CENTAL AND NORTH WEST LONDON NHS FOUNDATION TRUST

QUALITY ACCOUNT

2011/2012

DRAFT

FOR PUBLIC CONSULTATION

CONTENTS

ANNEX 3

- Statement of director's responsibilities in respect of the quality account*(to be included atlater 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 thingsin 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

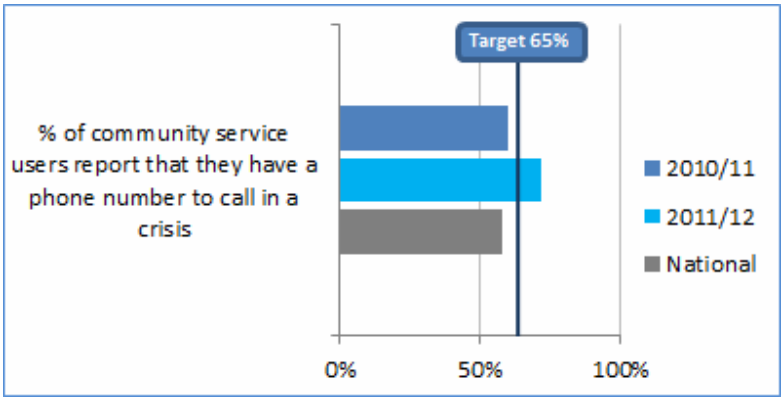
Excellence: Liberating the NHS, 2010, demonstrated the commitment to put patients at the heart of the NHS – and improve their experience of the NHS and the quality of care they receive. We recognise how important patient experience and feedback is in informing what we do, and how we do it. Over the next 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.

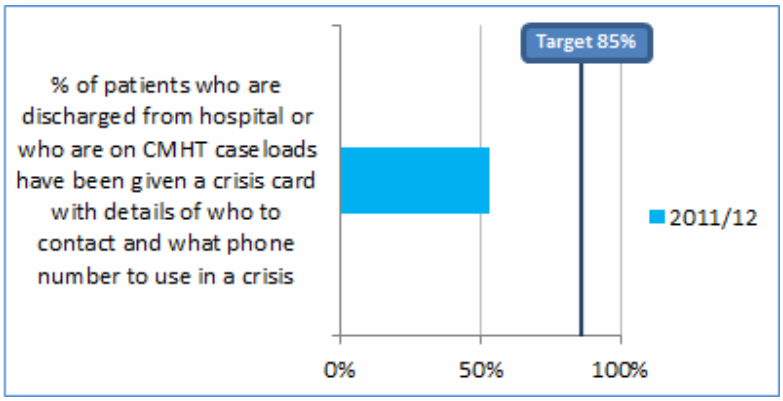


External source: CQC National Community Service User Survey 2011

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.***

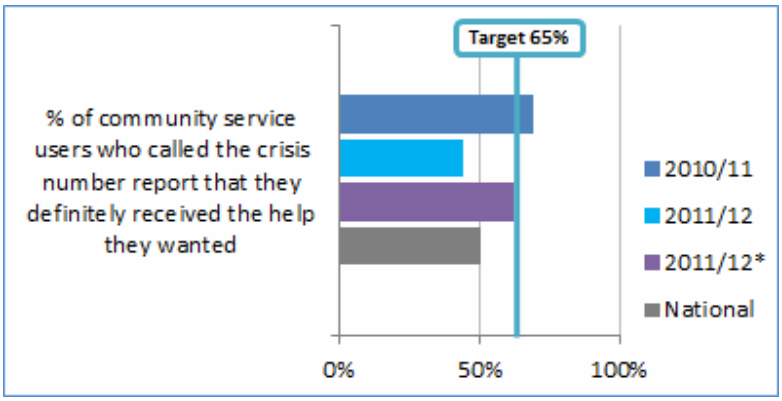
This measure looks at how well we are doing at providing our service users with a crisis card including details of how to contact our services when in an emergency or crisis.These cards let our service users know who to contact when they are in a crisis and most in need of our services. Based on feedback 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.

