: none"> Distribution of services meets local needs 	<ul style="list-style-type: none"> Part of access criteria; primary and community care access being addressed as part of the out of hospital strategy
<ul style="list-style-type: none"> Flexibility across pathway 	<ul style="list-style-type: none"> Addressed through patient choice

Some criteria were not included because they would not differentiate between different options

Examples of suggestions	Reasons why these were not included
<ul style="list-style-type: none"> ● Integration of services 	<ul style="list-style-type: none"> ● This is a major focus for NHS NW London and is in the Commissioning Strategy Plan (CSP). We've been working with providers to support the development of integrated care services. ● It was not included in the criteria as it should be possible under all options and was not considered a factor that would set apart different options
<ul style="list-style-type: none"> ● Health equality across NWL 	<ul style="list-style-type: none"> ● Health inequalities and life expectancy differences are addressed through prevention programmes, easy access to good quality primary care, our integrated care programmes and borough-level out-of-hospital strategies. ● Hospital access is not a driver and so this criteria would not differentiate between options however we will do an equalities impact analysis on the shortlisted options and identify actions to address any adverse impacts on specific groups.
<ul style="list-style-type: none"> ● Support for preventative care and help for patients to manage their own conditions, encouraging independence 	<ul style="list-style-type: none"> ● These are important priorities for NHS NW London and are outlined in the CSP however these criteria do not differentiate between the options for change.

We have now refined this list into 5 key areas

1

2

3

4

5

Criteria	Sub-criteria
Quality of care	<ul style="list-style-type: none"> Clinical quality Patient experience
Access to care	<ul style="list-style-type: none"> Distance and time to access services Patient choice
Affordability	<ul style="list-style-type: none"> Recurrent cost to system Capital cost to system Financially sustainable Trusts Transition costs
Deliverability	<ul style="list-style-type: none"> Workforce Expected time to deliver Co-dependencies with other strategies
Research and Education	<ul style="list-style-type: none"> Education and research

Gallery walk

Instructions

- Please go first to the stand corresponding to the coloured dot on your badge
- Please take a few minutes to review the posters:
 - The first poster describes the proposed approach to applying the criterion to evaluate the options
 - Subsequent posters contain data proposed to assess each criterion
- Please write down any comments you have on the post it notes and stick to the relevant poster
- There will be a person on each stand with detailed knowledge of the criterion and analysis who can answer any questions you might have
- After 10 minutes, you will be directed to the next stand – you will visit all stands
- There will be time at the end for general discussion and to ask any further questions

- 1 Quality of care
- 2 Access
- 3 Affordability
- 4 Deliverability
- 5 Research & education



North West London

*Breakout session on the detail of
short-listing criteria*

Gallery walk



North West London

Feedback

Gavin Grey



North West London

Q&A

Dr Mark Spencer
Dr Susan LaBrooy
Dr Tim Spicer



North West London

Next steps

Dr Mark Spencer

Next steps

- Feedback from today's event will be fed back to our Clinical Board and our Programme Board to inform our ongoing work including planning for public consultation
- The next stage of work and emerging plans for consultation will be shared at our next event on Tuesday 15 May – please see cards in your delegate packs for registration details
- Materials from today's event and a short report will be published on the website:
 - <http://www.northwestlondon.nhs.uk/shapingahealthierfuture/>
- In the meantime, please do not hesitate to contact the team either via the comments cards in your packs or using the contact details supplied

