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HILLINGDON
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A

External Services Scrutiny Committee

Councillors on the Committee

Michael White (Chairman)
Dominic Gilham (Vice-Chairman)
Josephine Barrett
John Hensley
Phoday Jarjussey (Labour Lead)
Judy Kelly
Peter Kemp
John Major

Date: **THURSDAY, 18 APRIL 2013**

Time: **6.00 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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Contact: Nav Johal / Danielle Watson
Tel: 01895 250692 / 01895 277488
Fax: 01895 277373
Email: njohal@hillingdon.gov.uk / dwatson@hillingdon.gov.uk

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http://modgov.hillingdon.gov.uk/ieListMeetings.aspx?XXR=0&Year=2013&CId=118&

Lloyd White
Head of Democratic Services
London Borough of Hillingdon,
3E/05, Civic Centre, High Street, Uxbridge, UB8 1UW
www.hillingdon.gov.uk

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Terms of Reference

1. To scrutinise local NHS organisations in line with the health powers conferred by the Health and Social Care Act 2001, including:

   (a) scrutiny of local NHS organisations by calling the relevant Chief Executive(s) to account for the work of their organisation(s) and undertaking a review into issues of concern;

   (b) consider NHS service reconfigurations which the Committee agree to be substantial, establishing a joint committee if the proposals affect more than one Overview and Scrutiny Committee area; and to refer contested major service configurations to the Independent Reconfiguration Panel (in accordance with the Health and Social Care Act); and

   (c) respond to any relevant NHS consultations.

2. To act as a Crime and Disorder Committee as defined in the Crime and Disorder (Overview and Scrutiny) Regulations 2009 and carry out the bi-annual scrutiny of decisions made, or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions.

3. To scrutinise the work of non-Hillingdon Council agencies whose actions affect residents of the London Borough of Hillingdon.

4. To identify areas of concern to the community within their remit and instigate an appropriate review process.

Agenda

PART I - MEMBERS, PUBLIC AND PRESS

Chairman's Announcements

1 Apologies for absence and to report the presence of any substitute Members

2 Declarations of Interest in matters coming before this meeting

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4 Exclusion of Press and Public

To confirm that all items marked Part 1 will be considered in public and that any items marked Part 2 will be considered in private

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PART II - PRIVATE, MEMBERS ONLY

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

19 March 2013

HILLINGDON
LONDON

Meeting held at Committee Room 5 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Michael White (Chairman) Dominic Gilham (Vice-Chairman) Josephine Barrett John Hensley Phoday Jarjussey (Labour Lead) Judy Kelly Peter Kemp John Major **Others Present**: Inspector Mark Luton, Metropolitan Police Service (MPS) Margaret O'Keefe, Deputy Justices' Clerk, Her Majesty's Courts & Tribunal Service (HMCTS) Phil Butler, Borough Commander, London Fire Brigade (LFB) Marcia Whyte, Assistant Chief Officer, London Probation Trust Ivor John, Hillingdon Police and Community Consultative Group **LBH Officers Present**: Ed Shaylor, ASB Manager Dr Ellis Friedman, Joint Director of Public Health Danielle Watson, Democratic Services Officer **Also Present**: Member of public - 1	
48.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies were received from Councillor Judy Kelly with Councillor Shirley Harper O'Neill substituting.	**Action by**
49.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* None.	**Action by**
50.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item)* **RESOLVED: That all items of business be considered in public.**	**Action by**
51.	**MINUTES OF THE PREVIOUS MEETING - 19 FEBRUARY 2013** *(Agenda Item 3)*	**Action by**

	RESOLVED: That the minutes of the meeting held on 19 February 2013 be agreed as a correct record.	
52.	**THE ROLE OF THE "CRIME AND DISORDER SCRUTINY COMMITTEE" IN RELATION TO THE SAFER HILLINGDON PARTNERSHIP'S PERFORMANCE AND PLANS** *(Agenda Item 5)* The Chairman welcomed those present to the meeting. Mr Ed Shaylor introduced the report to the Committee and gave Members an update on the Safer Hillingdon Partnership performance since the last meeting held on 11 October 2012. Mr Shaylor explained the charts contained in the report which indicated crime performances up to December 2012 by category, for example, fire, hate crime, burglary and anti-social behaviour. **<u>Metropolitan Police Service</u>** Inspector Mark Luton spoke about the Committee report and highlighted the various work carried out by the Metropolitan Police Service (MPS) since the last update to Committee. Inspector Luton informed Members that it had been a good year for the Borough and explained the performance graphs in more detail. Overall the total number of offences had decreased by 15% over the past 5 years. Members noted the current targets to respond to calls. 'I calls' (immediate response) were expected to be answered within 15 minutes. The target requirement was 90% of all calls and Hillingdon had answered 84% of calls within the 15 minute period. Inspector Luton asked Members to note that the Borough covered a large geographical area which had not been factored in to the target figure. 'S graded calls' were expected to be answered within an hour. The target requirement was 80% and Hillingdon was above target with 82% of the calls answered. Inspector Luton highlighted the 'Aladdin's Cave' initiative. An event was held at the Civic Centre, Middlesex Suite which had the aim of reuniting people with stolen property that had been recovered by the police. Over 1,200 people attended the event. There were 51 identifications from victims who believed they had recognised their stolen property. Inspector Luton updated Members on the success of various operations carried out in the Borough which included the following: • Operation Cubo focused on seizing motor vehicles of those with no driving license and/or no insurance. Over 200 cars had been seized during the operation. • Operation Big Wing was carried out across London on 27 February 2013. The Territorial Police were involved and 10 warrants were executed. The operation involved searching for people who were wanted by Police or those who had	**Action by**

failed to appear at court.

- Operation Hawk was run by the Safer Neighbourhood Teams to increase their operational activity. The operation focussed on tackling drug dealing on street level.

Inspector Luton informed Members that Hillingdon was the 3rd best performing Borough within the MPS for positive outcomes of stop and searches.

Inspector Luton explained that the Local Policing Model would go live from 10 June 2013. There would be less PCs in Hillingdon and from 25 March 2013 posts would be identified. The Borough would be split up into 4, north, east, south and west with 102 PCs spread amongst the 4 areas. A map would be circulated to the Committee.

Members were concerned that some Police Community Support Officers (PCSOs) were not aware about the Local Policing Model. Members suggested that all police staff should be briefed on the policing model to ensure residents were given correct information.

It was explained that Sergeants would be shared between Wards. Each Ward would have its own dedicated PC, PCSO and Special Constables. Shift patterns were from 7am until midnight Monday to Thursday, and 7am until 2am Friday to Sunday. The Criminal Investigation Department (CID) would continue to deal with serious crime, and the response team would respond to 'I' and 'S' calls. Safer Neighbourhood Teams would deal with high volume low risk crimes.

Members were informed that the teams used public transport when necessary. Inspector Luton informed the Committee that there would be cars, a mini-bus and bikes available for each team to use if needed.

Members were keen to hear what new technology the police were using to assist them in their jobs. Inspector Luton informed the Committee that there was going to be a new computer system called 'airspace' and training was due to take place on 25/26 March 2013.

Inspector Luton informed Members that there were 25 homophobic crimes reported last year, this had dropped to 20 this year. Members were keen to know the figure of hate crimes reported by disabled residents. Members highlighted that homophobic or racially motivated hate crimes were recorded separately. Inspector Luton would forward the details to Democratic Services.

Members praised the efforts of the Metropolitan Police during the Olympic period as they were able to keep a tab on crime in Hillingdon despite competing demands. Inspector Luton explained that during the Olympic period shift patterns were changed and sometimes officers were not needed for Olympic duties and were therefore assigned back to the Borough.

Members were happy to hear that there would be two dedicated Special Constables per Ward. Members were also keen to have dedicated Town Centre Teams. Inspector Luton informed Members

that there was no allowance for dedicated Town Centre Teams, although the Borough Commander did recognise that increased visibility in town centres helped reduce crime that there could not be a focus on one particular place. Town Centres were good areas to train new officers or officers who had a poor record.

Inspector Luton explained to Members that the Safer Transport Team based in Hayes patrolled the buses and trains and that they were funded separately by Transport for London (TfL). Members questioned whether staff on public transport received appropriate training. Inspector Luton could only comment on those employed by the MPS and suggested if the member of staff was a Special Constable then they would be trained to deal with any issues.

Members questioned the figures for shoplifting and retail theft figures. Inspector Luton informed Members that there had been no trend. Members were concerned that crimes were being watered down. Inspector Luton had not noticed an increase in the number of cautions and believed some offences would not warrant a caution at all.

Her Majesty's Courts & Tribunal Service

Ms Margaret O'Keefe, Deputy Justices' Clerk, Her Majesty's Courts & Tribunal Service, informed Members that there had been no major change since the last update was given.

Ms O'Keefe explained to Members that Uxbridge Magistrates was part of the West London Justice area. Workload had reduced by 10% across the Boroughs as there had been a reduced number of court rooms that were sat. There was a target to reduce the workload by a further 5% in the next 6 months due to budget cuts. It was noted that approximately 19% of court cases that had to be rearranged. Results of cases had to be given to the police within 2 days and bail conditions within 24 hours.

Members discussed the frustration of licensing applications that had been refused by the Council's Licensing Sub-Committee, and were then being over turned on appeal by the courts. Ms O'Keefe informed Members that this was raised at the last meeting and requested details of specific appeals.

Members were keen to hear how Her Majesty's Courts & Tribunal Service was working with multi agencies. Ms O'Keefe informed Members that Her Majesty's Courts & Tribunal Service regularly attend safer neighbourhood and other multi agency meetings.

Ms O'Keefe informed Members that there had been a slight increase of witnesses not turning up to court. In cases of domestic violence it was quite common for a witness to not attend and was normally due to the person not wanting to attend, rather than the location. There had been number of trials that had been lost as witnesses did not turn up. Ms O'Keefe informed Members that Ealing and Hounslow had Special Courts which specialised in cases of domestic violence.

Members asked for the difference between common assault and common assault by beating. Members noted that the common assault figures were rising and the more serious crimes were going down. Mr Shaylor informed Members that the figures would be stable if they were added together. Ms O'Keefe believed that there were more powers of punishment for the prosecution to charge on common assault by beating, rather than just common assault.

Members questioned whether there was still a backlog of anger management courses which were sometimes given as a bail condition. Ms O'Keefe explained that such courses was not a bail condition but would be part of a community order. Ms O'Keefe informed Members that the backlog was being reduced.

Hillingdon Community and Police Consultative Group

Mr Ivor John, Chairman of the Hillingdon Community and Police Consultative Group, updated the Committee on the work of the group. Mr John informed Members that the group was sponsored by The Mayor's Office of Policing and Crime (MOPAC). The meetings were held bi-attended by various partners and local residents.

Mr John informed Members that local youths were able to have their say via 'Question Time' which was held in the Council Chamber on October 2012. Between 50-70 young people attended to ask questions on policing in the Borough.

Mr John informed the Committee that the Consultative Group was meeting on 17 April 2013 to discuss the future of the Consultative Group and the Safer Neighbourhood Boards that were proposed to replace them.

London Probation Trust

Ms Marcia Whyte, Assistant Chief Officer, London Probation Trust updated the Committee on the work being carried out in Hillingdon by the London Probation Trust. Ms Whyte stated that overall Hillingdon was performing well.

Ms Whyte informed Members that there had been the introduction of an Offender Management Scheme for which the Borough received an allowance. London Probation Trust continued to work closely with statutory individuals and had a strong community partnership with P3, a local charity.

Ms Whyte explained to Members that the Foreign National Unit was currently located in Hillingdon. The unit could hold 500 foreigners in custody. The unit was moving to Southwark Borough where it was proposed to be more centralised.

Ms Whyte updated Members on the community payback scheme. Work was being carried out between agencies. The community payback scheme focused on work in areas such as canals and rural areas.

Members were informed about the probation service review. Hillingdon's Probation Service had responded and was waiting for an outcome about what the Probation Service would look like in the future. Ms Whyte assured Members that it was business as usual and work would be maintained with high risk individuals. The Multi-Agency Risk Assessment Conference was on-going with external partners. Members were informed that Ms Whyte would forward information of any changes.

Members questioned whether there had been a strain on probation services as young people were not being remanded as of December 2012. Ms Whyte explained to Members that under 18 year olds were dealt with by the Youth Offending Team. Members noted that the probation service only dealt with 18 year olds and upwards. Ms Whyte informed Members that the 18-24 age group was the largest group the London Probation Trust worked with, which was challenging but rewarding.

Mr Shaylor advised Members that there had been a change in law, whereby under 18 year olds could only be remanded if the offence to which the proceedings relate were imprisonable. Members noted this legislation came into force as a result of too many young people being kept on remand.

Members were keen to hear of the re-offending rate figures for the Borough. Ms Whyte informed Members that the figure had reduced and she would make the details available to Committee. It was noted that the performance was below the average trend as a result of all agencies working together.

Members discussed the living arrangements of re-offenders in the Borough and how many properties were available for re-offenders. Ms Whyte informed Members that the London Probation Trust continued to liaise with the Council's housing department and local landlords which had proved to be challenging.

London Fire Brigade

Mr Phil Butler, Borough Commander, London Fire Brigade, introduced the report and updated the Committee of the work being carried out in the Borough by the London Fire Brigade.

Mr Butler explained there had been a reduction of hoax calls; and it was noted that a repetitive hoaxer was traced to Ireland. Mr Butler explained the figures included in the report to the Committee and informed Members that Hillingdon was ahead of the game compared to other London Boroughs.

There had been a focus on reducing arson in hotspots. Arson had reduced by 20% compared to last year. There had been an increased use of the fire crew in the Borough. It was thought that the implementation of CCTV in Harefield had reduced the number of incidents in Harefield Ward to just two since July 2012. Mr Butler

informed Members that there were a handful of Wards that had a low level of arson.

Members were concerned that the 4 youngest Wards (in terms of age) in the Borough had higher figures for arson than other wards. Mr Butler explained to Members that these wards were some of the most densely populated areas in the Borough. Members were informed that there was a need to reduce rubbish related fires which was on target. Members noted that there was an arson attack in West Drayton where a bag of clothes left for a charity shop was set on fire.

Members discussed the use of refuse bins and the advice of the London Fire Brigade to keep them covered and secure. However the police informed residents that the bins were used by criminals to gain entry to a property. Mr Butler explained to Members that flats normally had a secure bin store which could only be accessed by contractors. Mr Butler informed Members that the London Fire Brigade advised commercial properties to keep rubbish secure and to put it out on day of collection. Residential rubbish should also not be put out until the day of collection to prevent arson as well as pests.

Mr Butler informed Members that the London Fire Brigade interacted with members of the public and were frequently available to attend community events such as school fetes. Mr Butler explained that if the presence of the London Fire Brigade was requested at such an event, the organiser would need to contact London Fire Brigade headquarters who would then forward the message on. Mr Butler informed Committee that the London Fire Brigade had attended 20 schools across the Borough. Members were informed that a Community Safety Team was deployed between April to September 2012. The team consisted of 16 people who had been working and engaging with the local community with a focus of preventing fire.

Mr Butler explained that there had been a rising trend in dwelling fires but the figure was still relatively low. There had been 2600 home safety visits carried out with 70-75% most at risk residents of the Borough. Most at risk residents were identified on a geographically basis using social demographic data and postcodes. Mr Butler explained to Members that people at risk included the elderly and those reliant on drugs or alcohol. Mr Butler explained that domestic fire systems continued to be promoted as they helped people remain independent.

Members discussed specialist equipment for the vulnerable and elderly, for example halogen fires and lights. Mr Butler informed Committee that sometimes dementia sufferers, for example, would light a cigarette and forget where they had placed. Mr Butler explained to Members that cooking was a bigger issue.

Members questioned whether there were still a high number of people who forget to replace the smoke detector battery. Mr Butler informed Members that this was still an issue although the figures were better than before.

	Mr Butler explained to Members that the Station Manager at Heathrow was negotiating for his team to respond to their own run. Members were keen to hear figures of automatic fire alarms, whereby the London Fire Brigade were called out instantly unnecessarily. Mr Butler explained that most callouts were from Heathrow Airport and Hillingdon Hospital, and that inspecting officers were working with the biggest perpetrators. There was a target to reduce the amount of automatic call outs in a year to 1,300. Mr Butler informed Members that hotels in the Borough were working with the London Fire Brigade, and this had assisted in reducing automatic callouts from 40 to 30. The Draft Fifth London Safety Plan consultation document outlined the proposed charge of £350 for false call outs. Members discussed the number of planning developments that had been approved over the past few months, and questioned whether there had been an increase in fires in areas where the population increased. Mr Butler explained to Members that 80/90% of fires were contained in the room they started in, depending on the time of day or the construction of the building. Therefore the risk of the fire spreading was low; however, Mr Butler agreed that the risk of fire was higher in densely populated areas. Members questioned whether Brunel University had received a high number of visits compared to last year, as students were often setting off fire alarms from cooking late at night. Members noted that Brunel Ward covered a large area and Mr Butler informed Members that Brunel was not a big problem. The Committee thanked those present for their presentations and answering Members questions. The Committee also thanked Dr Ellis Friedman for his support to the Committee during his time as Joint Director of Public Health and wished him luck in his new role at Sutton Council. **RESOLVED: That:** **1. the presentations be noted;** **2. Inspector Luton forward details of the map indicating the north, east, south and west split of wards to Democratic Services for circulation to Committee Members; and** **3. Inspector Luton forward details of the number of disabled motivated crimes to Democratic Services for circulation to Committee Members; and** **4. Ms Whyte to forward details of any changes to the London Probation Trust to Democratic Services for circulation to Committee Members; and** **5. Ms Whyte to forward details of the reoffending figures to Democratic Services for circulation to Committee Members; and** **6. the Committee thanked Dr Ellis Friedman for his support to the Committee during his time as Joint Director of Public Health and wished him luck in his new role at Sutton Council.**	Democratic Services Inspector Mark Luton Marcia Whyte

53.	**WORK PROGRAMME** *(Agenda Item 6)* Consideration was given to the Committee's Work Programme. It was noted that the next meeting would consider Quality Accounts and CQC evidence gathering. The meeting would be starting at 6pm. Democratic Services would be putting together a draft Work Programme for 2013/14 in due course. **RESOLVED: That:** **1. the Work Programme be noted;** **2. Democratic Services compile a draft work programme for 2013/14.**	**Action by** Democratic Services
	The meeting, which commenced at 5.00 pm, closed at 6.55pm.	

These are the minutes of the above meeting. For more information on any of the resolutions please contact Danielle Watson/ Nav Johal on 01895 250472 / 01895 250692. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

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PERFORMANCE REVIEW OF THE LOCAL NHS TRUSTS

Officer Contact	Nav Johal and Danielle Watson, Administration Services
Papers with report	***To Follow***

REASON FOR ITEM

To enable the Committee to submit comments to the Care Quality Commission (CQC) on the performance of local NHS Trusts and to comment on the Trusts' Quality Account Reports.

OPTIONS AVAILABLE TO THE COMMITTEE

1. Members question the Trusts on their Quality Account Reports for 2012/13 and identify issues that they would like included in the Committee's statement for inclusion in the report.
2. Members use information from their work this year to question the Trusts on issues measured by the CQC.
3. Members decide whether to use this information to submit a commentary to the CQC.

INFORMATION

Introduction/background

Quality Account Reports

1. The Department of Health's *High Quality Care for All* (June 2008) set the vision for quality to be at the heart of everything the NHS does, and defined quality as centered around three domains: patient safety, clinical effectiveness and patient experience. *High Quality Care for All* proposed that all providers of NHS healthcare services should produce a Quality Account: an annual report to the public about the quality of services delivered. The Health Act 2009 placed this requirement onto a statutory footing.

2. Quality Account reports aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda. The details surrounding the form and content of Quality Account reports were designed over a year long period in partnership between the Department of Health, Monitor, the Care Quality Commission and NHS East of England. This involved a wide range of people from the NHS, patient organisations and the public, representatives of professional organisations and of the independent and voluntary sector.

3. For the first year of Quality Accounts (2009/2010), providers were exempt from reporting on any primary care or community healthcare services. During the second year, the community healthcare service exemption was removed. In the third year of Quality Account reports, providers reported on activities in the financial year 2011/2012 and published their Quality Accounts by the end of June 2012.

4. Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the overview and scrutiny committee (OSC) in the local authority area in which

the provider has a registered office and invite comments prior to publication. This gives OSCs the opportunity to review the information contained in the report and provide a statement of no more than 1,000 words indicating whether they believe that the report is a fair reflection of the healthcare services provided. Scrutiny Committee's can also comment on the following areas:

- whether the Quality Account report is representative
- whether it gives a comprehensive coverage of the provider's services
- whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to Quality Account reports.

5. The OSC should return the statement to the provider within 30 days of receipt of the Quality Account report to allow time for the provider to prepare the report for publication. Providers are legally obliged to publish this statement as part of their Quality Account report.

6. Providers must send their Quality Account report to the appropriate OSC by 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account report ready for review by its stakeholders.

7. The primary purpose of Quality Account reports is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer and encourage then to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. If designed well, the reports should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

8. It should be noted that Quality Account reports and statements made by commissioners, LINks/Healthwatch and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

9. Where possible, draft copies of the Trusts' Quality Account reports will be appended to this report for consideration.

<u>CQC Assessment</u>

10. The CQC is the independent regulator of all health and social care services in England. Its job is to make sure that the care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets Government standards of quality and safety. These Government standards cover all aspects of care, including:
    - treating people with dignity and respect.
    - making sure food and drink meets people's needs.
    - making sure that that the environment is clean and safe.
    - managing and staffing services.

11. The CQC registers care services that meet the standards, inspect them to check that they continue to do so, and take action when they don't. The CQC inspectors visit health and adult social care services across England to check that they are meeting the standards and make unannounced inspections of services on a regular basis and at any time in response to concerns. During these inspections, the CQC:

- ask people about their experiences of receiving care.
- talk to care staff.
- check that the right systems and processes are in place.
- look for evidence that care isn't meeting government standards.

12. When standards aren't being met, the CQC can use its powers to:
    - issue fines or warnings.
    - stop admissions into a care service.
    - suspend or cancel a care service's registration.

13. The CQC regulates:
    - treatment, care and support provided by hospitals, dentists, ambulances, GPs, primary medical services and mental health services.
    - treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care).
    - services for people whose rights are restricted under the Mental Health Act.

14. The CQC expects the services it regulates to demonstrate that they involve people and respond to what people tell them. Providers have told the CQC that engaging with people can benefit all aspects of care, including how services are planned, organised and provided, how services are used, the outcomes of care, and wider benefits for those who are involved, for their staff, as well as for the public. The public, including people who use services and carers have said that effective involvement can give them a voice in services, recognise their right to be heard, and can increase their understanding, trust and confidence in services and their knowledge about their local services, and lead to improvements in their health and wellbeing.

15. Local authorities are being encouraged to send evidence to the CQC about the quality of local NHS services to help inform decisions about providers' compliance with the core standards assessment (previously known as the Annual Health Check). Unlike the Annual Health Check, Councils can now send evidence to the CQC on an ad hoc basis. The assessment now covers adult social care as well as health and mental health services.

16. From April 2010, new essential standards of quality and safety were introduced gradually across all health and adult social care services. Providers of health and adult social care are registered with the CQC if they meet essential standards and are constantly monitored by the CQC to ensure that they comply with new legislation.

17. Under the Health and Social Care Act 2008, NHS Trusts were the first providers that were incorporated into the new system which started on 1 April 2010. Providers of adult social care and independent health care started in October 2010. Primary dental care providers were registered by the Care Quality Commission from 1 April 2011 - this included NHS and private dentists, and those who worked in both sectors.

18. Any feedback received from the External Services Scrutiny Committee will help the CQC decide whether the health services provided within the Borough meet the essential standards of quality and safety. This evidence can be submitted online or to the CQC Area Manager and could potentially look at:
    - what matters most to the people in your community?
    - examples of good practice, as well as areas that should be improved.

- recent experiences of care and whether these are common among the people using a service or in a community.
- notes from meetings or visits to a service, the results of a local survey, or a set of personal stories from individuals with dates and supporting documents.

Witnesses

19. Senior officers from each Trust will be attending and will be able to go into more detail with regard to the contents of their Trust's draft report. Representatives have been invited from the following organisations:
    - The Hillingdon Hospitals NHS Foundation Trust
    - Central & North West London NHS Foundation Trust
    - Royal Brompton & Harefield NHS Foundation Trust
    - Care Quality Commission (CQC)
    - NHS Hillingdon
    - London Ambulance Service
    - Hillingdon Clinical Commissioning Group (CCG)
    - Local Medical Committee
    - Healthwatch

SUGGESTED SCRUTINY ACTIVITY

20. Members review the evidence collected during the year and, following further questioning of the witnesses, decide whether to submit commentaries to the CQC.

21. To consider and agree the Committee's comments for inclusion in the Trusts' Quality Account reports.

BACKGROUND INFORMATION

None.

SUGGESTED KEY QUESTIONS/LINES OF ENQUIRY

1. What factors have led to the non-achievement of targets? What has been done to address failed targets?

2. What is latest financial position of the PCT and the Trusts? What is the forecast for the financial year end?

3. What initiatives have been implemented during the course of the last year? What had been the impact of these initiatives? What has been the feedback from patients on these initiatives?

4. What plans are there for Trusts to improve their facilities in Hillingdon?

5. How do the Trusts ensure that learning and innovation continues and is filtered through the organisation?

6. What impact (if any) has the any work undertaken by the Trusts on their priorities over the last year had on non-priority services?

7. What developments have there been in relation to the Safe and Sustainable consultation?

8. What impacts are likely with the transition of public health services to the local authority and how is this change being monitoring to ensure services to residents remain unaffected?

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Central and North West London NHS
NHS Foundation Trust

QUALITY ACCOUNT
2012 – 2013

DRAFT

v.4.0.0

Wellbeing for life

CONTENTS

PART 1 – Chief Executive Statement

Welcome to Central and North West London NHS Foundation Trust's (CNWL) annual Quality Account for 2012/13. I am proud to present to you this report on the positive strides, innovations and achievements we have taken in the past year to drive up and maintain quality at every level within the organisation, as well as to indicate where our services are to be improved.

As you may know, most organisations providing healthcare funded by the NHS are required to produce a Quality Account annually. The purpose of this document is to hold our organisation to account for the quality of the services we deliver. We do this by presenting our achievements against our quality priorities for 2012/13, national priorities and the wider quality and service improvement work we have completed. We also demonstrate how we will continue to enhance the quality of services we provide, and what our focus is going to be this coming year. Our quality priorities for the coming year have been developed in conjunction with our staff, patients, carers and our external stakeholders.

In summary CNWL is the provider of a wide range of health care services across London and the surrounding area. These include mental health, sexual health, community physical health, addictions, eating disorders, offender care and learning disability services. For a detailed description of the services we offer, please refer to Part 2, page 39.