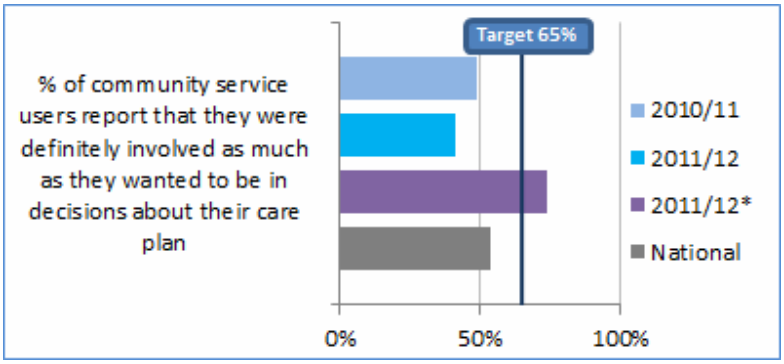
We have also added crisis cards to the discharge checklist as a reminder for staff when a patient is discharged from inpatient care.

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'*

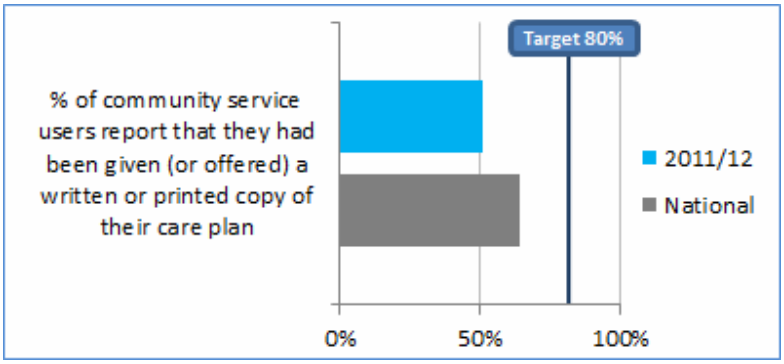
Note that the exact wording for the national measure differs slightly from the CNWL measure. National survey asks: 'Do you think that your views were taken into account when deciding what was in your NHS care plan'?

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.

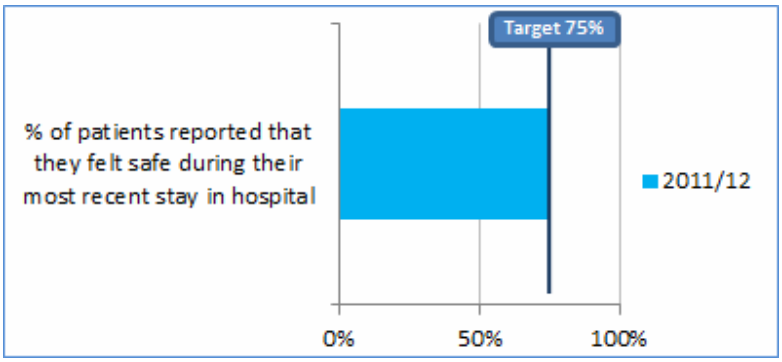


External source: CQC National Community Service User Survey 2011

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.

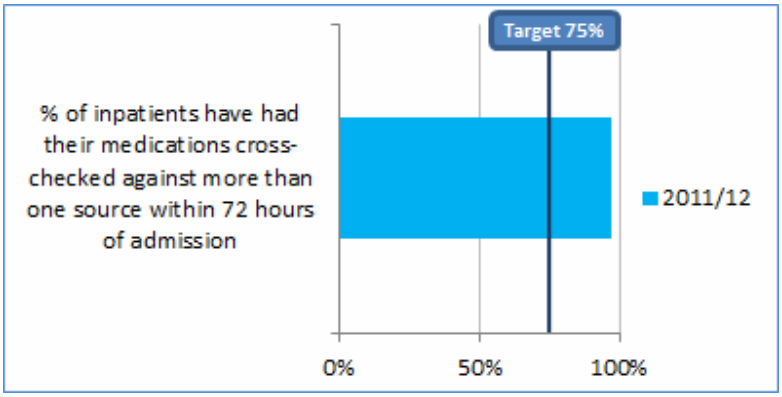
We have continued to deliver training to our staff on the implementation of CPA, Recovery and Personalisation, with recovery at the heart of the service model. This has already had an impact on our service user experience, and will help to ensure that our focus on recovery and collaborative care planning 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 of96%.

