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A

External Services Scrutiny Committee

Councillors on the Committee

Councillor John Riley (Chairman)
Councillor Ian Edwards (Vice-Chairman)
Councillor Teji Barnes
Councillor Mohinder Birah
Councillor Tony Burles
Councillor Brian Crowe
Councillor Phoday Jarjussey
Councillor Michael White

Date: **WEDNESDAY, 26 APRIL 2017**

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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Published: Tuesday, 18 April 2017

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

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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

Chairman's Announcements

PART I - MEMBERS, PUBLIC AND PRESS

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

2 Declarations of Interest in matters coming before this meeting

3 Exclusion of Press and Public

To confirm that all items marked Part I will be considered in public and that any items marked Part II will be considered in private

PART II - PRIVATE, MEMBERS ONLY

7 Any Business transferred from Part I

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

15 March 2017

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors John Riley (Chairman), Ian Edwards (Vice-Chairman), Teji Barnes, Mohinder Birah, Tony Burles, Brian Crowe, Michael White and Jas Dhot (In place of Phoday Jarjussey) **Also Present**: Colin Wingrove, Borough Commander - Metropolitan Police Service Lynn Hawes, Service Manager - Youth Offending Service Antony Rose, National Probation Service **LBH Officers Present**: Dr Steve Hajioff, Director of Public Health Mike Wolski, Interim Emergency Management and Response Neil Fraser, Democratic Services Officer
35.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies were received from Councillor Jarjussey. Councillor Dhot was in attendance as his substitute.
36.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* Councillor Dhot declared a non pecuniary interest in respect of Item 5: Youth Offending / Safer Hillingdon Partnership Performance Monitoring, in that he worked for HM Prison Service in Feltham Young Offender's Institute.
37.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**
38.	**MINUTES OF THE PREVIOUS MEETING - 15 FEBRUARY 2017** *(Agenda Item 4)* The Chairman, together with the other Committee Members, asked for a note of thanks to be passed to the Head of Democratic Services regarding the high quality of the clerk's minutes from the previous meeting. It was recognised that the meeting had been challenging to record, due to the high number of speakers, but that the minutes were of exceptional quality and accuracy. It was suggested that the minutes be used as the basis of a report to be forwarded to the Chairman of the Local Safeguarding Children Board for review, before being brought to a future Cabinet meeting.

	In addition, Councillor Burles requested that the topic be considered for a future Member Development session. The Chairman advised that a discussion had been held with the Conservative Group's Chief Whip, who had confirmed that there was session on Mental Health forthcoming. CSE and other topics could be incorporated into future sessions, potentially via Member Training days or through items brought to meetings of the Corporate Parenting Board and other relevant committees. Debby Weissang, CSE Strategic Manager - Children's and Young People's Service, who spoke at the previous meeting, would likely be involved in any such sessions, though these matters were still being discussed. **RESOLVED:** 1. **That the minutes of the meeting held on 15 February 2017 be approved as a correct record.** 2. **That a further report be forwarded to the Chairman of the Local Safeguarding Children Board for review, before being brought to a future Cabinet meeting.**
39.	**YOUTH OFFENDING / SAFER HILLINGDON PARTNERSHIP PERFORMANCE MONITORING** *(Agenda Item 5)* The Chairman welcomed those present to the meeting and thanked them for giving their time to attend. The purpose of the meeting was to enable the Committee to comment on the impact of the work being undertaken locally by the Safer Hillingdon Partnership partners and the Youth Offending Service. It was recognised that youth offending was a 'hot topic' and Members were eager for additional information and updates on this important issue. Mark Wolski, Interim Emergency Management and Response, addressed the Committee on the topic of Crime and Disorder Reduction. Mr Wolski confirmed that that, upon review of the overall crime statistics for the Borough, it was apparent that violent crime including knife crime and knife crime with injury, together with the number of young people involved in such crime, had increased over the past 12 months. In comparison to other London Boroughs, Hillingdon was 15th highest for knife crime, a comparatively low figure. Instead, Hillingdon saw a higher prevalence of robbery and burglaries. Work was being undertaken to determine where and why violent crime was occurring. The Botwell and Townfield Wards showed the highest instances of knife crime within the Borough, while Hayes was often a focal point for such crime. The cohort of young offenders seen to be involved were from within the Borough, with local postcode addresses, though there were instances of groups committing crimes within the Borough but residing in areas outside the Borough, such as Southall. Early intervention and outreach were recognised as important factors when addressing these issues. The Hayes Initiative was designed to bring partners together, focussing on Hayes as a crime centre and crime generator. It was confirmed that a paper would be brought to the Safer Hillingdon Partnership to further elaborate on this. Colin Wingrove, Borough Commander, addressed the Committee on behalf of the Metropolitan Police Service. Mr Wingrove confirmed that within London, knife crime as a whole had increased. Within Hillingdon instance of knife crime had risen from 150 to 200 instances. To address this, the Police and Crime Plan 2017 - 2021 had been drafted set out the strategy for policing and crime reduction in London over the next

four years.

46 knife crime offences had been recorded within Hillingdon over the current calendar year, an increase of 14 offenses in comparison to the same period in the previous year. Incidents of crime, including robbery against commercial entities (such as betting shops) and personal robberies, had increased from 299 to 405. However, this was a stark reduction compared to the approximately 1000 offenses recorded annually five years ago. This overall downward trend was likely due to an increase in quality education as well as a wider public use of technology, for example the increase in usage of smart phones with tracking and encryption made these items less attractive to steal. Burglaries and robberies were more commonly seen in the south of the Borough.

£7.5m, via Crossrail investment, had been allocated to regenerate the Hillingdon area and provide the means for partners to come together and coordinate actions to prevent crime. This included improved store frontages, engagement schemes within local communities, and an increase in CCTV coverage, all of which were designed to make the area safer for honest residents and more hostile to criminals. The Safer Hillingdon Partnership, alongside the Youth Offending Service and the Probation Services, would work together to instigate initiatives and provide support across the Borough.

There was a reliance on receiving notice from members of the public to detect possession of knives, though officers were also being trained to search for knives during stop-and-search instances, in the same manner in which they checked for possession of drugs. It was recognised that there was often a link between drug use and knife crime. 29.4% of offenders using knives when committing crimes were subsequently detected. It was agreed that the figures for detections of offenders causing injury by knife, together with crime statistics broken down by ward, and inclusive of comparisons to neighbouring and nearby Boroughs, would be forwarded to Committee Members outside of the meeting.

When comparing crime statistics to other nearby or neighbouring Boroughs, Dr Hajioff, Director of Public Health - London Borough of Hillingdon, confirmed that the Office of National Statistics defined Hillingdon's neighbours based on a variety of contributory factors, including population, age, and ethnicity. Hounslow was recognised as having a similar population and a commensurate number and type of offences to Hillingdon (64 offenses with injury in rolling year). Ealing (57 offenses with injury) and Brent (83 offenses with injury) displayed higher proportional knife crime. Harrow, a smaller Borough, had comparatively less crime (46 offenses with injury). Hotspots for crime included Southall and the Uxbridge corridor, and particularly within areas of high footfall such as large town centres.

Members suggested that analysis be undertaken to review contributory factors to crime, such as population demographics including age, ethnicity, and gender, to enable targeted assistance within those problem areas. Colin Wingrove confirmed that the Neighbourhood Confidence and Crime Comparator Tool could be used to look at all Wards within London. Areas were split into clusters, with the Hayes cluster ranking 38th out of 106 clusters for instances of criminal activity. The tool was confirmed to be available for use by members of the public.

In addition, the Home Office provided measures to compare areas of similar population density and demographics, to enable strategic analysis. Mr Wolski confirmed that a target date of 8 weeks for strategic analysis of the data had been set, for review by the Local Safeguarding Children Board.

Mr Wingrove discussed drugs within the Borough, and confirmed that the most commonly possessed drugs were cannabis, cocaine, and heroin. Young people (under 18) most commonly abused cannabis and alcohol, rather than opiates or cocaine. Certain areas, such as Hayes, were seen as having a high prevalence of openly available drugs, which in turn contributed to possession of knives, violent crime, and anti social behaviour such as street drinking. Future plans to address such matters would include profiling, analysis, and early intervention.

Through analysis of the individuals arrested for possession of drugs, a picture of the characteristics and personality traits of the people involved was formed. Often, such people would have a chaotic lifestyle, or potentially mental health issues, that contributed to them wanting to drink or use drugs in higher quantities. It was pleasing that recent targeted actions against the suppliers of drugs had led to convictions.

London's next Police and Crime Plan recognised the growing issue of knife crime, and proposed to incorporate a pan-London knife crime strategy. As the strategy developed, it was expected that there would be increased working with offenders and victims as well as partners, such as the Child Protection Service, to create a unified strategy across all London Boroughs and thereby reduce knife crime. A response to the draft plan consultation had been sent to the Mayor's Office of Policing and Crime (MOPAC), requesting clarity of what the plan's proposed initiatives, and its implications towards safeguarding, would mean, particularly in light of the proposals outlined within the Wood Report.

The Chairman thanked Mr Wingrove for his attendance and presentation, and Lynne Hawes, Service Manager - Youth Offending Service (YOS), then introduced a presentation on the YOS, part of the Youth Justice System.

Members were informed that the Local Authorities, in partnership with police, probation and health authorities, were required to establish multi-agency youth offending teams to co-ordinate the provision of youth justice services in their area. The YOS worked with young people aged 10-17 who came into contact with the criminal justice system, and its aim was to prevent offending by children and young people through interventions designed to address those risk factors associated with the behaviour.

The service was currently comprised of 16.5 fte practitioner posts, 16 sessional, workers, 26 volunteers (a statutory requirement), 2 students, and 3 operational managers together with a Service Manager. Specialists within the team included YOS officers, Social workers, Police officers, Probation Officers, Substance misuse workers, Interventions coordinators, Mental Health Workers, Restorative Justice Officers, and Education, Training and Employment workers. It was felt that the good core of specialists provided a 'wrap-around' package for young people.

Services for young people included an Appropriate Adult for under 18s within the police station, triage of low level first time offenders out of the criminal justice system, the delivery of formal pre-court disposals and support programmes, court services (including remand management and court reports), Referral Order Panels (trained community representatives devising intervention programmes for young offenders), management and implementation of community court orders (including parenting orders) and custodial through-care and licensing.

The number of First Time Entrants into the Criminal Justice System had reduced since October 2012 (from 109 to 99, and from 121 in October 2013 to September 2014), predominantly due to the increased intervention of people seen to be at risk.

Hillingdon's numbers were lower than the London average and lower than similar authorities such as Harrow, Hounslow and Sutton. Though not quite at the national average, it was accepted that this was not a true reflection as national figures were skewed due to differing population densities and demographics within county councils.

Custody rates had been seen to have reduced by approximately 50% since 2013 (from 30 to 14), and Hillingdon's figures compared favourably in comparison to neighbouring authorities. Those remanded into custody were detained within youth offending facilities or secure children's homes. As the total number of young people aged 10-17 years within the Borough had not reduced, a reason for the reduction was suggested as there being a smaller cohort in the criminal justice system, although these people had more complex needs and some challenging personal circumstances. In addition, Courts had increased confidence in local programmes and services, such as 'tag and supervision'.

Re-offending rates had reduced since 2011/12 (from 120 to 74), a trend seen throughout the last 10 annual quarters. However, the most recent quarter had seen an increase, possibly due to a group of young people well known to the service who were consistently re-offending. This particular group had complex needs, which required input from a number of different agencies including Health and Education. Despite this, Hillingdon had continued to perform better than London and the neighbouring family of authorities.

It was highlighted that if a young person re-offended, they were often placed back with their families. Whilst this was not always felt to be the best outcome for the young person, the young person could not be removed without sufficient grounds to do so. There were very few families for whom accommodation was an issue, and some families often colluded with their child regarding their offending behaviour.

Statistics relating to Looked After Children (LAC) were not separated from the data, and it was known that LAC comprised a high percentage of the cohort in question. Often this was due to the complex needs and challenging circumstances of the child, but equally, it was apparent that residential units and foster homes would often rely on the police to mediate and manage a situation that, were the child living at home, would be dealt with by the parent or guardian. Moving forward, it was important to train these guardians to manage such challenging behaviour without resorting to calling the police and thereby criminalizing the child, in a similar manner to how schools and other service providers dealt with issues. However, it was recognised that there were occasions when calling the police was the most appropriate action to take.

Restorative Justice included a victim offender conference, comprising formal face to face meetings between the victim and the offender, led by a trained facilitator. Indirect restorative justice involved messages being passed between the victim and the offender by a trained facilitator. Participants did not meet, and messages were passed via letter, recorded video or audio. Direct Reparation was an activity completed by the offender, as identified by the victim, whilst Indirect Reparation was an activity completed for the good of the wider community.

Improvements had been seen over the last 18 months. Previously, victims were contacted by the police directly, though very few wanted to be contacted in this manner. A specific post had since been created to support victims and as a result, engagement with victims had increased, with most reporting that they were very satisfied with the process and outcome.

Challenges for the service included the introduction of the new national Assetplus assessment and planning tool. The recruitment, development and maintenance of a skilled workforce was a national issue, and it was felt that there was too much emphasis placed on academia rather than having the appropriate skills to properly work with young people.

Whilst the cohort of young people was smaller, the young people had greater and more complex needs, for which there were no quick fixes. Budgetary pressures on agencies were leading to higher thresholds and longer waiting lists, and positive opportunities for young people were reducing. Uncertainties over central government funding remained, and time would bear out what impact the governments' changing expectations would have on the young people themselves.

Statistics were discussed, and it was highlighted that the number of young men offending was broadly the same as seen previously. However, the number of young women involved in group offences or girl on girl violence had been seen to have increased. The number of young people involved in the supply of illicit substances had increased in previous years, an activity mainly controlled by adults. This activity was also linked to the sexual exploitation of young women, with reports of young women being used as 'rewards' for young men who had 'performed well' in their roles within the group.

To address the concerns regarding youth violence and associated offences, a newly developed Violence and Vulnerability Panel now met every 6 weeks, and included representation from the Police, Health, and YOS services, among others. The panel was tasked with identifying young people at high risk of youth violence, mapping who they were associating with, and formulating strategies on how best to disrupt this behaviour. It was recognised that there was often adults involved in the violence, and not just young people.

An example of the kind of work undertaken was discussed. Staff had been tasked with mapping certain young people's interactions through social media. Through this mapping it had become apparent that the young people were associating with a particular group involved in CSE, which had led to an intervention operation. Testimony from young women involved in similar matters had revealed that social media often acted as a catalyst for girl on girl violence, as the individuals involved often had underdeveloped conflict management skills, which led to issues escalating beyond proportion and resulting in violence.

Dr Hajioff confirmed that he had recently attended the London Digital Mental Health Wellbeing Forum, at which concerns over the impact of social media on young people were discussed. Of particular concern were closed messaging groups, such as WhatsApp, the contents of which were not visible to those outside the group. For obvious reasons, this made it difficult to identify and address problems.

Ms Hawes confirmed that helping young people with substance abuse problems was challenging, as the young person involved would often disengage and refuse treatment, stating that there was no problem. Work remained on formulating a treatment and referral system, and how to communicate sufficient messaging regarding available services to promote service uptake. Public Health was confirmed to be reviewing this, for future incorporation into the Local Plan for Hillingdon. Further actions were being taken through the Local Safeguarding Children Board (LSCB) and Child Sexual Exploitation (CSE) Awareness Week. A Multi Agency Support Hub, inclusive of Children's Services, shared data and intelligence to instil best practice and avoid

duplication.

Councillor Crowe highlighted that further work needed to be undertaken with LAC at their schools, as often their use of drugs and alcohol was linked to frustrations with their academic achievement.

The Chairman thanked Ms Hawes for her presentation, and suggested that Ms Hawes attend a future meeting of the Corporate Parenting Board to present on this topic. Members were supportive of this suggestion, and it was further requested that details of crimes reported from the Borough's residential units be fed back to Members outside of the meeting.

Antony Rose, National Probation Service (NPS), addressed the Committee, confirming that the aim of the service was to ensure public protection, rehabilitate offenders, and prevent victims. The service was now a commissioning service, working with service providers to provide support as per licence conditions, (such as conditions mandating access to drug rehabilitation services). The NPS was accountable to the Secretary of State, with commissioned services scrutinized by the Ministry of Justice.

The NPS worked with offenders aged 18 and over, and received individuals from the YOS and other services. Individuals were worked with jointly from the age of 17 ½, to ensure a smooth transition from children's services. The seconded Probation Officer within the YOS would then determine, by way of individual assessments, where the young person was to be directed to, with high risk and MAPPA cases remaining with the NPS, and medium and low risk cases transitioning to the London Community Rehabilitation Company (LCRC). Some interventions were confirmed to be kept at the NPS, including sexual offender treatment services.

Assessments were carried out via the OASys Assessment Tool, which reviewed individuals on a case-by-case basis. The Tool looked at previous and current offences, personal circumstances, the motive and nature of the offending, victim issues, whether the offense was a one-off, and other pertinent information, and assessed the likelihood of an offender to re-offend, identified and classified offending, assessed the risk of serious harm, as well as risks to the individual and others, among other risks. Actuarial data was reviewed as a starting point. If the score was deemed sufficiently high, then the individual would be referred to the NPS. If below a certain score threshold, then the individual would be referred to the CRC. Reassessments could be carried out and individuals could be referred back to the NPS, but once registered with the NPS, that individual would remain with the NPS, regardless of whether the risk was deemed to have reduced.

The allocated Probation Officer would then develop a plan to manage the risk presented by the offender and then link this assessment to a supervision plan. With regard to those offenders sentenced to probation, key performance indicators specified that they must be allocated to community rehabilitation companies within 2 working days. If the case was deemed to be under NPS authority, then the case officer would arrange an appointment with the individual.

Partnership working was often challenging due to budget constraints. Staffing was an issue, with the availability of suitable practitioners recognised as a longstanding challenge that remained to be overcome.

Data from 2014 onwards was still be to reviewed, but information obtained prior to 2014 showed staff case loads, and the number of re-offenders, to have slightly

	increased within the Borough. This was made up of re-offenders and new offenders, often linked to drug use, with an understanding that often offenders would use stronger drugs as they grew older. The Chairman thanked Mr Rose for his attendance and acknowledged the good work being undertaken by the NPS in what was a challenging period of change for the service. **RESOLVED: That:** **1. Details of detection rates for knife crime with injury be forwarded to Members by email;** **2. Knife crime statistics per Hillingdon Ward, and in comparison to neighbouring Authorities, be forwarded to Members by email;** **3. Ms Hawes be invited to present an item at a future meeting of the Corporate Parenting Board;** **4. Details of crimes reported from Borough LAC residential units be forwarded to Members by email;** **5. the discussion be noted.**
40.	**WORK PROGRAMME 2016/2017** *(Agenda Item 6)* Consideration was given to the Committee's Work Programme. Possible items for future meetings were noted, and it was agreed that Members were to email the Chairman or the Interim Senior Democratic Services Manager, should they have ideas for further topics. It was suggested that the London Community Rehabilitation Company (LCRC) and the National Probation Service (NPS) be invited to a future meeting, to elaborate on some of the topics discussed at this meeting, and to discuss how the proposals outlined within the Wood Report may affect them, were the proposals to be implemented. Councillor Edwards confirmed that due to time constraints, the proposed Community Sentencing item was likely to roll over to the new municipal year, and that he would work with the Interim Senior Democratic Services Manager to finalise meeting dates and report timeframes. **RESOLVED: That:** **1. The LCRC and NPS be invited to attend a future meeting of the Committee;** **2. Members email the Chairman or Interim Senior Democratic Services Manager with suggestions for future items; and** **3. The Work Programme be noted.**
	The meeting, which commenced at 6.00 pm, closed at 8.05 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran / Neil Fraser on 01895 250472 / 01895 250692. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

EXTERNAL SERVICES SCRUTINY COMMITTEE: PERFORMANCE REVIEW OF THE LOCAL NHS TRUSTS

Contact Officer: Nikki O'Halloran
Telephone: 01895 250472

Appendix A: Central & North West London NHS Foundation Trust Quality Account 2016/2017
Appendix B: The Hillingdon Hospitals NHS Foundation Quality Account Briefing Paper
Appendix C: Healthwatch Hillingdon Report - Expecting the Perfect Start
Appendix D: Healthwatch Hillingdon Report - Safely "home" to the right care

REASON FOR ITEM

To enable the Committee to receive updates from local health organisation as well as comment on the Trusts' Quality Account reports. The Committee's comments on the performance of the local NHS Trusts may then be submitted to the Care Quality Commission (CQC).