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

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

We believe that delivering world-class healthcare services is done in partnership with all our stakeholders. We proactively seek to facilitate engagement with our stakeholders, both internal and external, for feedback and shared-decision making which help to shape how our services are run, developed and monitored. It is not only about 'listening to views' but about facilitating open and continuous *dialogue* between all our stakeholders and from the Board to ward. Dialogue underpins the Trust's core values of *dedication*, *empowerment*, *partnership* and *diversity*. To emphasise this approach our Trust logo reflects this as a series of speech bubbles.

This is demonstrated by the development of our quality priorities and final version of this Quality Account year on year: Achieved through wide and on-going consultation with our key stakeholders including our staff, Council of Governors, service users, carers, Local Involvement Networks (LINks), commissioners, GPs and local authorities.

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

I am pleased that we have met fifteen of our seventeen quality priority measures for 2012/13. This is an improvement in our performance compared to last year, and in Part 2 we explain the detail. We were disappointed however that we did not meet two measures relating to involvement in care planning and patient experience, specifically how we responded to call bells at our St Pancras unit. We know that these are areas we need to strengthen and that is why this year we have included involvement in care planning and satisfaction with our services as our quality priorities to further drive improvement.

Over the year feed back we received from our stakeholders included that we should focus our quality priorities on fewer areas, and that these should be applied to all areas of the organisation. Feedback was that this would enable better embedding of quality across services, and provide opportunity to benchmark and standardise service quality. Through an extensive programme of consultation, our quality priority areas for 2013/14 will be:

- Care planning;
- Carer involvement; and
- Satisfaction with services

Quality priority areas indentified through consultation run by Milton Keynes Community Health Services, our new partners, will include:

- Transfer of care and discharge;
- The Safety Thermometer and avoidable pressure ulcers; and
- Satisfaction with services

I would like to reiterate our commitment to working in partnership with you over the coming year as we work toward our common goal: the delivery of safe and effective care to our patients and their families or friends. I would also like to thank you for your continued support, engagement and feedback in the shaping of our service developments, our innovations and how we monitor the quality of our services.

The Quality Account is also produced in an easy-read format, forms part of our Annual Report and is available on the NHS Choices website.

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

Claire Murdoch
Chief Executive
24 May 2013

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

[insert here – 6 May 2013]

KPMG LLP, Statutory Auditor, London
30 May 2013

Part 2 – Priorities for improvement

2.1 A review of our performance in 2012/13 against last year's Quality Priorities

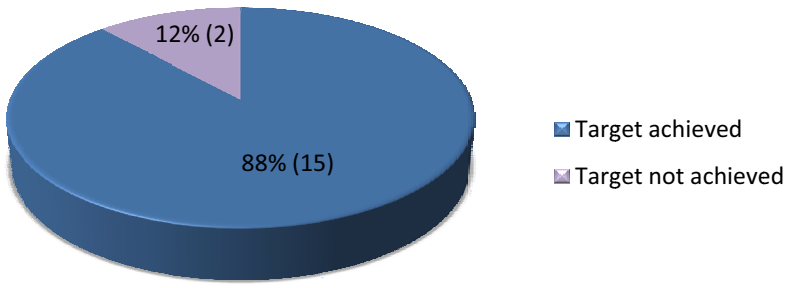
We take great pride in the healthcare services we deliver to our local communities, and want to be the best at what we do. We strive to continually innovate and improve our services through closely monitoring and proactively reacting to performance against a wide variety of measures and information streams;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

In this section we tell you how we performed against our quality priorities set last year in partnership with our stakeholders. We also explain how we developed and agreed our quality priorities for 2013/14. This will include a description of our wide consultation process, the rationale for these indicators and how we will measure, monitor and report on these throughout the coming year.

Summary of performance against our 2012/13 quality priorities
For 2012/13 CNWL had a total of 17 quality priority measures. Eight of these originated from our mental health and allied specialty services (MHAS), five from Hillingdon Community Health (HCH), and four from Camden Provider Services (CPS).

These 17 measures were tracked throughout the year and action plans developed where improvements were highlighted. It is important to note that depending on the methodology used to collect the data against each measure, our year end reporting figures are either achievements 'year-to-date' or at 'quarter four'. This will be made clear throughout the Quality Account.

The chart below indicates our achievement against these 17 quality priority measures for 2012/13. Eight of these measures were also CQUIN.



This year we achieved 88% (final position to be updated) of our quality priorities, representing an increase in our achievement from last year of 69%.

An 'at a glance' overview of how we performed against these 17 quality priorities is provided in a summary table overleaf. The details of how we performed against each of our quality priorities and how we achieved them, or our actions to be taken, are presented to you over the subsequent pages.

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

Central and North West London NHS
NHS Foundation Trust
Wellbeing for life

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

Target achieved Target not achieved * To be updated with quarter 4/year end data

	Quality Priority 2012/13	Target	2012/13	2011/12	National
Mental health and allied specialties					
Quality priority area: Recovery and involvement					
1	At least 65% of community patients report that they were 'definitely' involved as much as they wanted to be in decisions about their care plan (Q4)	65%	57%	41%	54%
2	At least 50% of service users on CPA whose care plans contain at least one personal recovery goal (Q4)	50%	83%	n/a	n/a
Quality priority area: Physical health					
3	At least 95% of service users with dementia prescribed anti-psychotic medication have three-monthly reviews, and output sent to GPs and families/patients within two weeks (Q3)	95%	100%	n/a	n/a
4	At least 65% of community service users on CPA report that they got enough advice and support for their physical health (Q4)	65%	75%	66%	65%
Quality priority area: Carer involvement					
5	Thematic review of responses via focus groups asking if carers felt supported by CNWL (Q4)	Focus group	Achieved	n/a	n/a
6	Thematic review of responses via focus groups asking if carers had the information they needed to access services in a crisis (Q4)	Focus group	Achieved	n/a	n/a
Service pathway and access in a crisis					
7	To establish supported discharge processes and protocols to support service users who have been discharged to primary care (Q4)	Protocol establishment	Achieved	n/a	n/a
8	At least 65% of patients reporting that they 'definitely' received the help they wanted from CNWL crisis contact points when they contacted them in a crisis (Q4)	65%	67%	44%	50%
Hillingdon Community Health					
Use of care plans					
9	At least 75% of end of life care patients on a district nursing caseload with an advanced care plan (YTD)	75%	76%*	n/a	n/a
10	At least 25% of patients with learning disability conditions using HCH services have personalised care plans (YTD)	25%	36%*	n/a	n/a
Reducing the number of avoidable pressure ulcers					
11	Reducing the number of avoidable grade 2/3/4 pressure ulcers (10% year on year reduction) (YTD)	<62	17*	n/a	n/a
Improving staff awareness in relation to carers					
12	Develop localised guidelines for all HCH staff to enable more effective support for carers which will include development and delivery of a training package for staff in conjunction with third sector partners	Develop guidelines and training	Achieved	n/a	n/a
13	Ensure at least 80% of all new referrals to the wheel chair service are given specific information for their carers about using a wheelchair and, where requested, provide additional training (YTD)	80%	100%	n/a	n/a
Camden Provider Services					
Clinical quality in HIV services					
14	At least 95% of HIV patients whose immune systems are maintained at a CD4 count greater than 200 (YTD)	95%	97%*	n/a	83%
15	At least 95% of patients with a viral load less than 50 copies/ml within one year of treatment commencing (YTD)	95%	95%*	n/a	87%
Patient experience					
16	At least 80% of patients with an appointment with sexual health services, who arrive on time, are seen within thirty minutes of the appointment time (M10)	80%	82%*	n/a	n/a
17	Number of responses stating poor responsiveness to call bells on the inpatient wing of St Pancras Hospital (Q4)	0	6	n/a	n/a

2.1.1 Our mental health and allied specialty services

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

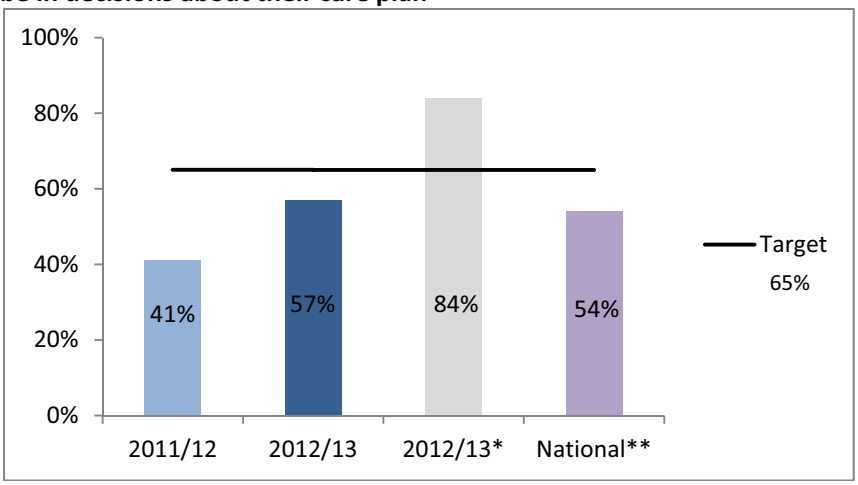
As set out in last year's Quality Account, we measured our performance in four main quality priority areas for our mental health and allied specialty services (namely recovery and involvement, physical health, carer involvement and service pathway/access to services in a crisis). Here we will present our performance, explain what we did to achieve this performance, or what we will be doing to ensure improvement. Note that all our 'service user reported' measures were collected via a telephone survey run by trained group of service users.

Recovery and involvement

CNWL strives towards a recovery focused model of care. Although there is no single definition of the concept of recovery, for many people recovery means staying in control of their life despite experiencing a mental health problem, with the guiding principle being one of hope. Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms[1].

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

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



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

*** Source: CQC National Community Service User Survey 2012. Note that the wording of the national measure differs slightly, and asks: 'Do you think that your views were taken into account when deciding what was in your NHS care plan?'*

[1]Mental Health Foundation

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

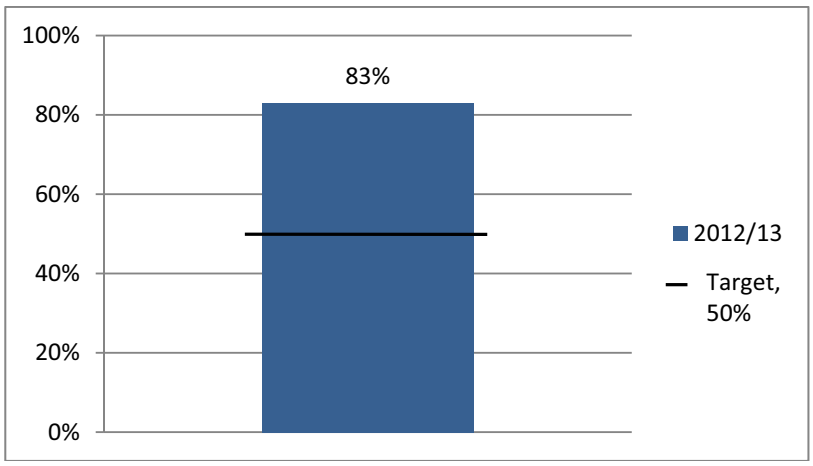
To gain a fuller understanding of how many of our service users feel this way we also consider those who also felt involved 'to some extent'. We have improved by 10% on last year, reporting 84% at the end of quarter four.

Whilst we are pleased to see improvement and are reporting better than the national average, we are not complacent. Work to improve service user involvement is taking place across a number fronts. This includes the development and dissemination of a briefing to staff about the importance of involving service users in care planning, presentation and review of data at local managers meetings, and the involvement of service users in the 'standardisation of the initial assessment process' and 'development of care packages' workstreams. Centrally we have also designed and disseminated staff and service user posters: one to encourage staff to involve service users, and another to encourage service users to follow up with their lead professional/care coordinator if they didn't feel as involved as they wanted to be in developing their care plan.

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

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

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



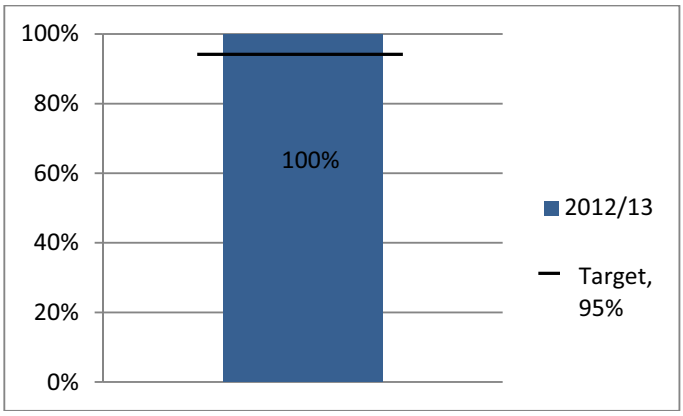
We are pleased to report that our performance improved throughout the year against our baseline target set last year. We achieved 83% at quarter four.

The quality priority was met as a considerable amount of work was undertaken in driving forward recovery focused practice across the organisation: This was underpinned by our engagement with the national Implementing Recovery through Organisational Change (ImROC Project), the rollout of the Trust Health and Wellbeing Plan and work undertaken as part of our CQUIN measures of recovery. This work included sixty-nine services from across our service lines completing Team Recovery Implementation Plans, benchmarking recovery practice in their service and agreeing action plans. Many of these were driven by the need to co-produce care plans with the service users and to ensure they reflect personal recovery as well as clinical goals. Information about personal recovery goals was produced, local presentations to teams were given and auditors trained. However, the Recovery College has offered the most influential input: Service users, their supporters and staff experience a range of recovery related training which impacts on the wider organisational culture. Together this brings about a sustainable shift to practice, and the significant improvement in recovery focused care plans is evidence of this.

Physical health

CNWL recognises the importance of assessing and seeing to the physical health care needs of its mental health service users. This is underlined by the Government's strategy 'No Health Without mental Health' which aims to improve the physical health of those with mental health conditions. This is of utmost importance as there is increasing research which suggests that the life expectancy of those with serious mental health conditions is up to 15 years lower than the average UK population.

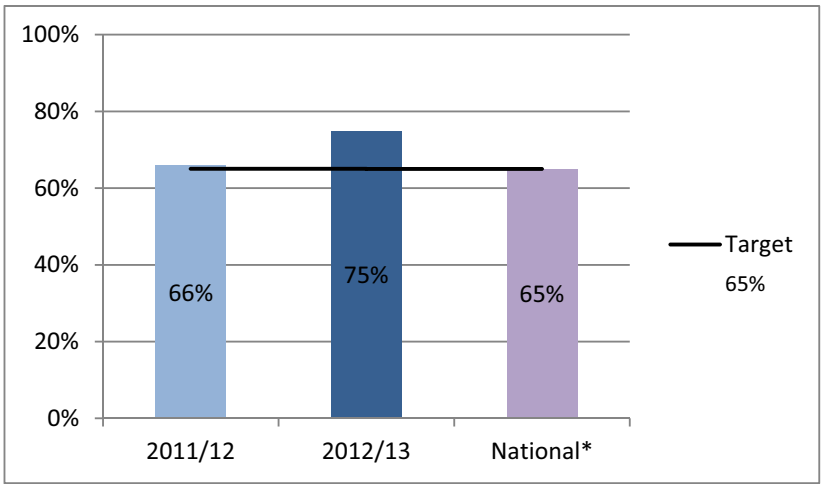
Measure A: At least 95% of service users with dementia prescribed anti-psychotic medication have three-monthly reviews, and output sent to GPs and families/patients within two weeks
Each year approximately 180,000 people with dementia receive antipsychotics in England. Of these around 1,650 result in cerebrovascular adverse events (such as a stroke)[1]. NICE recommends that this treatment is only prescribed for this frail population if non-cognitive symptoms (like psychosis and/or agitated behaviour) develop and the patient is severely distressed or at immediate risk of harm to themselves or others. It is therefore essential that our dementia patients who are prescribed antipsychotics in these circumstances are monitored very closely. We wanted to ensure the treatment our older adult service users were receiving was safe, effective and joined up with primary care. This was also a CQUIN measure for this year.



[1] The use of antipsychotic medication for people with dementia: Time for action. A report for the Minister of State for Care Services by Professor Sube Banerjee. Department of Health 2009
NICE Guidance on Dementia, 2009

We did well at this target, and achieved a quarter four result of 100%. Over the year we worked to raise awareness within our older adult service line to ensure that this practice becomes embedded. To support this, we also implemented a new system whereby service users with a diagnosis of dementia and also prescribed antipsychotics are readily identified within the service line. Once identified, there is a system to remind lead professionals when reviews are due, to follow-up that these have taken place and that the outcome has been shared with GPs/families/patients within the timescale.

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



** Source: CQC National Community Service User Survey 2012.*

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

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

We will continue to work hard to maintain and improve this good result and will monitor and report on it in our next Quality Account.

Carer involvement

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

We wanted to understand how we could better support our carers, and what support they felt they needed. We also wanted to assess what information carers wanted, and if they had the information to

access services in a crisis. Focus groups were held with different carer groups, such as young carers, carers of older people and people with learning disabilities and carers supporting someone accessing Community Recovery services. This was also a CQUIN measure for 2012/13.

Focus group outcomes
The following key themes which emerged from focus groups undertaken:

- Carers told us that they wanted more general information about services and how to access them, including better sign-posting. As a result our service lines are developing general information leaflets about the services, team or ward, to be given to services users and carers.

- Carers told us that it wasn't always clear who to contact when out of hours advice was needed. This year we launched a single contact number for the out of hours Urgent Advice Line for our service users. Concurrently we developed, in partnership with carers, Carer Contact Cards for carers supporting someone accessing adult mental health services. (See In Focus, page 30).

- Carers also told us that services needed to recognise their role in supporting service users and patients accessing our services. We will continue to develop 'family inclusive practice' across all services, which includes improved performance in identifying carers; improved recording of carer involvement in care and discharge planning; and for each service line to run two annual focus groups to hear feedback from carers about their experience of services and discuss service improvements.

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

Service pathway and access to services when in a crisis

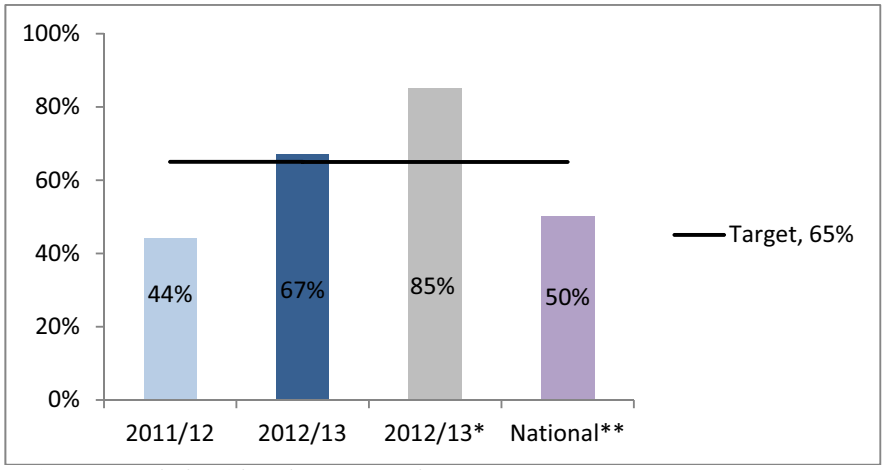
Our service pathway quality priority was about taking the first step to developing a more robust process when discharging service users to their community and care to their GP. This is to ensure that service users remain well during this transition, have their needs effectively met and supported, and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

Measure A: To establish supported discharge processes and protocols to support service users who have been discharged to primary care.
This was also a CQUIN measure for 2012/13, and we are pleased to report that we achieved the development of this piece of work. The next phase will be to implement these protocols across our services. This will be taken forward and monitored locally and progress reported to the Quality and Performance Committee.

The second part of this quality priority was to monitor whether service users were getting the help they wanted when they contacted CNWL's crisis contact points.

Measure B: At least 65% of patients reporting that they 'definitely' received the help they wanted from CNWL crisis contact points when they contacted them in a crisis

Last year we focused on ensuring that our community patients had a crisis card or a phone number to call in a crisis. While we continue to monitor this (see item 6, page 49), this year our focus was on whether service users received the help they wanted from the crisis line.



** This represents those who responded 'definitely' and 'to some extent'.*
*** Source: CQC National Community Service User Survey 2012.*

We consistently achieved this target in 2012/13, showing a good improvement from our result last year: We achieved 67% in the quarter four telephone survey. We are heartened that this is 17% better than the national average.

To gain a fuller understanding of how many of our service users felt this way we also consider those who also felt they got the help they wanted 'to some extent'. We reported 85% for these responses, which is a great improvement from last year where we achieved 64%.

We made many changes and put much effort into improving our crisis line this year. This included, based on feedback from our service users and carers, the introduction of a new out-of-hours single number crisis contact line for CNWL . We will continue to measure this next year.

In Focus: New Crisis Cards and single Out of hours Crisis Number

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

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

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

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

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

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

	Quality Priority 2012/13	Period	Target	Brent*	Harrow*	Hillingdon*	Kensington & Chelsea*	Westminster*	CAMHS	LD	ED	Addictions	Offender Care	Psychological Medicine	Q4 Trust Position
Quality priority area: Recovery and involvement															
1	At least 65% of community patients report that they were 'definitely' involved as much as they wanted to be in decisions about their care plan	Q4	65%	53%	58%	53%	64%	55%				78%			57%
2	At least 50% of service users on CPA whose care plans contain at least one personal recovery goal	Q4	50%	86%	88%	84%	73%	86%							83%
Quality priority area: Physical health															
3	At least 95% of service users with dementia prescribed anti-psychotic medication have three-monthly reviews, and output sent to GPs and families/patients within two weeks	Q4	95%	100%	100%	100%	100%	100%							100%
4	At least 65% of community service users on CPA report that they got enough advice and support for their physical health	Q4	65%	90%	50%	63%	73%	80%							75%
Quality priority area: Carer involvement															
5	Thematic review of responses via focus groups asking if carers felt supported by CNWL, and why	Q4	n/a												Achieved
6	Thematic review of responses via focus groups asking if carers had the information they needed to access services in a crisis	Q4	n/a												Achieved
Quality priority area: Service pathway and access in a crisis															
7	To establish supported discharge processes and protocols to support service users who have been discharged to primary care	Q4	n/a												Achieved
8	At least 65% of patients reporting that they 'definitely' received the help they wanted from CNWL crisis contact points when they contacted them in a crisis	Q4	65%	83%	67%	60%	100%	57%				50%			67%

*Borough data includes results from the following service lines: Acute, Older People & Healthy Aging, Recovery, Rehabilitation and Assessment & Brief Treatment

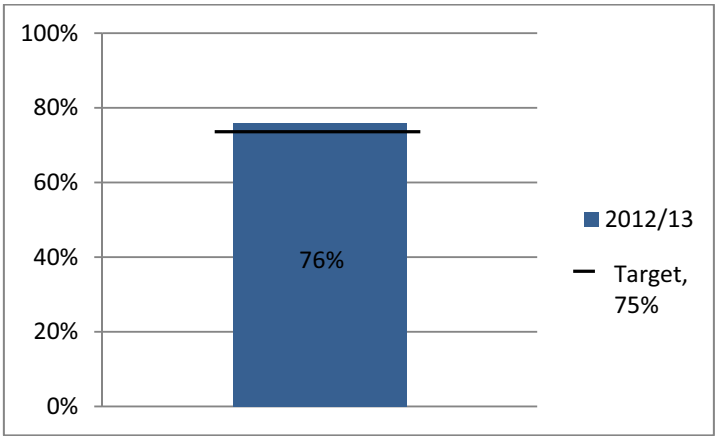
2.1.3 Our community physical and sexual healthcare services

Hillingdon Community Health

As a result of last year's quality priority stakeholder consultations, our Hillingdon Community Health (HCH) services measured quality priorities within three main areas: use of care plans, reducing the number of avoidable pressure ulcers, and improving staff awareness in relation to carers.

Use of care plans
It is important that patients who are coming to the end of their lives have an advanced care plan in place. This care plan allows patients to communicate their wishes if a time comes when they become unable to, and ensures that the needs of the patient and their families/carers are met. End of life care is a national priority, and was also a CQUIN measure for this year.

Measure A: At least 75% of end of life care patients on a district nursing caseload with an advanced care plan



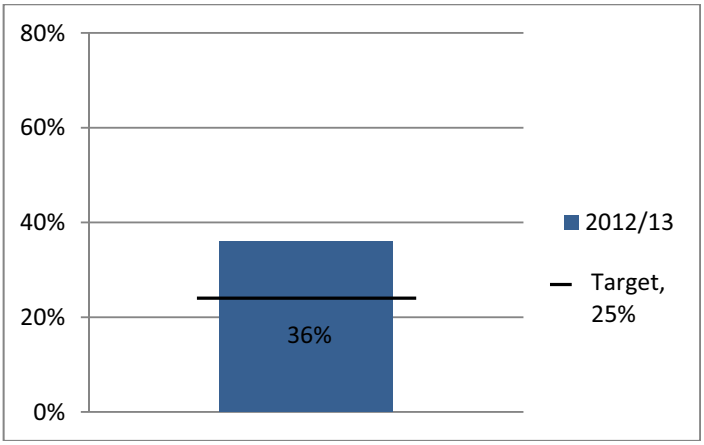
We are pleased to report that we achieved this target at month 11 (to be updated), achieving 76%.

This was achieved through the following actions: a) delivery of 'end of life' (EoL) training for staff, b) identification of a lead senior district nurse to champion EoL amongst colleagues, c) monthly meetings with relevant teams to review progress team by team and action planning, d) reviewing the existing EoL lists and the identification of those patients eligible for an Advance Care Plan for EoL (through use of prognostic indicators, and e) Advanced Care Plans put in place or recorded via 'Coordinate my care', and monthly audits undertaken. We will continue to monitor and report on this important measure internally through the coming year.

In Focus: Appreciation from relative - District Nurses
"We are writing to thank you and your staff for all their help during your nursing of our son, particularly during the last stages of his life. The attention we received whilst obtaining prescriptions for drugs and when trying to contact people was first class and very caring and it really made our lives bearable. The organisation involving you, your staff and the District Nurses was first class and is to be applauded. Thank you once again for al your help during a troubled time".

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

Patients with learning disabilities sometimes have more complex health care needs. We have done a lot of work to develop our services to more effectively see to their needs, such as better systems to identify and record learning disability patients, the roll out of a training package for staff and the evolvement of specific care planning. This quality priority is about measuring our on-going work to ensure that learning disability patients have a personalised care plan. This is a national priority and is also a CQUIN measure this year.



Our on-going focus and work in this area is improving, and we achieved above our target at 36% (at month 11, to be updated).