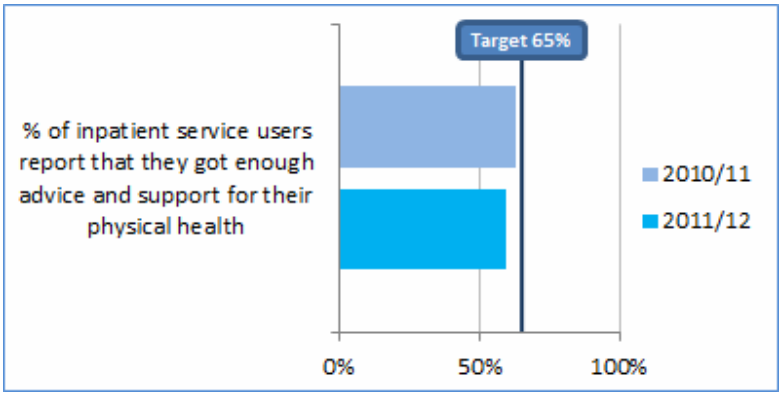
We will work to maintain our high performance in this area, and will continue to monitor via our quality dashboard.

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

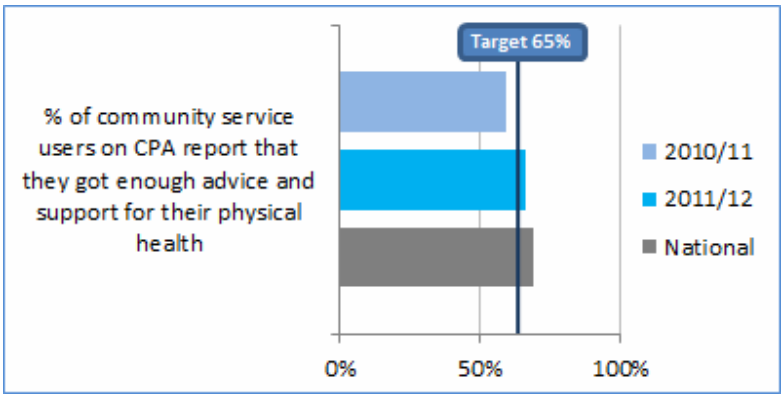
Measure C:***percentage of community service users on CPA report that they got enough advice and support for their physical health***

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 priory that we set.

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

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

Carers are also included as part of our work through the 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

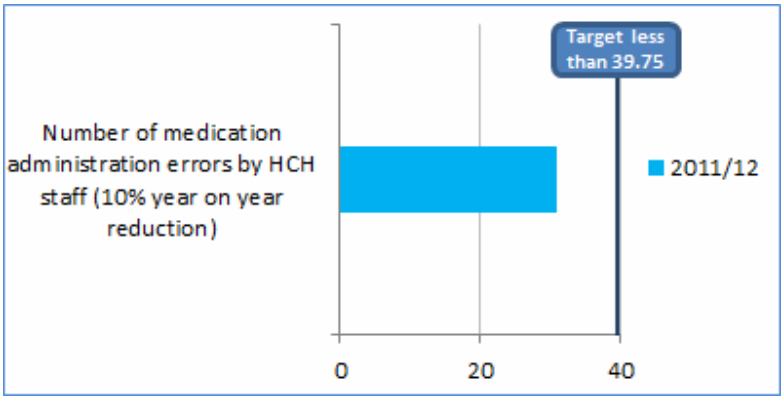
Key
- Not applicable
- Data not available by Directorate/ Data not collected in the quarter