OPTIONS AVAILABLE TO THE COMMITTEE

1. That Members question the Trusts on their Quality Account reports for 2016/17 and identify issues that they would like included in the Committee's statement for inclusion in the final report.
2. That Members use information from their work during the course of the year to question the Trusts on issues measured by the CQC.
3. That 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. We are now in the eighth year of Quality Account reports and providers are expected to report on activities in the financial year 2016/2017 and publish their Quality Accounts by the end of June 2017.

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:
    a) Do the priorities of the provider reflect the priorities of the local population?
    b) Does the Quality Account provide a balanced report on the quality of services?
    c) Are there any important issues missed in the Quality Account?
    d) Has the provider demonstrated they have involved patients and the public in the production of the Quality Account? and
    e) Is the Quality Account clearly presented for patients and the public?

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 them 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, Healthwatch, OSCs and Health and Wellbeing Boards will be an additional source of information for the CQC that may be of use operationally in helping to inform local dialogues with providers and commissioners.

9. Where available, draft copies of the Trusts' Quality Account reports have been appended to this report for consideration.

Witnesses

10. To ensure that equal attention is given to each Trust, the Committee has two meetings scheduled on two consecutive days. Senior representatives 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. Invitations have been sent to the following organisations for the following meetings:

- **6pm Wednesday 26 April 2017**
  - The Hillingdon Hospitals NHS Foundation Trust
  - Central & North West London NHS Foundation Trust
  - Healthwatch Hillingdon

- **6pm Thursday 27 April 2017**
  - Royal Brompton & Harefield NHS Foundation Trust
  - The London Ambulance Service NHS Trust
  - Hillingdon Clinical Commissioning Group
  - Local Medical Committee

11. As Members will have read the Quality Accounts attached to this report, witnesses are asked to ensure that they address the impact on residents of the outcomes for 2016/2017 and the proposals for 2017/2018.

SUGGESTED SCRUTINY ACTIVITY

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

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

BACKGROUND INFORMATION

None.

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Central and North West London NHS
NHS Foundation Trust

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

5 April 2017

Dear Colleagues,

Re. Consultation with Overview and Scrutiny Committees/Health and Wellbeing Boards on CNWL DRAFT Quality Account 2016-17

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

Please find attached to this letter CNWL's draft Quality Account 2016-17 for 30-day consultation.

As you will be aware, all NHS providers have had a legal duty to publish an annual Quality Account since June 2010, and are required to publish the *draft* version for a 30-day formal consultation to various groups, including OSCs, commissioners and local Healthwatch.

This marks the start of that consultation, which runs from **Wednesday, 5 April – Friday, 5 May 2017**.

Through discussions with you over recent years, we have put together the timetable to allow a two-step feedback process: First, to feedback your *informal suggestions on document changes (optional)*, and second, *your final statement* based on the key points below recommended by the Regulation.

With your help, this process will hopefully result in a much improved document for all.

Activity	Completion date
Consultation start	**Wed, 5 April 2017**
Optional: Your informal feedback on suggested document changes	*Any time before* ***Mon, 24 April 2017***
Revised draft Quality Account submitted to you	*Fri, 28 April 2017*
Consultation close, and your final statements due	**Fri, 5 May 2017**

OSCs have a role in the external assurance of Quality Accounts through formal consultation. We have included in this letter (embedded below) guidance for OSCs published by the Department of Health in 2010 which sets out what your role is in assuring our Quality Account.

Roles of Commissioning PCTs 1

We welcome and encourage your feedback on our draft Quality Account 2016-17.

There are some points to note when reviewing this document:

- In Part 1, KPMG, our external auditors, still need to publish their statement of assurance based on audit findings (due in May 2017)
- The document has set sections and information requirements as laid out by the NHS Foundation Trust Annual Reporting Manual 2016-17
- The final format and page numbers will all change once designed and incorporated into the Trust's full annual report (therefore, it is advisable to not include page references in your final statements)
- The document includes quarter 3 or year-end data, but in a few cases data as at month 10. This will be updated with Q4 position in the final version; this is not expected to greatly change the current data positions reported
- An EASYREAD version of the Quality Account will be produced once the final Quality Account has been signed off in May 2017, and published on NHS Choices in June 2017.

Your responses

Your initial informal feedback on document changes (optional): Please provide this any time before Mon, 24 April; and clearly reference your comments.

Your final formal statement for inclusion in the Quality Account: Please provide this statement by **Fri, 5 May 2017** (this has a 1000 max word limit).

The guide recommends the following points are covered in your final statement:

- *Do the priorities of the provider reflect the priorities of the local population;*
- *Does the Quality Account provide a balanced report on quality of services;*
- *Are there any important issues missed in the Quality Account;*
- *Has the provider demonstrated they have involved patients and the public in the production of the Quality Account; and*
- *Is the Quality Account clearly presented for patients and the public?*

Your statement has a word limit of **1000 words** as set out in the NHS (Quality Accounts) Amendment Regulations 2011. If this is exceeded we will write to you to ask that your statement is reduced in line with this.

Your statement will be included **verbatim** within the Quality Account. Therefore it is not necessary to restate sections of information already presented in the document. Also, where possible do not refer to specific page or section numbers as these will change when the document is incorporated into our annual report and will no longer make sense to the reader.

Submission: Please email all feedback, whether informal comments or your final statement, to Jeni Mwebaze at j.mwebaze@nhs.net

Many thanks for your continued support and engagement with us in the development of this year's Quality Account. Please do not hesitate to contact us on the above email address if you have any queries.

Yours sincerely,

Ela Pathak-Sen
Associate Director for Quality & Service Improvement

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Central and North West London NHS
NHS Foundation Trust

Draft Quality Account 2016-17

v.4.0

Glossary of terms

QAP	Quality account priorities
CNWL	Central and North West London NHS Foundation Trust
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
FFT	Friends and family test
GP	General Practitioner
HTT	Home Treatment Team
LD	Learning Disability services
MDT	Multi-disciplinary team
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OSC	Overview and Scrutiny Committee
POMH	Prescribing Observatory for Mental Health
Q3	Quarter 3
SPA	Single Point of Access
YTD	Year-to-date; an aggregation of performance data over 2016/17

Contents

Comment [P1]: Page numbers will be corrected in the final document.

Part 1 – Letter from our Chief Executive

This is our Quality Account for 2016-17; it details our quality story for the year, how we've performed against the priorities that we set through consultation last year and what we are going to focus on in the coming year. This is all about the quality of our patient care and the quality of our staff and their working life here; both are linked.

I am pleased to report that at the time of writing this report the CQC have re-inspected our Adult and Older adult inpatient mental health wards and rated us 'good'.

I want to take this opportunity to thank our staff who work in these specific teams for the dedication and determination they have shown to drive up quality standards.

I am particularly pleased to report that our adult mental health inpatient wards in Milton Keynes received accreditation for Inpatient Mental Health Services (AIMS) by the Royal College of Psychiatrists and our wards in North West London are working towards accreditation in 2017/18.

But our quality focus is about our determination to do what is best for patients, their families and carers against a backdrop of tight resources and having to work smarter, in partnership with other parts of the health and social care system; with a greater focus on prevention, making sure care is provided close to the patient rather than just in hospital.

To deliver this we need to work in partnership with patients, their carers, staff and others in the health and social care system – other Trusts , social care but also and vitally the voluntary sector.

Therefore this year we want to continue to focus on patient and carer involvement and staff engagement as our overarching quality priorities.

I am pleased to report that we have made strong progress on the projects we committed to. The Board led the way in signing up to the *#hellomynameis campaign* and we are on target to achieve our ambition that 100% of our clinical teams signed up by the end of 2017/18.

We hosted our first Carers Conference and set up our Staff Carers Network. We set up special events to listen to our staff and as a result developed our work plan that demonstrates we've listened. We refreshed our Health & Wellbeing plans, are working on our leadership programmes and are particularly focussed on the development of our BME staff. I am proud to report that we were accredited by the Mayor of London's office with the Healthy Workplace Charter.

We agreed with you a set of indicators that we would use to help us test whether or not our actions were having an effect. I am pleased to report that at Quarter 3 we have met or exceeded the targets our entire patient reported indicators. We agreed three staff indicators and in this quarter report from the National Staff Survey. We have not met our internal targets but have exceeded the national average. I am pleased to report our staff engagement scores too were above the national average. We have seen a reduction in our use of agency staff and over the last six months we have more staff join us than those who leave. And our turnover has reduced over the year from 19% to 16%. This year we used local and trust wide events and celebrations to share best practice and learning.

Over 200 staff attended Safety and Quality learning events across our localities and a Trust wide learning event attracted over 70

attendees. The outcomes from these events have helped shape our plans throughout the year. I am particularly proud of the SHINE Quality Improvement project that helps us improve the physical health of patients with serious mental illness. This project was awarded our Annual Gem Project of the year and commended by NICE as an example of good practice.

When it comes to listening to our patients, their families and carers, this year at the end of quarter 3 we have heard from over 10,000 patients across our Trust in the FFT survey.

By the end of Q3 94% of our patients and carers tell us that they felt involved in their care and 94 % tell us that their care helped them achieve what matters to them. This represents a 5% improvement on last year. However as with all of these Trust level indicators performance varies by service and locality and so on Page xxx we provide the detail. But I am pleased to say that we have seen improvement across our services.

As a Board we will sustain quality so that we provide safe, clinically and cost effective services that meet the needs of patients

To the best of my knowledge and belief the Quality Account is true and accurate. It will be audited by KPMG in accordance with NHSI guidance

Claire Murdoch
Chief Executive

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

[KPMG to provide this following their audit in May 2017]

May 2017

KPMG LLP, Statutory Auditor

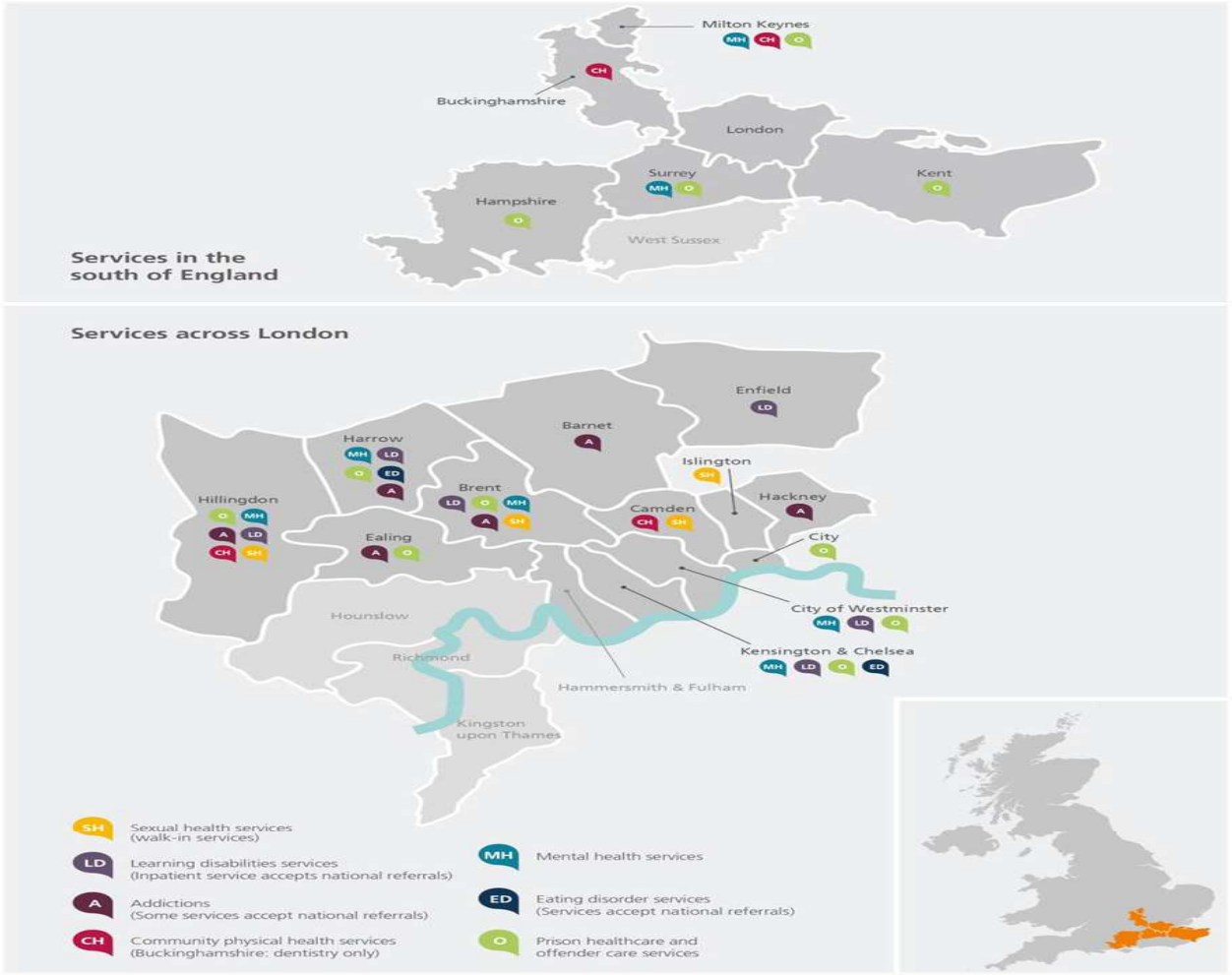
KPMG LLP

15 Canada Square, London

E14 5GL

Overview of our services

The map below provides a useful visual summary of the services CNWL offers and in which boroughs and counties these services are located.



PART 2 - Our priorities for improvement

There are two sections to Part 2.
In Section 2.1, we look back at our Quality Priorities for improvement which we set last year in partnership with our patients, carers, staff, commissioners, Healthwatch and public. In this section, we provide a brief update and overview of our Trust-wide achievements during the past year and include our performance on the Friends and Family test.

In Section 2.2, we look forward to our Quality Priority plans for 2017/18. We describe our plans and include our statements of assurance from our Trust Board.

Section 2.1 Our Quality Priorities 2016/17

Last year, we reaffirmed our commitment to keeping patients safe, effectively cared for and treated with respect and dignity. In doing this, we reviewed all the sources of information available to us and consulted with our stakeholders. Together, we agreed to focus on two areas to drive improvement in the quality of care we provide to our service users/patients and the support we provide to those who care for them.

We wanted our patient and carers to feel involved and supported in taking ownership of the decisions about their care and we recognise that to deliver this we need staff that are well supported, trained, committed and engaged.

With this in mind, we agreed to focus on two Quality Account Priorities (QAPs).

- Patient & Carer Involvement
- Staff Engagement.

We agreed to move away from a metric focussed approach and instead agreed that quarterly, we would report on a series of projects and actions that we are committed to. We also agreed that we would use a handful of indicators to help us understand whether our projects were having the desired impact and outcomes.
Below we highlight the key actions we took under each of the two quality priorities;

2.1.1 Quality Priority 1: Patient & Carer Involvement

What we achieved

***#Hellomynameis… Campaign*:** The Trust Board led the way making a public commitment to the #hellomynameis… campaign at the Annual General Meeting in September 2016. All of our three Divisions followed suit and publically signed up to the Campaign. A Twitter campaign with daily updates on the #hellomynameis… campaign roll-out is in place. We published staff stories on the importance of the campaign and a video of a Health Care Assistant urging colleagues to support the campaign is available on our website. We set ourselves a target of at least 25% of our teams signing up to the campaign by the end of the year with an aim of achieving 100% signup by the end of 2017. At present, we have met our target with 26% of our clinical teams signed up to the campaign. We know that this is not about just 'ticking a box' it's about hearts and minds and getting teams to engage and we will continue this work in 2017/18.

Patient and Carer Stories:
We are committed to harnessing the power of Patient and Carer Stories to educate ourselves in how to improve experience of care and inspire quality improvement.

Every one of our Trust Board meetings opens with a Patient or Carer Story presented by a patient or carer invited to share their views and experience. The Board has found this an invaluable part of the meeting providing a focus on patient experience that carries through the Board discussion and decision-making.

Our most recent Board had an inspiring presentation from a Peer Support Worker from Milton Keynes and his recommendations and ideas will be taken forward in our refreshed Patient and Carer Involvement strategy.

Our Carers Week events in 2016 included an afternoon of Carers' Stories shared with an audience of CNWL staff who listened, learned, asked questions and fed back very positively, describing the event as "very moving" and "an eye opener".

We are keen to continue using patients and carer stories to improve staff engagement, patient experience and service quality. This year, we have started asking patients and carers on our FFT (friends and family) feedback cards if they would like to share their stories with us to help us educate staff and improve experience and quality. We are collecting these stories and have made a number of short films to share these accounts highlighting what works well for patients and carers and what needs to improve.

Examples of the work that has been done to harness the power of patient and carers' stories.

A pilot of Patient and Carer Stories using the Discovery Interview technique was conducted in our Palliative Care service. The interviews revealed insights into the patient and carer experience throughout the end of life healthcare journey.

Following the pilot, the team reflected on the feedback and learning and the implications for their practice and agreed a number of actions. These included using Patient and Carer Experience in future staff training, setting up an Information Leaflet redesign group with patients and carers, and establishing a Facebook group for patients and their families.

The Palliative Care service made a short film 'A Patient's Journey with Palliative Care Services' to show how the service supported a patient and her family and, in the patient's words, *"gave me the confidence to rebuild myself."*

Our Carers Council co-produced a short film 'I am a Carer' showcasing a collection of personal stories describing what it means to be a carer. The film was screened at our Carers Conference where it was well received. It is now available to view on the CNWL website and can be used for staff training.

The Specialist Memory Service in Milton Keynes has made a moving film about carers and patients with dementia.
In the short film, carers talk about the importance of meeting other people, sharing their caring role and receiving help to support them in their caring role. The video can be seen on the CNWL website and is being shared with carers and carer groups.

Carer Involvement
We have evidenced Carer Involvement across our services and employ a number of established methodologies including:

- Carer involvement in the Recruitment and Selection of Staff
- Carers Surgeries
- Carers Champions at the Campbell Centre, Milton Keynes
- Carers Forums
- Carers Information – Information Boards and Carers Packs
- Membership of strategic meetings : the Carers Council

The Carers Council ensures that carers collective voice reaches right to the heart of CNWL. Chaired by a Carer from Hillingdon, the membership includes Carer representatives from across services, representatives from Carers organisations, our Chief Operating Officer, and other senior leaders within the Quality team

Key achievements of the Carers' Council in 2016/17
-Carers Week; The Carers Council co-produced our first ever *Carers Week* celebrations at Trust HQ in June 2016. Claire Murdoch, our Chief Executive and Robyn Doran, our Chief Operating Officer launched the Carers Week events by signing a public pledge to make CNWL a *Carer Friendly Community*, more than 100 staff attended Carer awareness training and Carer engagement events and signed personal pledges to make CNWL Carer Friendly.

During Carers Week, CNWL joined *Employers for Carers* in order support the estimated 1 in 9 of our staff who have caring responsibilities. We also launched our *Carers at Work Network* which has been set up as a source of support and advice to our staff who are also carers.

-Carers Information Booklet; This year we launched our Carers Information Booklet. The booklet was the designed and developed by our Carers Council and contains a huge range of information, support and resources available locally for Carers. The booklet was launched by our Chair, Prof. Dorothy Griffiths, at the end of Carers Week and was reported in the local press.

-The Carers Conference 2016; With the support of the Trust Board and Carers Council, we hosted our first co-produced Conference for carers and staff, *Caring Together*, in October 2016. The conference focused on the twin themes of 'Caring for Carers' and 'Working in Partnership with Carers'. The event was a great success with almost 100 delegates attending. Feedback has been positive. Staff highlighted how useful it

was hearing carers' perspective and seeing how it can influence their work. Carers who attended fed back about the importance of being recognised and listened to and meeting other Carers. The conference outcomes have now been turned into a workplan for the Carers Council to take forward.