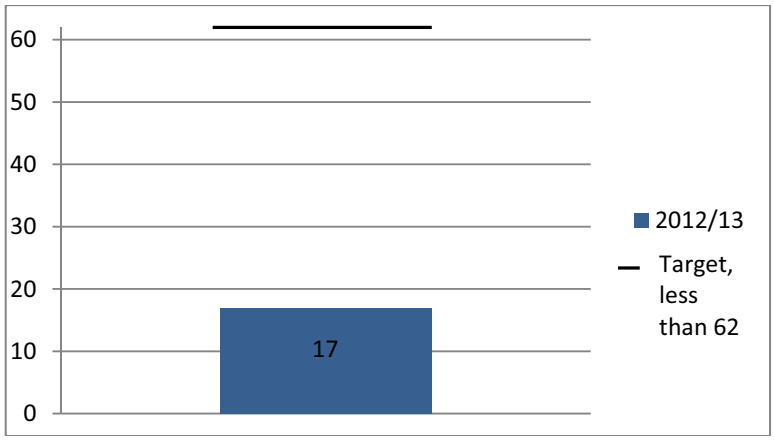
This indicator was achieved through a variety of complex actions which included the development of a standard operating procedure to ensure all staff record accurately on our electronic patient records whether a patient has a personalised care plan; information dissemination; placing an alert on our systems for all patients with a learning disability; and undertaking monthly audits to ascertain whether these patients have a personalised care plan. We want to continue to improve in this area and so we will continue this work and closely monitor this measure internally.

Reducing the number of avoidable pressure ulcers

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

We aimed to reduce the incidence of avoidable 2/3/4 pressure ulcers by 10% this year. These numbers indicate the seriousness of the pressure ulcer.

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



It is important to note that all 3/4 pressure ulcers were investigated and reported via the HCH quality governance group and clinical teams involved for action. We are pleased that our focus in this area brought the number of these avoidable pressure ulcers down to 17 (at month 10, to be updated), well below our target.

We achieved this reduction by developing a register of all patients with or at risk of developing a pressure ulcer within each of our district nursing teams; ensuring daily handover of all vulnerable patients, and escalation where needed to GP or the tissue viability team; completing root cause analysis investigations for all reported grade three and four pressure ulcers to identify actions and learning for sharing at team meetings; and pressure ulcer training undertaken for our district nursing teams. We worked hard to achieve this good result and will continue to monitor this internally throughout 2013/14.

In Focus: CNWL has a Complex Wound Treatment Centre (CWC)
The CWC aims to provide care closer to people's home for patients with chronic wounds preventing secondary care episodes when appropriate, and provide in-house training to staff in Hillingdon in the management of complex wounds. In June 2012 the team developed an outreach clinic (ORC) in Oak Farm Clinic, Uxbridge, and offering complex wound care weekly by a designated Tissue Viability Nurse (TVN). The clinic allows patients living in the local area easier access to specialist services. Patients are seen for assessment and a care plan outlined together with the patient and GP. Patients are seen for shared management within the Ambulatory Wound Clinic (AWC) at Oak Farm. The service has improved communication and education and provides a seamless service for patients with complex wounds. The close partnership working has improved outcomes for patients.

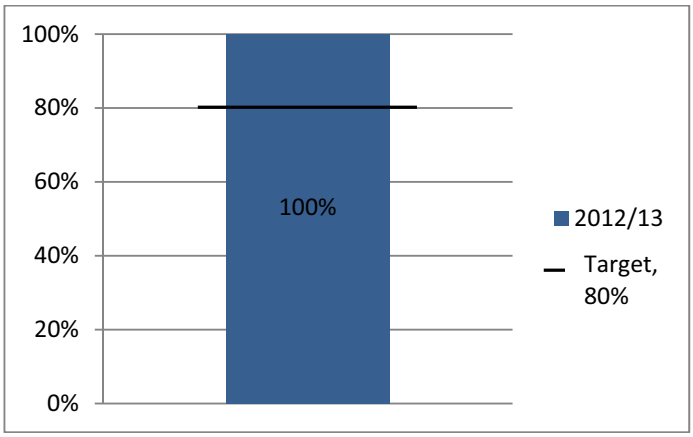
Improving staff awareness in relation to carers

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

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

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

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



We set a high target for ourselves of 80% and we are proud to report that this was achieved. At month 11, 100% of our carers were given information on the safe use of their wheelchair, and provided training where they required it.

Our actions included sourcing and obtaining appropriate wheelchair information for carers; undertaking an audit of new referrals to the service who received carer information; staff training on recording the provision of information leaflets; the offer for further training to carers; and the development of a user training programme for carers to be tailored for individual training sessions with patients and carers.

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

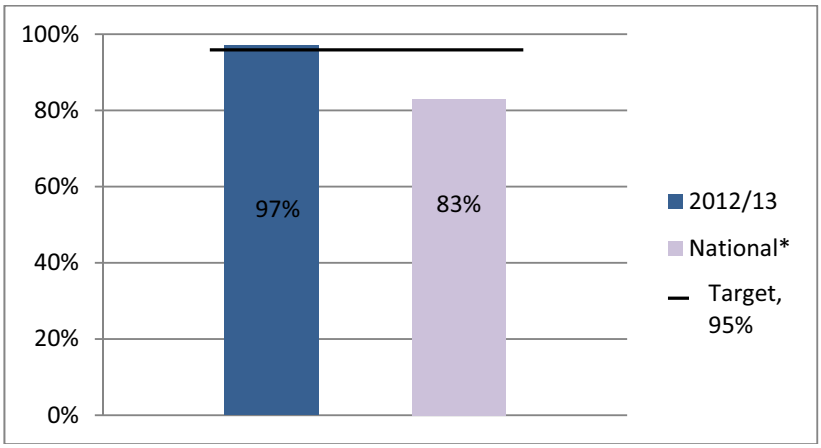
Camden Provider Services

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

Clinical quality in our HIV services

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

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

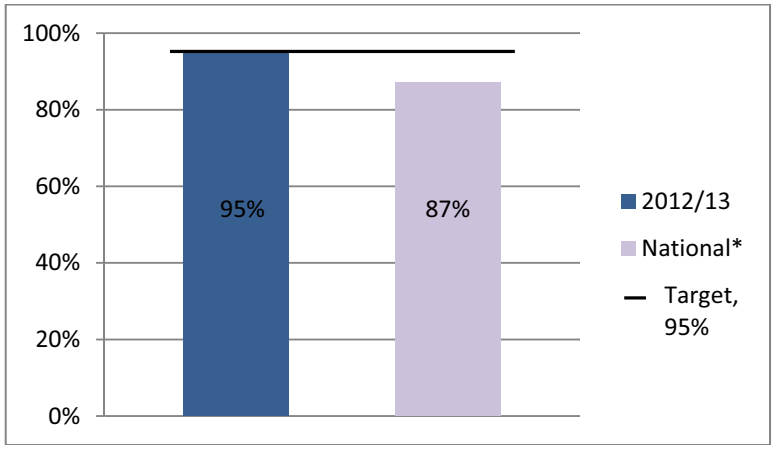


** Source: Health Protection Agency, November 2012. Data for those maintained at a CD4 count greater than 350*

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

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

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



** Source: Health Protection Agency, November 2012*

This measure indicates how well the infection is monitored and controlled once treatment has begun. Viral loads less than 50 copies/ml, deemed 'undetectable', ensures that the damage the infection can have to the immune system and other organs is kept to a minimum and that the patient is much less infectious. We therefore monitor this very closely.

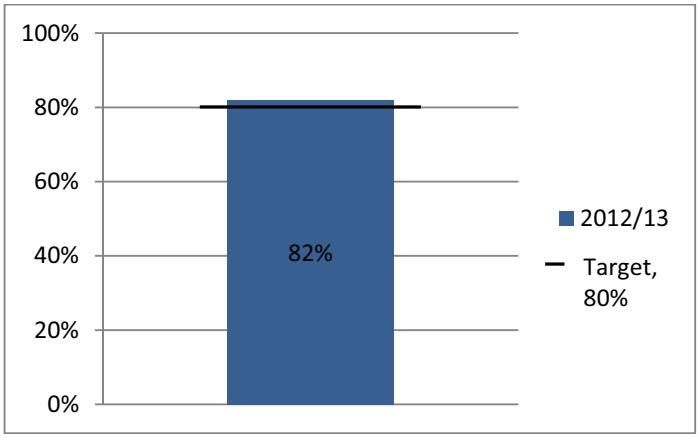
At quarter three we met the target, achieving 95%, and out-performed the national average of 87%. This again is due to our electronic filtering system which automatically flags to clinicians when a patients' viral load is no longer undetectable while on treatment. This can then be appropriately managed as soon as possible.

Both these measures are vital in monitoring patient safety and effectiveness of the treatment provided within our sexual health services and will be reported on throughout the next year, and in our Quality Account.

Patient experience

Measure A: At least 80% of patients with an appointment with sexual health services, who arrive on time, are seen within thirty minutes of the appointment time

Our sexual health services can be very busy, dealing with 'walk-in' patients as well as those who have scheduled appointments. We wanted to ensure that this is being effectively managed and that those who arrive on time with an appointment do not have to wait long.



Our performance at month 10 (to be updated) was 82%, so we met our target.

It is important to note that appointment numbers were higher than ever for our sexual health services. For example, Mortimer Market Centre saw an increase in 11% in activity levels compared to the same period in the previous year.

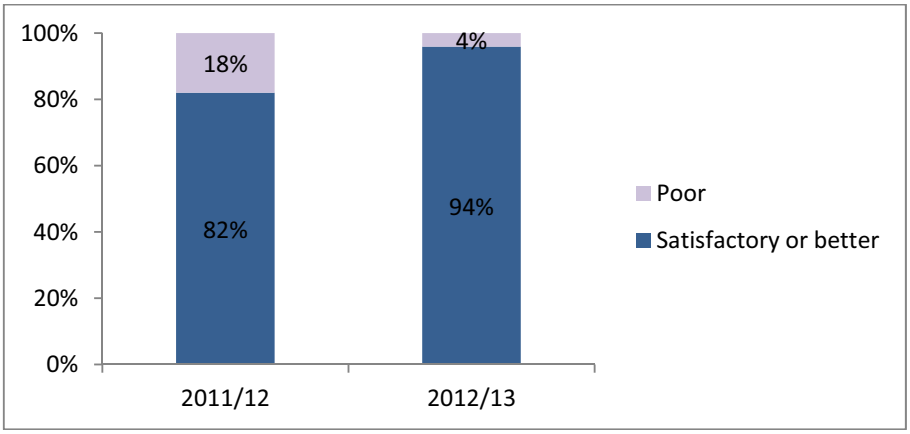
In order to ensure we continue to meet this target we are:

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

We would like to improve our performance further in this area, and so we will continue to monitor this on a monthly basis throughout next year. Our year end performance will be reported in next year's report.

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

Last year a patient survey indicated some concern regarding the responsiveness to the call bells on the inpatient wing. This year we set ourselves the challenge that by year end we would have no responses stating that responsiveness was 'poor' in subsequent surveys. Unfortunately we received six 'poor' responses, and so did not meet this target. However, for context, the graph below shows the results are overall good, and improved from the previous year.



The graphs show that this year 96% of patients (154/160) rated the response to call bells as satisfactory or better. This represents a significant improvement when compared with 2011/12 where this figure was 82% (204/248). Call bell response was measured as part of the Inpatient Exit Questionnaire on a quarterly basis. Following comments from patients regarding delayed response to patient hand-held call bells, an electronic system was put in place in June 2012. A snapshot audit of response times was undertaken in October covering response times over a 24 hour period. Results indicate that the electronic system encourages a prompt response from staff. In tandem with this work a questionnaire on patient perception regarding call bell response times was planned for March 2013 in order to compare the empirical data that is collected via the electronic system with patient experience.

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

2.2 Our Quality Priorities for 2013/14

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

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

It is important to note that these are not the only indicators of quality we monitor and our work is not limited to delivering against these. To this end we have included 'Did you know' good news stories to give you further understanding of the varied and innovative work we are doing to enhance the core values of quality services: a safe and effective service, which our services users and carers are satisfied by.

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

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

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

- Our performance against our current quality priorities and other quality indicators throughout the year;
- Our organisational learning themes;
- Our feedback from consultation with our stakeholders.

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

Organisational learning themes
Our organisational learning themes are an important source for identifying areas for improvement within the Trust as these are identified through analysing and 'triangulating' data from complaints, claims, PALS, incidents, staff and patient survey and clinical audit.

Our organisational learning themes from 2011/12 were:

MHAS	COMMUNITY
Involvement, communication & information sharing with users, carers and professionals	Reduction in falls
Managing transitions in care pathways	Reduction in transfer & discharge issues with outside organisations
Physical health in a mental health context	Reduction in avoidable pressure ulcers
Policies & procedures, better understanding, better compliance, safer patients	Reduction in medication administration issues
Protecting staff from violence	Reduction in waiting time s for District Nurse visits (HCH)
	Reduction in complaints about wheelchair supplier (CPS)

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

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

Consultation with stakeholders

We value the views of our stakeholders and proactively facilitate engagement and partnership with them. This year we aimed to strengthen our working relationships further with our LINks: We hosted quarterly Public Engagement Meetings to feed back to them our progress against our quality priorities, other quality indicators, associated action plans and organisational learning themes. These forums were also to begin discussions and hear back from them what it was felt CNWL's quality priorities should be for the next year.

Throughout December 2012 and January 2013 we hosted a further programme of quality priority consultation workshops with our staff, service users, carers and Council of Governors. Here we shared similar information to inform discussions and feedback. Key messages from each group were collated and analysed for consistency in emerging themes.

Key messages

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

Stakeholders felt that CNWL should reduce and consolidate our current quality priorities to allow for further focus, embedding and improvement of current quality priorities, rather that develop a brand new

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

Regarding the quality priorities, we consistently heard that these should be developed around three key areas: care planning, carer involvement and support, and service satisfaction.

Our discussions throughout the year culminated in the all-stakeholder consultation event which was held on 7 March 2013. Here our draft quality priorities for 2013/14 were presented for further feedback and refinement. It was attended by over 50 delegates and was held for representatives from LINks, service users, carers, Council of Governors, commissioners, GPs, Overview and Scrutiny members, staff and the Chair of our Board. Each stakeholder group was given the opportunity to feed back their views, share stories and network. The event received very positive reviews with one anonymous service user requesting more events like these as "they have given service users more hope and reminded the staff members why they work here and what it is all for".

Specifically, key themes from our discussions on the day included:

- Stakeholders valued CNWL's ambitions for culture change towards one of 'partnership', 'personalisation' and 'hope'; where both service users and carers are part of the on-going care planning process; however, that this does not solely focus on their needs/wants and ignores the full spectrum of need, risk and safeguarding;
- Access to information and resources: knowing what services are available to service users and carers, and how these can be accessed, with one stakeholder stating "I have a problem seven days a week, not nine to five";
- To assess service satisfaction through eliciting the qualitative feedback – the understanding of the rationale for responses, as well as the context of the responded, for example, how long ago they were discharged, provides far richer and useful feedback for service development;
- That our quality priorities utilise a universal language which is used and understood by all services, service users and carers.

The feedback from this event helped inform the final quality priorities for 2013/14 as are shown over the next few pages.

The following section also introduces Milton Keynes Community Health Services, and describes their quality priorities for 2013/14, how they were developed, and how they will be monitored and reported on in 2013/14.

2.2.1. CNWL quality priorities 2013/14

Priority 1: Care planning

CNWL continues to develop and embed the new 'culture' of a recovery approach to care. Recovery and involvement have been strong themes during this and previous years' quality priority consultations. It also forms part of the NICE quality standard for service user experience, and is recognized in national policies.

Key to achieving our recovery goals is the involvement of our service users in the creation of their care plan, thereby developing ownership of their goals and treatment. To this end we want to make sure that all our patients are offered a copy of their care plan and report feeling involved in decisions about their care.

Our priorities for this year

Measure	Target 2013/14	Target 2012/13	New measure this year	Measure same as last year but sample extended	Is a CQUIN for 2013/14
1A. Patients report being *'definitely'* involved as much as they wanted to be in decisions about their care plan *	65%	65%		Y	
1B. Inpatients and community patients have been offered or given a copy of their care plan	95%	95%			
1C. Community (physical) health patients have an agreed care plan	95%	-	Y		

* Responses possible include 'yes, definitely', 'yes, to some extent', or 'no'

Why have we set these priorities?
Fundamental to developing a collaborative, recovery-focused approach is to assess service users' satisfaction with how involved they felt in the creation of their care plan. Based on our quarter four result from 2012/13 it is clear that this needs to remain a priority, and so agreed that it will roll-forward, and will be extended to our community physical health services, for which it is a new measure. Measure 1A represents a challenge which we set ourselves – to gain more than 65% of respondents reporting 'yes, definitely' to the question.

Measures 1B and 1C apply to mental health and allied specialties and community physical health care services respectively. In further developing themes of recovery and partnership, each is aimed to assess whether service users have and were offered a copy of their care plan. Measure 1B is a quality indicator monitored by our mental health and allied specialty services currently, and one which has shown need for improvement. As such it has been carried forward as a quality priority for 2013/14. Measure 1C is a new measure for our community physical health patients.

How are we going to achieve and monitor them?
Measure 1A will be measured via a quarterly telephone survey. Our telephone surveys are carried out by trained service users to service users, and on average make around 2500 calls a survey, with a response rate of approximately 20%. For some of our service users for whom telephone surveys are difficult we will use focus groups to understand their experiences. As an organisation we believe that we need to go

beyond measuring our processes. We also focus on outcomes and so we continue to use patient-reported experience measures as extremely valuable in obtaining a view of our quality of services. Measures 1B and C will be measured by audit via our internal electronic systems.

Data will be reported via our integrated dashboard, fed back to service lines for action planning, and reviewed and scrutinised by our internal committees, as detailed at section 2.3.

To ensure these measures are achieved, action will be two-pronged:

- Our staff will continue to be trained in embedding the recovery approach into work practices; and made aware of the need to log on the system when they have offered a service user a copy of their care plan. Posters promoting these messages are being disseminated to all our front-line staff areas, and posters prompting service users to request information are being disseminated to all patient areas across the Trust.
- Service lines will be provided with individual service user details for local services to put things right for: building quality on a patient by patient basis.

Our approach to embedding good clinical practice is multi-pronged:

- We continue to develop systems and processes that make it easier to prompt our staff to complete certain actions as well as act as useful communication between clinicians and teams, and encourage service users to request information they may not have had. For example the development of posters promoting key messages of good practice to both staff and service users;
- We continue to provide training and education using a variety of approaches – from our in-house Recovery College to one-on-one mentoring;
- We continue to embed staff appraisal and clinical supervision to help develop good clinical practice;
- Our approach to the achievement of our quality indicators also includes what we call 'building quality one patient at a time'. This means that where our clinical audits and patient surveys indicate quality has been lacking for specific patients, we report this data to the teams responsible so that they can put things right.

In Focus: CNWL has an established Recovery College

CNWL's Recovery College launched in April 2012 and is the third college of its kind to be developed in the UK. The college follows an adult education model and delivers a responsive, peer-led learning and development curriculum of recovery focused courses. The college promotes opportunities for the recovery and social inclusion of people with experience of mental illness. All courses are designed to re-skill and assist students to grow in the way they want to, to have a say in what works for them, to have a voice, to be heard, to have choices and to have control in their recovery journey. One student has said 'The course has given me food for thought… It's OK for me to know what I would like in terms of my recovery and to be more assertive or resourceful about achieving this'.

CNWL's Recovery College is run by staff with lived experience of mental health problems and mental health practitioners, co-producing and co-delivering all the courses in recognition of the value of both types of expertise. It is open to people who use services, their supporters and CNWL staff. This joint learning environment helps to break down the barriers between 'them' and 'us' that can perpetuate stigma and exclusion.
So far the college has sucessfully completed 3 terms, 554 individual students have attended, 415 of whom were people who use services, 21 carers and 118 staff. In total there were 2,020 attendances. Courses are currently offered across five London boroughs that the Trust provides services and is developing Recovery College 'spokes' across all service lines. (Syena Skinner, Manager CNWL Recovery College)

Priority 2: Carer involvement

Identifying carers and involving them as partners in care is a priority for CNWL. We continue to work with carers and carer organisations to further enhance and develop our knowledge and understanding of the various roles that carers provide when supporting service users accessing our services. With the provision of Community Health services in Camden and Hillingdon, we need to better understand the needs of carers supporting individuals accessing the various community health services provided, as we continue to introduce carer-inclusive practice across all service lines.

In addition to the work we have already undertaken through surveys and focus groups, we have established a Carers Council, chaired by a Carer Governor, to oversee carer developments across the Trust. The Carer Council established three priorities for the coming year, which are: Identifying Carers; Carer Support and Assessment; and staff training, all of which underpin carer inclusive practice.

Our priorities for this year

Measure	Target 2013/14	Target 2012/13	New measure this year	Measure same as last year but sample extended	Is a CQUIN for 2013/14
2A. Patients have their 'carer status' identified	70%	55%		Y	
2B. A thematic review of the feedback from carer focus groups/surveys when asked 'Did/Do you feel supported by CNWL staff', to inform action plans for improvement	Identification of key themes from responses to inform action plans	Identification of key themes from responses to inform action plans		Y	

Why have we set these priorities?

Early identification of carers, providing carers with information and signposting to additional support is a key part of carer involvement for CNWL. 'Carers' are family members or friends providing support to a patient/service user accessing our services, and by identifying carers, establishing the 'carer status', we continue to recognise the invaluable role of carers and involve them as partners in care.

Carers' early identification and involvement are also key to ensuring that the carers' own health and wellbeing are not adversely affected by the support they provide. We will continue to work with our partner organisations to ensure that carers access services available to them.

An important element to carer involvement is hearing directly from them about their experiences, to enable us to continue to develop our services and improve the carer experience. This year we ran a number of carer focus groups to hear from carers about their experiences of services. These groups included young carers, carers from BME communities, carers of older people and for someone with a learning disability, and carers supporting someone accessing the Community Recovery services.

A strategic collaboration between CNWL and Lancaster University's Spectrum Centre will provide the Trust with a unique opportunity to review and research carer involvement in mental health care. This collaboration will involve a review of current practice, interviewing carers, service users and staff on issues

relating to carer involvement. Expected outcomes from this project include better knowledge and understanding of how to gather information on carer experience; improved access to and knowledge of services for carers during a crisis; further development of Recovery College courses to benefit carers and improved carer inclusive practice.

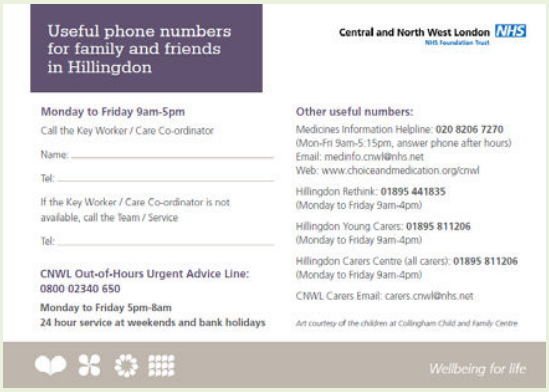
This measure is a new measure for our community physical health services.

How are we going to achieve and monitor them?
Measure 2A will be collected quarterly via clinical audit of our computer systems for a sample of patients from across our services. This information will feed our integrated dashboard and be fed back to services to put right, and to produce local actions to ensure that where patients do or don't have a carer, that this is routinely noted.

Measure 2B is to be assessed via a programme of focus groups and surveys twice a year. A review of the qualitative data will result in key themes for the Trust to better understand carer expectations, and better able to deliver against these to ensure carers feel supported by CNWL staff.

Data will get reported via our integrated dashboard, fed back to service lines for action planning, and reviewed and scrutinised by our internal committees, as detailed at section 2.3.

In Focus: We have developed Carer Contact Cards
We heard from our Carer Focus Groups that carers wanted the contact numbers of whom to contact if their family member or friend is in crisis. As a result, and with the development of the new Urgent Advice Line, we have designed and produced new Carer Contact Cards. These were created in partnership with carers, and are for those supporting someone accessing adult mental health services when they need it most. The contact cards were rolled out across our services in April 2013.



Priority 3: Satisfaction with the services we provide

This is a new quality priority for the Trust and represents a key message received through our stakeholder consultations.

Our priorities for this year

Measure	Target 2013/14	Target 2012/13	New measure this year	Measure same as last year but sample extended	Is a CQUIN for 2013/14
3A. Service users response to the question 'How likely are you to recommend CNWL services to friends and family if they needed similar care or treatment?' *	Baseline set Q1; with an improvement by Q4	-	Y	-	
3B. Overall, how would you rate the care you have received from CNWL services in the last 12 months? **	Baseline set Q1; with an improvement by Q4	-	Y	-	
3C. A thematic review of the follow-up question 'Please can you tell us the main reason for the score you have given?' to inform action plans for improvement	Identification of key themes from responses to inform action plans	-	Y	-	

* Applicable to Community (physical) health services (HCH and CPS); responses possible include 'extremely likely', 'likely', 'neither likely nor unlikely', 'unlikely', 'extremely unlikely' or 'don't know'
** Applicable to Mental Health and Allied Specialties (MHAS); responses possible include 'very good'/'good'/'fair'/'poor'/'very poor'

Why have we set these priorities?

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

It is important for us to understand how satisfied our service users are with the care they receive; both to share and develop good practice across the Trust where things are working well, as well as to make changes and innovate in areas which are not working as well. These may be service-wide or team-specific recommendations.

We also would like to use a measure which has been nationally recognised and tested for validity: The Department of Health's (DoH) roll out of the Friends and Family test (to acute services from April 2013) provides a simple and comparable test which, when combined with further follow up questions, provides robust information for the Trust to use. This will be used for our community physical health surveys in Hillingdon and Camden, and reflects one of Milton Keynes Community Health Services' quality priorities. Measure 3B, also featuring in the national patient survey, will be applied to our mental health and allied specialty services.

How are we going to achieve and monitor them?
Data for these priorities will be collected via telephone surveys and focus groups on a quarterly basis.

As these are new measures for our services, data collected in quarter one will act as our baseline which we will aim to exceed by quarter four.

In order to score how we have achieved against measure 3A, we will adopt the 'net promoter score' which is considered by the DoH to be the most effective at delivering the benefits from this measure. In summary it means the proportion of patients who would 'strongly recommend' the service minus those who would 'not recommend', or are 'indifferent'. Measure 3B performance will be calculated by including those who rate services as 'good' or 'very good'. Finally, measure 3C represents a follow-up question to understand the reasons service users have responded in a particular way. This qualitative data will be reviewed for common themes and further inform where actions are needed.

Data will get reported via our integrated dashboard, fed back to service lines for action planning, and reviewed and scrutinised by our internal committees, as detailed at section 2.3.