YTD Data represents 'year to date' positions
Q4 Quarter 4 data
Note: Some data for Quarter 4 is not avaiable at this point and will be included in the final published Quality Account

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*



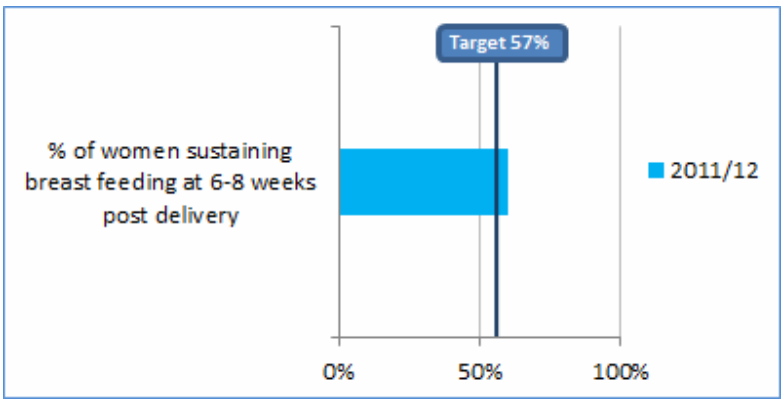
The organisation on a year-to-date basis has reduced medication administration errors and has managed to remain below monthly target in most months. The target was for us to achieve a 10% reduction from last year, which meant our target was to have less than 39.75 errors. We are pleased to report that 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:

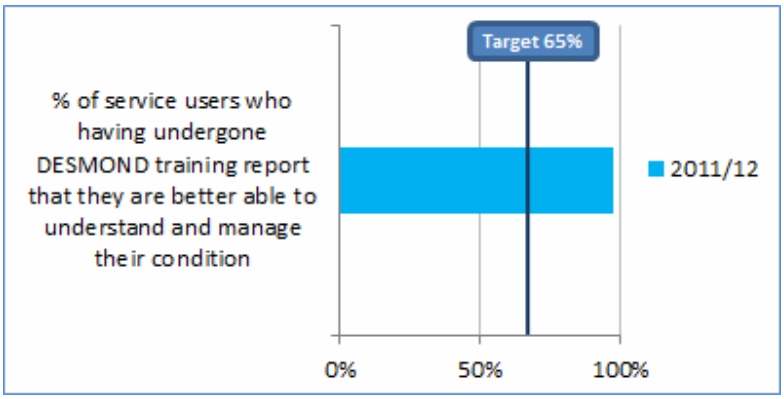
"'Started at hospital today, and just had the most wonderful time there, I learnt so much (from the Infant Feeding Coordinator), it was great to finally get that much needed practical hands on approach with the new mums. Can't wait to get back there on Monday. I almost didn't want to go home!!!"

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.

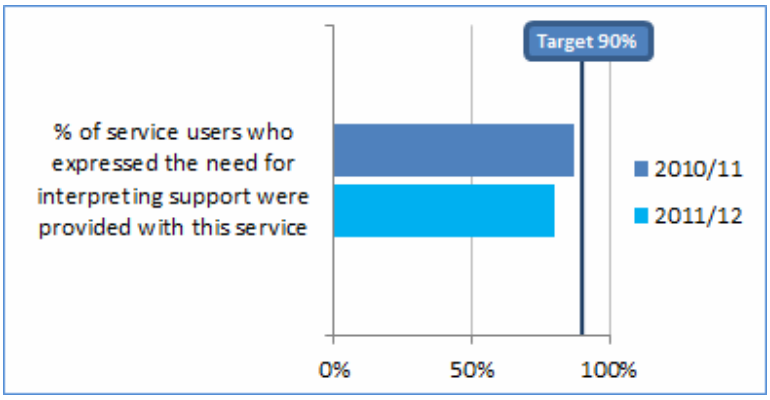
As part of the initiative related to training of carers the Team continues to consider training for carers as a piece of work.