-Carers Thematic Review: One of the outcomes of the Carers Conference was to highlight that Carers Assessments were an issue of concern to our carers. In partnership with our North West London commissioners, Local Authority partners and members of the Carers Council we undertook a thematic review of the Carer Assessment process and experience across Brent, Harrow, Hillingdon, Westminster and Kensington and Chelsea. The learning from this review is being co- developed into an action plan and will be shared across the Trust and with our partners including carers.

Involvement to Influence

-Patient and Carer Involvement in Recruitment and Selection:

This year, we delivered regular recruitment and selection training workshops for patients and carers to equip them with the skills and knowledge to interview new CNWL staff. We also rolled out a new model of separate Service User Panels for Consultant Psychiatrist posts with very positive feedback from patients who took part.

Participating Service users *described* the process as *interesting, empowering' using their expertise to shape services.*

We want to continue to involve even more patients and carers in recruitment. To support this, we have developed a database of trained patient and carer interviewers from across the Trust and we will be co-producing new Trustwide good practice guidance: *Involving Patients and Carers in Recruitment* with our Patient Partnership Board.

-The Patient Reference Group:

Following the success of our Carers Council, we have established our Trustwide Patient Reference Group bringing together patient representatives, Governors and Healthwatch members from services across the Trust. The Patient reference Group will refresh our Trust wide Patient and Carer Involvement Strategy and action plan and make sure views and guidance of experts by experience have influence and impact across the whole Trust.

A patient from the Patient Reference Group and a carer from the Carers Council acted as co-facilitators of the Quality Account consultation event in March 2017 and both of these groups will play a key role in taking forward our quality priorities next year.

***Involvement for better care planning*:**
The work to review all 'Care Programme Approach' documentation in advance of SystmOne implementation continues to be aligned with the 'Improving GP communications' CQUIN work in North West London. The aim of this work is to standardise our processes and documents across mental health services thereby reducing bureaucracy and enhancing the patient and carer experience. We held co-design workshops through the year and incorporated patient and carer feedback. We now have revised CPA standards and letter templates which are consistent with the revised mental health community care pathway and offer more streamlined, user-friendly documentation for our staff, patients and carers.

Strengthening our approach to hearing feedback:
We know that to improve satisfaction with services we need to create as many opportunities for patients to tell us about the care they have received. We also know that we have to respond to this feedback by demonstrating what we have improved.

Over the past year, we have really focused on encouraging more patients and carers to provide feedback and, encouragingly, we have seen a significant increase in patients and carers using the Friends and Family Test to tell us about our services and quality priorities. By the end of Quarter 3 we have heard from almost 10,000 patients across our services. We set ourselves an ambitious target of reaching 6% of all patients by the end of the year; at present (at end Q3) our response rate stands at 2.1% which is a threefold increase in the number of FFT responses compared to the same time last year.

To achieve this, we implemented a number of initiatives across the Trust, from bespoke feedback cards in 28 different languages at our Immigration Removal Centres to ensuring our wards all display posters on how to give feedback. We've introduced the 'You Said, We did' poster for our wards and teams encouraging them to display how they have listened to and responded to their feedback.

2.1.2 Quality Priority 2: Staff Engagement

What we achieved

We started by holding five 'Talking Quality' workshops across our services and Divisions went on to hold regular 'listening' events, we used what we heard to inform our projects and work plans in this area.

On the 1st November 2016 and on the 28 November 2016 Diggory Division held a festival for its staff in Milton Keynes and in London respectively. The aim of the festival was to celebrate and showcase the work of the teams. Ashley Belotn, National Patient Champion, opened the festival and inspired staff and visitors alike to celebrate the fantastic work that the NHS does. Over 350 staff attended the events. There were awards and workshops and an opportunity to learn and share not just across the division but also across the Trust.

***Refreshing the Workforce Strategy and Implementation Plan*:** We refreshed our Workforce Strategy. This was approved by the Board in July 2016 and the Quality & Performance Committee (a sub-committee of the Board that keep oversight of all workforce issues.) The Recruitment & Temporary Staffing Group continued its work on recruitment of permanent and bank staff leading to a stabilisation of vacancy rates around 15% and a reduction in turnover rate from approximately 19% at the end of last year to about 16% as at the end of Q3 In addition, to date the Trust has approximately 100 more staff joining the Trust than those leaving. The work of the group has also included extending the pilot of 'Golden Hellos', rolling out weekly pay to increasing numbers of bank workers and bonus payments for bank workers to incentivise working extra shifts. This has led to a decrease in the use of agency administration staff and Health Care Assistants. The focus of the group will now shift to registered nurses and Allied Health Professionals.

***Developing our Health & Wellbeing (HWB) Plan*:** The Trust's Health and Wellbeing strategy was approved by the Executive Board in November 2016. This was launched In January 2017. We continue to align our CQUIN work to our internal programme.

A staff survey was launched to further refine our staff offering. We introduced the staff physiotherapy service in the autumn. We also appointed to a Staying Well at Work Co-ordinator post that will work across Occupational Health and HR to provide support to staff who have a mental health condition.
The Employee Assistance Programme is in place to help staff with any personal problems that they may not want to talk about at work. This programme is run by People at Work and staff can turn to them for support and advice. This is a free, confidential service to all staff and includes
We are pleased that we were accredited by the Mayor of London's office with the Healthy Workplace Charter

***Review and promotion of the staff benefits package*:** Staff benefits have been reviewed and existing benefits summarised and communicated to staff. We introduced a HMRC approved 'salary sacrifice' scheme that enables staff to purchase a varietys of items including Childcare vouchers in a more tax efficient way. From 1st April 2017 we are introducing a process that allows staff to buy and sell annual leave.

***Leadership programmes**:* In October 2016, the Retention and Engagement group reviewed the leadership courses on offer and it is now working on a broader piece of work on leadership. In March 2017 the Trust held a Senior Leadership workshop to listen from and engage senior leaders across the Trust.

Work on Workforce Race Equality standards (WRES):
The Work Race Equality Standard (WRES) programme has begun to make good progress with the establishment of a WRES action group. Chaired by the Chief Operating Officer, the Executive Lead for Equalities and Diversity, key objectives have been identified; the most prominent of which is the promotion of BME staff using a variety of advancement methods,. This includes shadowing and mentoring opportunities for staff by Directors, the inclusion of BME staff to appoint members of the Trust Governing body and participate on recruitment panels, with concomitant mentoring being made available so that staff can reflect on their experiences.

The BME staff network is beginning to develop in its scope; it has used the findings from a survey of BME staff to help shape a series of programmes to support BME staff in their development. In the summer of 2016, the network hosted a 'Question Time' panel made up of senior BME staff who answered questions from other BME staff on career development.

***Improving staff environments*:** The Trust allocated a sum of money for improving staff environments in our capital plans for 2016/2017. Our junior doctors' on-site accommodation was refurbished. We created a Patient Gym at the Campbell centre that staff once inducted will be able to access for personal use. There is a programme in place for de-cluttering staff areas and we have a programme of purchasing furniture, decorating and flooring specifically for community sites.

The Trust launched a new Staff Carers Network this year: The Trust launched a new CNWL Carers at Work Network this year. The network is run by staff who are Carers themselves and welcomes all CNWL staff who are Carers or wish to support Carers who work at the Trust. The Carers at Work Network offers meeting and events, a network to connect with, signposting to support, specialist workshops and advice on relevant policies that support carers in the workplace.

The National Staff Survey

The national staff survey measure staff satisfaction in 32 areas-CNWL performed above average in 13, was about average in 13 more and below average in 6 areas. Overall staff engagement is above the national average with staff recommending CNWL as a place to work or be treated. Staff motivation-a key indicator-is better than average.

Claire Murdoch, Chief Executive, said: "These results are very important; telling us lots about the NHS's biggest resource – its people and how they're feeling. There are many stresses and great pressures but staff are recording more satisfaction in more areas but also telling us where they need more help from managers and the senior leaders of the Trust.

2.1.3 Measuring and testing our actions

To test whether our actions were having the **desired impact**, we selected **five indicators** to help us measure, track and monitor our progress; these are outlined below (under each QAP)

Patient & Carer Involvement-Indicators for measuring the impact of our actions

- We wanted at least 85% of our patients to report feeling (definitely and to some extent) involved in their care or treatment
- We wanted at least 85% of our patient to report that their care or treatment helped them achieve what mattered to them

Staff Engagement- Indicators for measuring the impact of our actions

- We wanted at least 70% of our staff report they would recommend the Trust as a place to receive care or treatment to a friend or relative
- We wanted at least 70% of our staff to report that they would recommend the Trust as a place to work
- We wanted to reduce our Trust wide Staff turnover to 15%

Throughout the year we collected feedback from our patients, carers and staff through various surveys. For the indicator relating to staff turnover, we reviewed our internal systems to track this indicator.

So how did we perform against the five quality priority indicators?

(Please note that at present, we are reporting at Quarter 3. When we refresh the quality account post consultation, we will include the final position)

We are pleased to report that we have achieved all of our **patient & carer** involvement quality priority indicators for 2016/17. For **staff engagement** quality priority indicators, we achieved two of the three indicators. Our performance against each indicator is summarised below.

Patient & Carer Involvement Indicators

Indicator 1: *Patients report feeling (definitely and to some extent) involved in their care or treatment*; Last year, we wanted to understand the extent to which we involved our patients. To this end, we added "definitely and to some extent" to the indicator relating to patient involvement in their care and treatment. We did this to ensure we identify specific areas we need to focus on in ensuring patients remain at the centre of care and treatment planning, have ownership of their plan, and know what they and health and social care professionals need to do to help their recovery.

Year to date (as at end of Q3), 91% of patients reported feeling involved in their care or treatment. This is above our target of 85% and better than our performance in the same period last year (89%)

Chart 1 displays our results for Q1 to Q3 as well as year to date performance against **Indicator 1** (**Patients reporting feeling (definitely and to some extent) involved in their care or treatment**). The graph compares performance in 2015/16 and 2016/17

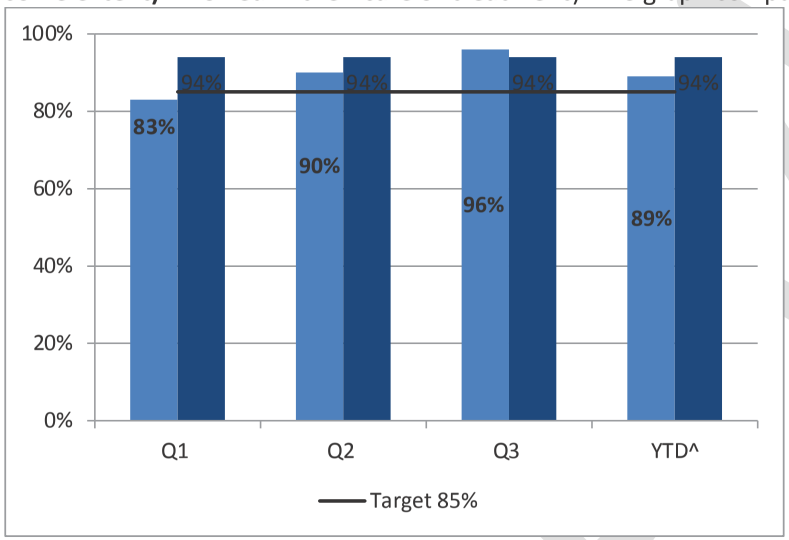


Chart 1

Key: [light blue]: 2015/16 CNWL results; [Dark blue]: CNWL 2016/17 (YTD result is as at Q3).
—Target 85%

Indicator 2: *Patients reporting that their care or treatment helped them achieve what mattered to them.* We wanted to test overall effectiveness of the care and/or treatment we provide. We wanted at least 85% of the patients surveyed to report that their care or treatment helped achieve what matters to them. We are pleased to report that overall, we achieved 94% (as at end of Q3). This is above the target we set ourselves and an improvement on last year (89%)

Chart 2 displays our quarter-on-quarter progression, and the final year-to-date reported position for **indicator 2. *Patients report their care or treatment helped them achieve what matters to them (Yes, definitely + Yes, to some extent).*** The graph compares performance in 2015/16 and 2016/17

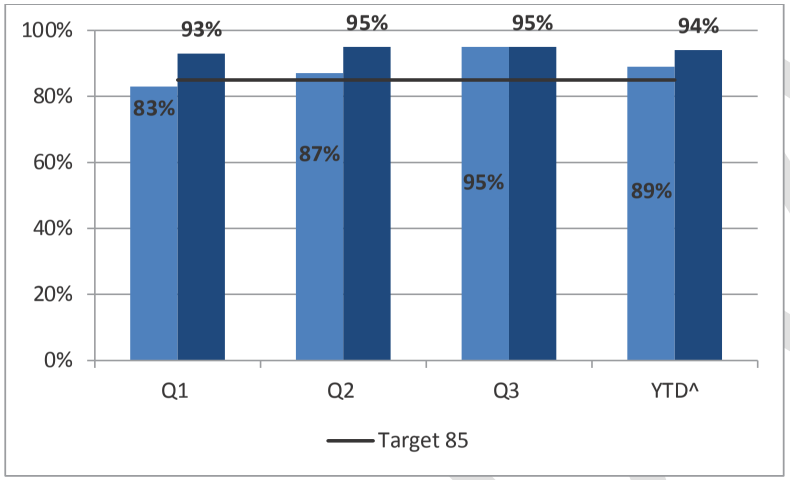


Chart 2

Key: [light blue]: 2015/16 CNWL results; [Dark blue]: CNWL 2016/17 (YTD result are as at Q3).
Target 85

Staff Engagement Indicators

Indicator 3: *staff report they would recommend the Trust as a place to receive care or treatment to a friend or relative.* We agreed that we would use the Staff FFT as good overall indicator of staff engagement and whether or not staff feel engaged and invested in their services so that they would recommend their service to others. We achieved the target for this indicator in quarter 1 and 2. In quarter three, we measured this through the national staff survey and although we did not meet our own internal target, we performed above the national average.

Chart 3 displays our quarter-on-quarter progression, and the final year-to-date reported position for ***indicator3***

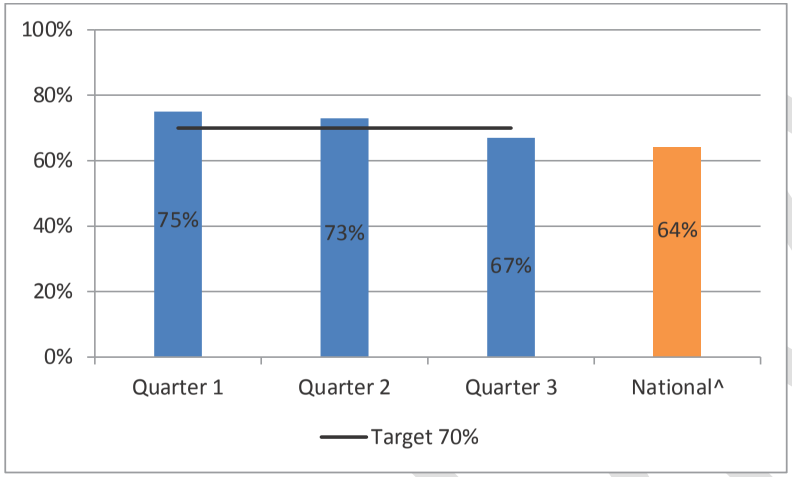


Chart 3

Key: [light blue]: CNWL quarterly results; [Orange]: National average
Target 70%

Indicator 4: staff reporting that they would recommend the Trust as a place to work. We wanted at least 70% of our staff to report that they would recommend the Trust as a place to work. We achieved 60% in quarter 1 and 66% in quarter 2. In quarter three, we participated in the national staff survey and achieved 60% which is above the national average of 58%. While the figure for quarter 1 and 2 is below the target we set ourselves, it is not inconsistent with the national picture, but we recognise that we have more to do.

*Chart 4 displays our quarter-on-quarter progression, and the final year-to-date reported position for **indicator 4***

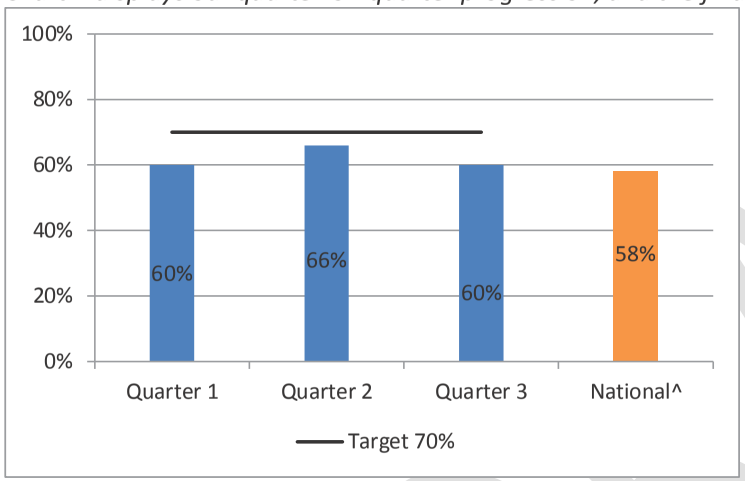


Chart 4

Key: [light blue]: CNWL quarterly results; [Orange]: National average
Target 70%

Indicator 5: We wanted to reduce our Trust wide Staff turnover. This indicator shows us whether our actions around staff engagement were having a positive impact in reducing staff turnover. We wanted to reduce our turnover from estimated 19%. Initially we set our target to 17%. By the end of Q1, we had met this target and decided to aim higher. We set our new target to 15%. While we have not met the revised target we have seen a significant reduction in staff turnover to around 16%.

Chart 5** displays our quarter-on-quarter progression, and the final year-to-date reported position for **indicator 5

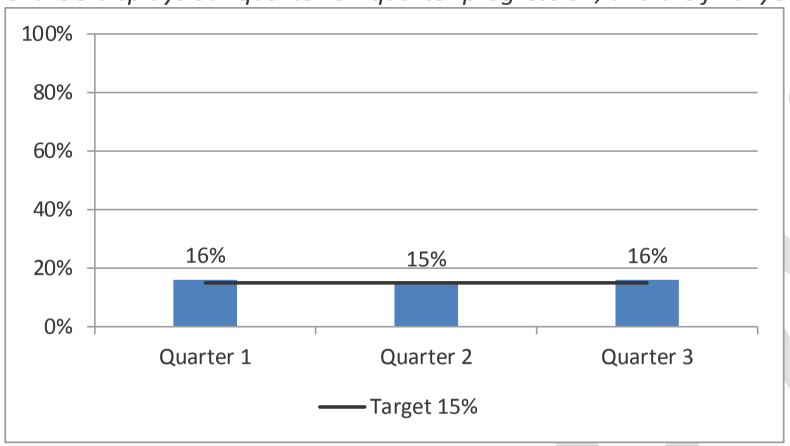


Chart 5

Key: [light blue]: CNWL quarterly results
Target 15%

What else did we measure?

From previous years, we identified and carried forward three quality indicators as these relate to areas that we need to show sustained improvement. The three indicators carried forward from previous years were;

i. We wanted at least 95% of our patients to report feeling treated with dignity and respect
ii. We wanted at least 90% of our patients to report that they would recommend the Trust as a place to receive treatment
iii. We wanted mental health risk assessments to be completed and linked to care plans in at least 95% of cases.

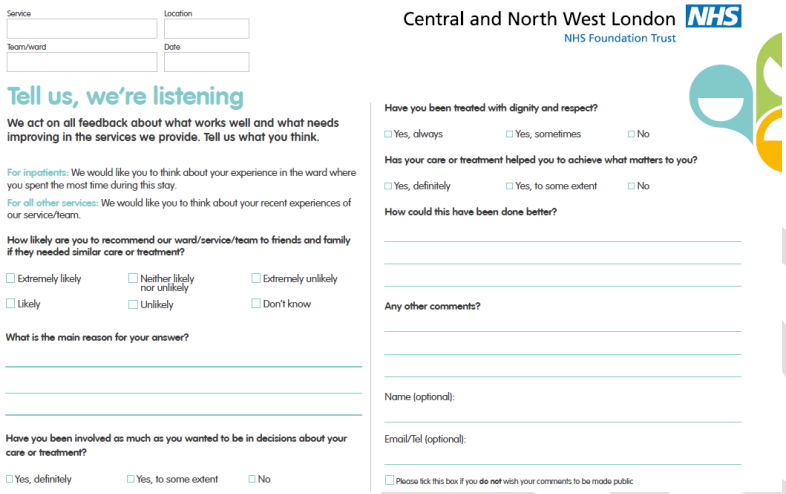
Like our quality priority indicators, two of these are patient reported. The third indicator (one relating to risk assessments linking to care plans in mental health), is audit based. We are pleased to report that we have met or exceeded our targets every quarter.