In Focus: Appreciation from relative - District Nurses

"We are writing to thank you and your staff for all their help during your nursing of our son, particularly during the last stages of his life. The attention we received whilst obtaining prescriptions for drugs and when trying to contact people was first class and very caring and it really made our lives bearable. The organisation involving you, your staff and the District Nurses was first class and is to be applauded. Thank you once again for al your help during a troubled time."

2.2.2 Introducing Milton Keynes Community Health Services

In December 2012 it was announced that CNWL had successfully bid to merge with Milton Keynes Community Health Services. CNWL formally welcomes colleagues from MKCHS on 1 April 2013. This represents a great opportunity for both organisations to pool their strengths and share learnings and resources to enhance the quality, safety and effectiveness of their healthcare services.

Milton Keynes Community Health Services (MKCHS) provides a wide range of NHS community and mental health services, including intermediate care, community equipment and learning disability services. In summary MKCHS:

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

MKCHS prides itself in providing high-quality health and social care services, tailored to the needs of individuals and delivered close to home. The Trust has experienced year-on-year improvements in staff survey results, with 9/10 service users stating they would recommend MKCHS to a relative or friend, and approximately 60% of residents rating Milton Keynes as having 'joined-up community and social care services' (20% higher than in other parts of the country).

2.2.3 MKCHS quality priorities 2013/14

MKCHS followed their own programme of consultation with their stakeholders to develop their Quality Priorities for the next year. Stakeholder engagement developed throughout the year via certain key meetings and committees. Specifically, leading up to the finalisation of MKCHS' quality priorities for 2013/14, consultation with the following groups took place:

- LINks Patient Participation Group
- LINks Quality Account presentation
- Commissioner Quality Review Group meeting,
- MKCHS Senior Managers Workshop
- Patient Experience Strategy Working Group Campaigns sign off meeting
- Health Overview & Scrutiny Committee presentation

MKCHS identified the following three Quality Priorities for 2013/14:

Priority 1: Transfer of Care
When people transfer from one clinical setting to another, we need to have effective systems in place to ensure that they are transferred safely. This is of particular importance for some of our most vulnerable service users who need complex arrangements to be put in place involving many different health and social care professionals.

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

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

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

- **Measure 1A)** MKCHS will forward 100% Transfer of Care incidents reported by our staff to the relevant organisation for investigation within one week;
- **Measure 1B)** The proportion of Transfer of Care incidents originating from MKCHS, that result in moderate or major harm or death, will fall to below 15% of the total by August 2013, to below 10% of the total by October 2013, and to below 5% of the total by year end.

Why have we set these priorities?
The nature of transfer of care incidents and their impact on service-users and carers in Milton Keynes is well understood through rigorous analyses of incident trends and complaints. Poor transfer of care affects:

- The safety and wellbeing of service users;
- Access to appropriate and timely treatment, care and rehabilitation;
- Service user and carer confidence in local health services;
- Relationships between service users and health care professionals and between staff in different settings.

Although this is not a national or local CQUIN, it is of high importance to the people of Milton Keynes.

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

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

Priority 2: Responsiveness to patient needs and improving patient experience

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

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

A further measure of patient experience is gathered via the 'Friends and Family (net promoter) test'. This asks all patients who have been discharged from an in-patient setting if they would recommend the service to their friends and family. At present this is only compulsory for acute hospitals to complete.

In 2012/13 our commissioners set a quality (CQUIN) target using this tool which solely focused on discharged inpatients. However, the majority of our community patients remain with us indefinitely owing to the nature of their health problems. For this reason we decided to target a percentage of each service's caseload in order to get a benchmark to work from, enabling us to collect standardised data across the whole of the organisation.

Our priorities for this year

- **Measure 2A)** Responsiveness to 'inpatient' needs: To improve on MKCHS Mental Health Services 2011/12 score based on the CQC national in patient survey for responsiveness to patient needs; and exceed the national average for this measure;
- **Measure 2B)** Friends and Family test (net promoter): To deliver the Friends and Family test across all MKCHS services (including discharged inpatients, and a sample of our community caseload), and achieve a year-end position within the top 50% of the national result;
- **Measure 2C)** Friends and Family test national staff survey results: To improve on the 2012 national staff survey result of 3.76/5 for this measure in the 2013 national staff survey.

CQUIN

The Friends and Family test is not a national CQUIN for community, learning disabilities or mental health providers, however MKCHS have committed to progress this agenda, knowing that in 2014/15 it will be come a requirement. By continuing to collect this data we will be able to benchmark progress against local and national NHS organisations.

Why have we set these priorities?

At the heart of the NHS Constitution putting the patient first is a priority. Over the years we have built on this overarching value and principle and are seeing real and positive changes in the way we deliver services. This has increased not only patient satisfaction but the satisfaction and pride of our staff in the services and care they deliver. We understand that improvements should be continuous and this agenda is still evolving. There is still much to do and it will be important to continue the momentum already achieved. The listed targets will enable us to further demonstrate and embed a culture of putting the patient first.

How are we going to achieve and monitor them?
We will continually monitor patient experience feed back through a variety of methods; patient stories, complaints, locally agreed patient experience campaigns, focus groups, family and friends test, and the national patient and staff surveys.

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

Priority 3: NHS Safety Thermometer - Organisational ambition of zero 'avoidable' pressure ulcers

The NHS Safety Thermometer is a national tool that was developed for acute hospital settings.
This tool has now been included in the National CQUIN targets for all NHS organisations (apart from Ambulance Services) and is use to monitor falls, urinary infections in patients with catheters, pressure ulcers and venous thromboembolism (blood clots).

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

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

Our priorities for this year

- **Measure a)** MKCHS to undertake a survey once a month using the NHS Safety Thermometer tool;
- **Measure b)** MKCHS to improve on the 2012/13 baseline data for collection of pressure ulcer data;
- **Measure c)** MKCHS to achieve a year end baseline for the number of recorded avoidable pressure ulcers to be measured against in the following year.

CQUIN
Compliance with the NHS Safety Thermometer is a requirement for MKCHS as a national CQUIN.

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

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

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

2.3 Monitoring and sharing how we perform

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

We monitor our performance against our national indicators and current and previous quality priority measures on a monthly and quarterly basis.

Data against these measures is collected in a variety of ways including both quantitative and qualitative methods, outcomes/patient reported and process information, to provide us with the most rich and informed picture of quality.

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

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

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

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

We are also a member of Prescribing Observatory for Mental Health (POMH-UK). CNWL undertakes clinical audits as part of a national programme relating to medicine prescribing and side effect monitoring in order to benchmark ourselves against other Trusts providing mental health services. Where areas for

improvement are identified, the actions are agreed with our services and performance monitored via the appropriate committee or service to ensure that improvement is made.

Reporting our performance

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

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

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

2.4 Statements relating to quality of NHS services provided

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

2.4.1 Services

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

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

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

Where we provide our seven NHS services:

	Mental health services			Other services					
	Adults	Older Adults	Child & Adolescent	Eating disorders	Learning disabilities **	Addictions	Offender Care	Sexual Health	Community (physical) Health services
Brent	Y	y	Y	Y	Y	Y	Y	Y	-
Harrow	Y	Y	Y	Y	Y	Y	Y	-	-
Hillingdon	Y	Y	Y	Y	Y	Y	Y	-	Y
Kensington & Chelsea	Y	Y	Y	Y	Y	Y	Y	-	-
Westminster	Y	Y	Y	Y	Y	Y*	Y	-	-
Camden / Islington	-	-	-	-	Y	Y	-	Y	Y
Enfield	-	-	-	-	Y	-	-	-	-
Hounslow	-	-	-	Y	-	Y	-	-	-
Ealing	-	-	-	Y	-	Y*	-	-	-
Hammersmith & Fulham	-	-	-	Y	-	Y	Y	-	-
City of London	-	-	-	-	-	-	Y	-	-
Surrey	Y	-	-	-	-	-	Y	-	-
Kent	-	-	-	-	-	-	Y	-	-
Barnet	-	-	-	-	-	-	Y	-	-
Hampshire	-	-	-	-	-	-	Y	-	-

*In partnership **Referrals accepted nationwide and includes Offender, Diversion and Treatment services

2.4.2 Participation in clinical audit

During 2012/13 four national clinical audits and two national confidential enquiries covered relevant health services that CNWL provides.

During 2012/13 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 2012/13 are as follows:

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
- National Cardiac Arrest Study
- Sentinel Stroke National Audit Programme (SSNAP)
- Prescribing in mental health services (POMH)
- National audit of psychological therapies (NAPT)
- National Parkinson's Audit

The national clinical audits and national confidential enquiries that CNWL participated in during 2012/13 are as follows:

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
- National Cardiac Arrest Study
- Sentinel Stroke National Audit Programme (SSNAP)
- Prescribing in mental health services (POMH)
- National audit of psychological therapies (NAPT)
- National Parkinson's Audit

The national clinical audits and national confidential enquiries that [name of provider] participated in, and for which data collection was completed during 2012/13, 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)	94.9% (for period January 2006 to January 2012)
National Cardiac Arrest Study	No cases requiring submission during the 2012/13
Sentinel Stroke National Audit Programme (SSNAP)	None submitted to date - data collection for the clinical component of SSNAP began in December 2012. Arrangements are being put in place to gather and submit the required data

Prescribing in mental health services (POMH) • Prescribing for people with a personality disorder • Screening for Metabolic Side Effects • Prescribing Antipsychotic Medication for people with dementia • Prescribing for Attention Deficit Hyperactivity Disorder (ADHD) in children, adolescents and adults	• 89 cases submitted • 57 cases submitted • 454 cases submitted • Data collection ongoing as at 31st March 2013 (No set number required - audit sample determined by Trust)
National audit of psychological therapies (NAPT)	Not available at 31st March 2013. NAPT are currently cleaning the data for analysis and reporting late in 2013
National Parkinson's Audit	100 cases submitted (HCH)

The reports of five national clinical audits were reviewed by the provider in 2012/13 and CNWL intends to take the following actions to improve the quality of healthcare provided:

- **National Schizophrenia Audit:** The audit results have been discussed at the Trust's NICE Group and Medicines Management Group. The NICE Group have asked that the Physical Health Steering Group consider the report with regard to the standards relating to physical health monitoring. The results have also been disseminated to the Recovery service line and Older People and Healthy Ageing Service Line, as well as presented though the academic programme.

- **POMH-UK Audit Topic 12a: Prescribing for people with a personality disorder:** This is a baseline audit aim at addressing prescribing for people with a personality disorder. The audit results have been circulated through local Care Quality Meetings and the trust's Medicines Management Group. Teams are required to respond to the audit and formulate an action plan to address any gaps in service provision.

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

- **POMH-UK Topic 11b: Prescribing Antipsychotic Medication for people with dementia Audit.** This is a follow up audit to the baseline audit undertaken in 2009. The audit results show that 5% (nationally: 13%) of patients were prescribed antipsychotics for dementia without co-morbid psychotic illness. The audit report has been circulated to the Older People and Healthy Ageing Service and an action plan is being drawn up by the service line to address gaps identified and ensure continued good practice in areas where standards have improved.

- **National Parkinson's Audit Report 2011 (published May 2012).** Camden Provider Services submitted data for the Occupational Therapy, Physiotherapy and Speech and Language sections of the audit. (To be updated with actions)

The reports of approximately 270 local clinical audits were reviewed by the provider in 2012/13 and CNWL intends to take the following actions to improve the quality of healthcare provided:

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

Sexual Health & HIV Services
Audit title: Genito-Urinary Medicine Audit - BASHH Guidelines for Gonorrhoea Management
Actions:

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

Camden Community Services
(Examples to be updated)

Hillingdon Community Health
Audit title: Cold Chain Monitoring Audit 2012
Actions:

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

Audit title: District Nursing deaths at home and in preferred place of care
Actions:

- The service plans to undertake another audit in 2013/2014 to capture how many patients were known to the service but were not identified on the end of life register. This will enable identification of educational gaps;

- To continue to capture how many patients with a non-malignant diagnosis are identified by teams and placed on the End of Life register.

Mental Health and Allied Specialties

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

Actions:

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

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

Actions:

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

Audit title: Acute Inpatient Service (Mental Health) Bank and Agency Audit

Action:

- Regular acute bank and agency audits that the Acute Service Line have undertaken has reduced their agency spend.

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

Action:

- Implementation of a project considering the referral pathways into the Acute Service Line for known patients as a joint project with acute bed management and psychiatric liaison to try and reduce re-admission by known patients.

Audit title: Missed Dose & Prescription Chart Audit – HMPYOI Feltham

The audit results show that there has been overall improvement from the previous audit, particularly in the following areas;

- Documentation of allergy status has improved since the last audit;
- Blanks on administration recording have improved;
- Missing photo ID has improve;
- Better documentation of the immunisation section on the charts.

2.4.3 Research

The number of patients receiving relevant health services provided or sub-contracted by CNWL in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 1445.

Throughout the year the Trust has been involved in 66 studies 56 funded of which 3 were commercial trials and 10 unfunded.

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

In Focus: Introduction of CNWL does Pharmacy Clinical Trials

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

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

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

2.4.4 Goals agreed with commissioners

A proportion of CNWL income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between [name of provider] and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at: **[website tbc]**

Last year (2011/12) CNWL achieved 96% of its CQUIN goals, securing the total CQUIN income of £5.8million**.**

For 2012/13, CNWL's CQUIN income equates to approximately £6.2million. Achievement against this was unconfirmed at the time of printing and will be reported next year.

2.4.5 What others say about the provider

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 2012/13.

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

CQC Reviews of Compliance:

Location	Outcome of Review	Progress with actions
South Kensington &Chelsea Mental Health Centre	Fully compliant with CQC Essential Standards assessed	None required
Woodfield Road	Fully compliant with CQC Essential Standards assessed	None required

Rosedale Court	Fully compliant with CQC Essential Standards assessed	None required
South Wing, St. Pancras Hospital	Fully compliant with CQC Essential Standards assessed	None required
Max Glatt Unit, SK&C Mental Health Unit	Not compliant with *Outcome 13: Staffing*	An action plan has been devised and a report on progress with the actions has been submitted to the CQC
HMP Young Offenders Institute Feltham	Fully compliant with CQC Essential Standards assessed	None required
North Westminster Recovery Team	Fully compliant with CQC Essential Standards assessed	None required

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

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

2.4.6 Data quality

NHS Number and General Medical Practice Code Validity
CNWL submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS Number at quarter four 2012/13 was:
94.9% for admitted patient care;
99.5% for outpatient care; and
N/A for accident and emergency care.
The percentage of records in the published data which included the patient's valid General Practitioner Registration Code was:
100% for admitted patient care;
100% for outpatient care; and
N/A for accident and emergency care.

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

Clinical coding error rate
CNWL was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission.

In Focus: An update on Payment by Results
The Trust has continued its work to prepare for the implementation of Payment by Results in our adult and older adult mental health services. Our focus at CNWL over the last twelve months has been on ensuring that we have rigorous systems in place to support this new system of funding allocation and to realise maximum benefits for our service users. PbR implementation will commence in a phased way from April 2013. Under this new system, rather than purchasing a 'block' of mental health service provision, commissioners will buy a number of integrated care packages linked to the needs of the populations they serve and the demand for secondary mental health services. The care packages are linked to twenty needs-based 'clusters' defined nationally by the Department of Health but their content is decided at a local level. At CNWL, the work to develop our care packages has been undertaken in partnership with our service users, carers, staff and commissioners and we have worked hard to ensure that they are in line with recognised best practice and recovery principles.

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

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

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

Part 3 – Other information

3.1 Our performance against national priorities and historical quality priorities

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

The indicators are grouped by the quality dimensions of Service User Safety, Clinical Effectiveness and Service User Experience as per Lord Darzi's High Quality Care for All report.

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

Our performance against national priorities and historical quality priorities

3.1.1 Service User Safety

Measure		Data Source	Target	2012/13	2011/12	2010/11	2009/10	Benchmark (where available): National average; and highest and lowest scores
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? (YTD)	JADE scan	95%	M11: 97%	95.2%	96%	97%	National Avg: 97.6% National Max: 100.0%; Min: 92.5%[1]
2. Risk assessment and management	What percentage of inpatient service users have had a risk assessment completed and linked to their care plans?* (Q4)	Internal audit	95%	88%	96%	92%	95%	Not available
3. Infection control	a. The number of cases of MRSA (MRSA infection) annually (YTD)	Internal database	0	0	0***	3***	9***	Not available
	b. The number of cases of MRSA (MRSA bacteraemia) annually (YTD)	Internal database	0	0	0	1	0***	Not available
	c. MHAS: The number of cases of Clostridium Difficile annually (YTD)	Internal database	< 7	0	0	0	0	Not available
	d. HCH: The number of cases of Clostridium Difficile annually (YTD)	Internal database	< 7	0	3	11	0***	Not available

	e. CPS: The number of cases of Clostridium Difficile annually (YTD)	Internal database	< 7	0	4	Not available	Not available	Not available
4. Service user safety	Service users reported that they felt safe during their most recent inpatient stay (Q4)	Telephone survey	75%	79%	75%	Not available	Not available	Not available
5. Medication reconciliation	Inpatients who have had their medication cross-checked with more than one source within 72hours of admission (Q4)	Internal audit	90%	97%	96%	Not available	Not available	Not available
6. Access in a crisis	Community service users report that they have a phone number to call in a crisis (Q4)	Telephone survey	65%	75%	72%	60%	Not available	60%^
7. HIV services	Percentage of patients diagnosed with HIV since 2000 are registered with, and have their HIV status disclosed to their GP# (YTD)	Internal audit	70%	M11: 78%	72%	Not measured	Not measured	Not available
	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# (YTD)	Internal audit	90%	M11: 90%	90%	Not measured	Not measured	Not available
8. HCH Falls	10% decrease in number of falls at Northwood & Pinner Community Unit on 2009/10 performance** (YTD)	Datix scan	10% reduction per annum	M11: 31	49	Not available	Not available	Not available
9. HCH medication errors	Number of serious / red medication incidents or errors** (YTD)	Datix scan	0	0	0	1	Not available	Not available

	Number of medication errors by HCH staff # (YTD)	Internal audit	10% reduction per annum	Retired measure	36	53		Not available
10. HCH hand hygiene	Percentage of patients happy with their HCP's attention to hand hygiene** (Q4)	Annual HCH patient survey	90%	Retired measure	85%	87%	Not available	Not available
11. CPS Syringe drivers	To have completed all actions required in response to the safety alert before 16.12.11#	Actions completed	Actions completed	Retired measure	Achieved	Not measured	Not available	Not available
	To identify a preferred new model ambulatory syringe driver to be used in CPS#	Actions completed	Actions completed	Retired measure	Achieved	Not measured	Not available	Not available
	To revise the syringe driver policy, training programme and competency assessments for safe operation#	Actions completed	Actions completed	Achieved	Not achieved	Not measured	Not available	Not available
12. Incidents	a. Number of patient safety incidents for the reporting period;	Datix scan	N/A	11,167	10,924	Not available	Not available	Not available
	b. Percent of patient safety incidents that resulted in severe harm or death; and reported as per 100,000 population	Datix scan	N/A	0.79% (88) 6.18 per 100,000^^	0.98% (107) 7.52 per 100,000^^	Not available	Not available	Not available

Key: * This was a QP for 2009/10
** This was a QP for 2010/11
# This was a QP for 2011/12
*** This figure is for CNWL Mental Health and Allied Specialties services only

1Source: Health and Social Care Information Centre
^ Source: CQC National Community Service User Survey 2012
^^ Population data taken from ONS 2011 Census for the main six boroughs we serve

Measure 1 CPA 7-day follow up: This measure is in place to ensure our service users remain safe and have their needs cared for after discharge from hospital to community care. We are pleased to report that, year to date, 97% of CPA cases received a follow-up contact within seven days of discharge, achieving the target. CNWL considers that this percentage is as described for the following reasons: Performance is monitored

locally each week via the Trust's Business Intelligence System (QIS) which identifies discharges and follow ups, and enables our business managers to alert clinicians and take focused, informed action. There is a CPA Policy to support this operationally, and the business rules are published and shared across the Trust to ensure we are acting on and recording this information correctly. This indicator is also tracked monthly via an integrated dashboard which is reported to the Quality and Performance Committee. CNWL has taken these actions to improve this percentage, and so the quality of its services, and will continue to do so through the coming year.

Measure 2 Risk assessment and management: This measure aims to ensure that a risk assessment has been completed and that any issues highlighted are directly addressed in the service users care plan. This is to ensure the service user's ongoing safety and management of any risk issues. This was achieved in 88% of cases for quarter four. Our service lines have received this data and are working on action plans to ensure this is improved for quarter four.

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

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

Measure 5 Medication reconciliation: It is important that, when a patient is admitted to our services, we check against two other sources to be certain of what medication the patient is currently on, to prescribe safely and appropriately while under our care. This year we increased our target from 75% to 90%, and achieved a quarter four position of 97%. This has been due to the hard and on-going work by our pharmacy teams throughout the Trust.

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

Measure 7 HIV services: These two measures are in place and will continue to be monitored by the service to ensure patients are receiving the safest possible care for their HIV. It aims to ensure open communication and information sharing with the patient's GP, so all practitioners involved are aware of the patient's condition(s) and current medications. We are pleased to report that we have achieved both our targets for

these measures. The importance of involving GP is raised by the clinician at each consultation, and there is great focus on this at patient workshops, especially around drug interactions with HIV and other medications.

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

Measure 9 HCH medication errors: The first measure relates to our services in Hillingdon community. Serious medication errors can harm our service users and so it is vital to that *none* occur. Strict systems, processes and staff training are in place to ensure medicines are stored, prescribed and administered correctly. We are pleased to report that no serious/red medication incidents occurred in the two last years. Similarly, the second measure aims to reduce staff medication administration errors by 10% per year and we significantly surpassed this target. While both these measures will continue to be closely monitored and reported on internally, we will not report them in next year's Quality Account.

Measure 10 HCH hand hygiene: Research shows that good hand hygiene is an effective way to prevent the spread of infection. This measure assesses our service users' satisfaction with the healthcare professionals' attention to hand hygiene in our Hillingdon community services. Last year well fell just short of our 95%, but this year good progress has been made on action plans. This indicator will continue to be monitored locally through the HCH Infection Control and Prevention Committee, and will not be reported on next year.

Measure 11 CPS syringe drivers: : These indicators related to a discreet piece of work in response to the National Patient Safety Agency report to introduce new syringe drivers. We are pleased to report that all actions relating to this where achieved last year: we successfully identified a new model, updated our Syringe Driver Procedure (ratified by the Clinical Standards and Medicines Management Group in March 2013), and training and procurement completed in March 2013. As this work concludes, implementation will be monitored internally and will not be included in future reports.

Measure 12 Incidents: We take reported incidents very seriously at CNWL. We have an electronic reporting system to support this and over the last few years have developed a positive reporting culture within the organisation. Incidents are graded, analysed and, where required, undergo a root cause analysis investigation to inform actions, recommendations and learning.

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

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

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

3.1.2 Clinical Effectiveness

Measure		Data Source	Target	2012/13	2011/12	2010/11	2009/10	Benchmark (where available): National average; and highest and lowest scores
1. Re-admission rates	What percentage of service users were re-admitted to hospital within 28 days of leaving? (YTD)	JADE scan	<11%	M11: 5.2%	4.1%	5%	*5.7%*	Not available
	a. For patients aged 0 - 14: b. For patients aged 15 or over:			M11: a. 0; b. 5.2%	a. 0; b. 4.1%	Not measured	Not measured	Not available
2. 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? (YTD)	JADE scan	90%	M11: 99%	98%	95%	94.5%	National Avg: 98.4% National Max: 100.0%; Min = 90.7%[1]
3. Crisis Resolution home treatment episodes	Did we achieve the commitments (set by commissioners) to deliver new crisis resolution home treatment episodes? (YTD)	JADE scan	5	M11: 4/5	5/5	5/5	Not measured	Not available
4. Early Intervention Teams	Did our Early Intervention Teams meet the commitments (set by commissioners) to serve new psychosis cases? (YTD)	JADE scan	95%	M11: 100%	99.5%	100%	Not measured	Not available
5. Mental Health	a. Identifiers (YTD)	JADE scan	99%	M11: 99.1%	99.18%	99%	99.6%	99.3%[2]

3.1.2 Clinical Effectiveness

Minimum Data Set (data completeness)	b. Outcomes (YTD)	JADE scan	50%	M11: 97.6%	97.2%	87.5%	59.6%	50.9%[2]
6. Physical health checks	a. Inpatient service users with physical health assessment after admission (Nursing)** (Q4)	Internal audit	95%	95%	96%	95%	Not measured	Not available
	b. Inpatient service users with physical health assessment after admission (Medical)** (Q4)	Internal audit	95%	89%	80%	89%	Not measured	Not available
7. HCH Edinburgh Post Natal Mood Assessment	Percentage of new mothers receiving an Edinburgh Post Natal Mood Assessment within four to six weeks of birth** (YTD)	RIO scan	90%	M11: 90%	92%	90%	78%	Not available
8. HCH wheelchair initial assessment waiting time	Waiting time for initial assessment in District Wheelchair Service (weeks)** (YTD)	RIO scan	13 weeks	M11: 9	24	11	Not measured	Not available
9. HCH sustaining breastfeeding	58% of women sustaining breast feeding at six to eight weeks post delivery# (YTD)	Internal audit	58%	Retired measure	60%	Not measured	Not measured	Not available
10. HCH DESMOND training	Service users who have undergone DESMOND training report that they are better able to understand and manage their condition# (YTD)	Patient survey	65%	Retired measure	98%	Not measured	Not measured	Not available

Key: * This was a QP for 2009/10
** This was a QP for 2010/11
# This was a QP for 2011/12

1Source: Health and Social Care Information Centre
2Source: Mental Health Minimum Data Set Q3 2012/13

Measure 1 Readmission rates: Readmission rates describe how many service users get readmitted to hospital post discharge within a given timescale. It is important for us to monitor this as it may warrant investigation into whether our service users are being discharged before they are ready or not given the appropriate support in the community. We are pleased to report that our readmission rates within 28 days of discharge are below 11% target at 5.2%. CNWL considers that these percentages are as described for the following reasons: Performance is monitored locally each week via the Trust's Business Intelligence System (QIS) which identifies patients that were readmitted. There are published and shared business rules across the Trust to ensure we are acting on and recording this information correctly. This indicator is also tracked monthly via an integrated dashboard which is reported to the Quality and Performance Committee and the associated service line care quality meetings.