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

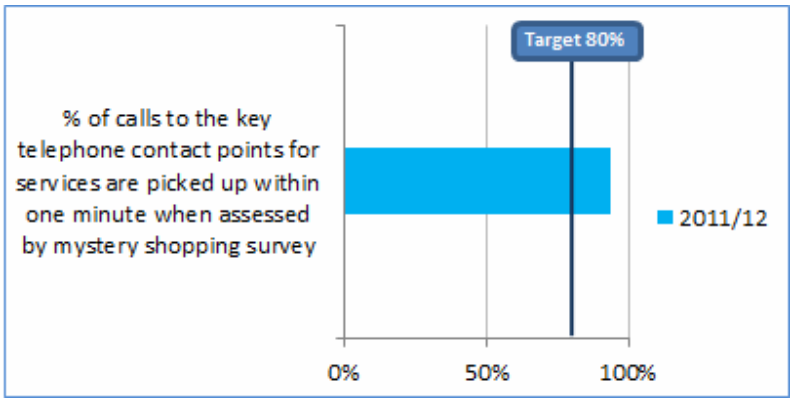
Measure A: ***percentage of service users surveyed (or asked using the Patient Experience Tracker (PET) or equivalent real time feedback tool) report finding it 'easy' or 'very easy' to get through to services on the phone***

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 below:

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

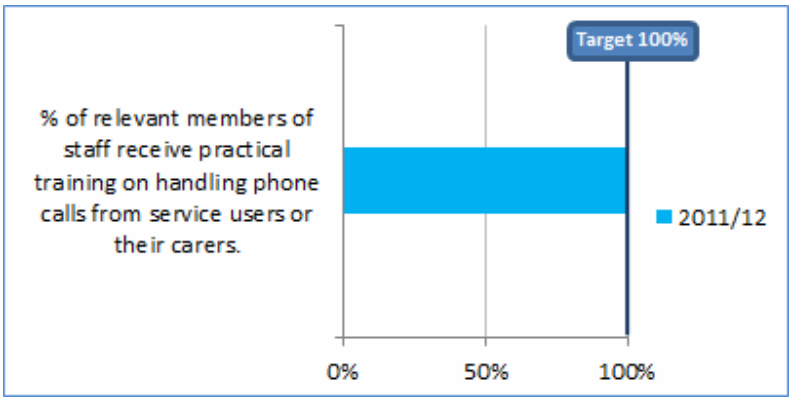
Measure B: ***percentage of calls to the key telephone contact points for services are picked up within one minute when assessed by mystery shopping survey***



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 data**	**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 assessent 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.

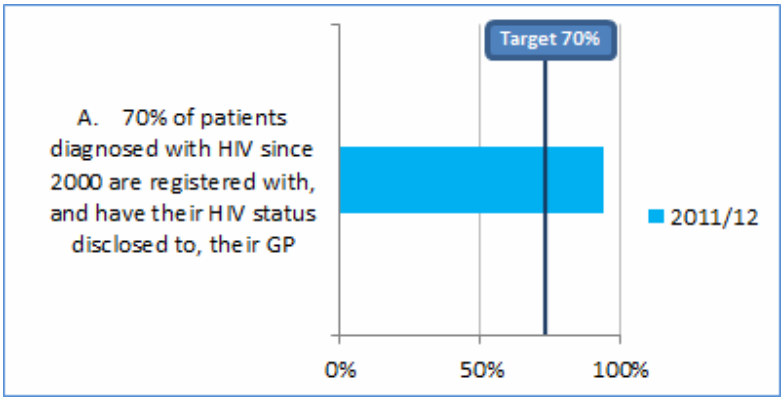
Measure E

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.