The table below demonstrates our performance against each indicator quarter on quarter.

INDICATORS brought forward from the previous year	Target	Q1	Q2	Q 3
Patients reporting **feeling treated with dignity and respect (M9; n=6571)**	95%	97%	98%	98%
Patients to report that they would **recommend the Trust as a place to receive treatment (M9; n=9348)**	90%	93%	90%	91%
Mental health Inpatient & community risk assessment completed and linked to care plans (M9; n=886)	95%	97%	92%	96%

2016/17 Friends and Family Test

We aim to deliver care that is compassionate, safe and effective that helps our patients achieve the outcomes that matter to them. This is enshrined in our Trust values of compassion, respect, empowerment and partnership. One of the tests we use to assess ourselves on how we are doing in achieving this is the Friends and Family test.



Service | Location
Team/ward | Date

Tell us, we're listening

We act on all feedback about what works well and what needs improving in the services we provide. Tell us what you think.

For inpatients: We would like you to think about your experience in the ward where you spent the most time during this stay.
For all other services: We would like you to think about your recent experiences of our service/team.

How likely are you to recommend our ward/service/team to friends and family if they needed similar care or treatment?

☐ Extremely likely ☐ Likely ☐ Neither likely nor unlikely ☐ Unlikely ☐ Extremely unlikely ☐ Don't know

What is the main reason for your answer?

Have you been involved as much as you wanted to be in decisions about your care or treatment?

☐ Yes, definitely ☐ Yes, to some extent ☐ No

Central and North West London NHS
NHS Foundation Trust

Have you been treated with dignity and respect?

☐ Yes, always ☐ Yes, sometimes ☐ No

Has your care or treatment helped you to achieve what matters to you?

☐ Yes, definitely ☐ Yes, to some extent ☐ No

How could this have been done better?

Any other comments?

Name (optional):

Email/Tel (optional):

☐ Please tick this box if you **do not** wish your comments to be made public

The Friends and Family Test (FFT) asks people *whether or not they would recommend the service to friends or family if they needed similar care or treatment*. The FFT invites patients to respond to the question by choosing one of six answers, ranging from 'extremely likely' to 'extremely unlikely'. At CNWL we have added some additional questions to our FFT test to give us a deeper understanding of our patients' experience and to be able to report on our quality indicators.

Throughout the year, we have sought feedback from our patients using the Friends and Family test. This feedback goes back to our services to help us recognise and share good practice and make improvements to our services. We know that by actively seeking feedback, we can learn

what makes a good experience for patients and what makes a high quality service. We also know that by acting on the feedback and actively demonstrating our response, our patients will be more likely to want to give us more feedback.

We are pleased to report that by the end of Q3 we had received feedback from 10,074 of our patients and, of those people who responded to the FFT question, 91% told us that they would be extremely likely or likely to recommend CNWL services to their family and friends.

The following chart demonstrates our performance in both community and mental health against national averages. It also demonstrates our overall performance year to date (end of Q3).

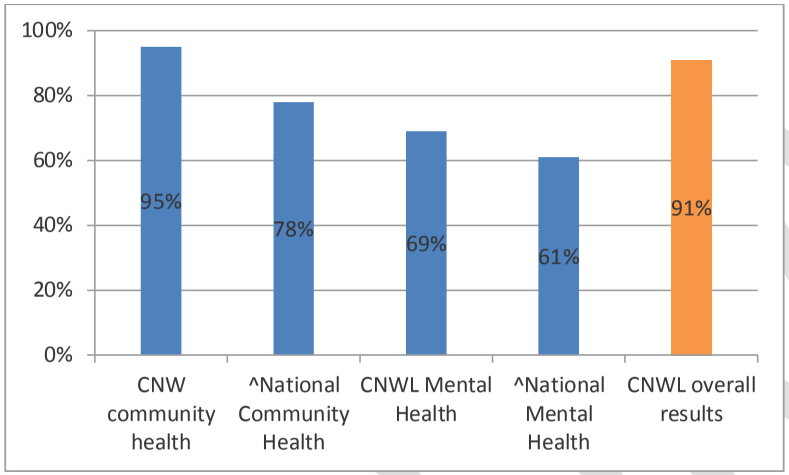


Chart 6

Key:

^ National: NHS England FFT data April 2016 to Dec 2016); Orange bar is Year to date

We want to hear feedback from even more of our patients and are pleased that our programme to drive up FFT response rates across the Trust has led to approximately a 150% increase compared to this time last year and satisfaction rates have remained above 90%.

Our programme to increase our FFT feedback includes regular Trust wide and local communications to staff; staff-facing and patient-facing webpages with guidance and resources; on-going staff training; Director-led Divisional programmes to drive up responses in every team; and local targets and trajectories to monitor and drive up performance in every service.

We recognise that we still have work to do and to make it easier for patients to return their FFT feedback so we are now preparing a pilot of FFT text messaging (SMS) in some of our services and will be putting feedback boxes at our inpatient sites. In the year ahead, we will do more work to share learning and good practice initiatives from our high-performing services; and continue our targeted work with services with lower FFT response rates.

Learning from Feedback

When a patient reports through FFT they would be unlikely to recommend a service, our patient feedback digital platform, Optimum Meridian (OM), shows a red flag to that service which remains on the system until action is taken. This allows services to quickly see and respond to negative feedback and helps us to show learning and service improvement as a result of the FFT feedback as part of our 'You Said, We Did' programme.

Analysis of all the qualitative feedback we receive from FFT allows us to look at the comments we receive from our patients by service and Division. We thematically analyse all comments received to understand where we are doing well and areas for improvement. Demographic data collected through FFT cards give an indication of the patient groups we are reaching. This year we updated our Easy Read and Children's FFT cards and developed a joint survey with Older Adults Mental Health services to make sure we are reaching seldom heard groups.

We aim to listen to all feedback and respond. One of the key ways we share feedback and our response with services, staff, patients and carers is **You Said We Did**. Below are some examples of **You Said, We Did** in our services.

You Said: Concerns were raised around a delay in contact between Health Visiting team and patient following answerphone messages requesting a visit.

We Did: The service has reviewed their processes to ensure that all telephone messages are responded to in a timely manner; arranged a home visit for the 6-12 month child development review with a Health Visitor; and provided further support and a monthly contact/visit with the family for the next three months

You Said: Patients reported long waiting times for appointments at their community service.

We Did: The team have addressed this by reducing the number of appointments and ensuring there is more time allowed between appointment slots to reduce potential waiting times in clinic.

You Said: Patient reported that the staff at the mental health service are friendly but there is not enough continuity of care as staff members change.

We did: The Service Manager acknowledged the feedback and apologised that the patient had a negative experience. The feedback was shared at the next Team meeting. The service agreed to make sure that, on assessment, patients will be informed that due to shift patterns, the Team cannot guarantee the same staff member will always be available. However, the Team do their utmost to ensure continuity of service for all patients with comprehensive daily handovers where progress and needs of patients are discussed and will ensure the shift coordinator allocates staff on duty who have had previous contact with a patient.
The issue of staff shortages or changes due to agency use is being addressed at a Trust wide level and, as a result, we have seen a significant reduction in staff turnover to around 16%.

Section 2.2 Quality Priority Plans for 2017/18

How we agreed our Quality Priorities for 2017/18

For the coming year (2017/18), we decided to link our new Clinical and Quality Strategy with our Quality Account Priorities.

The Clinical and Quality Strategy was spearheaded by our incoming Medical Director, Dr Cornelius Kelly and our Director for Nursing Andy Mattin. They are clear that to ensure quality the clinician and patient voices need to be heard. and that we are all reminded that in all we do, the patient is the focus. It is easy to be distracted with worries about money and new policy direction.

In writing our Clinical and Quality Strategy, we consulted on this with our internal and external stakeholders through a number of consultation events, culminating in a workshop for all. The event was attended by the following;

- Patient, carer and staff representatives
- CNWL Council of Governors
- Healthwatch
- Overview and Scrutiny committees
- Commissioners

We launched our Clinical and Quality Strategy and sought feedback and asked participants to identify Quality Priorities and milestones for year one to year three. We also asked for feedback on what quality means to the participants. Participants were fully engaged and we received excellent feedback through mini workshops and discussions.

Participants told us that Quality means…….

They described Quality as:

"Being able to access services that the patient feels meets their needs"

"Not just about systems analysis but with humanity –social process and software process uniting"

"Having a stable motivated workforce"

"Giving choice and preserving dignity"

"Doing it right the first time"

We agreed five key themes that will lie at the heart of our Clinical and Quality strategy:

1. Keeping patients at the centre of everything we do
2. Making sure staff, patients and carers understand what is on offer as part of the service
3. Clear, regular information for staff, patients and carers that show how we are doing against our goals
4. Support for the Trust, in partnership to innovate and share best practice
5. Having the right support to achieve our goals – this includes infrastructure that is fit for purpose such as ICT, buildings etc but equally importantly the 'right' staff doing the 'right' jobs.

An important part of delivering this will be our Quality Improvement programme – so we need to ensure our work aims are aligned.

When it came to thinking about our **quality priorities** participants told us that the immediate priorities continued to be:

- **Engaging, supporting and developing our staff to be the best they can be**
- **Involving patients, carers and families in their care, in services and beyond, truly taking a co-production approach to our work.**

By continuing with these two quality account priorities, we build on the gains made this year. We are in keeping with NHS planning principles that span three to five years, we can align national programmes such as the CQUIN and we will continue to embed the actions we have taken so far throughout the past year.

Delivering our Clinical and Quality strategy. Sustaining quality means that we have to plan over longer periods and to be clear about using systematic approaches to quality improvement. In year 1, we will be establishing a series of actions to deliver our objectives and focus our resources – against a background of reduced investment in health and social care. In Year 2 we will review and evaluate the outputs from Year 1, benchmarking services and re-aligning the 'offer 'to demonstrate improvements. By year 3 we will be carrying on with delivery our objectives, and also moving in some new areas. The Trust is committed to continuing the conversation in the development of our Clinical and Quality Strategy, linked to our operational and strategic planning.

Our strategy will be **the roadmap** to help us deliver outstanding services that are safe, caring, responsive, effective and well –led across our organisation. We will continue to build on what we hear at our consultation events. We are clear quality has to start with the patient as expert in their own lives and health, and staff who are expert in health and social care delivery. This is reflected in our vision illustrated below.

Quality Priority 1: Involving patients, carers and families in their care, in services and beyond, truly taking a co-production approach to our work.

What do we want to achieve?

Our staff are very skilled in *what* they do and *how* they do it; we want to make sure that all treatment and care plans concentrate on what the patient (and carer) wants to achieve, within their particular circumstances. Care and Treatment Plans belong to the patient; we want patients to feel the skills of the staff are being used to help them achieve the outcomes which matter most to them.

Why are we doing this?

- **There is evidence that show that when patients, carers and staff work together to plan care or treatment, we are more likely to see better recovery and health outcomes for our patients.**
- **We're building we've made on the progress with this partnership.**
- **We will measure this by what patients and carers say themselves**

We want to capitalise on the additional benefits we have seen in this previous year, the more engaged patients and carers are, the more likely they are to provide feedback. This in turn leads to improvement and better patient satisfaction.

What will we do? Our plans for the year:

- **We will work with the Patient Reference Group and Carers Council to complete the refresh of our Patient and Carer Involvement strategy**
- **We will continue the roll out of the #hellomynameis campaign achieving 100% of clinical teams signed up by the end of 2017.**
- **We will work with our Carers Council to begin the implementation of the Triangle of Care programme; and we will continue with the delivery of the Carers Council work plan.**

How we will know?

Our outcome measures which will test the impact of our actions quarterly

Measure	Method	Target	Roll-forward from 16/17?	Rationale
1. Patients report feeling involved as much as they wanted to be in decisions about their care or treatment	Patient survey	85%	Yes	This measure directly tests the achievement of our objective, provides the ability for trend analysis and historical benchmarking, and provides rich information to inform improvement given the follow-up up question which asks 'why'. This indicator is also used in the national patient surveys and so we can compare ourselves to other organisations.
2. Patient report that their care or treatment helped them to achieve what matters to them	Patient survey	85%	Yes	This measure tests the overall effectiveness of the care or treatment, and follows the same rationale as the measure above.
3. We will report on the measures in the Triangle of Care Programme	Carer rated	TBA	No	The measure will test the impact of the implementation of the Triangle of Care.

Quality Priority 2: Engaging, supporting and developing our staff to be the best they can be

What do we want to achieve?

Staff 'engagement' is shorthand for whether our staff are reaching the goals they had when entering their professions; how they make a difference to suffering and illness; their ability to determine how their skills are used and local resources marshalled; to use innovation, research and experience-generated insights to do good, with space and support that engender compassion for patients, colleagues and themselves; with opportunities to learn, develop and grow from study, professional development and to reflect on their clinical experiences frankly and make corrections that will lead to better care for others. They will understand the circumstances and frustrations that an organisation inevitably confronts with resilience and positive challenge. The emphasis always being on the good they do becoming better; always doing all that can be to fight illness and promote wellbeing and recovery, but with systems that are clinical care friendly, that expand the skills the Trust teams deploy. Confident, resilient, ambitious clinicians with objectives they set themselves and account for to their colleagues; Adopting a supportive, inclusive leadership style and demonstrates the Trust's values of compassion, respect, empowerment and partnership

Why are we doing this?

Our objective is evidence based: a valued engaged workforce in turn promotes greater motivation, empathy and compassion in staff behaviour, whether clinical or non-clinical. Our patients, their carers and our work colleagues all benefit. We know that like many other NHS trusts we face significant recruitment and retention challenges. We want to develop a workforce that is proud to work for the Trust in the service of patients and carers and we want to be the employer of choice.

What will we do? Our plans for the year:

We want to build on the excellent work we started last year. We will continue with the delivery of our new Health & Wellbeing Plan in line with the national CQUIN. We will continue to listen to and engage our staff and align our programmes to their needs, this includes the work on leadership and in particular the development of our BME staff through a bespoke mentoring programme. Having signed up to be a Carer friendly organisation we want to continue the implementation of family friendly policies such as flexible working. This year we particularly want to focus on improving issues identified in the National Staff survey especially making sure that staff have access to good IT systems to enable them to do their jobs.

How we will know?

Our outcome measures which will test the impact of our actions quarterly

Measure	Method	Target	Roll-forward from 16/17?	Rationale
Staff recommend the Trust as a place to work	Staff FFT survey	70%	yes	The Friends & Family Test for patients and staff has been introduced as an overall marker of quality and provides an indication of the outcomes of our work through the year. In this year we need to work to improve our response rates and
Staff recommend the Trust as a place to receive care or treatment to a friend or			yes	

relative				demonstrate much more overtly to staff that we have listened and acted on their feedback
Staff turnover	Internal database	15%		This indicator demonstrates whether or not our actions are having an effect. Our target was originally 17% but given we met this in Q1 we reset the target to a more challenging 15%. Our turnover rate is approximately 16% and we know that to provide good care, imbued with our Trust values, we to reduce our staff turnover.

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2.3 Monitoring and sharing how we perform

Reporting our performance and achieving our targets

The measuring and monitoring of the clinical safety, effectiveness and experience of our patients, carers and staff is a top priority.

This work is monitored and scrutinised by the Quality and Performance Committee (chaired by a non-executive director, and made up of executive and other non-executive directors) and the Quality section of the Operations Board (chaired by the Director for Nursing & Quality), who in turn provide assurance and recommendations to the Board of Directors.

CNWL services are governed locally by three Divisions, Jameson, Goodall and Diggory. These divisions are locality and specialist service based; which means better accountability and closer local relationships with our local public, commissioners, local authorities, Healthwatch and other local health and social care partners.

Divisions have the responsibility to monitor and report on their key quality & performance indicators and put in place improvement action where necessary. This is overseen by monthly Divisional Boards, which report to the Executive Board.

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

- An **integrated dashboard** which brings together key performance indicators from NHSI targets, Quality Priorities, complaints, incidents, workforce and finance information;
- Our **organisational learning themes** which are extrapolated from the analysis of our incidents, complaints, claims, audits, feedback and other information streams;
- **Divisional Quality Governance Reports** which assess their compliance against the **CQC's standards** or 'key lines of enquiry'; and
- Our **learning walks, internal Quality Inspections** and visits by the CQC and their findings.

Benchmarking

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

We are also a member of HQIP and the Prescribing Observatory for Mental Health (POMH-UK), and participate in their national programme of audits and Enquiries..

2.4 Statements relating to the quality of NHS services provided

Review of services

During 2016-17 CNWL provided and/or sub-contracted seven healthcare services.

These included:

- Mental health (including adult, older adult, CAMHS, and forensic services)
- Eating disorder services
- Learning disabilities services
- Addiction services
- Offender care services
- Sexual health/HIV Services
- Community physical health services (Camden, Hillingdon and Milton Keynes

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

The income generated by the NHS services reviewed in 2016-17 represents 100% of the total income generated from the provision of NHS services by CNWL for 2016-17.

Participation in clinical audit

During 2016/17, the Trust participated in 14 National audits and 3 national confidential enquiries which covered health services that Central and North West London provides.

During that period, CNWL participated in 93% (13/14) of the national clinical audits and 100% (3/3) of the national confidential enquiries which it was eligible to participate in. One NCEPOD audit programme is currently in the data collection period due to report in the autumn 2017.

The national clinical audits and national confidential enquiries that CNWL participated in during 2016/17 are as follows:

- National Diabetic Foot care Audit (NHS Digital)
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Royal College of Physicians)
- National Audit of Cardiac Rehabilitation (British Heart Foundation)
- Falls and Fragility Audit (Royal College of Physicians) Sentinel Stroke National Audit (Royal College of Physicians)
- Sentinel Stroke National Audit (Royal College of Physicians)
- Early Intervention in Psychosis (HQIP)
- Learning Disability Mortality Review Programme (University of Bristol)
- National CQUIN on Physical health care for mental health patients Audit 1: Care planning and discharge notification
- National CQUIN on Physical health care for mental health patients Audit 2: improving physical health to reduce premature mortality in people with severe mental illness (Cardio metabolic assessment and treatment of patients with psychosis)
- POMHUK Topic 7e: Monitoring of patients prescribed lithium
- POMHUK Topic 11c: Prescribing antipsychotic medication for people with dementia
- POMHUK Topic 14b: Prescribing for substance misuse: alcohol detoxification
- POMH-UK Audit Topic 15a Prescribing for BPAD – the use of sodium valproate
- POMHUK Topic 16a: Prescribing Observatory for Mental Health (POMH-UK) - Rapid tranquilisation

National Confidential Enquiries (NCEPOD) into patient outcome and death:

- National Confidential Enquiry into Suicide and Homicide by people with Mental Illness (NCISH)

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Child health outcome review programme
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD Young People's Mental Health Study

CNWL did not participate in the Learning Disability Mortality Review Programme (University of Bristol) as this was a pilot programme and the decision was made by the senior clinical team. The Trust will participate in the full audit when this is announced. An audit lead for this has already been identified.