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

Measure 2 Crisis resolution gate-keeping: Our crisis resolution teams assess service users when they are in crisis to quickly determine if they are suitable for home treatment rather than being admitted to hospital. It is important to treat our service users in the most appropriate settings to ensure their safety and that they receive the effective treatment. We are proud that we have done well on this measure for two years running, achieving 99% (month 11) against our 90% target. CNWL considers that these percentages are as described for the following reasons: Performance is monitored locally each week via the Trust's Business Intelligence System (QIS) which identifies admissions and gate-keeping which informs actions as required. The Crisis Resolution Team policy and business rules are published and shared with all staff via our intranet to ensure we are acting on and recording this information correctly. This indicator is also tracked monthly via an integrated dashboard which is reported to the Quality and Performance Committee. CNWL has taken the following actions to improve this number, and so the quality of its services, by reviewing, updating and distributing the Crisis Resolution Team policy this year, as well as providing weekly reports to local business managers for action planning. This is also reviewed at local care quality management groups or senior management team meetings within the appropriate service line.

Measure 3 Crisis resolution home treatment episodes: This indicator is a way in which we measure that we can offer 24 hour services to people in crisis. Our local commissioners set the targets and are based on how they have resourced these services and the size of the local population. At month 11 four out of five boroughs (Brent, Harrow, Hillingdon, Kensington and Chelsea and Westminster) met their locally set targets, however action has been taken and we expect to meet this target at year end.

Measure 4 Early intervention teams: This indicator assesses whether we have met our commitments, set by our commissioners, to serve new cases of first episode psychosis. We are pleased to report that we achieved 100% (month 11) against a 95% target.

Measure 5 Mental health minimum data set: This information is important for us to collect as it helps ensure that we are delivering services that meet the needs of our population, and so we can plan and re-design services appropriately. We have exceeded our targets again this year for completeness of our outcomes and identifier data set. As these are Trust-level indicators we do not present performance by borough.

Measure 6 Physical health checks: Measure 6a and b indicate the percent of service users who have received nursing and medical physical assessment respectively after their admission to an inpatient service. The results for quarter three indicate that there is still work to do in this area, specifically around medical staff completing physical health checks and that these are correctly recorded on the electronic system. Action plans are in place to address this.

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

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

Measure 9 HCH sustaining breastfeeding: There is evidence which suggests good health benefits for babies if breast fed for longer post delivery, and we are pleased that we achieved this target in 2011/12. Although this indicator was not measured for 2012/13, our work and breast feeding programmes continue in HCH. Breast feeding attainment is a national indicator which we continue to monitor and report on this as part of our normal DoH returns.

Measure 10 HCH DESMOND training: HCH runs a training course to help patients understand and manage their diabetes. This measure aimed to assess if the training improved patient's knowledge and coping abilities with their condition. At quarter four last year we achieved a 98% performance against a 65% target, and so this measure was not carried forward to 2012/13. We do however still monitor our training evaluations for scope for any improvements throughout the year.

Measure 11 CPS Stroke rehabilitation: Last year CPS worked with the Stroke Network to set targets for a community non-acute care unit, and this work has continued through 2012/13. This on-going work has informed Stroke Network standards. As a result, over 2012/13, measures have changed and the service currently reports a number of measures both internally and to the Stroke Network which are now more in line with commissioned service provision. Long term monitoring of these has indicated stable results. A decision was thus taken cease monitoring the older quality priority indicators at quarter three this year, and focus on the newer, more relevant indicators.

In July 2012 our Stroke REDS (Rapid Early Supported Discharge Service) was awarded a Care Integration Award. See In Focus below for further detail.

In Focus: Care Integration Awards – Stroke REDS
The Care Integration Awards celebrate partnership working across agencies to improve patient care and are presented by Health Service Journal (HSJ) and Nursing Times.

From a pool of 60 nominations the Stroke REDS (Rapid Early Supported Discharge Service) were awarded a Care Integration Award in July 2012. This team is part of the newly formed Integrated Stroke and Neurology Service. The team won this award not only for their joined up working with acute hospitals, community teams and social services but also the efficiency and cost saving to the NHS that having an integrated early supported discharge team can make. Early supported discharge helps to prevent unnecessary hospital admission or long-stays in inpatient facilities.

The team based at St Pancras Hospital, work with patients in their homes to ensure they receive the specialist care and support that they would have received on a stroke unit. This involves rehabilitation and aftercare for approximately six weeks after returning home. The service is integrated with acute hospital stroke units across London and is a conduit between acute and community health, social and preventative services to ensure those patients and carers, receive the best care and support possible. Following the success of the service, this early supported discharge framework has been expanded to other neurological conditions.

3.1.3 Service User and Carer Experience

Measure		Data Source	Target	2012/13	2011/12	2010/11	2009/10	Benchmark (where available): National average; and highest and lowest scores
1. Delayed transfers of care	On average, what percentage of hospital beds are being used by service users who should have been discharged? (YTD)	JADE scan	7.5%	M11: 6.3%	3.1%	2.8%	4.4%	Not available
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? (YTD)	JADE scan	95%	M11: 95.9%	95.6%	95%	99% (Jan-Mar 2010 audit)	National Avg: 79.4% National Max: 98.9%; Min: 10.5% 79%[1]
3. Care plans	What percentage of our service users have been offered a copy of their care plan? (inpatients & community) (Q4)	Internal audit	95%	71%	88%	88%	90%	Not available
	Community service users report that they had been given/offered a copy of their care plan# (Q4)	Telephone survey	80%	56%	51%	Not measured	Not measured	49%^
4. Understanding care plans	The percentage of community service users on CPA who say they definitely understand what is in their care plan**	Telephone survey	75%	Retired measure	48%	63%	Not measured	48%^

5. Access for people with a learning disability	Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability (YTD)	Internal database	7/7	M11: 7/7	7/7	6/6	Not measured	Not available
6. Carer identification and assessments	Percentage of service users who have their carer status identified# (Q4)	Internal audit	55%	75%	78%	Not measured	Not measured	Not available
	Percentage of carers recorded as having been offered a carers assessment# (Q4)	Internal audit	40%	Q3: 48%	98%	Not measured	Not measured	Not available
7. CPS Telephone responsiveness	At least 80% of calls to the key contact points are picked up within one minute# (Q4)	Mystery shopping	80%	75%	94%	Not measured	Not measured	Not available
	Service users surveyed (or asked through PET) report finding it 'easy' or 'very easy' to get through to services on the phone# (Q4)	Patient survey	80%	Retired measure	80%	Not measured	Not measured	Not available
8. CPS Telephone handling	All relevant members of staff receive practical training on handling phone calls from service users/carers# (Q4)	Internal audit	100%	Retired measure	100%	Not measured	Not measured	Not available
9. HCH Referral to Treatment	The referral to treatment waiting times: non-admitted (YTD)	RIO scan	95%	M11: 99.8%	99.9%	100%	99.8%	Not available

10. HCH service users feedback	Percentage of service users who knew how to compliment or complain about a service** (YTD)	Annual HCH patient survey	60%	63%	56%	62%	TBC	Not available
11. HCH interpreting service	Service users who expressed the need for interpreting support were provided with this service# (Q4)	Internal audit	90%	Retired measure	80%	Not measured	Not measured	Not available

Key: * This was a QP for 2009/10
** This was a QP for 2010/11
# This was a QP for 2011/12

1Source: Health and Social Care Information Centre
^Source: CQC National Community Service User Survey 2012

Measure 1 Delayed transfers of care: This measure assesses the percentage of inpatient beds that are being used by those who should have been discharged to our partner agencies, but are being delayed. We work closely with our local authority partners to ensure discharge takes place at the right time to ensure service user satisfaction of services and that our beds are kept free for those who most need them. We have seen good performance in this area far achieving our <7.5% target.

Measure 2 CPA 12 month review: This indicator monitors whether those on CPA receive a full CPA review at least annually. This enables service provision to be updated as per the service user's changing needs to ensure they are receiving the most effective care. We are pleased to report that we are achieving our target for this measure.

Measure 3 Care plans: This target is fundamental to involving and developing a partnership with our service users in their care journey. The first measure checks our service user's file to see if we have logged that we have given or offered the service user a copy of their care plan. The second measure asks community service users if they were offered or received a copy of their care plan. We did not perform as well as we had liked at quarter four, and this forms a fundamental part of our recovery and involvement focus this will be rolled forward as a quality priority for 2013/14, and extended to our community providers (HCH/CPS).

Measure 4 Understanding care plans: This measure was aimed at ensuring that service users understood what the plans for their care were. Although we matched the national benchmark for 2011/12 this was not measured for 2012/13. This is because it was replaced with what was seen to be a far more useful and 'proactive' measure of assessing whether service users felt *involved as much as they wanted to be* in decisions about their care plan. This was a quality priority for 2012/13 and is reported in Part 2.

Measure 5 Access for people with a learning disability: This measure assesses whether those with a learning disability have the same access to care rights as those who don't, to ensure they are not disadvantaged and receiving the care they need. The assessment is against seven questions based on the recommendations set out in 'Healthcare for all' (2008), the Independent Inquiry into Access to Healthcare for People with Learning Disabilities. We are proud to report that we achieved the maximum score (seven out of seven) at year end for this measure.

Measure 6 Carer identification and assessments: Identifying the 'carer status' means logging on our system whether the service user has a carer or not. Identifying carers is the first step to getting carers the information, support and services they need to support them in their caring role. We exceeded our target achieving 75% at quarter four. This year we reviewed the methods of recording carer assessment data across services, working to ensure consistency across services. The quarter three carer assessment data reflects this work and we expect a positive shift in our quarter four target.

Measure 7 CPS Telephone responsiveness: These two indicators measure the satisfaction with accessibility to our telephone services in CPS. Our most recent mystery shopper exercise indicated that 75% of calls to our key contact points were picked up within one minute. Action plans are being developed by our business unit sub-committees at the time of this report. Our second measure was achieved last year, however highlighted an issue within School Nursing. Although this indicator was not measured for 2012/13, actions have been put in place including the introduction of a centralised telephone number advertised on service leaflets and on school nursing letter. A review of telephone access undertaken in 2012 revealed no concerns. This measure will continue to be monitored internally but will not be reported in future.

Measure 8 CPS Telephone handling: This was a quality priority for 11/12 and included an action to train all relevant members of staff in the handling of phone calls from service users and carers. This was achieved with 100% of relevant staff receiving training, and new members are trained as required. As this action is completed, this measure will not be reported in future.

Measure 9 HCH Referral to Treatment: This indicator monitors the waiting times from referral to treatment and has been consistently achieved since 2010, with a year to date position of 99.8%. Although this indicator will be monitored closely and reported on internally, this will not feature in future Quality Accounts.

Measure 10 HCH service user feedback: It is important that our service users know how to compliment or make a complaint about our services, so we can learn and share good practice, and also put things right. This measure is monitored through our annual patient experience survey and achieved 63%, a seven percent increase from last year. This measure will continue to be measured and reported locally.

Measure 11 HCH interpreting service: This indicator measures whether our service users received interpreting services when it was needed. Although we performed well and just missed our target for this last year, the majority of respondents stated that they were able to access this service if it was needed. This area will continue to be monitored closely through HCH's annual patient experience survey and reported internally.

3.2 A borough breakdown: Our mental health and allied specialties performance against national priorities and historical quality priorities

The following three tables reflect the data relevant to mental health and allied specialties from sections 3.1.1 – 3.1.3 broken down by borough. Results for these indicators for HCH and CPS can be found within the main tables from sections 3.1.1 – 3.1.3.

Measure		Target	Brent	Harrow	Hillingdon	Kensington & Chelsea	Westminster	CAMHS	Learning Disabilities	Eating Disorders	Addictions	Offender Care	Trust-wide
a. Service User Safety													
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? (YTD)	95%	98%	99%	99%	99%	98%	94%	86%	91%	n/a	n/a	**M11: 97%**
2. Risk assessment and management	What percentage of inpatient service users have had a risk assessment completed and linked to their care plans? (Q4)	95%	84%	85%	88%	95%	84%	100%	100%	83%	100%	-	**88%**
3. Service user safety	Service users reported that they felt safe during their most recent inpatient stay (Q4)	75%	63%	73%	86%	75%	83%	-	-	-	-	100%	**79%**
4. Medication reconciliation	Inpatients who have had their medication cross-checked with more than one source within 72hours of admission (Q4)	90%	92%	97%	100%	94%	97%	100%	100%	100%	100%	-	**97%^**
5. Access in a crisis	Community service users report that they have a phone number to call in a crisis (Q4)	65%	77%	75%	77%	78%	77%	-	-	-	-	57%	**75%**

Key: ^: Includes data for Horton Haven Rehabilitation services which scored 100%; "-": Not measured or no response received; n/a: Measure not applicable

Measure		Target	Brent	Harrow	Hillingdon	Kensington & Chelsea	Westminster	CAMHS	Learning Disabilities	Eating Disorders	Addictions	Offender Care	Trust-wide
b. Clinical Effectiveness													
1. Re-admission rates	What percentage of service users were re-admitted to hospital within 28 days of leaving? (YTD)	>11%	6%	9%	2%	6%	6%	0%	0%	2%	0%	n/a	**M11: 5.2%**
2. 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? (YTD)	90%	100%	97%	98%	100%	100%	n/a	n/a	n/a	n/a	n/a	**M11: 99%**
3. Crisis Resolution home treatment episodes	Did we achieve the commitments (set by commissioners) to deliver new crisis resolution home treatment episodes? (YTD)	5	no	yes	yes	yes	yes	n/a	n/a	n/a	n/a	n/a	**M11: 4/5**
4. Early Intervention Teams	Did our Early Intervention Teams meet the commitments (set by commissioners) to serve new psychosis cases? (YTD)	95%	100%	100%	100%	100%	100%	n/a	n/a	n/a	n/a	n/a	**M11: 100%**
5. Physical health checks	a. Inpatient service users with physical health assessment after admission (Nursing) (Q4)	95%	100%	95%	96%	95%	90%	100%	100%	90%	100%	-	**95%**
	b. Inpatient service users with physical health assessment after admission (Medical) (Q4)	95%	93%	90%	70%	97%	88%	100%	100%	100%	100%	-	**89%**

Key: "-": Not measured or no response received; n/a: Measure not applicable

Measure		Target	Brent	Harrow	Hillingdon	Kensington & Chelsea	Westminster	CAMHS	Learning Disabilities	Eating Disorders	Addictions	Offender Care	Trust-wide
c. Service User and Carer Experience													
1. Delayed transfers of care	On average, what percentage of hospital beds are being used by service users who should have been discharged? (YTD)	7.5%	9%	6%	12%	5%	8%	n/a	7%	n/a	n/a	n/a	**M11: 6.3%**
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? (YTD)	95%	99%	99%	99%	99%	99%	96%	94%	94%	88%	n/a	**M11: 95.9%**
3. Care plans	What percentage of our service users have been offered a copy of their care plan? (inpatients & community) (Q4)	95%	85%	61%	68%	53%	74%	100%	86%	80%	100%	n/a	**71%**
	Community service users report that they had been given/offered a copy of their care plan (Q4)	80%	72%	38%	58%	54%	58%	-	-	-	44%	n/a	**56%**
4. Carer identification and assessments	Percentage of service users who have their carer status identified (Q4)	55%	76%	86%	87%	48%	64%	n/a	92%	80%	90%	-	**75%^**
	Percentage of carers recorded as having been offered a carers assessment (Q3)	40%	40%	94%	38%	60%	37%	n/a	-	-	-	-	**Q3: 48%**

Key: ^: Includes data for Horton Haven Rehabilitation services which scored 80%; "-": Not measured or no response received; n/a: Measure not applicable

3.3. Other indicators of quality

3.3.1 Staff satisfaction

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

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

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

Measure	CNWL performance 2012	CNWL performance 2011	National average for similar Trusts	Top performing Trust score
Staff recommendation of the Trust as a place to work or receive treatment*	3.75 / 5	3.68 / 5	3.54 / 5	4.06 / 5
Staff motivation at work	3.88 / 5	3.97 / 5	3.84 / 5	4.03 / 5
Staff feeling satisfied with the quality of work and patient care they were able to deliver	81%	80%	78%	86%
Staff ability to contribute towards improvement at work	72%	72%	71%	79%

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

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

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

- We have started 'The Conversation' on our values within the Trust: this means that we will continue to build our value base in partnership with our staff and test these with our patients and public. We are continuing to build a culture of care that permeates every level of our organisation;
- We ensure our service users are involved in recruiting to key posts within the Trust, and are rolling out Band 5 Nursing Assessment Centres where we 'test' for compassion;

- As a diverse workforce serving the needs of a diverse population we want to ensure all of our staff feel equally able to contribute to the work of our organisation. We launched the posts of Race Awareness Advisors and have trained thirteen staff so far.

Whilst it is good to understand where staff's needs are being met, it is important to consider where they are not in order to implement targeted action plans to improve staff experiences of the workplace. The following table demonstrates where CNWL has performed below the national average (for similar Trusts) and where improvements need to be made:

Measure	CNWL performance 2012	CNWL performance 2011	National average for similar Trusts	Top performing Trust score
Staff receiving job relevant training, learning or development in the last 12 months	78%	82%	82%	87%
Staff receiving health and safety training in the last 12 months	63%	74%	73%	90%
Staff reporting that hand washing materials are always available	51%	47%	55%	64%
Staff feeling pressure in the last 3 months to attend work when feeling unwell	27%	18%	22%	9%

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

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

Measure	Target	2012/13	2011/12	2010/11
Staff turnover (including CNWL, HCH and CPS) The number of staff leaving as a percentage of total staff	Year on year improvement	tbc	14.5%	*12.6%
Average sickness per employee (including CNWL, HCH and CPS) The time lost to sickness per employee as a percentage of total time available	Year on year improvement	tbc	See breakdown below	See breakdown below
Average sickness per employee (including CNWL and HCH) The time lost to sickness per employee as a percentage of total time available	Year on year improvement	See combined figure above	3.8%	3.8%
Average sickness per employee (including CPS only) The time lost to sickness per employee as a percentage of total time available	Year on year improvement	See combined figure above	2.7%	2.7%

* CNWL only

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

3.3.2 Patient experience

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

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

Measure	2012* CNWL	2011* CNWL	2012^ National Average
Did this person listen carefully to you? Yes definitely	81%	76%	79%
Yes to some extent	16%	20%	17%
No	3%	4%	4%
Did this person take your views into account? Yes definitely	73%	72%	73%
Yes to some extent	23%	23%	22%
No	3%	5%	5%
Did you have Trust and confidence in this person? Yes definitely	70%	70%	72%
Yes to some extent	25%	26%	21%
No	4%	5%	7%
Did this person treat you with respect and dignity? Yes definitely	88%	87%	87%
Yes to some extent	10%	11%	11%
No	2%	2%	2%
Were you given enough time to discuss your care and treatment? Yes definitely	76%	72%	72%
Yes to some extent	20%	22%	20%
No	3%	7%	8%
Overall how would you rate the care you have received from Mental Health Services in the last 12 months? Excellent	30%	26%	30%
Very Good	29%	26%	30%
Good	21%	28%	20%
Fair	12%	11%	12%

Poor	5%	6%	5%
Very Poor	3%	3%	4%

*CNWL results supplied for 2011 and 2012 surveys by Quality Health Ltd.
^ National averages as supplied by the CQC's National Community Service User Surveys

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

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

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

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

3.3.3 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.

275 formal complaints were made to CNWL during 2012/13. Most of these were graded as moderate or low, and three were related to a serious incident. At the end of March we had responded to 185, 8% of which were fully upheld. The remaining complaints have a response in draft and is being finalised, or remains under investigation. Eleven of these complaints were referred to the Parliamentary and Health Service Ombudsman, none of which were accepted for their reinvestigation.

The complaints procedure was updated during the year, and the 25 day response timeframe reintroduced. In addition to this, more robust monitoring is planned to take place during 2013/14. Learnings from

complaints, PALS and claims are reviewed by the Organisational Learning Group throughout the year, and their findings will feed the organisational learning themes for 2012/13.

The Trust will provide information on complaints received during the year to the Department of Health, in line with Regulation 18 of the Local Authority Social Services and NHS Complaints (England) Regulations 2009.

3.3.4 Equalities and diversity

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

In addition, the Trust published five 4-year Equality Objectives in April 2012, three of which were highlighted within last year's Quality Account: a commitment to community engagement events with service users, carers and local communities, improving recording rates disability, religion or belief and sexual orientation for service users and for service users', and reducing the level of violence, discrimination and harassment, bullying and abuse at work from patients/service users, their relatives or other members of the public towards staff.

We report on our progress below.

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

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

- A programme of carer events including: Carers Forum Focus Group involving: Family members from various BME communities including, East Asian, Chinese, Kenyan Asian, Ghanaian Asian, Jamaican, Irish, British Asian; Young Carers events in Harrow and Brent involving carers from a range of communities; Engagement events throughout the year for carers of people having a learning disability;
- Arabic speaking women's group (Moroccan, Bangladeshi, Iraqi, Somali Women) in Westminster to raise awareness of services mental health services for children and adults;
- Mental Health First Aid training targeting members of BME communities in Westminster (Bangladeshi, Arabic and South American communities);
- Extensive programme of community engagement by Sexual Health services including: Outreach to members of African communities to raise awareness of HIV and access to health care; young people's sessions at The Archway Clinic and Mortimer Market – services have been awarded the "You're Welcome" accreditation by Young Ambassadors from the local council which recognises how the service has tailored itself toward the needs of young people;
- Engagement events at London University campuses to meet with foreign students to raise awareness of mental health problems and services. This initiative was undertaken as part of the Trust's recognition of World Mental Health Day;

- Following on from a Tamil Well-being Conference held in partnership with West London Mental HealthTrust, engagement is taking place with representatives from the Tamil community to discuss how CNWL can facilitate access to services and develop information resources for the community;
- Participation in borough-wide events in Kensington and Chelsea bringing together service users and service providers from a range of communities providing opportunities for information sharing, signposting to services and encouragement to services users in recovery;
- A new LGB&T Forum is being developed in partnership with the Local Authority and the Voluntary sector in Harrow following on from a half-day workshop 'Getting to know you', which involved stakeholders from the LGB&T community; a similar event has also been held in Camden helping to foster stronger links with LGB&T support services and networks.

2. Improve the recording rates for new service users for religion or belief, sexual orientation and disability. [1]

	Recording rate for new service users January to March 2012	**Recording rate for new service users October to December 2012**
Religion or Belief	73.2%	75.4%
Sexual Orientation (includes 'do not wish to disclose')	51.6%	58.6%
Disability	5.7%	6.45%

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

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

The CNWL Staff Survey 2011 indicated that CNWL staff are reporting unacceptable levels of violence, bullying and harassment, and discrimination, from patients/service users, their relatives or other members of the public towards staff, particularly though not exclusively related to ethnicity. The Trust is alarmed that staff experience of violence, harassment, bullying and abuse has increased according to the 2012 staff survey. There has been a slight drop in discrimination. Whilst there were some changes in the way the questions were asked between the two surveys, this cannot be taken as a cause of the increases.

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

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

	2012 Staff Survey[2]	2011 Staff Survey
Percentage of respondents reporting to have personally experienced violence from patients/service users, their relatives or other members of the public	18%	12%
Percentage of respondents reporting to have experienced harassment or bullying from patients/service users, their relatives or other members of the public	31%	20%
Percentage of respondents reporting to have experienced discrimination from patients/service users, their relatives or other members of the public	13%	14%

In May 2013 we plan to publish a document to show how we are progressing against all of the Trust's Equality Objectives, including actions that have been taken, and further actions that have been identified.

[2] Also included reference to abuse in the question

Annex 1 – Statements provided by our commissioners, OSCs or Healthwatch

[insert statements received post 6 May 2013]

Annex 2: Quality Account glossary of terms

ABBREVIATIONS

CAMHS	Child and Adolescent Mental Health Service
CD4	Cluster of differentiation 4
CPA	Care Programme Approach
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
ED	Eating Disorders (service line)
GP	General Practitioner
HCH	Hillingdon Community Health
HoNOS	Health of the Nation Outcome Scales
LD	Learning Disability (service Line)
LINks	Local Involvement Networks
LPC	Lead Professional Care
NHS	National Health Service
NHSLA	NHS Litigation Authority
NICE	National Institute for Health and Clinical Excellence
OSC	Overview and Scrutiny Committee
PALS	Patient Advice and Liaison Service
PCT	Primary Care Trust
POMH	Prescribing Observatory for Mental Health

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

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

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: 2012/13 Statement of Director's responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2012/13*;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2012 to[date of signing this statement];
- Papers relating to quality reported to the Board over the period April 2012 to [date of signing this statement];
- Feedback from the commissioners dated 6 May 2013 (closing date of the Quality Account 30-day consultation);
- Feedback from governors dated 6 May 2013 (closing date of the Quality Account 30-day consultation);
- Feedback from local Healthwatch organisations dated 6 May 2013 (closing date of the Quality Account 30-day consultation);
- The Trust's Annual Complaints Report (2012-13) published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The national patient survey dated 2012;
- The national staff survey dated 2012;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated XX/XX/20XX;
- Care Quality Commission quality and risk profiles dated to March 2013;

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275).

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

By order of the Board

Claire Murdoch
Chief Executive
31 May 2013

Dame Ruth Runciman
Chairman
31 May 2013

Royal Brompton & Harefield NHS
NHS Foundation Trust

Quality account 2012-13

DRAFT

This is a draft version of the quality account for comment. All information and data included in this document relates to 2012-13 and is accurate and will not change. Where data is currently unavailable this will be incorporated into the account prior to publication of the final report. This year's account reflects the feedback received last year in relation to content and format, simplifying the account, however all mandatory sections are included.

The document will be formatted professionally prior to publication of the final version (see last year's report as an example). We are therefore seeking comments on the content and not the formatting of the account.

In response to last year's feedback we will also be producing an easy read version of the quality account which will include key highlights for patients, their families, carers or advocates, and members of the public.

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About the Trust's quality account

About the Trust

Royal Brompton & Harefield NHS Foundation Trust is the largest specialist heart and lung centre in the UK and amongst the largest in Europe. We work from two sites, Royal Brompton Hospital in Chelsea and Harefield Hospital near Uxbridge. As a specialist trust our doctors, nurses and other healthcare staff are experts in their chosen fields and we are known throughout the world for our expertise, standard of care and research success.

We offer some of the most sophisticated treatment that is available anywhere in the world and treat patients from all over the UK and around the globe. Over the years our experts have been responsible for several major medical breakthroughs – transplanting the first combined heart and lung in Britain, implanting the first coronary stent (to unblock an artery) and founding the largest centre for cystic fibrosis in the UK.