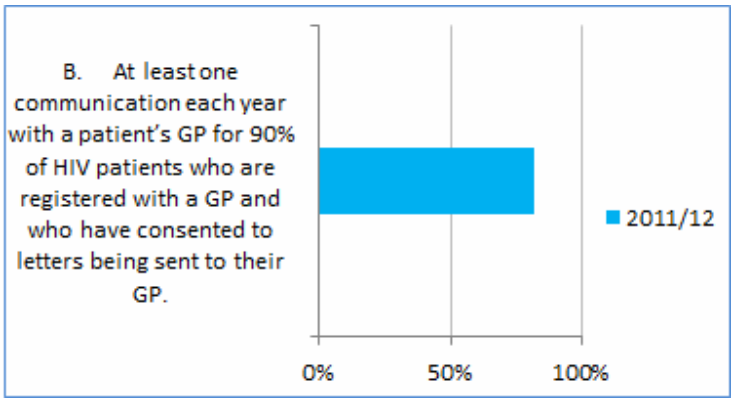
Priority 4 Communication with GPs about the care of HIV patients

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.

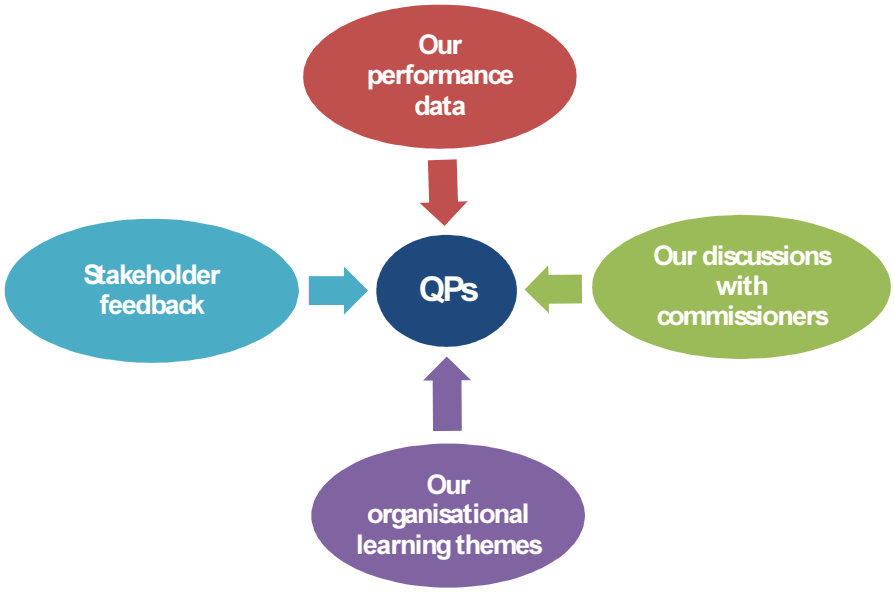
For each quality priority we have identified indicators and targets to measure our performance in this area. These indicators help us to check how we are performing throughout the year and will be used to report on our performance in next year's quality account. However, we are keen to emphasise that 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 withtin 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 there care is being managed appropriately.

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

How are we going to achieve them?

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

We have a wide programme of work that is looking at all of our out of hours services and how these can be improved to ensure that they meet the needs of our service users. We will continue to review service user feedback and will also look toundertake 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 appointmnt 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) • Assessment of the side effects of depot antipsychotics • Monitoring of patients prescribed lithium • Use of antipsychotic medication in CAMHS	• 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 andwelfare 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 10th 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	What percentage of our service users who are on Care Programme Approach did we contact within seven days of them leaving the hospital?	95%	*95.5%*	96%	97%	96%[1]
2. Risk assessment and management	What percentage of inpatient service users have had a risk assessment completed and linked to their care plans?*	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	What percentage of service users have crisis/contingency plans completed as part of their CPA**	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

[1]Source: 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 Ediburgh 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

[2]Source: 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 asses 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. Weare 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 forwheelchair 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

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

[4]Source: 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 prat 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 PERFORAMNCE 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
PCT	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]