The national clinical audits and national confidential enquiries that CNWL participated in, and for which data collection was completed during 2016-17, 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 Audits	Cases submitted
National Diabetic Foot care Audit (NHS Digital)	Contributed to audit led by acute sector providers.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Royal College of Physicians)	Secondary care continuous audit – continuous audit of admissions to hospital with COPD exacerbation (began on 1 February 2017). Data not yet available.
National Audit of Cardiac Rehabilitation (British Heart Foundation)	Hillingdon Community Cardiac Team participated but status with HQIP – entry was considered partial with insufficient patient information.
Falls and Fragility Audit (Royal College of Physicians) Participating: Hillingdon Community Adult Rehab services	Hillingdon Community Adult rehabilitation services contributed to the audit led by Hillingdon hospital where 181 case were submitted
Sentinel Stroke National Audit (Royal College of Physicians)	24 cases submitted
Early Interventions in Psychosis (HQIP)	100% of relevant cases submitted
National CQUIN on Physical health care for mental health patients Audit 1: Care planning and discharge notification	100% of relevant cases submitted
National CQUIN on Physical health care for mental health patients Audit improving physical health to reduce premature mortality in people with severe mental illness (Cardio metabolic assessment and treatment of patients with psychosis)	100% of relevant cases submitted
POMHUK Topic 7e: Monitoring of patients prescribed lithium	Data collection was July to August 2016 Final report received from POMHUK : CNWL summary report writing in progress – to go to the Trust Medicines Management Group in April 2017
POMHUK Topic 11c: Prescribing antipsychotic medication for people with dementia	Data submitted for 319 patients from over 17 Older Adults and Healthy Ageing clinical teams.
POMHUK Topic 14b: Prescribing for substance misuse: alcohol detoxification	Data submitted for 67 patients across 5 clinical teams was submitted (Total National Sample: 1,143 across 177 clinical teams).
POMH-UK Audit Topic 15a Prescribing for BPAD – the use of sodium valproate	422 patients prescribed valproate, only 32 (CNWL: 7.5%, TNS: 8.5%) were women of child-bearing age (defined as 'female patients under 50 years old'). Total National Sample

National Audits	Cases submitted
	was 6,705
POMHUK Topic 16a: Prescribing Observatory for Mental Health (POMH-UK) - Rapid tranquilisation	Data submitted in November 2016 – due to receive the report July 2017 – data not yet available
National Confidential Enquiry into Suicide and Homicide by people with Mental Illness (NCISH)	Findings discussed at Mortality Review Group and lessons learnt disseminated by the Listen, Learn, Act newsletter
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Child health outcome review programme	Data collection for Audit 1 and Audit 2 – April 2016-March 2017
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Young People's Mental Health Study	19 questionnaires and extracts from case notes requested. 58% of questionnaires submitted and 26% of case notes submitted Currently ongoing (14 March 2017 position)

The reports of 9 national clinical audits were reviewed by the provider in 2015-16 and CNWL intends to take the following actions to improve the quality of healthcare provided:

- **National Diabetic Foot care Audit (NHS Digital)**

The national report was published on 7 March 2017. Outcomes included that less than half of responders confirmed all three care structures were in place (43 per cent), and only 54 per cent of commissioners responded to the survey in 2016. Two fifths of the ulcer episodes referred by a health professional had an interval of two or more weeks before their first expert assessment (40 per cent). Almost one third of ulcer episodes were self-referred (30 %). Self-referring patients were less likely to have severe ulcers (34 per cent). Patients not seen for two months or more were most likely to have severe ulcers (58 per cent). A number of recommendations have been made.

Action

- *Report recently published and the recommendations are under consideration by the podiatry teams*

- **The national audit of cardiac rehabilitation annual statistical report 2016**

The national report was published in July 2016. The reports state that the UK continues to lead the world in uptake to rehabilitation and prevention for patients following a cardiac event or procedure, with an average of 50% of patients accessing Cardiac Rehabilitation (CR) services. England's mean CR uptake increased by 2% however, Northern Ireland and Wales are leading the way with a 9% and 17% increase respectively.

Action

- *services have considered the report's recommendations, have reviewed their practice and developed an action plan to address the relevant recommendations*

- **Falls and Fragility Audit Participating (Royal College of Physicians)**

Hillingdon Community Adult Rehab services participated in this audit. One the RCP published the Falls Prevention in Hospitals: a guide for patients, their families and carers in August 2016. Guide to be referenced in service quality and development meetings and programmes.

- **Sentinel Stroke National Audit (Royal College of Physicians)**

The report published in June 2016, based on stroke patients admitted to and/or discharged from hospital between January – March 2016. The report makes 14 recommendations.

Action

  - *services have considered the recommendations and have developed action plans to improve local services*

- **POMH-UK Audit Topic 7e: Monitoring of patients prescribed lithium**

Final report received from POMUK : CNWL summary report writing in progress – to go to the Trust Medicines Management Group in April 2017

- **POMH-UK Audit Topic 11c: Prescribing antipsychotic medication for people with dementia**

This was a supplementary audit. Data collection was carried out in April/May 2016 via the Older Peoples Network. Final report has been received from POMH-UK is due October 2016.

Action

  - *To circulate the results of this audit to the OPHA Clinical Network, Jameson Division, Local Borough Care Quality Meetings, Medicines Management Group and Team Leaders/Managers.*
  - *Individual teams are required to respond to the audit, review the action plan from the 2012 results and formulate and submit an updated action plan to address on-going poorer areas of practice and safeguard areas where standards have improved.*
  - *Actions plans should be held and overseen by the Divisions.*

- **POMH-UK Audit Topic 14b**: **Prescribing for substance misuse: alcohol detoxification:** This is a re-audit on patients who had been admitted to an acute adult ward in the past year (prior to January 2016) and who had undergone alcohol detoxification whilst an inpatient. Data collection was in January - February 2016. CNWL submitted data for 67 patients across 5 clinical teams (Total National Sample: 1,143 across 177 clinical teams). Audit standards were derived from the NICE clinical guidelines on alcohol-use disorders (NICE CG100, 2010 and CG115, 2011).

- **POMH-UK Audit Topic 15a: Prescribing valproate for bipolar disorder:**

This was a baseline audit on patients with a primary clinical diagnosis of bipolar disorder, who had been under the trust's care between the 7th and 30th September 2015 and had had at least one contact with services in the preceding 12 months. CNWL submitted data for 422 patients (Total National Sample: 6,705)

Action

  - *Report disseminated to all teams that have participated in the audit for consideration and action.*
  - *Findings presented at Medicines Management Group and at Physical Healthcare Steering Group.*

- *Summary of findings and areas for improvement communicated via various methods, including to divisions and to local care quality groups for local action*

POMH-UK Audit Topic 16a: Rapid Tranquilisation
Audit data submitted to POMH-UK. Final report due June 2017

Additional Trust wide clinical audits:

- Quarterly Controlled Drugs Audit
- Antimicrobial Audit
- Safe and Secure Handling of Medicines
- CNWL annual F10 prescriptions (RV codes) audit
- Medicines reconciliation audit
- Care records annual audit
- Quarterly Mental Health Act audits (for example S132 compliance)
- Infection and Prevention Control audits
- Rapid tranquilisation audits

Trust wide audits:
The Trust undertook a number of Trust-wide audit programmes. Outcomes from all of these audits are reported at divisional level to the divisional quality boards and action plans agreed, implanted and monitored as appropriate. These audits included the following:

Antimicrobial Prescribing: The aim of this audit was to monitor antimicrobial prescribing trends and quality indicators and to demonstrate compliance with the Trust Antimicrobial Stewardship Policy and associated local and national guidelines. Most areas of the Trust audited demonstrated good compliance. The exception was the Immigration and Removal Centre (IRC) Heathrow with 33% compliance. The medicines management team have been working with staff to improve practice in the IRC. In Q3, between October 2016 and December 2016 a total of 120 antimicrobial prescription audit forms across 33 bedded and offender care sites were submitted. 5 audit forms were eliminated due to missing or incomplete data and a total of 115 audit forms were included in this analysis.

Action

- *circulate report to all Pharmacists, Prescribers, and Divisional Medical Directors to discuss at respective quality and governance meetings*
- *present findings of the audit to each divisional IPC subgroup and IPC Committee*
- *advertise the e-Learning for Health Care module on Antimicrobial Resistance to all prescribers and pharmacy staff*
- *implement the Public Health England antimicrobial guideline Trust wide (excluding St Pancras Hospital, Camden, Hawthorne Intermediate Care Unit, Hillingdon and all Milton Keynes services who will continue to use their respective local guidelines).*
- *services with poor compliance (RAG rated as red) were asked to develop local action plans to improve antimicrobial prescribing*

(Progress against these action plans will be monitored by the antimicrobial pharmacist and the Antimicrobial Stewardship Group)

- *a new antimicrobial audit process implemented which included briefing all pharmacy staff involved in data collection as part of the audit process*

Safe and Secure Handling of Medicines Safe and secure handling of medicines: improved results in Goodall and Diggory Divisions compared to the previous audit in 2015 . This compliance audit is an annual mandatory audit carried out across all services where medicines are used, kept or stored. The aim of the audit was to ensure all processes, procedures and legal requirements in relation to delivery, transport, distribution, storage, ordering, supply, administration and disposal of medicines are adhered to. Goodall Division was audited in Q1 and Diggory Division was audited in Q2.
Action across all divisions included the following:

- *circulate report to: all teams and services who have participated in the audit; the Divisional Governance Lead and Divisional Director of Nursing for consideration and discussion*
- *present report at Pharmacy Leads Meeting, Borough/Service Line Quality Governance Meetings and at Medicines Management Group (MMG)*
- *follow up of action plans to ensure they are completed (outstanding action plans to be escalated to the Divisional/Service Line Leads and Governance teams for action)*
- *purchase blue lidded bins for disposal of pharmaceutical waste and purple lidded bins for disposal of cytotoxic/cytostatic waste*
- *purchase digital maximum and minimum thermometer for monitoring temperature of the room where medicines are kept and recording daily medicines room temperature on the monitoring sheet*
- *warning signs need to be displayed in the area where medical gas cylinders are stored/ kept. Equipment/facilities to ensure safe storage of medical gases needs to be in place*

Medicines reconciliation audit
Final report to be presented to the Medicines Management Group in April 2017

Annual care records audit
A detailed and extensive audit of care records was carried out in November 2016. Audit outcomes were analysed and reported to the Care Records Group and will form part of the Trust Information Toolkit 2016/17. The audits found that the Diggory audit was completed to a high standard and The Care Records Group agreed with their action plan, submitted with the audit report. The Divisional Quality Team leads the action plan for each team.

The Goodall division recommended that a 'Not Applicable' option was included on future audit tools. This would be more meaningful and can be accompanied with a request that services explain the reason for non-applicability, as necessary. The Care Records Group agreed. The action plan for the division is in preparation. The action plan for Jameson division is in preparation.
Action across all divisions included the following:

- *audit results to be widely disseminated to local teams*
- *local teams to produce and implement and establish local on-going auditing processes*
- *the divisional quality governance to monitor*

Infection and Prevention Control (IPC) audits
Quarterly IPC audits are conducted in all divisions. So each division has four reports a year and the level of assurance is identified and reported. A network of team 'link IPC' nurses is in place to support the implementation of actions from IPC audits. The quarterly reports are presented and discussed at divisional quality meetings. Action plans are in place for specific local action, monitoring and review.

Mental Health Patient risk assessments completed and reflected in care plans: This is audited across the Divisions quarterly and reported on the Quality & Performance Dashboard. It is also included as a Quality indicator in the Quality Account.

Physical health check monitoring following the administration of Rapid Tranquilisation for mental health patients:
The Trust commenced weekly auditing of the use of Rapid Tranquilisation recording of physical health checks in November 2016. The weekly audits are reviewed by the relevant modern matron for the ward and reported to the divisional quality teams. Reports are submitted for inclusion in the monthly CQC compliance report. In December, overall compliance with physical healthcare monitoring post RT across the Trust was 99%. In January the occurrences of rapid tranquilisation decreased from 142 to 124. Overall in February Trust compliance level of compliance across the Trust decreased by 1.2% to 97.8%. Local weekly audits continued to be undertaken and monitored by senior clinical staff and reported divisionally and to the Trust Restrictive Interventions Group

Local Clinical Audit Programmes:
The reports of over 500 local clinical audits were reviewed by the provider in 2016/17 and local services have taken action following audit outcomes to both sustain and 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.

A sample of examples of the range of audits is provided below:

Addiction Services:
The Addictions Quarterly Priority Audit for Q3 was completed and showed progress over 16 indicators. Significant improvements to note are around the completion of current risk assessments, management plans and recovery focused care plans. The indicator for improving all of these metrics as a package has also seen significant improvement which was 49% in QI and had improved to 67% in Q3. Improving physical health screening, corresponding with GP's and reviewing patients who are using substances, on top of their treatment, had also shown improvement.
Action

- *ensuring that patients have details of crisis numbers*
- *ensuring care plans relating to sub interventions match recovery needs*
- *risk assessments and Care Plans updated and reviewed within 3 months.*
- *reinforce compliance of all staff to ensure risk assessment and care planning meet clinical standards and protocols.*

Offender Care:
Several audits completed on Tasman ward have showed improvements including the care records audit, staff knowledge of

Comment [P2]: We will update the position in the final QA

ligature risk audit, management of section 17 leave and security checks. The rapid tranquillisation audit showed that all patients received physical health monitoring and a de-brief after the incident. In completing this quarterly audit it is becoming clear that when staff are reminded of the requirements accuracy improves.

Action

- *ongoing reminding should not be required, as it becomes more embedded within the daily routine.*
- *continue the ensure that all records are kept up to date at all times*

Sexual Health:

Excellent audit results noted – The British HIV Association National HIV Audit completed at Mortimer Market - outperformed national target in most categories.

Cervical Cancer Screening in Mental Health Patients:

Quality Improvement Project: cervical screening status on the triage ward. This audit focused on cervical screening of female patients admitted to Danube ward between August 2015 and January 2016 was undertaken. This comprised 50 female patients. Patients were identified, screened, audited and re-audited.

Action

- *to add cervical screening to weekly nursing audit*
- *to order more patient information leaflets to the ward*
- *to raise awareness of the project at the wards weekly staff meeting*
- *to create a referral form for arranging cervical screening tests for patients*

Liaison psychiatry:

A four-month audit of all referrals received from the Chelsea and Westminster (CWH – electronic) and St. Mary's (SMH- paper-based) hospitals focussed on three parameters: the inclusion of reason for admission, past medical history and medications. The audit found that the rate of completion of information from paper referral was consistently higher than electronic referral

Action

- *collaborative design of a new electronic proforma modelled on the superior paper tool*
- *clinician engagement to the design and implementation of a reliable electronic referral system*
- *a proforma that uses decision support and blocks transmission of an incomplete form is part of a proposed solution*
- *to meet in November for progress review and further action planning*

Safeguarding Children Records: Analysing the accuracy and quality of the child protection data:

This audit collected data from patient records and the outcome of this audit showed that Children's services staff are consistently placing CP alerts on records, only one out of 20 (95%) was absent in 2016.

Action

- *There is a continued multi-agency focus on recording children's views and the multi-agency partners are in agreement that this is a priority area for the Local Safeguarding Children Board in Hillingdon*.

District Nursing Records spot check audit:

The aim of this audit was to assess if spot checks were being carried out; monitor if recurrent themes identified were improving; identify

gaps in standards of assessment; measure staff compliance with DN standards; to collect evidence that spot checks are being carried out by Senior Nurses; To ensure patients are having appropriate holistic assessments covering pressure areas & To ensure care plans are updated. The audit found 97% of the patients had an up to date pressure ulcer risk assessment, 98% of patients had Care plans in place, and 83% of the care plans were updated in the last 3 months.

Action

- *Team leaders and senior nurses to continue with random spot checks and to have a main emphasis on dates on care plans, Walsall score dates, and handling assessments;*
- *re-audit 6 monthly*
- *new recruits to be made aware of this audit outcome and use as a teaching tool for the new skin bundle to enable them to achieve appropriate holistic full assessments.*

Pre-school special needs and early years:

The results show that across the Early Years' Service, 90% (85% in 2015) of parents have reported progress in their child's communication. The results show that across the Preschool Special Needs Team, parents have reported progress on 86% (75% in 2015) of their child's communication targets.

% of patients with foot ulceration who have had a vascular assessment completed in the last 12 months:

The Safeguarding Adults and Pressure Ulcer Decision Making Tool was designed and piloted to assist in deciding if the person has developed a pressure ulcer as a result of neglect or abuse. The aim of the audit was to determine the effectiveness of treating and caring for people in a safe environment and protecting them from avoidable harm. The audit found that the implementation of the Safeguarding Adults and Pressure Ulcer Decision Making Tool was partly successful. Good examples were found, and areas for further development were found:

Action

- *the systematic collection of the assessments by ward managers and clinical team leaders is put in place in order to comprehensively capture data*
- *feedback to the well-performing team and clinician and using their skills and knowledge with others.*
- *The Pressure Ulcer Data Spreadsheet designed by the Pressure Ulcer Board is to be updated with an additional tab of the scores that would automatically indicate safeguarding concerns and the potential need for safeguarding referrals.*
- *training on Pressure Ulcer Management*
- *Pressure Ulcer Champions to look at the spread sheet once a week and e-mail the team leader about the tool score*

Assessing and managing referrals for Challenging Behaviours in Dementia:

The aim of this audit was to establish current clinical practice within Brent older people's services, in the management of challenging behaviour in Dementia against NICE guidelines.

Action

- *duty workers to request physical health check-ups (Blood tests, mid-stream urine samples and physical examinations) from the GP at the point of referral*
- *mental health professionals to carry a prompt sheet for all assessments*

- *initial assessments to reflect evidence of exploration of all criteria*
- *training for all mental health professionals at the commencement of post and team training once a year*
- *re-audit in one year.*

Research

The number of patients receiving relevant health services provided or sub-contracted by CNWL in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 520 (this number will be refreshed at the end of the year) Throughout the year, the Trust has been involved in 50 studies; 31 were funded of which 4 were commercial trials, and 19 were unfunded.

Goals agreed by commissioners

A proportion of CNWL's income in 2016-17 was conditional on achieving quality improvement and innovation goals agreed between CNWL and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016-17 and for the following 12 month period will be available electronically at www.cnwl.nhs.uk.

For 2015-16, CNWL's CQUIN income equates to approximately £5.99m. CNWL achieved 90% securing the total CQUIN income of £5.430m

For 2016-17 CNWL's CQUIN income equates to approximately £6.6m. Achievement against this was unconfirmed at the time of printing and will be reported next year.

The key aim of the CQUIN framework is to support improvements in the quality of services and the creation of new, improved patterns of care. The following are a few examples of where the 2016-17 CQUINs have resulted in positive change for CNWL:
WE WILL INCLUDE THIS AT THE END OF THE FINANCIAL YEAR

CQC Reviews of Compliance

CNWL is required to register with the Care Quality Commission (CQC) and our current registration status is 'unconditional registration'. CNWL has no conditions on its registration.

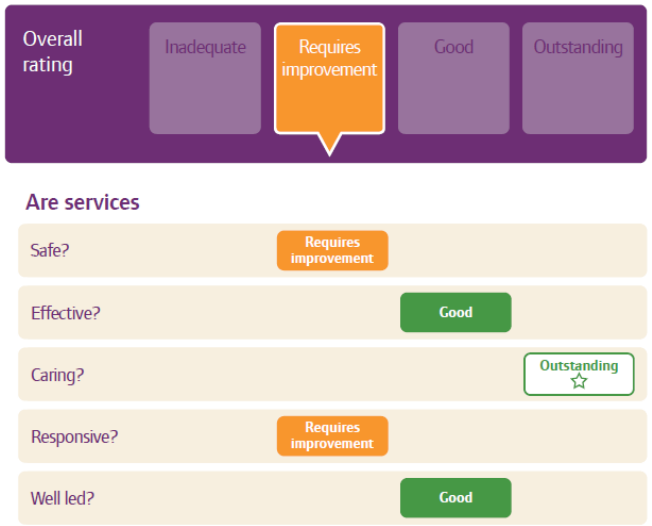
The CQC has not taken enforcement action against CNWL during 2016/17.

CNWL has participated in special reviews or investigations by the CQC relating to the following areas during 2016/17: below are details of the Trust locations inspected by the CQC.

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

CQC Reviews of Compliance during 2016/17:

Following a full inspection of the Trust in February 2015, the CQC are in the process of re-inspecting the core services to check whether or not improvements have been made. The Trust was rated as follows:



The CQC is in the process of re-inspecting in line with their methodology, they will re-inspect those core service rated ' inadequate' or 'requiring improvement.' They will further test one service rated 'good' and test the 'well led' domain across the Trust.

- **CQC inspection of Acute Mental Health wards for adults of working age and PICU's in October 2016 (previously rated Inadequate):** The final report confirmed the overall rating of GOOD. The report identified four regulatory breaches and issued 3 Requirement Notices. These concerned the monitoring of physical health following the administration of rapid tranquillisation, risk assessments and the management of risks and the use and recording of physical restraint. The report also contained 16 recommendations

Actions we are taking in relation to CQC inspection of our Adult Mental Health and PICU's and our progress so far;

Monitoring of physical observations and recording of Rapid Tranquilisation: We are Strengthening the guidance regarding the administration of Rapid Tranquillisation, particularly around the completion of debriefs and reviews to help consider alternative strategies to reduce the need for restrictive interventions.