Some useful facts about the Trust:

- In 2012-13 we cared for over 144,000 patients at our outpatient clinics and more than 33,000 patients of all ages on our wards.
- We are Europe's top-ranked respiratory research centre and our cardiac, cardiovascular and critical care teams are rated in the top three most highly cited health research teams in Europe.
- Our Heart Attack Centre at Harefield Hospital has pioneered the use of primary angioplasty for the treatment of heart attacks and has one of the fastest arrival-to-treatment time in the UK, a crucial factor in patients' survival.
- Our on-site foetal cardiology service enables clinicians to begin caring for babies while still in the womb; many are scanned at just 12 weeks, when the heart measures just over a millimetre.
- The VAD (artificial heart) programme at Harefield Hospital is one of the world's most established programmes with a long history of clinical and scientific excellence.
- Our on-site foetal cardiology service enables clinicians to begin caring for babies while still in the womb; many are scanned at just 12 weeks, when the heart measures just over a millimetre.
- Europe's largest unit for the treatment of cystic fibrosis is based at Royal Brompton Hospital.
- We are the country's largest centre for the treatment of adult congenital heart disease.
- The cardiac catheterisation lab at Harefield is one of the most advanced facilities of its kind in Europe. The state-of-the-art equipment includes a remote-controlled robot that uses high-tech 3D mapping enabling precise

catheter manipulation and the reduction of exposure to X-rays for patients and staff.

- Every year we help over 8,000 adults who have breathing problems caused by diseases such as COPD (chronic obstructive pulmonary disease) and severe asthma every year.

- We provide specialised care for patients with suspected or diagnosed cancer affecting the chest (thoracic oncology). We have a specialist 'lung laser' theatre that uses a special wavelength laser beam to remove tumours from patients' lungs with minimal damage to neighbouring healthy lung tissue.

What is a quality account?

A quality account is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. All NHS providers strive to achieve high quality care for all, and the quality account provides the Trust an opportunity to demonstrate our commitment to quality improvement and show what progress we have made in 2012-13. The quality account is a mandated document which is laid before parliament before being made available to the public on NHS Choices website.

What is included in a quality account?

As the quality account is a mandated document it contains specific mandatory statements and sections. These statements cover areas such as our participation in national audits, research activity, and our registration as a healthcare provider with the Care Quality Commission (CQC). It also includes sections on the Trust's quality priorities, the areas identified for improvement this year, what the project was, how we performed against the targets and what that means for patients; plus a section on the quality priorities that have been identified for improvement projects in 2013-14. To ensure our priorities for 2012-13 and 2013-14 reflected the priorities of our patients, the public, staff, and people we work with, they were identified through a voting system, which asked people to choose the topics that were most important to them within the three areas of patient safety, patient experience and patient outcomes. These three areas are mandated by the department of health and give us a framework in which to focus our quality improvement programme.

There is a glossary at the back of the account that lists all abbreviations included in the document with a brief description of the term. You will also find blue speech bubbles and text boxes throughout the account with comments from the inpatient and outpatient surveys in 2012.

Quotes found in the report in these blue speech bubbles are from our patients via the NHS inpatient and outpatient surveys in 2012

This is a "what is?" box.
It explains or describes a term or abbreviation found in the report

Statement of directors' responsibilities

The directors of Royal Brompton & Harefield NHS Foundation Trust have prepared this Quality Account 2012-13, as required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

The directors are satisfied that:

- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012-13;
- the content of the Quality Account is consistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2012 to May 2013
    - Papers relating to quality to the Board over the period April 2012 to May 2013
    - Feedback from the commissioners dated xx/xx/2013
    - Feedback from governors dated xx/xx/2013
    - Feedback from Local Healthwatch organisations xx/xx/2013
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xx/xx/2013
    - The national inpatient and outpatient surveys 2012
    - The national staff survey 2012
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated xx/xx/2013
    - CQC quality and risk profiles dated February 2013
- the Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Account (available at www.monitornhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

Sir Robert Finch
Chairman
XXXX 2013

Robert J Bell
Chief Executive
XXXX 2013

Part 1: Chief executive statement

To be included in final report

Part 2: Review of quality priorities for improvement

Part 2a: Quality priorities for improvement 2012-13

In this part of the report, we tell you about the quality of our services and how we have performed in the areas identified for improvement in 2012-13. These areas for improvement are called our quality priorities and were identified in 2012 via an online vote. One of the priorities were also Commissioning for Quality and Innovation or CQUIN measures (see part 3 for more information). The priorities fall into three areas of quality as mandated by the Department of Health: patient safety, patient experience and patient outcomes, and we are required to have a minimum of one priority in each area.

Patient safety

The Trust has prioritised patient safety and is always striving to improve. In 2012-13 we had two quality priorities which focused on improving patient safety. One of these had the aim of ensuring the effective content and organisation of paper-based notes. The other priority focussed on patient satisfaction on advice and information on medications.

What is patient safety?

Patient safety is ensuring we treat and care for people in a safe environment and protecting them from avoidable harm (DH definition)

Quality priority one

Patient satisfaction on advice and information on medications

What was the issue? In the patient surveys our patients told us that they did not always feel fully informed in relation to their medications and how to take them. Therefore this priority aimed to established the aspects of their medication patients would like more information on.

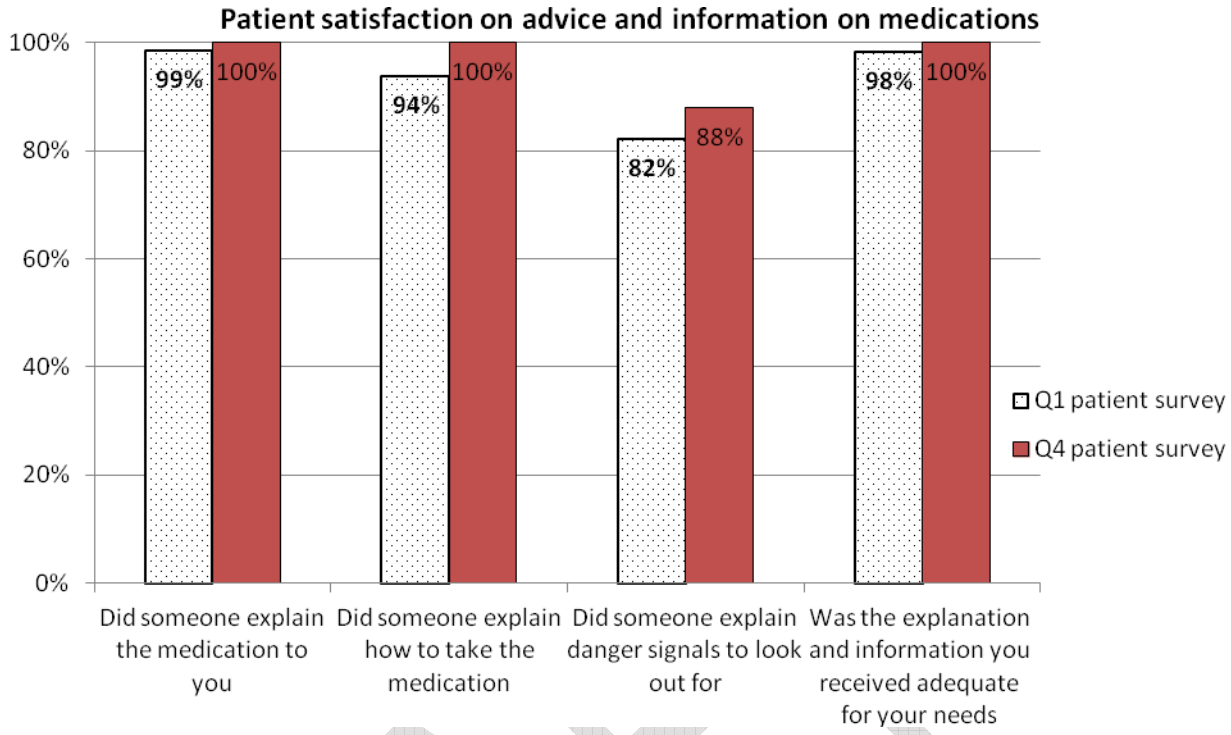
More should be done to make very clear the medication regime purpose & dosage as so much can go wrong if a patient takes the wrong drugs at the wrong time.

What did we do? Quarter 1 saw patient feedback collected via paper and electronic formats from inpatients on both sites just prior or following discharge. Feedback was received from 68 patients, of which 65 patients stated they had been given medication to take home. Patients were asked whether overall, they felt the explanation and information they received was adequate for their needs to which 98.4% responded yes.

In the vast majority of patients surveyed, they were informed about their medication and judged the level of information to be adequate for their requirements. There were 14 patients who stated they did not receive an understandable explanation about side effects and/or danger signals to look out for. By site, this constituted 36.4% of RBH respondents and 14.3% of HH respondents, with most reporting that the explanation was delivered by a pharmacist or nurse.

In response to the results from the patient surveys and additionally this patient feedback the pharmacy department has launched updated clinical ward pharmacy guidelines which include recommendations to explicitly counsel patients on potential side effects of their prescribed medicines wherever possible.

In Quarter 4 we collected further patient feedback to see if the changes that had been implemented had an effect. In this survey 100% of patients reported that someone had explained the medication to them, and told them how to take the medication. 100% of patients reported that the explanation and information they received had been adequate for their needs. The graph below compares the quarter 1 and quarter 4 patient survey results.



What does this mean for patient safety? It is important that not only patients, but also the family/carers/advocates are aware of how medications should be taken. Understanding what to expect when taking medications, has been shown to improve compliance; so taking the time to explain clearly to patients and their families/carers is an important part of ensuring our patients continue to receive the best care even after discharge.

Following on from this, the Trust will continue to focus on the explanation of danger signals in 2013-14 and we will re-audit this area to monitor improvement.

Quality priority two

Effective content and organisation of paper-based patient records

What was the issue? Every patient seen at the hospitals as an inpatient or outpatient has a unique set of paper records. Although the Trust is using electronic patient records for many aspects of healthcare, the paper records are still an important source of clinical information. Previous reviews of patient records have shown them to be in varying states of organisation and tidiness. Unsecured or disordered records are considered a risk. This project focussed on three specific aspects from the Royal College of Physicians guidance on records[1]:

- are there unsecured papers
- are the clinical hand-written entries legible
- is there written evidence the patient has had contact with their consultant during their admission

[1] http://www.rcplondon.ac.uk/projects/developing-record-standards

What did we do? Baseline data was collected from a monthly sample of records across the Trust from patients going through the Trust mortality process. For unsecured documents within the records a zero tolerance standard was set; for legibility overall compliance was down to the reviewer. For legibility and consultant review, the last admission was assessed.

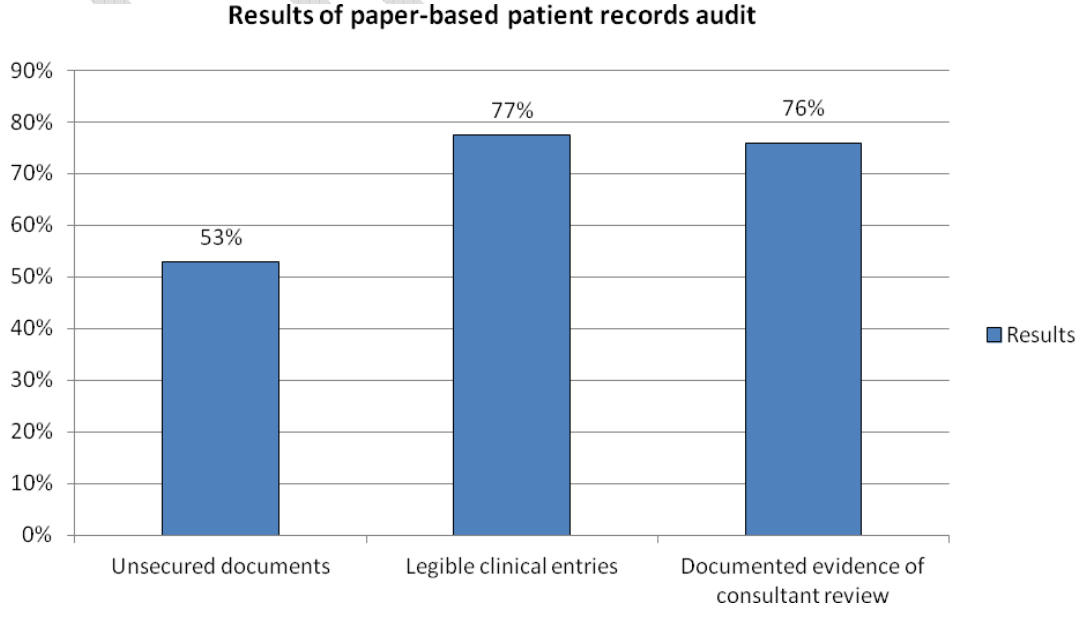
On both sites unsecured documents in patient records was a common problem. The results from the audit were then publicised across the Trust and actions taken to make improvements. Although the general state of records is the responsibility of all staff, the focus for the priority was on staff groups who handle a high volume of records on a regular basis.

The following specific actions have been instigated to highlight staff responsibilities in relation to records and to improve the physical state:

- the clinical records manager now has a regular slot at staff induction to highlight the importance of good record-keeping;
- a new process has been implemented to ensure loose documents received by the clinical records department are filed directly into the records as soon as possible;
- Loose documentation received for filing is being scanned in preparation for upload directly onto the Electronic Patient Record rather than filing in the records;
- new medical staff are being reminded about the importance of legibility of their documentation at junior doctor induction.

Once the above actions had time to be implanted across the Trust, we carried out Trust-wide documentation audit to assess the records against standards set by the Royal College of Physicians.

The audit looked at 240 sets of paper based patient records, covering all specialties, and assessed them against the Royal College of Physicians standards for clinical entries, tidiness and order. The graph below shows the average result from the Q1 and Q4 audits of paper based records.



What does this mean for patient safety?

When a patient comes to the hospitals to be admitted, it is essential that the paper records are in good order for the doctor and the rest of the clinical team to review. It enables the teams to be informed of the patients past and current health status. In order for all of the necessary information about patient to be available, all paperwork needs to be attached to the patient file, and written in a legible format. Unsecured and disordered records are considered a risk.
There will continue to be a focus on this area in 2013-14. As the trust moves towards an electronic patient record, there will be less information filed in the paper records, which will minimise the unsecured documents. Additional training for junior doctors around documentation and legibility of handwritten entries has been added to the induction programme. This will include ensuring that consultant review is documented more clearly in the notes.

Patient experience

Quality priority

Effective communication with patients

What was the issue? Results from the inpatient survey[2] our patients told us that we could communicate better with them when it comes to providing information on tests and treatments, when to expect results and so on. In response to this feedback, this priority will focus on two aspects, one for outpatients and one for inpatients.

What is patient experience?

Patient experience is ensuring people have a positive experience of care (DH definition)

What did we do? For outpatients, we looked at improving the communication of tests and treatments to ensure patients are informed about why, when and where such tests will take place.

For inpatients, we focussed on patients whose treatment plan is discussed at a multidisciplinary meeting (MDT), where a group of specialist doctors discuss and agree on the best treatment for each individual patient. Once the decision is made, patients are then admitted for treatment. Patients told us that although they are told they will be discussed at a meeting they were not always informed of the outcome and are unsure what their treatment plan will be. This priority built on one of the 2011-12 priorities where we implemented a monitoring process to electronically record all patients discussed at cardiac, thoracic and lung cancer surgery MDT meetings.

What is an MDT meeting?

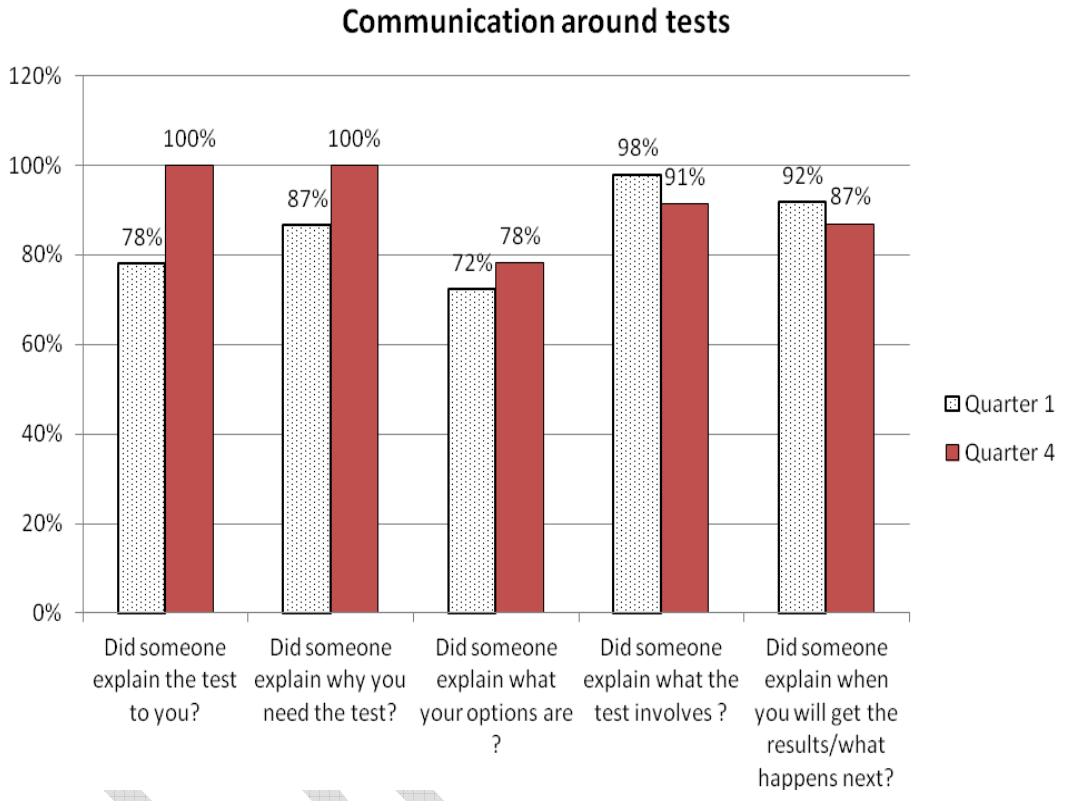
An MDT meeting involves healthcare professionals with different areas of expertise discussing and planning the best care and treatment option for specific patients.

Part one - outpatients
Outpatient data was collected in the form of patient feedback during outpatient appointments. The feedback form focused on what information was received by patients and who delivered the information. It also captured whether their experience had met their expectations. In quarter 1, feedback was collected from patients on paper forms whilst attending their outpatient's appointment or electronically following the appointment. 95.4% of patients reported their experience met their expectations with many positive comments received.

In quarters 2 and 3 the results of the audit were fed back to the outpatient departments who cascaded the findings to their teams. The results were also publicised across the Trust, and new medical staff were reminded about communication methods with patients via junior doctor induction.

[2] National NHS inpatient survey 2011

In quarter 4, feedback was collected again from patients on paper forms whilst attending their outpatient's appointment or electronically following the appointment. This focused on what information was received by patients and who delivered the information. It also captured whether their experience had met their expectations. Responses were received from 78 patients across both sites. Of these patients, 47 stated they had a test but not all respondents answered all the questions. 21 patients considered the questions not to be applicable to them as having had the same tests on numerous occasions previously they did not require any explanation. 88.3% of patients reported their experience met their expectation.



What does this mean for patient experience?

The work undertaken this year resulted in us achieving a consistently high standard of ensuring patients have tests and the reasons for the test explained. However, further work is required to ensure we are consistently explaining to patients what the test involves, whether there are alternative options to the test, and what will happen after the test. Therefore in 2013/14 there will be ongoing work with this project, and we will carry a spot check audit of this area as part of the ongoing project.

Part two - inpatients
For the inpatient project, we continued to monitor how many patients are discussed at an MDT meeting and then measured how many of these patients had a letter sent to them within a set period of time. The year-end aim was to improve throughout 2012-13.

This project focussed on the joint cardiac and cardiology (JCC) MDT meeting. Patients who are discussed at JCC have one of the following decisions made:

- to proceed to cardiac surgery
- to proceed for PCI
- to be medically managed
- inoperable
- for further discussion

We were able to confirm from Trust systems that all patients had followed the care plan that was agreed as most appropriate for them at the MDT meeting. All patients received a letter from the Trust detailing the next step in their care. On average letters were sent to the patient within 1-2 weeks.

What does this mean for patient experience?
Having a treatment plan discussed between doctors from different specialties ensures the most appropriate treatment is being individualised for each patient. The project this year has demonstrated that robust processes are in place when patients are discussed at MDT meetings and those patients, their families and carers are kept informed as to the decision made at the meeting.

Patient outcomes

Quality priority

Participation in national Patient Reported Outcome Measures (PROMs)

What was the issue? Collecting information from PROMs tells us how our patients feel before and after they have treatment or a procedure. Although we already collect clinical information on how patients recover after a procedure, PROMs data complements this by telling us how the patient feels the treatment or procedure has gone. The Trust has developed some PROMs to use locally, as well as participating in the new national pilot PROM, which is the only national PROM applicable to our care. The new PROM that was piloted focussed on patients who undergo procedures for cardiac artery grafting and unblocking the arteries of the heart (called coronary artery bypass grafting and angioplasty).

What are patient outcomes?

Patient outcomes look at the patient's health as a result of the treatment and care they receive e.g. if the patient suffered any complications following surgery (DH definition).

What did we do? The Trust began participation in the pilot PROM that ran from November 2011 that focuses on patients who undergo revascularisation. The project applied to all Trust patients undergoing planned angioplasty and coronary bypass grafting. Patients received a questionnaire when they attended their pre-admission clinic appointment (or if not then when they were admitted to hospital). The questionnaires are completed and returned to staff who submitted the completed forms on a monthly basis. The patients who completed the first questionnaire were then sent a post procedure questionnaire by the national PROMs team 6 months later. The data from the first questionnaire was compared

to data from the second questionnaire to see how patients felt about their health and the effectiveness of the procedure afterwards.

What does this mean for patient outcomes?
Patients' experience of treatment and care is a major indicator of quality and there has been a huge expansion in the development and application of questionnaires, interview schedules and rating scales that measure states of health and illness from the patient's perspective. Patient-reported outcome measures (PROMs) provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.
The PROMs pilot that we took part in was a success, although we are still awaiting published data back from this project. It is likely that this pilot will become an ongoing project, and we will continue to take part when it restarts.

Quality priority five

Managing complications effectively

What was the issue? The Trust is constantly striving to reduce the number of patients who experience a complication after treat or a procedure, complications can still occur. The Trust strives to ensure that when complications do occur they are managed effectively for the patient.

There were complications, but the support the staff provided made me feel I was part of a new family whose care & compassion aided my recovery. They were amazing.

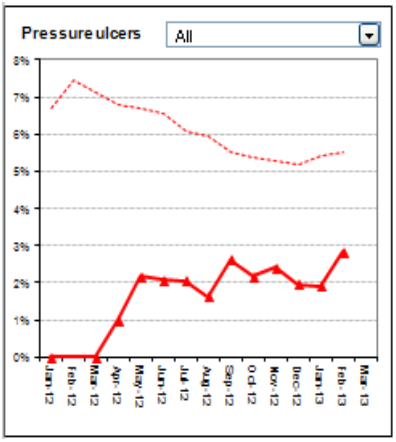
What did we do? In 2012-13 the Trust used an NHS improvement tool called the 'safety thermometer'[3] to measure, monitor and analyse patient harm and local improvement. The tool is being used to measure five specific topics:

- Pressure ulcers
- Surgical site infections
- Venous thromboembolisms
- Patient falls
- Catheter-related urinary tract infections
- Harm free care

The above tool was used to monitor occurrences of the above complications to measure improvements we made. The following graphs show how the Trust compares with national benchmarks for the specific topics.

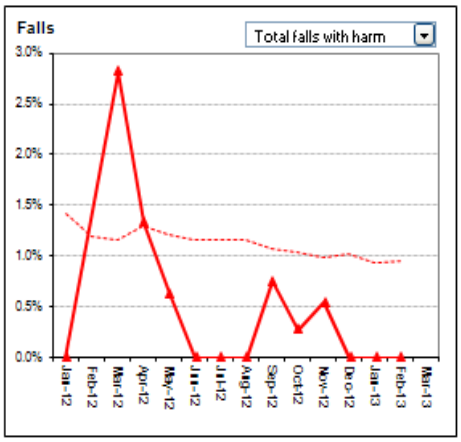
The solid line on the following graphs show the data for the Trust, the dashed line represents the national figures for the specified areas.

[3] NHS Safety Thermometer http://www.hscic.gov.uk/thermometer

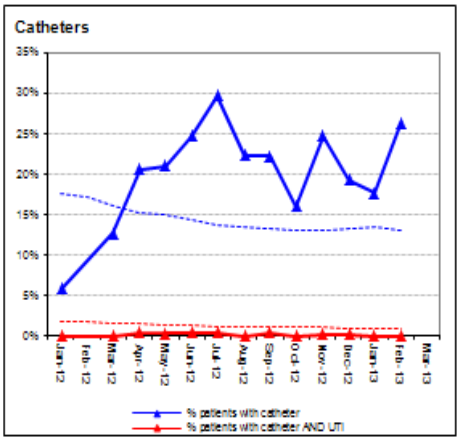


Pressure Ulcers

The above graph shows the Trust is below the national rate for pressure ulcers.



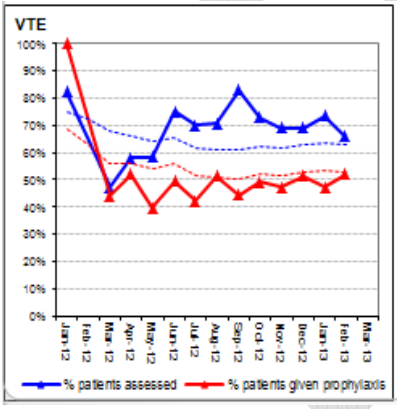
Although there was a spike in this graph for March 2012, since then we have been either at the national rate, although more often we have been below the national rate for falls.



The line that is above the national average rate shows that the Trust has many more patients with a catheter in place than other hospitals. As a specialist Trust we see many there are many more patients than usual that need catheters. In spite of this, we remain below the national average for the number of patients with a catheter in place with a urinary tract infection (UTI).

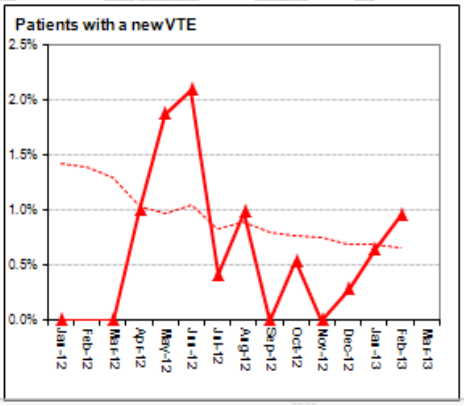
Falls

Catheters



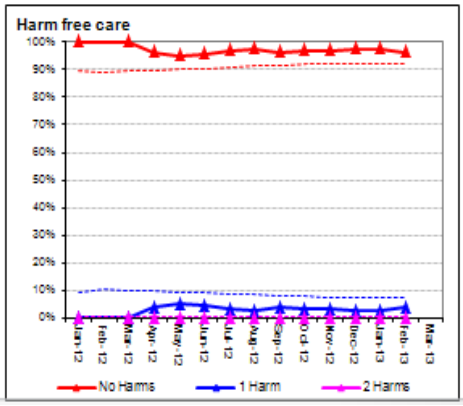
Venous Thrombo-embolism (VTE)

The above graph shows that for the past 9 months we have consistently assessed more patients for VTE than the national average rate. The Trust has been similar to the national rate to providing prophylaxis (preventative measures).