We have strengthened the monitoring of the weekly audit reporting process through producing exception reports around risks, management plans for, if or where, required monitoring of physical health checks has not been undertaken. This is presented to relevant borough care quality meetings and the restrictive intervention group.

Reduction in restraint and prone restraint, accurate and complete recording
We are strengthening the Prevention and Therapeutic Management of Violence and Aggression, particularly around patient's personal care. We have increased focus and support to specific areas where the use of restrictive interventions is higher than in similar services. This will include a suite of material to support primary interventions and initiatives such as the implementation of the 'Safety Cross'. Additional funding has been put in place to increase the number of full time tutors who deliver physical intervention and de-escalation training.

Ensuring the accuracy, completeness and clarity of patient records includes the following:
We are using of the Datix system to ensure the reporting of the use of restraint is accurate and complete. Deep dive qualitative reviews are undertaken on a monthly basis and learning from incident reporting is shared at the Borough Care Quality Meetings

- **Wards for Older People with Mental Health problems**. (previously rated 'Requires Improvement') At the time of writing this report the CQC have concluded their inspection and have issued the Trust with a draft report indicating that they now rate this service as 'Good.'
- **Wards for people with learning disabilities or autism** (Previously rated 'Good') : At the time of writing this report the CQC are inspecting this service.
- **The CQC have yet to announce their inspection for Well led** (previously rated 'Good') and Community based mental health services for adults of working age (previously rated 'Requires Improvement')
- **CQC inspection of HMP Woodhill; the** report identified an area of outstanding practice in relation to the extended services to cover weekends. The inspection identified one regulatory breach and **issued** one Requirement Notice concerning staffing levels. Two recommendations relating to patients with complex needs and self-referrals were made

Actions we are taking in relation to CQC inspection of HMP Woodhill and our progress so far;

A detailed action plan has been submitted to the CQC. This outlines actions under the control and influence of CNWL and actions dependent on external assurances. Key actions include the following:

- A workforce strategy to focus on innovative ways to improve recruitment to HMP Woodhill.
- The development of rotational posts
- The development of an apprenticeship scheme
- Targeted recruitment campaigns

Data quality

NHS number and General Medical Practice Code Validity

CNWL submitted records during 2016-17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was (at month 10):

- 96 % for admitted patient care;
- 98 % for out-patient care; and
- N/A for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice code was (at month 10):

- 98% for admitted patient care;
- 100% for out-patient care; and
- N/A for accident and emergency care.

Information Governance Toolkit attainment level

CNWL Information Governance Toolkit score for 2016-17 performance will be available at the end of Quarter 4.

CNWL continues to take the following actions to maintain and improve data quality:

- The trust has a business intelligence system is in place. A new, improved system utilising Tableau is currently being rolled out with full implementation and go-live in April. This includes training all staff in use of new system and reviewing all reports currently supplied. It will enable team and staff level reporting, as well as benchmarking across the trust.
- Data Quality monitored at all levels of trust – including Trust Board, QPC, Divisional Board, local SMT's and Care Quality, team meetings

and staff supervision sessions. Incorporated within reports at all levels of the trust.

- Business rules published by trust for all indicators and available to staff members on intranet.
- Number of areas of data quality improvement have been identified throughout the year with dedicated projects across Divisions to improve. This included increased scrutiny and analysis of areas, and targeted training for teams and staff members.
- A full review of any new services into the trust has been undertaken to ensure they are fully compliant with business rules and follow the same processes for data entry as current services. This has included the establishment of Data Quality forums with the new services where necessary.

Clinical coding error rate

CNWL was not subject to the Payment by Results clinical coding audit during 2016-17 by the Audit Commission

PART 3 – Other information

The following section describes how we have performed against core indicators required by NHS England, NHS Improvement (our regulator) and our current and previous years' Quality Priorities.

Section 3.1 provides these indicators with year-on-year comparative data and national benchmarks where these are available. The indicators are also explained beneath each table. Section 3.2 shows performance against Quality Priorities broken down (where applicable) by locality and specialist service for ease of comparison.

The indicators are grouped in tables as per the three care quality dimensions of patient safety, clinical effectiveness and patient and carer experience. Our measures are reported year-to-date, and so is an aggregation of performance over the year.

3.1 Our national priorities and Quality Priorities (current and historical) performance tables

ALL WILL BE UPDATED AT THE CLOSE OF THE YEAR

3.1.1 Patient Safety

Measure		Data Source	Target	2016/17	2015/16	2014/15	Benchmark (where available): National average; and highest and lowest scores
1. CPA 7-day follow-up	What percentage of our patients, who are on Care Programme Approach, did we contact within seven days of them leaving the hospital? (YTD M10)	Clinical system scan	95%	**97.3%**	96.7%	97%	NAT= 96.7% MAX = 97.3% MIN = 96.5%

Measure		Data Source	Target	2016/17	2015/16	2014/15	Benchmark (where available): National average; and highest and lowest scores
2. Infection control	a. The number of cases of MRSA (MRSA bacteraemia) annually (YTD M12)	Internal database	Year on year reduction	0	0	0	Not available
	b. The number of cases of Clostridium Difficile annually (YTD M11)	Internal database	Year on year reduction	5	7	5	Not available
3. Incidents	a. Number of patient safety incidents for the reporting period (01/04/16 – 09/03/17);	Datix scan	N/A	17,386	16,635	18,210	Not available
	b. Percentage of patient safety incidents that resulted in severe harm or death	Datix scan	N/A	144 (0.83%)	141 (0.85%)	129 (0.70%)	Not available

Key:
"YTD " denotes year to date
"Q3" denotes results at quarter three

Measure 1 CPA 7-day follow up: Evidence suggests that people with mental health problems are particularly vulnerable in the period immediately after they have been discharged from a mental health inpatient ward. This measure is in place to ensure our patients remain safe and have their needs cared for after discharge from hospital to community care, and reduce risk of relapse or incident. Year to date (month 10), 95% 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 via the Trust's Business Intelligence Systems which reports all discharges so that local performance teams can track patients who have or have not been followed up. Clinicians are alerted to those patients requiring follow up, so that they are able to take focussed and informed action. The CPA policy supports operational delivery of follow up contacts, and the business rules are published and shared across the Trust to ensure data captured is representative of activity. This indicator is also published monthly via an internal integrated dashboard, which is reported to the Quality and Performance Committee and is discussed at local management and team meetings. CNWL has taken these actions to improve this percentage, and the quality of its services, and will continue to do so through the coming year to aid compliance.

Measure 2 Infection control: ***Measure 3 Infection control:*** We have a duty of care to ensure that our patients do not get any avoidable healthcare associated infections (HCAI's) while in our services. At year end we are pleased to report that we did not acquire any MRSA bacteraemia cases. Five cases of Clostridium difficile (C.diff) were reported across the Trust. CNWL considers this data is as described for the following reasons: Following the undertaking of root cause analyses (RCA's), for C.diff lapses in care were not identified for CNWL. In the identified cases patients were known to have had C.diff prior to admission and had relapses of C.diff during admission. This can occur and can be unavoidable. The rationale for undertaking RCA's is to highlight where lessons can be learnt and to improve clinical practice.

It needs to be noted that a national target for C. Diff for Provider Community Services and Mental Health Services has not been set nationally. In view of other national targets these single figures are relatively insignificant also given the wide geographical spread of bedded units across the Trust. CNWL adopt a zero tolerance approach to all avoidable HCAI's.

CNWL has taken and intends to continue to take the following actions to improve this number, and so the quality of its services: The Infection Prevention and Control (IPC) Team adheres to national guidelines and strictly scrutinises practices when managing HCAI's. Robust systems, quarterly audits and actions are in place to ensure that avoidable HCAI's within the Trust are kept to a minimum by undertaken the following audits and actions:

- Cleaning and clinical environmental audits
- Essential Steps audit tool: Our services monitor their own practice and provide assurance against the fundamental principles of infection control, for example, hand hygiene, safe disposal of sharps and appropriate use of personal protective equipment
- Antimicrobial auditing and stewardship monitoring
- Alert Organism Surveillance
- Outbreak management investigation
- All IPC polices were reviewed and kept up to date in 2015/2016, and new policies were developed,
- Mandatory IPC training programme for staff, yearly for clinical staff and three yearly for non-clinical staff.
- Quarterly IPC Link Practitioner meetings are held across all Divisions. The rationale being to encourage best IPC practice locally across CNWL
- Quarterly newsletters are published across all Divisions, to inform staff of recent IPC issues and national updates on IPC surveillance, upcoming events and practical application of best practice in IPC.

IPC assurance is provided to the Divisional Infection Prevention & Control Subgroups, Quality Governance, the CNWL Infection Control Committee, chaired by the Director of Infection Prevention and Control and to the Board on a quarterly basis..

Measure 3 Incidents:
This measure indicates the total number of safety incidents reported during 2016-17 and, of these, what number and proportion resulted in severe harm or death.

We take reported incidents very seriously at CNWL. The total number of safety incidents reported on the incident reporting system for this time range was 17,386. We've seen evidence of a positive reporting culture, where our total number of incidents has increased with the percentage of incidents resulting in severe harm or death reducing marginally.

All incidents are graded, analysed and, undergo an appropriate level of investigation using root cause analysis methodology to inform actions, recommendations and learning. The Trust has an established Serious Incidents Investigation Team that undertakes investigations and provides specialist advice and guidance to investigating teams. Patient and family involvement is central to this process and all serious incident investigations consider any issues raised by those who have been affected. The Divisions provide quarterly information and learning from their incidents and serious incidents for central analysis and reporting to the Board. This information is also reviewed and analysed alongside other data from complaints, compliments, patient and staff feedback and is then shared via the our organisational learning themes, and 'Listen, Learn and Act' newsletter.

CNWL reported no 'never events' during 2016-17.

CNWL considers that measure number 3 is as described for the following reasons: the Trust provides a broad range of services and supports the reporting of all incidents whether related to patients, staff or other parties. As such, the Trust has a positive reporting culture which supports a culture of learning. The data included within the report relates to all safety incidents and includes incidents which have been graded as resulting in no harm, low harm, moderate harm, severe harm and death. The data covers all services provided by the Trust.

CNWL has taken the following actions to improve incidents reported under measure 6, and so the quality of its services:

- Strengthened its arrangements for ensuring learning is shared across the Trust as well as developing its systems for monitoring the implementation of actions following root cause analysis investigations.
- Conducting non-executive director chaired panels of inquiry into the highest level incidents. The reports are reviewed by the Board of Directors, along with the action plans into the recommendations
- Better monitoring of patient safety incidents reported, incorporated in reporting for internal and external stakeholders
- A more comprehensive training schedule, providing more sessions throughout the year for staff
- Local support to set up local dashboards for teams to own their local incident data and support local improvement projects

In addition, the Trust has supported with key safety improvement projects. One such project was developed on an acute inpatient ward to improve the reporting culture, incident management and learning opportunities. There is evidence of sustained improvement in these areas and the ward has subsequently developed a weekly learning forum for staff on the wards called the "Datix Huddle". This model has been shared across all acute wards at this site, with a wider spread to the acute wards at St Charles hospital and our Learning Disabilities services underway.

Progress in using learning from death to inform our quality improvement plan:

The Trust has a well-established Mortality Review Group. This is chaired by the Medical Director and attended by clinicians and managers from across the Trust's Services. Clinical representation includes Divisional Medical Directors, Consultant Psychiatrists for Older Adult and Learning Disabilities as well as other key areas. The patient voice is also represented to reflect the importance of lived experience along with representation from the local CCG. Through the work of the Mortality Review Group key learning has been identified and shared across the organisation and supported changes in practice in key areas including the management of physical health in mental health settings.

During 2016/17 the Trust has reviewed and updated its Incident and Serious Incident Policy, In doing so we have strengthened our arrangements to ensure that all relevant deaths are reported and reviewed. The Trust has strengthened its arrangements to support the identification of deaths which are serious incidents using a new reporting framework, which was introduced in December 2016. The Confidential Enquiry into Stillbirths in Infancy (CESDI) grading system has been added to the incident reporting system to support teams and services to make decisions in relation to the identification of deaths and to consider whether deaths were potentially unavoidable or whether suboptimal care contributed to the patient's death. The grading system compliments existing systems and is designed to inform future management and aid learning.

Sign up to Safety Campaign / Patient Safety Improvement Work

There is extensive work in place across all Trust teams and services to enhance patient safety and patient experience. The following highlights the extent of staff engagement and commitment in the drive to improve services and protect our patients from avoidable harm. This work is integral to the Trust's Sign up to Safety Campaign.

The Trust is committed to continually learn from incidents and improve and sustain patient safety through the application of a patient safety model and quality improvement methodology. Analysis of reported incidents, themes and trends has supported the identification of the Trust's key clinical priorities in relation to patient safety. Co-production with patients and carers underpins each of the projects and will shape our improvements.

The following key areas remain the focus of the patient safety improvement work that is in place:

- Reducing restrictive interventions

- Suicide reduction
- Reducing failure to return from leave
- Prevention and management of slips, trips and falls
- Prevention and management of pressure ulcers
- Reducing medication errors

Duty of Candour

The Trust is committed to a culture of openness and transparency - to facilitate an improved patient experience, inspire trust in our services, learn from when things go wrong and also fulfil our statutory and contractual duty of candour. The Duty of Candour regulations set out requirements that must be followed when things go wrong, for example, informing people about the incident, and providing reasonable support and an apology. We therefore have action plans in place to address these aspects.

From the very start, our Chief Executive makes it clear during staff inductions that openness and transparency are core to the philosophy of CNWL, and an expectation of every member of staff. This message is supported in regular bulletins to staff.

There is a policy in place and a facility on Datix (incident management system) for monitoring compliance.

3.1.2 Clinical Effectiveness

Measure		Data Source	Target	2016/17	2015/16	2014/15	Benchmark (where available): National average; and highest and lowest scores
1. Re-admission rates	Percentage of patients were re-admitted to hospital within 30 days of leaving (YTD M12)	Clinical system scan	<8.1%	4.4%	5.0%	4.2%	5.3%
	a. For patients aged 0 - 15: b. For patients aged 16 or over:			a) 1.4% b) 4.5%	a.1.4% b.5.1%	a. 0% b. 4.2%	Not available
2. Crisis Resolution Team gate keeping	The percentage of patients admitted to acute adult inpatient beds who were assessed as to their eligibility for home treatment prior to admission? (YTD M10)	Clinical system scan	95%	99.4%	98.9%	99.7%	NAT= 98.7% MAX = 100% MIN = 98.1%
3. Early Intervention	Did our Early Intervention Psychosis Teams meet the commitments (set by commissioners) to serve new psychosis cases? (YTD M10)	Clinical system scan	95%	100%	100%	100%	Not available
4. Mental Health Minimum Data Set (data completeness)	a. Identifiers (YTD M10)	Clinical system scan	97%	98.8%	99.0%	99.1%	Not available
	b. Outcomes (YTD M12)	Clinical system scan	50%	96.3%	88.6%	92.6%	Not available

Measure		Data Source	Target	2016/17	2015/16	2014/15	Benchmark (where available): National average; and highest and lowest scores
5. Referral information (data completeness)	Referral information data completeness (referral source, priority, and discharge date)(YTD M10)	Clinical system scan	50%	74.2%	77.2%	88.5%	Not available
6.Early intervention in psychosis (EIP)	% of people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	JADE/System one	50.0%	70%	Not applicable	Not applicable	NAT = 63%
7.Improving access to psychological therapies (IAPT):	% of people with common mental health conditions referred to the IAPT programme treated within 6 weeks of referral	IAPTUS	75%	93%	Not applicable	Not applicable	Not available
	% People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral		95%	99.9%	Not applicable	Not applicable	Not available

Key:
^ Source: Quality Health 2015 NHS community mental health service user survey
** This was a QP for 2010/11
# This was a QP for 2011/12
+ This was a QP for 2012/13
"n=" denotes total sample size
"YTD M12" denotes year to date at month 12
"Q4" denotes results at quarter four

Measure 1 Readmission rates: Readmission rates describe how many patients get readmitted to hospital within 28 days post their discharge. It is important to monitor this as action is required if it indicates patients are being discharged before they are ready or not given the appropriate support in the community. We are pleased to report that our readmission rates are below the 8.1% target at 4.4%. CNWL considers that these percentages are as described for the following reasons: Performance is monitored locally via the Trust's Business Intelligence Systems which identifies all patients who were re-admitted. The business rules are published and shared across the Trust to ensure that activity is recorded and captured accurately. This indicator is also published monthly via an internal integrated dashboard, which is reported to the Quality and Performance Committee. It is also discussed at local management and team meetings.

CNWL has taken the following actions to improve this number, and so the quality of its services: Performance of this indicator is monitored on a weekly basis by the operational ward teams, using the appropriate business intelligence reports. Where a patient has been re-admitted within 28 days, the local team investigates the causes, looking across the patient pathway and shares lessons learnt at quality and operational management meetings. Exceptions are also reported monthly to the trust board and quality and performance committee. The trust plans to continue undertaking these activities to aid in compliance throughout the coming year.

Measure 2 Crisis resolutions gate-keeping: Our crisis resolution teams assess patients when they are in crisis to quickly determine if they are suitable for home treatment rather than being admitted to hospital. It is important to treat our patients in the most appropriate settings to ensure their safety and that they receive the effective treatment.

We are proud that we have done well on this measure for five years running, achieving 99.4% against our 95% target. CNWL considers that these percentages are as described for the following reasons: Performance is monitored daily via the Trust's Business Intelligence Systems which identifies all admissions and all associated gate-keeping information. The Crisis Resolution Team (CRT) policy is published and shared with all staff to support operational delivery of gate-keeping activity and the business rules are published and shared across the Trust to ensure that activity is recorded and captured accurately. CNWL has taken the following actions to improve this number, and so the quality of its services, by: Where this target is not met results are discussed and reviewed at local care quality groups, senior management team meetings or the Divisional Board. The CRT Operational Policy clearly indicates the procedure for gate-keeping is widely circulated and published on our staff Intranet. There are clear Business Rules, which are published ensuring accurate data recording across all trust teams.

This measure is also reported monthly via the integrated performance dashboard, which is reviewed by the Quality and Performance Committee. The trust plans to continue undertaking these activities to aid in compliance throughout the coming year.

Measure 3 Early intervention psychosis teams: This indicator assesses whether we have met our commitments, set by our commissioners, to serve new cases of first episode psychosis. We are pleased to report that we achieved 100% against a 95% target.

Measure 4 Mental health minimum data set: This indicator monitors that we are consistently recording key patient information so that we can plan and re-design our services appropriately to continually meet the demands of our local populations. We have exceeded our targets for the past five years for completeness of our outcomes and identifier data set. As these are Trust-level indicators we do not present performance by borough.

Measure 5 Community health referral information: This measure monitors the completeness of our patient records with regards to referral information. Specifically, this monitors the completeness of referral source, priority and discharge date, which enables us to effectively plan and manage our community health referrals in, reducing any delays, and plan for discharge. At M10, we achieved 74%, exceeding the national 50% target.

Measure 6 Early interventions in psychosis (EIP) this measure monitors the percentage of people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral. The trust has achieved 70% against a target of 50% and is well above the national average. CNWL considers that these percentages are as described for the following reasons; Performance is monitored daily via the Trust's Business Intelligence Systems. This indicator is reported to the Quality and Performance Committee. It is also discussed at local management and team meetings.

Measure 7 Improving access to psychological therapies (IAPT) This measure monitors the percentage of people with common mental health conditions referred to the IAPT programme treated within 6 weeks of referral and those treated within 18 weeks of referral. CNWL considers that these percentages are as described for the following reasons; Performance is monitored via the Trust's Business Intelligence Systems. This indicator is reported to the Quality and Performance Committee. It is also discussed at local management and team meetings.

3.1.3 Patient, carer and staff experience

Measure		Data Source	Target	2016/17	2015/16	2014/15	Benchmark (where available): National average; and highest and lowest scores
1. Mental health delayed transfers of care	On average, what percentage of hospital beds are being used by patients who should have been discharged? (YTD M12)	Clinical system scan	<7.5%	5.6%	4.6%	4.4%	National Avg: 3% National Max: 11%; National Min: 0%
2. CPA 12 month review	What percentage of our patients who are on CPA received a full CPA review within the last 12 months where appropriate? (YTD M12)	Clinical system scan	95%	96.1%	96.6%	98.0%	National Avg: 78% National Max: 99%; National Min: 14%
3. Care/treatment plans	a. Quality Account Priority 2016/17: Patients report that they were involved as much as they wanted to be in decisions about their care/treatment (definitely and some extent)YTD M9; n=7778)	Patient survey	85% Increase from 75%	91%	Trust: 82% MH: 67% CH: 87% (YTD)	81% (Q4)	56%^
	b. Quality Account Priority 2016/17: Patient report that their care or treatment helped them to achieve what mattered to them (Yes, definitely + Yes, to some extent (YTD M9; n=7429)	Patient survey	85%	94%	Trust: 91% MH: 89% CH: 92% (YTD)	n/a	93%^

Measure		Data Source	Target	2016/17	2015/16	2014/15	Benchmark (where available): National average; and highest and lowest scores
4. Dignity and respect	Patients report that they were treated with dignity and respect (YTD M12; n=3534)	Patient survey	95%	97%	Trust: 97% MH: 96% CH: 98% (YTD)	98% (Q4)	93%^
5. Community mental health patients' experience of their health worker	a. Did the person or people you saw listen carefully to you?	National patient survey ^	n/a	90%	92%	93%	93%^
	b. Were you given enough time to discuss your needs and treatment?		n/a	86%	89%	90%	89%^
	c. Did the person or people you saw understand how your mental health needs affect other areas of your life?		n/a	83%	86%	85%	87%^
	d. Did you feel that you were treated with respect and dignity by NHS mental health services?		n/a	89%	91%	90%	93%^
	e. Were you involved as much as you wanted to be in discussing how your care is working?		n/a	91%	92%	93%	93%^

Measure		Data Source	Target	2016/17	2015/16	2014/15	Benchmark (where available): National average; and highest and lowest scores
6. Service satisfaction/ Friends and Family Test	Patient FFT: Patients report how likely they are to recommend CNWL services to family or friends if they needed similar care or treatment (YTD M9; percentage of 'likely' and 'extremely likely' responses; n=9348)	Patient survey	90%	91%	Trust: 92% MH: 86% CH: 94% (YTD)	95% (Q4)	^^ National Avg MH: 87% National Avg CH: 95%
	Staff FFT (internal survey): Staff report how likely they are to recommend CNWL services to family or friends if they needed similar care or treatment (YTD M12; percentage of 'likely' and 'extremely likely' responses; n=1234)	Internal staff survey	66%		70% (YTD)	72% (Q4)	^^^ National Avg: 79% National Max: 100% National Min: 48%
	Staff FFT (national survey): Staff report how likely they are to recommend CNWL services to family or friends if they needed similar care or treatment (score reported out of 5, with 5/5 being the maximum possible)	National Staff Survey 2016	n/a	3.74/5	3.71/5	3.68/5	* National Avg: 3.63/5 National Max: 4.04/5
7. Equal opportunities for progression or promotion	Staff believing that the organisation provides equal opportunities for career progression or promotion	National Staff Survey 2016	n/a	83%	85%	87%	* National Avg: 84% National Max: 93%
8. Staff experience of bullying or abuse	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months		n/a	23%	22%	21%	* National Avg: 22% National Max: 16%

Key:
^ Source: Quality Health Ltd 2016 NHS community mental health service user survey
^^ Source: NHS England national patient FFT results (April 2016 to Dec 2016)
^^^ Source: NHS England national staff FFT results (Quarter 3; to be updated)
* Source: NHS National Staff Survey 2016
# This was a QP for 2011/12
+ This was a QP for 2012/13
"n=" denotes total sample size
"YTD M9" denotes year to date at month 9
"Q3" denotes results at quarter 3
"MH" denotes results for mental health; "CH" denotes community health

Measure 1 Mental health delayed transfers of care: This measure assesses the percentage of inpatient beds that are being used by those who should have been discharged to our partner agencies, but are being delayed. We work closely with our local authority partners to ensure discharge takes place at the right time and therefore make beds promptly available to people who most need them. We have seen good performance in this area achieving 5.6% against a <7.5% target. This is higher than the last three years.

Measure 2 CPA 12 month review: This indicator monitors whether those on CPA (Care Programme Approach) receive a full review at least annually. This enables service provision to be updated as per the patient's changing needs so care provided is most effective. We are pleased that we continue to achieve our target for this measure.

Measure 3 Care/ treatment plans:

a) Community patients report that they were involved as much as they wanted to be in decisions about their care/treatment (definitely and some extent) this was a Quality Account Priority for 2016/17 and is explained in Part 2. We are pleased to report that we have achieved the target for this indicator.
b) Patient report that their care or treatment helped them to achieve what mattered to them (Yes, definitely + Yes, to some extent**:** This was a Quality Account Priority for 2016/17 and is explained in Part 2. We are pleased to report that we have achieved the target for this indicator.

Measure 4: Dignity and respect: Patients report that they were treated with dignity and respect: we continue to measure this indicator from previous years. Overall, we achieved 97% which is above our target. This is explained in Part 2.

Measure4; Dignity and respect: While we achieved this as a Quality Account Priority last year, we have continued to monitor it and will continue to do so. This forms one of our core patient reported outcome measures which we include on all questionnaires as it provides assurance that our patients are being treated with professionalism at all times, and would provide an early warning to where service improvement is needed. We are pleased to report that overall we have achieved 97%, achieving our target.

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Measure 6 Community mental health patient experience of contact with their health care worker: These five indicators assess our community mental health patients' experience of the health care worker, as reported from the results of our National Community Mental Health Survey 2016. 991 community mental health service user took part in the annual Mental Health Community Service User survey 2016

CNWL considers that these indicators are as described for the following reasons: The Trust scored highly across many areas in the survey such as being seen often enough by our services, knowing who to contact in a crisis and receiving clear medicines information, however, there was much local variation and there is still work to do to address this and ensure gains are not lost but built upon. Patients rated the Trust highly for staff listening, giving time and understanding their mental health needs but we want these scores to be even higher to take us above the national average.
We know from our own collecting of patient feedback over the past year that we need to continue to focus on improving involvement in care and making sure our patients and carers report that they are always treated with Respect and Dignity.

CNWL is taking the following actions to improve these scores and the quality of services:

- Priorities: We recognise that it takes time to embed quality in a sustainable way so we will continue the work we have started and maintain as a key Quality Priorities for 2017/18 patients and carers feeling involved, supported and taking ownership of the decisions about their care. This will remain a key focus for us over the coming year.

- #Hellomynameis campaign: The Trust Board made a public commitment to the #hellomynameis campaign at this year's AGM. All three Divisions and one quarter of our teams have signed up. The Trust has recently decided to replace the NHS lanyard with a #hellomynameis… branded lanyards.
- Patient and Carer Stories: sent to you in previous narrative
- Carers Council: sent to you in previous narrative
- Involvement for better Care Planning: We are now completing a comprehensive review of all CPA documentation to standardise processes and documents across mental health services and improve the patient/carer experience. Two co-design workshops took place in September 2016 incorporating patient feedback.

We will continue to listen to our patients and carers and, more importantly to act on their feedback

Measure 7 Service satisfaction: Patients and staff recommending our services: We monitor whether patients and staff would recommend our services to family or friends if they needed similar care or treatment (known as the 'Friends and Family Test' or FFT) and the reasons that they gave for this. This gives us a good indication of what needs improvement, and a key source of intelligence for the setting of our Quality Account Priorities for the forthcoming year.

Patient FFT results: Our year-to-date results show that 83% of our patients would be extremely likely to recommend Trust services, achieving our target. Breaking this down, we achieved 61% for our mental health services and 78% for our community services, both just above the national average.

Staff FFT results: Our internal staff survey showed that 70% of our staff would be likely or extremely likely to recommend Trust services year-to-date, achieving our 66% target.

CNWL's results from the **National Staff Survey** showed that we achieved 3.74/5, which represents an increase on the previous year's achievement, and above the national average of 3.63/5.

CNWL considers that this data is as described for the following reasons: Staff report that patients and service users (76%) are seen as the organisation's top priority with 91% of staff feeling that their role makes a difference to patients and service users and 82% agreeing or strongly agreeing that they are satisfied with the quality of care they personally are able to give to patients/service users. 78% of staff also report that the organisation acts on concerns raised by patients/service users. These are all improvements compared with last year and whilst only 60% would recommend CNWL as a place to work this is a slight improvement on last year (58% in 2015).

CNWL is considering the following actions to improve this score and these are being embedded through strong leadership, governance and partnership working with Staffside. Each Division has had to develop a staff engagement plan and provide examples of key actions taken. Key actions include:

- Improve managerial awareness of health and wellbeing by promoting Trust wide initiatives
- Increase the number of flexible working requests approved
- Promote mentoring programmes for BME staff
- Learn from areas of best practice in cases where violence has been experienced from patients or service users
- Senior management commitment to reduce unpaid additional hours worked

Our challenge this year is to improve further on these measures and we will do this by holding a series of events between management, HR and Staffside in response to the Staff Survey. Other key Workforce strategies will be refreshed both centrally and divisionally. The Staff Health and Wellbeing strategy will be implemented.

The key workforce objectives this year include: Improving recruitment rates and reduce vacancy rates looking at resigning roles and developing apprenticeships throughout the Trust with a view to creating and growing our own clinical and non-clinical staff.

Ensuring front line managers all receive leadership and management training; Developing an open and equitable culture where staff can influence change and hold accountability at the right level; Implementation of the Workplace Race Equality standard; Work towards the organisation becoming fully compliant with the NICE guidance on healthy workplaces.

Measures 7 and 8 Staff career progression and experience of harassment: These measures represent our performance from the National Staff Survey 2016. Measure 7 shows that 83% of our staff feel there are equal opportunities for career progression or promotion and staff, and this is slightly lower when compared with the national average for similar Trusts. Measure 8 shows that 16% of our staff experienced harassment or bullying from colleagues in the last 12 months which is on par with the average for similar Trusts.

3.2. Our quality indicators presented by locality and specialist services.

The following three tables reflect borough performance against our quality priority indicators (including indicators brought forward from previous the previous year). Where possible, we have broken this down to borough and specialist services.

3.2.1. Clinical Safety

			Mental health services						Specialist services						Community physical services				
Measure		Target	Brent	Harrow	Hillingdon	Kensington & Chelsea	Westminster	Milton Keynes	CAMHS	Learning Disabilities	Rehabilitation	Eating Disorders	Addictions	Offender Care	Camden	Hillingdon	Milton Keynes	Sexual Health	Trust-wide
2. Risk assessment and management	Inpatient & community risk assessment completed and linked to care plans (YTD M9; n=887)	95%	96%	92%	95%	93%	97%	73%	100%	92%	90%	96%	n/a	n/a	n/a	89%	80%	n/a	83%

Key: "-": Not measured or no response received; n/a: Measure not applicable; "n=" denotes total sample size;
"YTD M9" denotes year to date at month 9

3.2.3 Clinical effectiveness

			Mental health services						Specialist services						Community physical services				
Measure		**Trus wide target**	**Brent**	**Harrow**	**Hillingdon**	**Kensington & Chelsea**	**Westminster**	**Milton Keynes**	**CAMHS**	**Learning Disabilities**	**Rehabilitation**	**Eating Disorders**	**Addictions**	**Offender Care**	**Camden**	**Hillingdon**	**Milton Keynes**	**Sexual Health**	**Trust-wide**
What percentage of service users were re-admitted to hospital within 28 days of leaving?		<8.1 %	5.8 %	4.5 %	3.6 %	3.7%	4.1%	4.9%	1.4%	9.1 %	n/a	n/a	n/a	**8.3%**	**n/a**	**n/a**	**n/a**	**n/a**	**4.4%**
The percentage of service users admitted to acute adult inpatient beds who were assessed as to their eligibility for home treatment prior to admission?		95%	99. 2%	100 %	100 %	98.2 %	99.3 %	99.5 %	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**99.4%**
Did our Early Intervention Teams meet the commitments (set by commissioners) to serve new psychosis cases?		100%	100 %	100 %	100 %	100%	100%	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**100%**

Key: n/a: Measure not applicable;

3.2.3 Patient and Carer Experience

Measure		Target	Mental health services						Specialist services						Community physical services				
			Brent	Harrow	Hillingdon	Kensington & Chelsea	Westminster	Milton Keynes	CAMHS	Eating Disorders	Learning Disabilities	Rehabilitation	Addictions	Offender Care	Camden	Hillingdon	Milton Keynes	Sexual Health	Trust-wide
3. Care/ treatment planning	a.i. Quality Account Priority 2015/16: Community patients report that they were involved as much as they wanted to be in decisions about their care/treatment (definitely) (YTD M9; n=7663)	75%	58%	60%	69%	64%	66%	71%	68%	72%	60%	62%	67%	49%	71%	78%	84%	86%	**78%**
	a.ii. Community patients report that they were *'definitely and to some extent'* involved as much as they wanted to be in decisions about their care and treatment (YTD M9; n=7778)	85%	83%	87%	84%	88%	81%	91%	74%	93%	80%	78%	93%	73%	92%	92%	96%	97%	**94%**

	b. Quality Account Priority 2015/16: Patient report that their care or treatment helped them to achieve what mattered to them (YTD M9; n=7430)	85%	55%	62%	48%	61%	52%	55%	63%	31%	40%	60%	58%	37%	73%	75%	86%	83%	**94%**
4. Dignity and respect	Percentage of patients who report being treated with dignity and respect (Yes always + yes sometimes) (YTD M9; n=7864)	95%	95%	94%	90%	95%	90%	63%	85%	100%	60%	80%	99%	89%	100%	99%	99%	97%	**97%**
5. Service satisfaction/ FFT	Patient FFT: How likely are you to recommend CNWL services to family or friends if they needed similar; (YTD M9; n=9348)	90%	78%	67%	87%	71%	80%	91%	82%	100%	84%	94%	93%	72%	96%	94%	95%	94%	**91%**
	Staff: How likely are you to recommend CNWL services to family or friends if they needed similar care or treatment (YTD; percentage of 'likely' and 'extremely likely' responses; n=1234)	66%	52%	62%	60%	58%	54%	67%	74%		61%	60%	72%		79%	82%	76%	83%	**70%**

Key: "-": Not measured or no response received; n/a: Measure not applicable; "n=" denotes total sample size; "YTD M9" denotes year to date at month 9; "Q3" denotes results at quarter 3

Annex 1 – Statements provided by our commissioners, Overview and Scrutiny Committees (OSCs) and Healthwatch

Our commissioners

[to be Included at close of the 30-day consultation 29 April 2017]

Our local Healthwatch

[to be Included at close of the 30-day consultation 29 April 2017]

Our Overview and Scrutiny Committees

[to be Included at close of the 30-day consultation 29 April 2017]

Annex 2 – 2016-17 Statement of directors' responsibilities in respect of the Quality Account

Comment [P3]: this section will be updated following the report from the Auditors and the external stakeholder comments.

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance;
- 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 2016 to March 2017
  - papers relating to quality reported to the board over the period April 2016 to March 2017
  - feedback from commissioners dated XXX (closing date of the Quality Account 30-day consultation)
  - feedback from governors dated XXXX (closing date of the Quality Account 30-day consultation)
  - feedback from local Healthwatch organisations XXXXXX (closing date of the Quality Account 30-day consultation)
  - feedback from Overview and Scrutiny Committee dated XXXXX (closing date of the Quality Account 30-day consultation)
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;
  - the 2016 national patient survey
  - the 2016 national staff survey

- the Head of Internal Audit's annual opinion over the trust's control environment dated TBC
- CQC Inspection Report 06/01/2017

- 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 NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

[signatures]

Claire Murdoch
Chief Executive
27 May 2017

Prof. Dorothy Griffiths
Chairman
27 May 2017

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THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST
Briefing Sheet – Annual Quality Report overview

Highlights

The Quality Report provides a summary of performance during 2016/17 in relation to quality priorities and national requirements. Overall, the Trust performed very well across a wide range of quality indicators. Particular successes included:

- The Trust improving compliance for patients being assessed for risk of developing thrombosis (blood clots) on a regular basis from 94.6% in 2015/16 to 96.3% in 2016/17, performing better than the London and national average.
- Patient mortality figures being 'as expected' within the Summary Hospital-level Mortality Indicator band. Aggregate Hospital Standardised Mortality Ratio 94.5 – below national average, improvement on 2014/15 (101.5).
- C difficile infection rates remaining below the London and national average (per 100,000 bed-days).
- The Trust continued to maintain its high Referral to Treatment (18 weeks) performance against this standard - better than London and national average
- Key cancer performance indicators being well maintained for all the national waiting times standards and performing better than the London and national average
- An improved patient safety incident reporting rate (better than London average)
- A reduction in emergency re-admissions within 28 days of 7.1% for year to date 2016/17, compared to 7.9% during 2015/16.
- Recruiting 50 staff safety champions as part of our Sign up to Safety Campaign. These staff members are now taking forward safety improvement projects in their clinical areas and are coming together as a support network to share and learn from each other.
- 63% of our staff saying they 'would recommend the Trust as a place to work' (2% higher than the average for acute Trusts) within the Trust's Annual NHS Staff Survey
- Achieving a 3.85 out of 5 staff engagement score, within the annual NHS Staff Survey which was above the national average (3.81). Overall, we scored above average in 17 areas with 12 of these being in the top 20% of all acute Trusts in England.

CQC Inspection

The Trust has been working through a detailed improvement plan since the Care Quality Commission (CQC) published its February 2015 inspection report and this continues to be presented to the Trust's Quality and Safety Committee on a quarterly basis. A recent review by the Trust's internal auditors, KPMG against the CQC's Key Lines of Enquiry will support the Trust in refreshing its action plan in 2017.

The Trust however, has continued to sustain compliance rates for staff training for all statutory and mandatory training above the 80% or more compliance target, the majority of which are now achieving 90%. The Trust also adopted cleaning targets in

line with the National Specification for Cleaning (NSC) standards and has exceeded the NSC targets during 2016/17. Recent infection prevention and control audits show improved compliance for hand hygiene and 'Bare below the elbows' practice and our safeguarding children and adults arrangements have continued to be strengthened with excellent partnership working with local health and social care partners. We have made significant improvements on medicines management and security of medicines in our clinical areas however mock inspections show that the Trust is challenged with regard to adequate storage facilities to ensure clinical and pharmaceutical supplies are stored appropriately. Actions are being taken forward where further improvement is required.

The Trust's ambition is to achieve an 'outstanding' (with 'good' as a minimum) CQC rating at future inspection. Moving forward, the Trust has agreed a programme of mock inspections using internal peer review and each core service will be benchmarked against the CQC inspection assessment frameworks to provide assurance on compliance and for key areas of improvement to be identified.

Service Developments

The Trust made great investments last year in new and improved services. These included:

- Spending more than £4 million on improving and expanding children's services that comprised of a major refurbishment of children's A&E and building a brand new four-bed extension wing on Peter Pan Ward. Seven new Paediatric consultants were also appointed to provide additional 24/7 support for children.
- Refurbishing and upgrading services and facilities. This included building a new extended Clinical Decision Unit, new A&E triage rooms and staff offices.
- Developing a brand new outpatient pharmacy at Hillingdon Hospital, which now means that patients get the medicines they need more quickly, reducing the need to visit their GP.
- Spending more than £300k on 400 state-of-the-art cots, cribs and electric beds as part of a hospital-wide bed replacement programme at both hospital sites.

A new Quality and Safety Improvement Strategy also saw many improvements being made across areas of patient safety including safety huddles as part of clinical handovers, safety ward rounds and the appointment of Patient Safety Champions through our staff and patients.

Easing the carer and patient journey played a key role in the improvements made this year with the implementation of national initiatives such as Johns Campaign. This enables carers to support their loved ones outside of visiting times in accordance with their wishes and can provide a significantly improved patient experience.