Patients with new VTE

Overall, the Trust has very low levels of patients developing new VTE, which explains the inconsistent results on the graph – as every new VTE represent a high % increase.



Harm Free Care

The Trust has had a period of over 12 months where we have consistently been better the national rate for harm free care. The Trust has not recorded any patients with more than 1 harm for a whole year.

What does this mean for patient outcomes?

The goal of the safety thermometer is to allow hospitals to measure the proportion of patient harm from any of the above listed specific topics. Once measured, it allows clinical data to be used for improvement work within the Trust, and allows us to compare ourselves to other hospitals, so we can constantly strive to improve to be above the national average, therefore reducing the rate of patient harm.

The safety thermometer is a tool that we will continue to use next year, and we will use as part of monitoring pressure ulcers as part of our quality priorities for 2013/14, and also as a CQUIN measure.

What is a CQUIN measure?

CQUIN is a payment framework that enables commissioners (who pay us for providing services) to reward excellence by linking a proportion of the Trust's income to the achievement of local quality targets.

Part 2b: Care group reports

In 2007 the Trust moved from having clinical departments and directorates to having care groups within 2 main divisions – heart and lung. This part of the report gives each care group the opportunity to show you where they feel they have improved quality this year. This may be a piece of work or a project or related to their practice where it is reflected in the patient outcomes.

Heart division

Cardiology

During 2012/13 there was a significant change in admissions policy for Cardiology at Royal Brompton Hospital. This involved acute admissions being made directly to Royal Brompton Hospital (RBH). The London Ambulance Service (LAS) began bringing patients with heart rhythm problems directly to an Arrhythmia Centre, rather than to an Accident & Emergency department. There are only 4 accredited arrhythmia receiving centres for this service in North London as part of the initial 6 month pilot phase.

The Trust is also one of four centres participating in the Non ST elevated acute coronary syndrome 6 month pilot where LAS is bringing patients directly to RBH rather than the Accident & Emergency Department.

There has been significant investment Harefield Hospital during 2012/13. Developments have included:

Acorn Ward – this ward has had an investment of £2m, which increased ward bed capacity by 18 beds. This was delivered in time to start welcoming patients in April 2012.

Cherry Tree Day-Case Unit – this has created a dedicated facility comprising 16 day-case beds.

The combined effect of these 2 projects has been to increase elective inpatient and day-case activity by 15%.

Fourth Cardiac Catheter Laboratory – Following on from the success of opening a new cardiac catheter laboratory equipped for electrophysiology in 2011, another new state of the art cardiac catheter laboratory was opened in June 2012. This new equipment has reduced exposure to X-radiation and has increased the overall capacity of Harefield Hospital to undertake cardiac catheterisation procedures.

Other service developments for 2012/13 have included:

Cardiomyopathy

The cardiomyopathy service at Royal Brompton Hospital has been restructured to provide expanded capacity and to deliver a day case model (Imaging & Consultation) to all new patients. The adult day-case clinics and the entire paediatric cardiomyopathy service were relocated to the Biomedical Research Unit (BRU) and an additional consulting room has been built in the BRU to ensure there is the capacity to support the reconfigured service. Further benefits following the restructure, include the ability to use the clinical genetics service to analyse family histories and family trees.

Syncope

The syncope service is a brand new service to the Trust and has completed its first year of operation. Two syncope specialist nurses were appointed and a new syncope and autonomic testing unit with tilt table was established on Paul Wood Ward in April 2012. This service has drawn in new referrals and repatriated diagnostic testing to the Royal Brompton Hospital. As well as rapid assessment, diagnostics and management of patients with unexplained transient loss of consciousness, the service offers direct access for patients and referrers to nurse specialists via email and mobile phone. The service also extends to paediatric patients. It is a cross site service which brings together Royal Brompton and Harefield Hospitals in a service with shared high quality standards. The service is led by a consultant cardiologist and an electro-physiologist. To date, the autonomic testing service has seen over 350 new patients.

Adult ECMO Service

The adult ECMO service has cared for increasing numbers of patients with severe but potentially reversible respiratory failure. The service is primarily responsible for patients in South West England, although in practice referrals are made from throughout the United Kingdom including Northern Ireland. The Trust has led the development of quality indicators for all five national centres. The established patient follow up service is demonstrating good quality of life in patients following discharge.

Heart Attack Centre

As part of the Heart Attack Centre, at Harefield we operate a large 24-hour primary angioplasty service, which has grown significantly over the past few years. Patients are brought to the hospital by ambulance either directly or via another hospital. For every 30-minute delay in treatment it is quoted there is a 7.5% increase in risk of death. We observe the national standards for these patients on specific time measures: the time from the initial emergency call is made or the time the patient enters Harefield to the time the first interventional device is deployed e.g. a stent is inserted into the blocked coronary artery.

I was rushed in suffering from a heart attack I was treated very quickly and by a brilliant doctor and the nurses were amazing

The table below shows the excellent outcomes we have against these measures and in fact we have the fastest treatment times in the country.

Measure	National standard	Harefield % 2012	Harefield median 2012 (mins)
Call to intervention	<150mins for >75% of patients	91.0	102
Arrival to intervention	<90 mins for >75% of patients	97.1	27

The Trust continuously monitors patient outcome measures such as the developing complications following a procedure. Data is submitted on a regular basis to national audits. This also provides us with data to benchmark ourselves against other Trusts.

Congenital Heart Disease Services

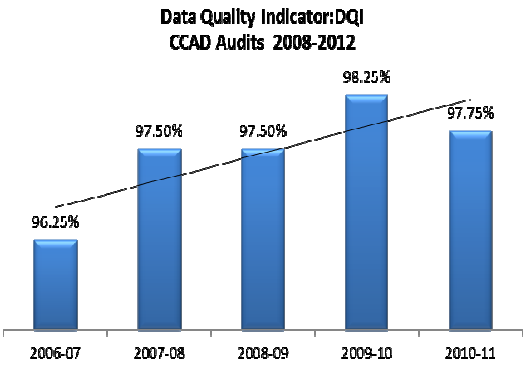
The Trust is currently subject to a review of the delivery of congenital heart surgery services to children in England and Wales. The Independent Reconfiguration Panel (IRP) visited the Royal Brompton on 24 January 2013. A comprehensive written statement was sent to the IRP in advance of the visit and on the day there was an opportunity for us to present new evidence to the panel and for members of staff to meet the panel and explain more about the work we do. The IRP will report to the Secretary of State for Health on 28th April and it is expected that their findings will be shared with us soon after that date.

In May 2012 we opened the new 4 bed sleep and ventilation unit and are now able to offer comprehensive evaluation and care for children with sleep and sleep related disorders. A large number of children will benefit from this, for example children with obstructive sleep apnoea, babies who were born premature who may have breathing problems when they are asleep, children with neuromuscular weakness, children with cerebral palsy, children with Down's syndrome or other inherited conditions, children with respiratory problems such as asthma, cystic fibrosis and numerous others.

The new unit means we have the ability to do far more sophisticated tests such as multiple sleep latency tests. This means we can provide more accurate information to help in the diagnosis and management of these children. Treatment can be tailored to the individual needs of each child. With this new Paediatric Sleep and Ventilation Unit we will be able to expand and improve the quality of the Royal Brompton Hospital clinical sleep service so that it compares favourably with the finest units around the world, in keeping with the Trusts' tradition of achieving excellence as a national and international referral centre. We will also be able to embark on a new programme of paediatric sleep medicine research. There are plans to foster collaborations not only with the adult sleep team here but also to build on our current ties with the top sleep centres in the world: Chicago, Brisbane and Toronto. We are developing a paediatric sleep medicine teaching programme for the trainee doctors, and organizing a National paediatric sleep medicine course.

Data quality

The Trust 2010-11 data submission to CCAD (NICOR) was audited in May 2012. The audit found a Data Quality Indicator of 97.75% and concluded that: *''On the whole the CCAD data was accurate, well documented, good quality. The centre has continued to maintain an excellent standard of data quality for the 5th successive year and although there has been a very small decrease this year (the overall score has decreased 0.5%) it is still in the 97-99% range*".



Clinical outcomes

The Trust continuously monitors patients' outcomes i.e. during their recovery or before they go home. As certain outcomes are collected nationally we can see how our patients are doing compared with nationwide figures.
National Institute for Cardiovascular Outcomes Research publishes aggregated (Surgery and Intervention) survival at 30 days figures and includes paediatric and adult congenital patients. The Trust's aggregate 30 days survival rate for 2012-13 is 99.2%. This means our results are 1.2% better than the most recently NICOR

published national 30 day survival aggregate figure of 98% for the year 2011-12. In light of recent happenings at Leeds Teaching Hospitals NHS Trust, we are aware that the way NICOR[4] review mortality is going to change and we are aware that this system is changing and that data will be published on the NICOR website.

Lung division

Centre for sleep

The adult centre for sleep build project was completed at the end of March 2013. This additional capacity, which has been created in new premises in South Block, will support growth in both NHS and private practice sleep services. It will also relieve pressure on existing facilities, such as Lind Ward and the Out-patient Department.

New appointments

A new medical consultant, specialising in asthma services, has been appointed within the Division to support the growing workload of the team, as well as develop new services such as the Cough Service and Continuous Laryngoscopy during Exercise (CLE) test. This new development is the start of a plan to develop a more specialist Lung Physiology service over the next 18 months.

A new Consultant appointment to the cystic fibrosis team has been agreed, and will be recruited shortly into the department. This development will support the service as its patients become increasingly complex in their care needs, as well as allowing the service to explore new ways of working alongside services local to the patient. It will also ensure that staffing levels of medical consultants meet national guidelines.

A new Higher Education Funding Council (HFCE) funded Consultant post has commenced at Harefield this year, and will support the development of the Non Invasive Ventilation (NIV) service on that site. This post compliments the rest of the Harefield Respiratory team, and takes forwards the development of Respiratory services at Harefield Hospital.

Adult Cystic Fibrosis Peer Review

The Adult Cystic Fibrosis service underwent an extensive Peer Review in March 2013. Initial feedback indicates that the clinical excellence of the service was recognised during the review process. Capacity restraints were also identified during the peer review process, and plans for managing these are being developed.

Fire Safety Improvement Programme

An extensive programme of Fire Safety improvements within the Fulham Road building commenced in 2012, and will continue over the next year. These improvements include changes to the fire compartmentation structures in clinical and non-clinical areas, improvements to the fire alarm system, and installing evacuation lifts within the existing list shafts.

Supporting Research

The successful generation of significant research grant income has allowed the Lung Division to extend the model of formalised backfill of consultant time to allow the busy clinical services to continue to flourish, whilst supporting the active research agenda across the Division

[4] NICOR - the National Institute for Cardiovascular Outcomes Research

Surgical oncology / thoracic surgery

The Trust is currently undergoing a London-wide review of cancer service provision. At present the Trust provides surgery for patients with thoracic cancer i.e. lung cancer, but we would like to expand our services and provide surgery to patients with other cancers as well.

The Trust participated in the 2011-12 National Lung Cancer Audit, results published in December 2012 showed that we met all relevant lung cancer standards, and exceeded standards in one area – active treatment. Active treatment is directed immediately to the cure of the cancer.

Transplant Services

During 2012/13, the number of heart transplants undertaken more than doubled compared to the two previous years, this exceeded our own target. Clinical outcomes of the heart transplantation programme also improved. These successes have been partly facilitated by the introduction of a new organ care system for transporting hearts. The system pumps blood around the heart, and it remains beating during transport. This means that organs can be collected from a wider geographical area and that they arrive in better condition than when a non beating heart is transported on ice.

These successes are of vital importance when seen against the backdrop of the national commissioner-driven review of cardiothoracic transplantation. This review has recommended the reduction of cardiothoracic transplant centres in England from five to four by 2015. With the best long-term survival rates, the largest survivor population, a robust surgical workforce model, a leading position in the adoption of innovative technologies and high rates of lung transplant and VAD activity, we are confident of continuing to provide a highly valued service into the future.

The transplant service has also participated in a number of clinical trials, including one involving a new reduced size mechanical heart assist device, and another which is investigating extension of the organ care retrieval system to transport lungs for transplant. A third trial has been investigating how the quality of lungs available for transplant can be improved by pumping a nutrient solution through them to optimise their condition prior to transplant.

Under the European Union Organ Donation Directive, from August 2012, all UK establishments conducting organ donation and transplantation activities were required to be licensed by the Human Tissue Authority (HTA). The purpose of the Directive was to set minimum standards for quality and safety of organs for transplantation across Europe, ensuring that risks to donors and recipients are minimised as far as possible. The Trust applied for a HTA licence in July 2012, including a self-report against the HTA's 27 assessment criteria; the licence was granted in August with no additional conditions attached, reflecting that the Trust is meeting all requirements. The HTA will audit this licence in April 2013.

Part 2c: Improvements in response to complaints/PALS contact

What is PALS?

PALS is our Patient Advice and Liaison Service. It is a confidential service that provides support, assistance and advice to patients, families and carers. The PALS team is here to listen to your concerns and queries about your experience in the hospital and help resolve problems quickly on your behalf.

In this section of the report we tell you about other improvements we have made in 2012-13 in response to feedback or contacts made with the PALS team or in response to complaints made to the Trust. Below is a summary of improvements which have been made this year:

- The cashiers now have an email address that patients can send their forms, receipt and letter of proof to for reimbursement of fares.
- As of January there is now a salad option on the menu every evening therefore providing inpatients with the choice of a healthy option.
- A new three week menu cycle has been introduced in Catering – giving more variation for patient's staying for a long time. All soups are now vegetarian and gluten free, all sauces, curries, casseroles are diary free and a wider range of vegetarian dishes has been introduced.
- Water jugs are changed right after lunch, which means that there are fewer disturbances during the quiet time.
- Discharge letters are now produced the night before, wherever possible, to reduce delays and allow patients to start the journey home earlier in the day. This message is being reinforced by additional training for new doctors at induction.
- The vehicle used to transport patients between Fulham Rd and Sydney St at the Royal Brompton Hospital site has been changed for one that meets the mobility needs of all patients.
- Two additional Pharmacy Porters have been employed to take patients discharge medication to the wards. They do two rounds each day, one in the morning and one in the evening; prior to this new system there was only one evening round. This further reduces the waiting time for patients to be discharged, so they can return home in a timely fashion.
- A service review is currently underway in Pharmacy to identify how to reduce length of time patients wait to receive medication.
- Monitors have been purchased for use in the Outpatient Departments to let patients, and their relatives/carers know when there will be delays in seeing doctors.
- We have accommodation for the use relatives/carers within the grounds of Harefield Hospital in Parkwood House; this accommodation is currently undergoing a refurbishment.

There is always room for discharge improvement we had to wait a while medicines to arrive.

Part 2d: Quality priorities for improvement in 2013-14

In this part of the report, we tell you about the areas for improvement in the next year in relation to the quality of our services and how we intend to do that. We call these our quality priorities and they fall into three areas: patient safety, patient experience and patient outcomes.

In October 2012 the Trust launched a paper and online survey to find out which topics people felt should be a priority when it comes to quality improvement in the hospitals. We wanted to have five quality priorities in 2013-14 but for these to be chosen by our stakeholders. With this in mind, we asked people voting to pick the category that best described them so we could then identify which topics mattered most to each group. The categories were as follows:

- Governors and Foundation Trust members
- Members of local involvement networks (LINks) – now known as Healthwatch
- Patients, their families/carers/advocates and the public
- Trust board members
- Staff

We had a great response to the survey with over 500 surveys returned, which culminated in the topics below being selected as the Trust's quality priorities for next year:

Respondent category	Quality priority topic 2013-14
	Patient safety
Staff	Reduction of pressure ulcers (complications)
LINks	Patient identification
	Patient experience
Governors and members	Developing a safety culture
Trust board members	Falls
	Patient outcomes
Patients and the public	Avoiding unnecessary readmissions

Further information and details on exactly what we will be measuring for each priority in 2013-14 can be found below.

Patient safety

Quality priority one

Reduction of pressure ulcers

What is the aim? Pressure ulcers are a type of injury that break down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are also sometimes known as 'bedsores' or 'pressure sores'.

Pressure ulcers can be unpleasant, upsetting and challenging to treat. Therefore, a range of techniques are used to prevent pressure ulcers developing in the first place. These include:

- regularly changing a person's position
- using equipment, such as specially designed mattresses and cushions, to protect vulnerable parts of the body

How will we measure this?

- The number of serious pressure ulcers in the Trust, which must be reported the Commissioners as a Serious Incident
- The percentage of patients who are risk assessed on the day of admission as to the likelihood of developing a pressure ulcer during their stay in hospital
- The overall rate for all pressure ulcers, benchmarked against the national rate, as reported through the Safety Thermometer tool (this is also a CQUIN measure for 2013-14 – see page 30 of this report for more information on CQUINs).

Quality Priority two

Patient Identification

What is the aim? Checking a patient's identity prior to any intervention is routine in hospital and wearing a wristband whilst in hospital ensures staff can identify patients correctly and give the right care. However, this can only happen if a patient is wearing a wristband and the information on it is accurate. This project will build on previous work, looking at the Trust's processes for patient identification, ensuring that we meet national standards and finding out whether the processes are acceptable to patients.

How will we measure this?

- The number of inpatients without a wristband.
- The percentage of patients meeting the gold standard of 2 printed, accurate wristbands.
- Where applicable, the percentage of patients with allergies wearing an accurate allergy band with allergy written in capitals in permanent marker.
- The percentage of staff who ask the patient to state their identification, not to confirm it e.g. 'what is your name', not 'are you Mrs Smith?'

Patient Experience

Quality Priority

Developing a safety culture

What is the aim? A positive safety culture has been shown to be a reliable indicator of an organisation's capacity for avoiding and managing patient safety incidents such as medication errors and patient falls, as well as an indicator of patient and staff satisfaction. Organisations with capacity to prevent, manage and learn from errors are better able to ensure the safety of their patients and staff. This project surveys staff on their beliefs about the importance of safety and the working culture in the hospital.

How will we measure this?

- The Trust staff culture survey will be conducted in June 2013, with all clinical teams across the hospital included.
- Every area to hold a multidisciplinary feedback session, and choose a topic for improvement.
- In March 2014 all areas will be re-surveyed with the aim of demonstrating improvement against the individual topic chosen

Quality priority

Falls

What is the aim? People are more likely to fall in-hospital than in their own homes, as a result of being in an unfamiliar environment, and sometimes as a side effect of the treatment they are receiving.

How will we measure this?

- The overall rate of falls which cause harm, benchmarked against the national rate, as monitored through the Safety Thermometer tool
- Review the root causes for all falls occurring in hospital; and develop specific indicators to monitor improvement as a result of this work

Quality Priority five

Avoiding unnecessary readmissions

What is the aim? The NHS uses the number of patients who have an unnecessary readmission to hospital as a measure of the quality of care provided. The reasons for readmission can be complex and relate to the care received after patients leave hospital as well as the quality of care in hospital. However, we aim to have as few unnecessary readmissions as possible so this project will be looking at our readmission rates, identifying the reasons associated with them and taking action to prevent recurrence.

How will we measure this?

- The percentage of inpatients requiring emergency readmission to any hospital within 30 days of discharge.
- For patients readmitted to our own hospitals, follow-up on all emergency readmissions to understand the reasons for this, and whether there is anything we could have done to prevent the readmission. Ensure any improvements identified are shared across the organisation.

Part 2e: Performance against national quality indicators

Royal Brompton and Harefield NHS Foundation Trust consider this data is as described because it is data from our HES (Hospital Episode Statistics) submitted data. Due to our processes around this data, we believe the data reported back to us to be accurate. We have checked the figures (where possible) with our own internal data and we believe it to be accurate.

Royal Brompton and Harefield NHS Foundation Trust is taking the following actions to improve these scores, and so the quality of its services by:

Patient Safety Incidents resulting in severe harm: this is being reviewed by our external auditors, as part of their review of the Quality Report 2012-13, and we will work to implement the recommendations they propose.

Please note the figures in the table below are obtained from the recommended sources and are the most up to date figures provided

Indicator	Applicable to Trust?	From local Trust data		From Health and Social Care Information Centre				
		2011-12	2012-13	Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average
Domain 3: Helping people recover from episodes of ill health or following injury								
Emergency readmissions to hospital within 28 days of discharge: ○ % of patients aged 0-15 readmitted within 28 days ○ % of patients aged over 15 readmitted within 28 days	✓	*[5]	*	9.89% 9.39%	2010-11 2010-11	0% 0%	25.80% 22.93%	10.15% 11.42%
Domain 4: Ensuring that people have a positive experience of care								
Responsiveness to inpatients' personal needs *Source: national NHS inpatient survey*	✓	74.3	77	74.3	2011-12	85.0	56.5	67.4
Percentage of staff who would recommend the provider to friends or family needing care *Source: national NHS staff survey*	✓	92%	93%	93%	2012	96%	22%	63%
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm								
Percentage of admitted patients risk-assessed for venous thromboembolism (VTE)	✓	96.3%	92.9% (up to M11)	94.3%	Q3 2012-13	99.9%	84.6%	94.2%
Rate of *clostridium difficile* (number of infections/100,000 bed days)	✓	7.41	10.1	11.7	2011-12	0	51.6	21.8
Patient safety incidents: ○ Rate of patient safety incidents (number of patient safety incidents reported / 100 admissions) ○ and percentage resulting in severe harm or death	✓ ✓	6.9 0.1%	6.6 0.2%	5.2 0.1%	Q1+2 2012-13	1.4 0%	24.9 0.3%	------ 0.1%

[5] Data on readmissions is reviewed by a different approach within the Trust, which is not comparable here.

Friends and family test

Improving patient experience is a key priority for the Government and is set out in the White Paper, '*Equity and Excellence*'[6]. The Friends and Family (FFT) test is a simple, comparable test that shows where organisations need to improve and provides the mechanism with which to investigate and act upon where they are failing and so improve their performance.

From April 2013, the results of the FFT from all NHS organisations will be made public.

Trust performance for March 2013 was very encouraging with an overall return of 24%. This score exceeds the DH target return of 15%.

When asked: How likely are you to recommend Royal Brompton and Harefield wards to friends and family?

- 84% of patients said Extremely likely
- 11% said Likely
- 1.7% said Neither likely nor unlikely

When asked: Overall, how would you rate the hospital?

- 81% of patients said their care was EXCELLENT
- 16% said care was GOOD
- 0.8% said care was FAIR
- 1.3% of patients did not record their choice

We will continue to monitor this in the following year, and the results will be made public.

[6] Equity and Excellence: Liberating the NHS, July 2010

Part 3: Formal statements of assurance

CQC registration

Royal Brompton & Harefield NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions.

The CQC has not taken enforcement action against Royal Brompton & Harefield NHS Foundation Trust during 2012-13.

Royal Brompton & Harefield NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Royal Brompton Hospital was inspected by the CQC in January 2013 as part of its routine inspection programme. The CQC declared Royal Brompton Hospital compliant with all of the standards that were inspected.

Harefield Hospital was inspected by the CQC in June 2012 as part of its routine inspection programme, and the CQC declared Harefield Hospital compliant with all of the standards which were inspected.

Provision of NHS services

During 2012-13 Royal Brompton & Harefield NHS Foundation Trust provided 16 NHS services. Royal Brompton & Harefield NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 16 of these NHS services.

The income generated by the NHS services reviewed in 2012-13 represents 100% of the total income generated from the provision of NHS services by Royal Brompton & Harefield NHS Foundation Trust for 2012-13.

Use of the CQUIN Payment Framework

http://www.hscic.gov.uk/thermometerTwo and a half percent of Royal Brompton & Harefield NHS Foundation Trust income in 2012-13 was conditional on achieving quality improvement and innovation goals agreed between Royal Brompton & Harefield NHS Foundation Trust and North West London Commissioning Partnership for the provision of NHS services, through the commissioning for Quality and Innovation (CQUIN) payment framework.

What is a CQUIN measure?

CQUIN is a payment framework that enables commissioners (who pay us for providing services) to reward excellence by linking a proportion of the Trust's income to the achievement of local quality targets.

The Trust's CQUIN goals for 2012-13 were as follows:

1 Improve VTE prevention
2 Responsiveness to patient needs
3 Improve awareness and diagnosis of dementia
4 NHS safety thermometer - improve collection of data in relation to pressure ulcers, falls and urinary tract infection in those with a catheter and VTE
5 Provide real-time information to GPs
6 Use of integrated formulary
7 COPD discharge bundle
8 End of life care planning

Further details of the agreed goals for 2012-13 and for the following 12-month period are available online at:

http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

The Trust has met the milestones for the first 6 months of the year, and if the Trust achieves 100% of CQUIN payment for 2012-13, this will equate to £4.7 million of income.

However please note: Achievement of CQUIN goals for January – March 2013 (quarter 4) has not yet been ratified by the commissioner.

Participation in clinical audit

During 2012-13, 22 national clinical audits and 5 confidential enquiries covered NHS services that Royal Brompton & Harefield NHS Foundation Trust provides.

The Trust participated in 95.4% of national clinical audits and 100% national confidential enquiries that it was eligible to participate in. The national clinical audits and national confidential enquiries that the Royal Brompton and Harefield NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2012-13, including actual participation rates, are listed below:

What is clinical audit?

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes. This is done through a systematic review of care against specific criteria followed by implementation of

Clinical Audit Topic[1]	Did the Trust participate?	Participation rate[2]
Children		
Paediatric pneumonia (BTS)	✓	**100%**
Paediatric asthma (BTS)	✓	**100%**
Paediatric intensive care (PICANet)	✓	**100%**
Congenital heart disease (paediatric cardiac surgery) (NICOR)	✓	**100%**
Acute care		
Emergency use of oxygen (BTS)	x	**n/a**
Adult community acquired pneumonia(BTS)	✓	**100%**
Non-invasive ventilation –adults (BTS)	x	**n/a**
Pleural procedures (BTS)	✓	**100%**
Cardiac arrest	x	**n/a**
Adult critical care (ICNARC)	✓	**100%**
Potential donor audit (NHSBT)	✓	**100%**
Long term conditions		
Chronic pain (NPA)	✓	**100%**
Bronchiectasis (BTS)	✓	**100%**
Elective procedures		
Cardiothoracic transplantation (NHSBT)	✓	**100%**
Coronary angioplasty (NICOR)	✓	**100%**
Adult cardiac surgery (NICOR)	✓	**100%**
Cardiovascular disease		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	**100%**
Heart failure	✓	**100%**
Cardiac arrhythmia (CRM)	✓	**100%**
Pulmonary Hypertension	✓	**100%**
Cancer		
Lung cancer (NLCA)	✓	**100%**
Blood transfusion		
Blood transfusion	✓	**100%**

[1] *list of all national clinical audits that RBHNFT was eligible to participate in*

[2] *cases submitted/number of cases required, as a percentage*

Confidential Enquiry[1]	Did trust participate?	Participation rate[2]
Asthma Deaths	✓	100%
Child Health	✓	100%
Maternal Infant and perinatal Death	✓	100%
Patient Outcome and Death	✓	100%
Elective Surgery (national PROMS programme - pilot for revascularisation)	✓	100%

[1] *list of all confidential enquiries that RBHNFT was eligible to participate in*

[2] *cases submitted/number of cases required, as a percentage*

The Trust was not eligible to participate in 25 national clinical audits and confidential enquires, as identified by HQIP for 2012-13. These are listed below:

Adult asthma, Bowel cancer, Carotid interventions, Diabetes (adult), Diabetes(paediatric), Epilepsy 12 (childhood epilepsy), Fever in children, Fractured neck of femur, Head and neck oncology, Hip fracture, Inflammatory bowel disease, National joint registry, Neonatal intensive and special care, Parkinson's Disease, Prescribing observatory for mental health, Psychological therapies, Renal colic, Renal registry, Renal transplantation, Stroke, Trauma, Vascular Surgery, Dementia, Maternal infant and perinatal death, Suicide and homicide in mental health.

The reports of 67 national and local clinical audits were reviewed by the provider in 2012-13. Details of some of the key findings and actions taken to improve the quality of healthcare are listed below.

National clinical audits

National lung cancer audit: 2012-13 was the first year that national results were provided comparing centres against each other for four key indicators. Royal Brompton & Harefield NHS Foundation Trust was found to be equivalent to other centres for all relevant standards, and performing above the level of other trusts for 'active treatment'. This is the proportion of patients receiving active treatment, and is important as a marker of the how quickly and efficiently patients receive treatment once they are admitted to our care.

Heart Surgery: In 2012-13, the Society of Cardiothoracic Surgeons published newly analysed results for cardiac surgery comparing centres against each other for 3 key types of procedure. The results published reflect historical data for 2008-11. These results show all surgeons operating on both sites have outcomes within the expected national parameters. The results for Harefield, as a whole unit, show that it is outside of the expected range. The SCTS has modified the way this data has been analysed and we await a full explanation about the new methodology, but the Trust has carried out an in-depth review of practices and outcomes, and is confident that the Harefield unit results are not a reflection of the current service.

Local clinical audits

Patient Identification: 715 in-patients were reviewed to check that they were wearing wristbands and that these contained the correct information. This is important, as it is the primary way of identifying patients prior to treatment (especially for those who are unwell and may not be able to answer questions about their identity). Over 99% of the wristbands reviewed were printed and had accurate information. However, we did not score so highly on ensuring patients were given a wristband promptly on arrival, or that the gold standard of wearing 2 wristbands was achieved across all the clinical areas. Therefore, patient identification has been chosen as a Quality Priority project for 2013-14 – see page 24 for more information.

Hand hygiene: Handwashing at the correct times and in the correct way is important for minimising the spread of infection. Monthly audits are carried out, where staff are observed as they go about their activities on the wards, and are assessed against the national standards for handwashing. The Trust totals for hand hygiene and bare below the elbows for April 2012-March 2013 were 84% and 96% respectively.

Participation in research

As a specialist tertiary centre, staying at the forefront of research and innovation is vital to the delivery of our services and is part of the overall mission of the Trust; to

"undertake pioneering and world–class research into heart and lung disease in order to develop new forms of treatment which can be applied across the NHS and beyond".

In 2012, the Trust revised and renewed its 3-year Research Strategy. It set out four key objectives aimed collectively at further extending and enhancing the national and international research profile of the organisation. The 4 research goals are:

- To support and develop research-active staff – increasing critical mass and productivity of research leaders and ensuring that all staff are appropriately trained and supported
- To exploit opportunities to attract and retain research funding – increasing the value of research funding coming to the Trust and ensuring high quality delivery of studies, to time and on target
- To promote and increase engagement in Trust research – by raising awareness of research activities amongst all staff and patients/carers
- To provide effective and well managed research facilities, research resources and administrative support.

These objectives map onto all areas of research activity within the Trust and will be achieved by working in collaboration with partners from the academic and industry sector.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Royal Brompton and Harefield NHS Foundation Trust during 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 4000[7]. These patients were recruited into 180 clinical research projects which involved 82 different principal investigators. Of these accruals, 1575 were into NIHR portfolio studies.

In addition over 1500 patients were consented to donate their tissue for retention within the Trust's ethically approved Research BioBanks during 2012/13.

[7] Please note that currently these figures are draft numbers that await confirmation.

Data quality

Statement on relevance of data quality and actions to improve data quality

In Royal Brompton & Harefield NHS Foundation Trust, data quality is seen as everybody's responsibility. Such an approach helps the Trust ensure that very high standards in data quality are maintained throughout the organisation.

The Trust uses the following initiatives to maintain very high quality of data and therefore a high quality service to all service users:

- Fortnightly batch tracing of service user records against Patient Demographics Service (PDS)
- Routine back office cleansing of difficult to trace records against PDS
- Prompt reporting and investigation of all data quality issues
- Regular briefing of frontline staff at team meetings
- Routine checking and updating of service user information with service users

GP Details and NHS number coding

The Trust scores are above the payment by result (PBR) targets for both NHS number (95%) and GP details (98%). Levels for both indicators are monitored retrospectively and prospectively.

Provisional data from PAS (April 2012 - March 2013)

The table reflects most recent data available from Trust PAS system. The same information should be available from SUS.

Indicator	Patient group	Trust score	Average national score
Inclusion of patient's valid NHS number	Inpatients	98.3%	98.7%
	Outpatients	99.6%	99.0%
Inclusion of patient's valid general medical practice code	Inpatients	99.9%	99.9%
	Outpatients	99.8%	99.7%

Figures for accident and emergency care are not applicable as the Trust does not provide this service.

Information governance toolkit attainment levels 2012-13

Royal Brompton & Harefield NHS Foundation Trust's Information Governance Assessment Report overall score for 2012-13 is 94%. It is graded satisfactory. In comparison with all the other London Trusts, the Trust was ranked second, the highest score was 96%.

Clinical coding error rate

Royal Brompton & Harefield NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2012-13 by the Audit Commission.

Performance against key healthcare targets 2012-13

What is payment by results (PbR)?

PbR is a system used in England to reimburse hospitals for the care they provide. It means payments are directly related to the number of procedures and other activity undertaken.

What is the information governance toolkit?

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The toolkit provides NHS organisations with a set of standards against

What is clinical coding?

Clinical coders use a set of nationally and internationally understood codes to classify the diagnosis and treatment for each admitted patient. These codes are submitted nationally and are used for statistics and studies and also enable to Trust to receive payment for the care we provide.

For NHS trusts there are national healthcare targets that enable the DH and other institutions to compare and benchmark trusts against each other. Trusts are required to report against the targets that are relevant to them. The table below shows the key healthcare targets that this Trust reports on a quarterly basis to the Trust board and also externally. They are from Monitor's Compliance Framework, the CQC and our commissioners.

National priority	Source	Target/ threshold	Monitor weighting	2012-13 Q1 Score	2012-13 Q2 Score	2012-13 Q3 Score	2012-13 Q4 Score	Indicator met
Clostridium difficile - DoH objective in dispute and Monitor de Minimis is 12	Compliance Framework	12	1.0	6	13	16	18	✗*
MRSA – maintaining the annual number of MRSA bloodstream infections at 5 or less (baseline year 2003/04) as agreed with commissioners	Compliance Framework	6	1.0	0	0	0	1	✓
Maximum waiting time of 31 days for subsequent surgical treatment for all cancers	Compliance Framework	94%	1.0	100%	100%	98.86%	100.00 %	✓
Maximum two-month wait from referral to treatment for all cancers	Compliance Framework	79%	1.0	90.32%	91.18%	82.35%	80.00%	✓
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	Compliance Framework	93%	0.5	100%	100%	100%	100.00 %	N/A
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	Compliance Framework	96%	0.5	98.55%	98.06%	100%	98.63%	✓
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance Framework	-	0.5	-	-	-	-	✓
Maximum two-week wait standard for Rapid Access Chest Pain Clinics	Care Quality Commission	98%	-	100%	100%	100%	100%	✓
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	Care Quality Commission	<2%	-	1.80%	1.40%	1.40%	1.30%	✓
Delayed transfers of care to be maintained at a minimal level	Care Quality Commission	3.50%	-	0.31%	0.19%	0.29%	0.10%	✗
Percentage of patients seen within 18 weeks for admitted and non-admitted pathways	Commissioners	Admitted: 90%	-	90.30%	90.30%	89.10%	86.50% (YTD)	✓
		Non-admitted: 95%		97.20%	97.50%	97.30%	96.90% (YTD)	

The use of "–" in the table above means there was no target set or this indicator was not measured in that year

Performance against key healthcare targets 2011-12

National priority	Source	Target/ threshol	Monitor weightin	2011-12 Q1	2011-12 Q2	2011-12 Q3	2011-12 Q4	Indicator met

		d	g	Score	Score	Score	Score	
Clostridium difficile - year on year reduction to comply with the trajectory for the year agreed with Kensington & Chelsea PCT	Compliance Framework	7	1.0	3	8	10	13	×*
MRSA – maintaining the annual number of MRSA bloodstream infections at 5 or less (baseline year 2003/04) as agreed with commissioners	Compliance Framework	1	1.0	0	0	0	0	✓
Maximum waiting time of 31 days for subsequent surgical treatment for all cancers	Compliance Framework	94%	1.0	100%	100%	100%	100%	✓
Maximum two-month wait from referral to treatment for all cancers**	Compliance Framework	79%	1.0	88.46%	83.33%	80.65%	80.65%	✓
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	Compliance Framework	93%	0.5	100%	100%	N/A	100%	N/A
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	Compliance Framework	96%	0.5	98.60%	97.60%	97.85%	97.50%	✓
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance Framework	-	0.5	-	-	-	-	✓
Maximum two-week wait standard for Rapid Access Chest Pain Clinics	Care Quality Commission	98%	-	100%	100%	100%	100%	✓
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	Care Quality Commission	<2%	-	1.30%	1.10%	1.10%	1.30%	✓
Delayed transfers of care to be maintained at a minimal level	Care Quality Commission	-	-	0.25%	0.25%	0.27%	0.28%	✓
Percentage of patients seen within 18 weeks for admitted and non-admitted pathways	Commissioners	Admitted: 90%	-	90.7%	90.1%	91.9%	92.4%	✓
		Non-admitted: 95%		98.4%	96.8%	96.2%	98.6%	

Part 4: Statements from our stakeholders

Statements from Healthwatch (formerly know as local involvement networks)

To be incorporated into final version once received.

Statement from our governors

To be incorporated into final version once received.

Statement from our oversight and scrutiny committees

To be incorporated into final version once received.

Statement from our commissioner – North West London Commissioning Support Unit

To be incorporated into final version once received.

Glossary

A	
Adult Intensive Care Unit (AICU or ICU)	A special ward for people who are in a critically ill or unstable condition and need constant medical support to keep their body functioning.
Atrial fibrillation (AF)	An abnormal heart rhythm in which the atria, or

	upper chambers of the heart, “quiver” chaotically and are out of sync with the ventricles, or lower chambers of the heart.
B	
Biobank	A cryogenic storage facility used to archive tissue samples for use in research.
Biomedical research unit (BRU)	A nationally recognised and funded unit to provide the NHS with the support and facilities it needs for first-class research.
C	
Cancelled operations	This is a national indicator. It measures the number of elective procedures or operations which are cancelled for administrative reasons e.g. lack of time, staffing, equipment etc.
Cardiac surgery	Heart surgery.
Cardiac valve procedures	A type of heart surgery, where one or more damaged heart valves are repaired or replaced.
Cardiomyopathy	Disease of the heart muscle.
Care Quality Commission (CQC)	The independent regulator of health and social care in England. www.cqc.org.uk
Clinical audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary.
Clostridium difficile infection	A type of infection that can be fatal. There is a national indicator to measure the number of *C. difficile* infections which occur in hospital.
Commissioning for Quality and Innovation (CQUIN)	A payment framework enabling commissioners to reward excellence by linking a proportion of the Trust’s income to the achievement of local quality improvement goals.
Compliance framework	The Compliance Framework sets out the approach Monitor uses to assess the compliance of NHS foundation trusts with their terms of authorisation and to intervene where necessary.
Coronary artery bypass graft (CABG)	A type of heart surgery where the blocked or narrowed arteries supplying the heart are replaced with veins taken from another part of the patients body.

D	
Delayed transfers of care	A national indicator. Assesses the number of patients who are delayed when being transferred from one health organisation to another e.g. from one hospital to another, or from hospital to community care.
Department of Heath (DH)	The government department that provides strategic leadership to the NHS and social care organisations in England. www.dh.gov.uk/
E	
Eighteen (18) week wait	A national target to ensure that no patient waits more than 18 weeks from GP referral to treatment. It is designed to improve patients' experience of the NHS, delivering quality care without unnecessary delays.
ECMO	Extracorporeal membrane oxygenation (ECMO) is an technique of providing both cardiac and respiratory support oxygen to patients whose heart and lungs are so severely diseased or damaged that they can no longer serve their function.
Elective operation/procedure	A planned operation or procedure. It is usually a lower risk procedure, as the patient and staff have time to prepare.
Emergency operation/procedure	An unplanned operation or procedure that must occur quickly as the patient is deteriorating. Usually associated with higher risk, as the patient is often acutely unwell.
End of life care (EOL)	Care in last 48 hours of life for expected deaths.
Expected death	An anticipated patient death caused by a known medical condition or illness.
F	
Foundation trust (FT)	NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. They still provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay. Royal Brompton and Harefield became a Foundation Trust on 1st June 2009.

G	
Governors	Royal Brompton & Harefield NHS Foundation Trust has a council of governors. Most governors are elected by the Trust's members but there are also appointed governors. http://www.rbht.nhs.uk/about/our-work/foundation-trust/governors/
H	
Health protection agency (HPA)	The Health Protection Agency is an independent organisation set up to protect the public from threats to their health from infectious diseases and environmental hazards. It provides advice and information to the government, general public and health professionals. http://www.hpa.org.uk/
Hospital episode statistics (HES)	The national statistical data warehouse for the NHS in England. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations.
Hospital standardised mortality ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths in each hospital and then compares trusts against a national average.
I	
Indicator	A measure that determines whether the goal or an element of the goal has been achieved.
Inpatient	A patient who is admitted to a ward and staying in the hospital.
Inpatient survey	An annual, national survey of the experiences of patients who have stayed in hospital. All NHS trusts are required to participate.
L	
Local clinical audit	A type of quality improvement project involving individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team.

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. http://www.nhs.uk/NHSEngland/links/Pages/links-make-it-happen.aspx
Liverpool care pathway	A care pathway specifically for patients who are dying.
M	
MINAP	**M**yocardial **I**schaemia **N**ational **A**udit **P**roject. A national registry of patients admitted in England and Wales who have had a heart attack or have severe angina and need urgent treatment
Monitor	The independent regulator of NHS foundation trusts. http://www.monitor-nhsft.gov.uk/
Multidisciplinary team meeting (MDT)	a meeting involving healthcare professionals with different areas of expertise to discuss and plan the care and treatment of specific patients.
multi-resistant staphylococcus aureus (MRSA)	A type of infection that can be fatal. There is a national indicator to measure the number of MRSA infections that occurs in hospitals.
N	
National clinical audit	A clinical audit that engages healthcare professionals across England and Wales in the systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care. The priorities for national audits are set centrally by the Department of Health and all NHS trusts are expected to participate in the national audit programme
National Institute for Health and Clinical Excellence (NICE)	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. http://www.nice.org.uk/
National patient safety agency (NPSA)	An arm's length body of the department of health that leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the

	health sector. http://www.npsa.nhs.uk/
National quality board	A department of health board established to champion quality and ensure alignment in quality throughout the NHS.
Never events	Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Trusts are required to report nationally if a never event does occur. The Trust has not reported any never events in 2011-12.
NHS institute of innovation and improvement (NHSIII)	Assists the NHS in transforming healthcare for patients by developing and spreading new work practices, technology and improved leadership.
NHS London	NHS London is the Strategic Health Authority (SHA) for the Greater London area. They provide strategic leadership for the capital's healthcare. http://www.london.nhs.uk/
NHS number	A 12 digit number that is unique to an individual, and can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care.
NICOR - National Institute for Cardiovascular Outcomes Research	NICOR is part of the Centre for Cardiovascular Preventions and Outcomes at University College London.
Northwest London Commissioning Partnership	The group responsible for commissioning the services provided by the Trust.
O	
Operating framework	An NHS-wide document outlining the business and planning arrangements for the NHS. It describes the national priorities, system levers and enablers needed to build strong foundations whilst keeping tight financial control.
Outpatient	A patient who goes to a hospital and is seen by a doctor or nurse in a clinic, but is not admitted to a ward and is not staying in the hospital.
Outpatient survey	An annual, national survey of the experiences of patients who have been an outpatient. All NHS trusts are required to participate.

Overview and scrutiny committee (OSC)	OSC looks at the work of the primary care trusts and NHS trusts and London Strategic Health Authority. It acts as a 'critical friend' by suggesting ways that health-related services might be improved. It also looks at the way the health service interacts with our social care services, the voluntary sector, independent providers and other council services to jointly provide better health services to meet the diverse needs of the area.
P	
PAR score – **P**atient **A**t **R**isk score	This is a national tool to help staff recognise and act appropriately when a patient's condition is deteriorating. Patients are scored depending on key observations such as blood pressure, pulse rate, respiratory, temperature etc. A patient with a high score may be deteriorating and should be referred for further review.
PAS – Patient Administration System	The system used across the Trust to electronically record patient information e.g. contact details, appointments, admissions.
Patient record	A single unique record containing accounts of all episodes of health care delivered to the patient at the Trust and any other relevant information.
PCI	Percutaneous coronary intervention (PCI), is also known as coronary angioplasty or simply angioplasty, it is a procedure used to treat the narrowed coronary arteries of the heart and angina in patients. It is sometimes used as an emergency treatment for patients who have had a heart attack.
Pressure ulcers	Sores that develop from sustained pressure on a particular point of the body. Pressure ulcers are more common in patients than in people who are fit and well, as patients are often not able to move about as normal.
Primary coronary intervention (PCI)	Often known as coronary angioplasty or simply angioplasty. A procedure used to treat the narrowed coronary arteries of the heart found in patients who have a heart attack or have angina.
Priorities for improvement	There is a national requirement for trusts to select

	three to five priorities for quality improvement each year. This must reflect the three key areas of patient safety, patient experience and patient outcomes.
Q	
Quality and risk profile (QRP)	A tool used by the CQC to monitor compliance with the essential standards of quality and safety. They help in assessing where risks lie and play a key role in providers' own internal monitoring as well as informing the commissioning of services. The QRP includes data from a number of sources which is analysed to identify areas of potential non compliance.
R	
Re-admissions	A national indicator. Assesses the number of patients who have to go back to hospital within 30 days of discharge.
S	
Safeguarding	Safeguarding is a new term which is broader than 'child protection' as it also includes prevention. It is also applied to vulnerable adults.
Safety Thermometer	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. http://www.hscic.gov.uk/thermometer
Secondary uses service (SUS)	A national NHS database of activity in trusts, used for performance monitoring, reconciliation and payments.
Serious Incidents	An incident requiring investigation that results in one of the following: • Unexpected or avoidable death • Serious harm • Prevents an organisation's ability to continue to deliver healthcare services • Allegations of abuse • Adverse media coverage or public concern • Never events
Surgical Site Infection	An infection that develops in a wound created by having an operation.
Single sex accommodation	A national indicator which monitors whether ward accommodation has been segregated by gender.

Sleep apnoea	A sleep disorder characterised by abnormal pauses in breathing or instances of abnormally low breathing, during sleep.
Society of Cardiothoracic Surgeons (SCTS)	http://www.scts.org/
Standard contract	The annual contract between commissioners and the Trust. The contract supports the NHS Operating Framework.
Summary Care Record (SCR)	A summary of a patient's key health information that will be available to anyone treating them in the NHS across England.
Surgical Site Infection Surveillance Service (SSISS)	A national scheme whereby trusts must collect and analyse data on Surgical Site Infections (SSI) using standardised methods. It provides national data that can be used as a benchmark allowing individual hospitals to compare their rates of SSI with collective data from all hospitals participating in the service.
Syncope	Fainting (syncope) is caused by a temporary reduction in blood flow to the brain.
V	
Venous thromboembolism (VTE)	An umbrella term to describe venous thrombus and pulmonary embolism. Venous thrombus is a blood clot in a vein (often leg or pelvis) and a pulmonary embolism is a blood clot in the lung. There is a national indicator to monitor the number of patients admitted to hospital who have had an assessment made of the risk of their developing a VTE.

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WORK PROGRAMME 2012/2013

Officer Contact	Nav Johal and Danielle Watson, Administration Services
Papers with report	Appendix A: Work Programme 2012/2013 & 2013/2014

REASON FOR ITEM

To enable the Committee to plan and track the progress of its work in accordance with good project management practice.

OPTIONS AVAILABLE TO THE COMMITTEE

1. Note the proposed Work Programme.

2. To make suggestions for/amendments to future working practices and/or reviews.

INFORMATION

1. The meeting dates for 2013/14 have been agreed by Council. Members are asked to highlight issues that they feel the Committee may want to examine in 2013/14. The meeting dates for the next municipal year are as follows and the meetings will start at 6pm unless indicated:

Meetings	Room
Wednesday 5 June 2013	CR6
Tuesday 16 July 2013	CR6
Thursday 5 September 2013	CR6
Thursday 10 October 2013	CR6
Tuesday 19 November 2013	CR6
Thursday 9 January 2014	CR6
Tuesday 18 February 2014	TBC
Tuesday 18 March 2014 – 5pm	TBC
Thursday 17 April 2014	TBC

2. Members of the Committee have agreed that, over the year, major reviews that were undertaken of the following topics:

- The role of Special Constables – The final report was considered by Cabinet at its meeting on 21 March 2013, and the recommendations were fully endorsed.
- Diabetes – The draft final report is being prepared and would be available for External Services to consider at this meeting.

SUGGESTED COMMITTEE ACTIVITY

1. Members to review the work to be undertaken in the 2013/2014 municipal year and highlight issues for potential scrutiny.

2. Members note the Work Programme and make any amendments as appropriate.

3. Ensure Members are clear on the work coming before the Committee.

BACKGROUND DOCUMENTS

None.

APPENDIX A

EXTERNAL SERVICES SCRUTINY COMMITTEE

2012/13 WORK PROGRAMME

NB – all meetings start at 6pm in the Civic Centre unless otherwise indicated.

Shading indicates completed meetings

Meeting Date	Agenda Item
6 June 2012	**NHS NWL** NHS North West London will attend to update the Committee to Shaping a healthier future.
17 July 2012 – 5pm	**LINk** To receive a report on the progress of LINk in the Borough since the last update received by the Committee in July 2011. **CNWL** To receive an update from CNWL. **Public Health** To receive an update in relation to public health from Dr Friedman.
13 September 2012	**NHS & GPs** Performance updates, updates on significant issues and review of effectiveness of provider services: • NHS Hillingdon • The Hillingdon Hospital NHS Foundation Trust • Royal Brompton & Harefield NHS Foundation Trust • Central & North West London NHS Foundation Trust • London Ambulance Service • Hillingdon CCG • Hillingdon LINk **Previous Major Review Updates** To receive an update on progress made with regard to the Committee's major review recommendations over the last four years - Members requested that they receive an update at the meeting on 13 September 2012 on progress made with regard to the Committee's major review recommendations over the last four years.

Meeting Date	Agenda Item
11 October 2012	**Safer Hillingdon** To scrutinise the issue of crime and disorder in the Borough (Safer Neighbourhoods Team, Metropolitan Police Service, etc).
20 November 2012	**Pharmacies and Opticians** To receive an update in relation to pharmacies and opticians in the Borough. **Prescription Services** To receive a report on prescription services in the Borough. **CNWL Consultation Update** To receive an update following the conclusion of the consultation in relation to proposed changes to the bed based mental health service at Hillingdon Hospital.
10 January 2013	**Utility Services** To receive an update on the impact of the provision and quality of services provided by the utility companies in the Borough (TfL, water, gas, electricity, cable and telephone). Other areas to be scrutinised include the standard of maintenance of the substations and the enforcement options open to the Council when utility companies fail to adhere to standards.
19 February 2013 – 4pm	**Community Cohesion Review** To review the community cohesion achievements since March 2012 – Young People in the Borough
19 March 2013 – 5pm	**Crime & Disorder** • Metropolitan Police Service (MPS) • Safer Neighbourhoods Team (SNT) • London Fire Brigade • Probation Service • British Transport Police

Meeting Date	Agenda Item
18 April 2013	**Quality Reports & CQC Evidence Gathering** • Hillingdon Primary Care Trust (PCT) • The Hillingdon Hospital NHS Foundation Trust • Royal Brompton & Harefield NHS Foundation Trust • Central & North West London NHS Foundation Trust • London Ambulance Service • Care Quality Commission (CQC) • Hillingdon LINk

Themes	Future Work to be Undertaken
The Role of Special Constable Working Group **Comprising Councillors:** • **Dhillon** • **Gilham** • **Kemp** • **Yarrow**	Detailed review of the role of special constables. Working Group Meeting dates: • 2pm, Wednesday 17 October 2012 – CR6 (1st witness session) • 2pm, Wednesday 24 October 2012 – CR4 (2nd witness session) • 4.30pm, Wednesday 10 January 2013 – CR7 (To review final report)
Diabetes Care Working Group **Comprising Councillors:** • **East** • **Gilham** • **Jarjussey** • **Kauffman** • **White**	Detailed review of the diabetes care in Hillingdon. Working Group Meeting dates: • Stakeholder event -1.30pm, Wednesday 30 January 2013 – Middlesex Suite • 2pm, Tuesday 5 February 2013 – CR3 (1st witness session) • 4pm, Thursday 21 February 2013 – CR6 (2nd witness session) • 4pm, Thursday 3 March 2013 – CR6 (2nd witness session) • 2pm, Tuesday 9 April 2013 – CR6 (To review final report) • Site visit to be arranged - TBC