Our Sign up to Safety Campaign, now in its second year, has continued to grow stronger with significant achievements including an improvement in incident reporting

on medication errors, raised awareness for our staff on malnutrition and ongoing education for our nutritional link nurses,

Substantial progress has also been made with the Shaping a Healthier Future programme and Whole Systems Integrated Care as we work closely with our partners in health and social care and key stakeholders to continue to deliver improvements in the services delivered across North West London.

Hillingdon Accountable Care Partnership Shadow Board functions with an agreed set of principles to deliver better quality integrated services for older people in Hillingdon. Under the umbrella of an Alliance partnership during 2017/18 the providers and commissioners have agreed to initially pool a range of service budgets which are specifically targeted at the over 65's that totals approximately £32m.

Quality Improvement

Our quality priorities for 2016/17 fell into the three areas as mandated by the Department of Health: patient safety, patient experience and clinical effectiveness. The priorities included:

1.	Achieving National Early Warning Score (NEWS) compliance to support early escalation of the deteriorating patient
2.	Achieving improvement in relation to seven day working priorities
3.	Delivering compassionate care and improving communication
4.	Safer staffing – improved recruitment and retention to ensure delivery of safe care

Regarding NEWS compliance, ongoing education of all staff remained a priority as well as understanding how we could address new ways in achieving the standards set. Work is currently being undertaken within the Trust to look at electronic monitoring systems which can enable some remote vigilance and observation of patients, as well as enabling medical and other healthcare professionals to clinically prioritise their caseloads. However, during 2017/18, it is recognized that we need to continue to educate and empower our staff to improve and ensure a patient focused approach as well as to improve and ensure patient safety.

Meanwhile, NHS Improvement is supporting all Trusts to meet the four seven day working priorities standards, identified as being 'must do' by 2020.

With regard to improving communication, all organisations that provide NHS or adult social care including the Trust, have had to implement the Accessible Information Standard by law from 31 July 2016. This includes making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email. The standard also includes providing support from a British Sign Language interpreter, deaf-blind manual interpreter or an advocate.

During 2016/17 the Trust continued to be a member of the Imperial College Health Partners Patient Safety Collaborative (PSC). The PSC programme of work is aligned with and supports the national Sign up to Safety campaign which the Trust signed up

to in the latter part of 2014. As part of this work the Trust has committed to: listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patients' safety.

In developing our quality priorities for 2017/18 the Trust wanted to ensure they were aligned with its newly published Quality and Safety Improvement Strategy (2016) and the North West London Sustainability and Transformation Plan. It also needed to ensure that the Annual Quality Account clearly outlines the Trust's progress against Care Quality Commission standards and that the 2017/18 quality priorities are aligned with this work.

We consulted with a wide group of stakeholders, including our Governors, Commissioners, People in Partnership and our local Healthwatch. Our aim is to continue to focus on the essentials of care in order to continue to improve clinical outcomes and to ensure that our patients have a positive experience. Key quality improvement priorities we aim to achieve in 2017/18:

1.	Improvements to End of Life care
2.	Continuing to deliver the seven-day working priorities
3.	Improving the care of patients with dementia
4.	Improving the discharge process

These priorities will be areas of focus alongside existing quality and safety improvement work that is already underway such as sepsis identification and management, and embedding the new arrangements for identifying, reporting, investigating and learning from deaths in care as outlined in the guidance issued by the National Quality Board. The Trust will continue to improve its safety culture via staff awareness and training and strengthening Trust policy and processes.

Specific indicators under these key priorities have been determined with the relevant clinical and management leads and are detailed in the Quality Report.

Areas of challenge in key performance indicators and actions being taken

It has been a challenging year for the Trust both in achieving A&E performance due to high level of patient activity exceeded by our physical capacity and generally across the Trust whereby we have had difficulty in attracting, recruiting and retaining sufficient staff to ensure high calibre and skilled workforce in areas which are hard to recruit. This impacted on the quality priorities including continuing to deliver seven-day working. As a result this remains a priority for us in 2017/18 and is outlined in this year's quality report. Key areas of concern include:

Accident and Emergency (A&E) waiting times

A detailed diagnostic piece of work was jointly commissioned by Hillingdon CCG, the Trust and an external consultant to identify areas for improvement that would serve to enhance patient flow. The resulting action plan focuses on:

- Reducing inappropriate attendances
- Achieving the four hour standard and reducing admissions

- Safely and effectively discharging patients
- Sustainability in workforce and workforce management

Average attendances of greater than 160 patients per day presents an ongoing challenge for the clinical team working in a confined physical space. The Trust is currently seeking support to expand the A&E Department footprint, to future proof emergency care services capacity and accommodate for current and future service demand. Quality reporting and data integrity remain a key priority for the A&E department and the Trust and it has implemented a new policy and data recording process that will improve compliance to national reporting standards.

Improved recruitment and retention to ensure delivery of safe care

The three year Recruitment and Retention Strategy approved by the Trust Board in September 2017 includes a wide range of initiatives to support safer staffing. We can see that through the interventions we have put in place in Year One of the Strategy that we are having a positive impact on the key metrics:

- Our turnover rate has decreased from 17.0% to 15.8%
- Our vacancy rate has decreased from 11.46% to 10.82%
- The Time to Recruit has decreased from 67 days to 55 days

We are continuing to implement further recruitment and retention initiatives as part of the Strategy in order to achieve the targets we have set ourselves for these key metrics.

Percentage of complaints responded to within agreed timescales

There were 353 complaint responses due during 2016/17, 67.7% (239) were completed within the timescale agreed with the complainant. This is disappointingly lower than achieved last year. Underlying reasons include staffing challenges due to sickness absence in the Complaints Management Unit and competing priorities within clinical divisions impacting on ability to responds to complaints in a timely manner.

To ensure a similar situation does not happen in the future, and to build on the service improvement already implemented to improve the timeliness and quality of responses to complainants, the following actions are underway:

- Complaints management process being strengthened to ensure quality-focused time-driven investigatory reports.
- Up-skilling of individual staff within the complaints team and closer working between the PALS and Complaints teams to create a flexible, multi-skilled workforce.
- Activity monitoring to identify surges in activity at an early stage to ensure appropriate allocation of resources.
- Divisional teams taking a proactive role in resolving concerns at an early stage, with increased personal contact with complainant.

- Provision of complaints investigation training for divisional and clinical teams.

Friends and Family Test (FFT)

During 2016/17, we achieved our FFT response rate target in one out of three areas. That is, Maternity achieved a response rate of 24.2% against a target of 20.0%, which is an improvement on 2015/16 when the area achieved 16.4%.

With respect to A&E and Inpatients, which had response rate targets of 20.0% and 30.0% respectively, the Trust fell short by achieving 8.7% and 27.3%, respectively. This compares to 2015/16, when A&E achieved a response rate of 9.6% and Inpatients achieved a response rate of 21.0%.

It has been identified that the poor response rate of A&E in particular, may be linked to only offering the survey in paper based format. The survey administration provider has now made the survey available on the iOS operating system and Information Technology is procuring an iPad with trolley for use in A&E. It is hoped this will have impact however greater volume would be anticipated from proceeding with SMS texting service; the business case for this is now with finance for final additions prior to presentation at Trust Management Executive.

Although response rates in the A&E department are not entirely where we would wish, the Friends and Family Test does still provide a valuable source of patient feedback alongside other mechanisms the Trust has in place to hear about the patient's experience.

Appendix C

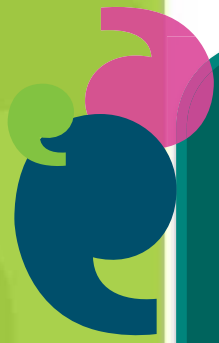
healthwatch Hillingdon

Expecting the Perfect Start

A report on maternity care in Hillingdon

March 2017

Contents



Throughout our engagement programme women and families have told us about a dedicated workforce who are committed to providing them and their families with compassionate care. Healthwatch Hillingdon would like to acknowledge this and say thank you to all the staff within the hospital and across the community who provide maternity care in Hillingdon

Acknowledgements

Healthwatch Hillingdon would like to sincerely thank the women and families who spoke to us during our project. Their open views and honest opinions of their experiences, have given us a clear understanding of the local maternity services provided to women, who give birth at The Hillingdon Hospital.

Throughout our engagement programme women and families have told us about a **dedicated workforce** who are committed to providing them and their families with **compassionate care**.

Healthwatch Hillingdon would like to acknowledge this and say **thank you to all the staff within the hospital and across the community who provide maternity care in Hillingdon.**

We especially thank The Hillingdon Hospital NHS FT, who have worked closely with us on this engagement programme. They have provided us with special access, to staff and women, across the whole maternity pathway, within the hospital and community. Without this partnership working we would not have been able to produce such a comprehensive report.

We express our thanks to the Children's Centres in both Hillingdon and Ealing who opened their doors to our researchers and enabled us to see the full spectrum of services offered to women and gauge their experience of them.

We would also like to thank all other the individuals and organisations who have taken part and assisted us with this project:

- Hillingdon National Childbirth Trust
- The various baby clubs we attended
- Ealing community organisations who facilitated our workshops
- Members of our Volunteer team

Executive Summary

Background:

In July 2015, Ealing Hospital maternity unit was closed under 'Shaping a healthier future'. An initiative to improve the quality of maternity care in North West London. Consequently, it was estimated that approximately 600 more women would deliver at The Hillingdon Hospital. This project intended to discover the potential effect that the closure has had on the quality of care that women and their families are receiving. It also aimed to investigate any possible inequalities that may have arisen owing to the re-configuration.

Methodology:

Healthwatch Hillingdon spoke to a total of 251 women. 198 from Hillingdon and 53 from Ealing. This included women who were currently using the hospitals maternity service and women who had given birth since the changes. We also engaged professional staff such as midwives, children centre workers and doctors. The experiences were collected via a range of methods such as one to one semi structured interviews, survey questionnaires and focus groups. Experiences were collected from women at various locations for example play groups, children centres, antenatal and postnatal clinics, other voluntary organisation programmes and from feedback collected directly at the Hospital.

Outcomes:

Our engagement revealed key themes from the feedback raised by the women and families, which included:

- An overwhelming majority of women stating that they were very happy with the care and service provision at The Hillingdon Hospital at every stage of their maternity care. With many stating that the quality of care given at the hospital is of a very good standard.
- Families were very pleased with the care and empathy provided by maternity staff. In most cases, women described midwives and doctors as informative and helpful.
- Women are very happy with the quality of information they are provided, however quite a few women said they would have preferred to have had a verbal explanation in addition to printed literature.
- Over 50% of women indicated that they were not given the choice of which hospital's maternity service they could use. In

the majority of cases this was because their GP routinely referred them to Hillingdon Hospital.

- Over half of the Ealing women who we spoke to described the difficulties with travelling to Hillingdon Hospital and explained a lack of choices/facilities for antenatal and postnatal services in the area.
- From the focus groups targeting women of the BME community it highlighted the need for greater cultural sensitivity.
- The feedback also highlighted the need for language service provision for women with language difficulties.
- Some women explained the need for increased uniformity in breastfeeding information and support from all healthcare professionals.
- 60% of the 40 women who requested smoking cessation did not receive this support.
- Women received mixed experiences of the Triage services, whilst 64% of women were positive about their experiences, 17% highlighted a dissatisfaction due to rudeness of staff and the need for a reduction in labouring in triage without adequate assistance.
- Our engagement showed that the perinatal mental health service is under pressure with waiting lists rising. This was partly attributed to Ealing women being referred to the Hillingdon service instead of the Ealing service.
- Both mothers and maternity staff advised us that they felt more midwives were required.

Recommendations:

Based on our engagement outcomes we have formulated 8 recommendations to help build upon the hospital's good performance and further improve women's experiences.

We recommend that:

1. There is a review of how information is given, so in addition to receiving printed literature, women are provided with more verbal information.
2. A review is undertaken of interpreting services to support women who do not speak, or have little understanding of English, to meet Clinical Maternity Standards[1].

[1] www.rcog.org.uk/en/guidelines-research-services/guidelines/standards-for-maternity-care/

3. To review the continuity of care between women and their health professionals to meet the expectations of The National Maternity Review[2].
4. There is a review of the referral process between the hospital and The London Borough of Hillingdon who provide smoking cessation service.
5. The hospital considers introducing a pager system in the antenatal department to allow women the choice of waiting elsewhere during their appointments.
6. There is a review of the referral pathway for Ealing residents to the Ealing perinatal mental health service; and that the Hillingdon Clinical Commissioning Group (CCG) review the perinatal mental health service in Hillingdon to see how future provision can be met.
7. Greater informed choice be given to women concerning where they can deliver their babies.
8. Hillingdon Clinical Commissioning Group work with The Shaping a Healthier Future team and Hillingdon Hospital to review the provision of antenatal and postnatal clinics in Ealing.

[2] www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Introduction

Healthwatch Hillingdon is completely independent from the NHS and the local authority. We represent the views of everyone who uses health and social care services in the London Borough of Hillingdon. We make sure that these views are gathered, analysed and acted upon, making services better now and in the future.

We exist to make health and social care services work for the people who use them.

We monitor local services to ensure they reflect the needs of the community, and where necessary, use statutory powers to hold those services to account.

Everything we say and do is informed by our connections to local people. Our sole focus is on understanding the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf.

As part of a network of local Healthwatch from every local authority area in England, we are also uniquely placed to raise issues nationally through Healthwatch England.

Reports and Recommendations:

Healthwatch Hillingdon produces evidence based reports for commissioners and providers, to inform them of the views and experiences of people who use health and social care services in the London Borough of Hillingdon.

Commissioners and providers must have regard for our views, reports and any recommendations made and respond in writing to explain what actions they will take, or why they have decided not to act.

Healthwatch have a duty to publish reports they share with commissioners and providers, and their responses, in public.

Our reports and recommendations are also shared with:

- Hillingdon Health and Wellbeing Board
- Hillingdon External Services Scrutiny Committee
- Healthwatch England
- The Care Quality Commission

Maternity Project

Maternity Care in North West London has been reconfigured under the Shaping a Healthier Future programme. Ealing Hospital's Maternity Unit closed in July 2015 and it was expected that an additional 600 women from Ealing will give birth at Hillingdon Hospital's Maternity Unit in the following year. Births at Hillingdon Hospital were expected to rise due to these changes and population growth from around 4,000 a year to 6,000 by 2018. Approximately 5000 births took place at Hillingdon Hospital during 2016 – 2017. We wanted to measure the impact of the closure of Ealing maternity unit on the experience of women giving birth at Hillingdon Hospital. Healthwatch Hillingdon gathered the views and experiences of women who planned to give birth, or had recently given birth at The Hillingdon Hospital.

Our Aims:

- To determine to what extent, the closure of Ealing Maternity Unit has impacted on the experience of women giving birth at Hillingdon Hospital.
- To identify any potential inequalities that may have arisen following the maternity service reconfiguration.
- To obtain a greater understanding about the barriers and enablers that shape maternity services.
- To provide commissioners and providers with evidence based data which evaluates current maternity provision and informs future delivery.

Methodology

Preliminary desk- based research was carried out to help inform the project on current maternity standards, guidelines and gathering local 'best practice'. Data was reviewed from various primary and secondary sources and included information from:

- North West London Maternity dashboard
- Friends and Family Test
- Maternity Liaison Committee reports
- Health Social Care Information Centre
- National Care Quality Commission maternity services survey
- Royal College of Obstetricians & Gynaecologists
- National Institute for Health and Care Excellence

We used a wide range of methods, that incorporated semi- structured discussions, focus groups and online surveys. These were conducted with individuals who used or were involved with the Maternity services at Hillingdon Hospital at all stages from Antenatal care through to Postnatal care. This included expectant mothers, postnatal mothers (baby 0- 6 weeks) recent mothers (baby 6weeks – 12 months), maternity staff, Children centre staff as well as families and spouses.

In total, we engaged with and collected feedback from 251 women on their experience of maternity services at The Hillingdon Hospital. The participants varied in age and ethnicity to help establish themes and trends that would be representative of the patient population. Many of the children centres within the Hillingdon Borough and 4 within the Ealing Borough were contacted to engage with the mothers that used their maternity services and/or baby group sessions. Weekly visits to the Antenatal and Postnatal wards in Hillingdon Hospital were made to collect live feedback of patient's experiences of the maternity care at the hospital. In addition to this, voluntary services, third sector organisations and charities such as National Childbirth Trust, were contacted to capture women's experiences.

Antenatal Feedback

When you first became pregnant who did you contact about antenatal care and how do you rate that experience?

46% of respondents contacted a GP to obtain information about antenatal care once they discovered they were pregnant, whilst 54% of respondents self-referred to the hospital via the online referral system. The majority of service users stated that they had a positive experience at this stage and were satisfied with the information they received describing the online self-referral process as **'straight forward'** and **'easy to navigate'**.

However, for service users that were referred to Hillingdon Hospital via their GP some highlighted the absence of hospital choice being offered with generally little information given to them by their GP. This was evidenced with 51% of respondents stating that they were not given a choice of hospitals to have their baby, many of which were GP referred.

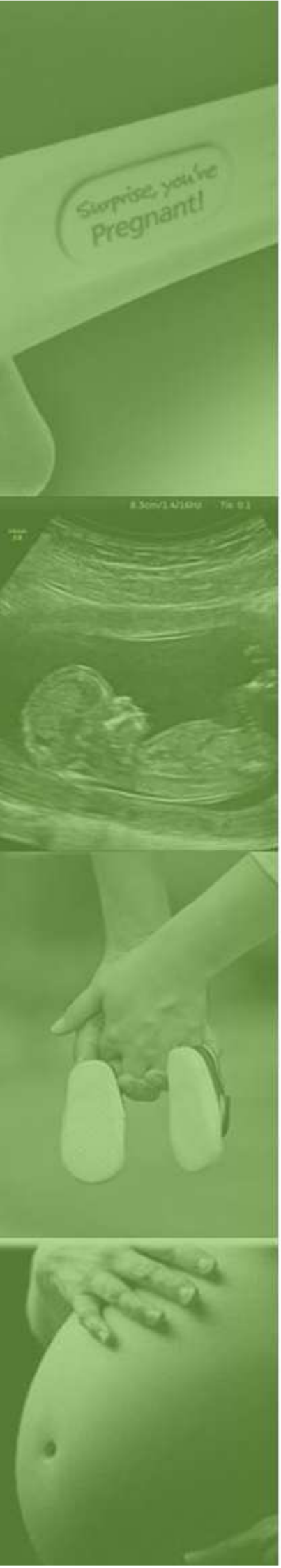
Most women elected to deliver at The Hillingdon Hospital because it was the nearest hospital to them and many previously delivered there, while a smaller number self-referred based on Hospital recommendation and reputation.

Where did you have your first 'booked appointment'?

Almost 80% of expectant mothers had their first booked appointment with a community midwife or a hospital consultant. The remaining 20% had their booked appointments with hospital midwives. When asked at which stage in their pregnancy they had their first booked appointment, 83% of expectant mothers had their first appointment within the first 12 weeks of their pregnancy. For the 16% of expectant mothers who stated that they had their booked appointment at 13 weeks or later, a large majority attributed this to late recognition of pregnancy with many stating **'didn't know I was pregnant'** and others explained that personal relocation was the cause of their late appointment. A very small number of women explained that the reason was due to a delay in receiving an appointment date by the hospital or a lack of their own availability.

Were you offered help to give up smoking during pregnancy?

In total, approximately 77% of expectant and recent mothers did not smoke therefore did not require any stop smoking support. However, for the women who did smoke only 16 were offered smoking support where 24 women were not. We found that the majority of women who received smoking support were individuals with special medical or social care



needs, that therefore needed more care. Where women did not receive smoking support, they told us it was because nobody had come back to them with further information. Whereas in other cases, conflicting information given by health professionals left women unclear about where to seek support or who to seek support from.

> "I requested for help to stop smoking and was told that I would get a phone call from the midwife that does the referrals, well that phone call never came and when I called up a few weeks later to chase this up I was told that that day was her last day before she went on annual leave so I should go to my local pharmacist to get whatever they had to help quit smoking.....this was so unhelpful and extremely unsupportive."
>
> "I was supposed to be referred to someone about stopping smoking, was waiting on the appointment but it never came. I ended up stopping on my own but a bit of support would have been nice though"
>
> "still awaiting smoking support a bit confused as to when I'm going to be seen"

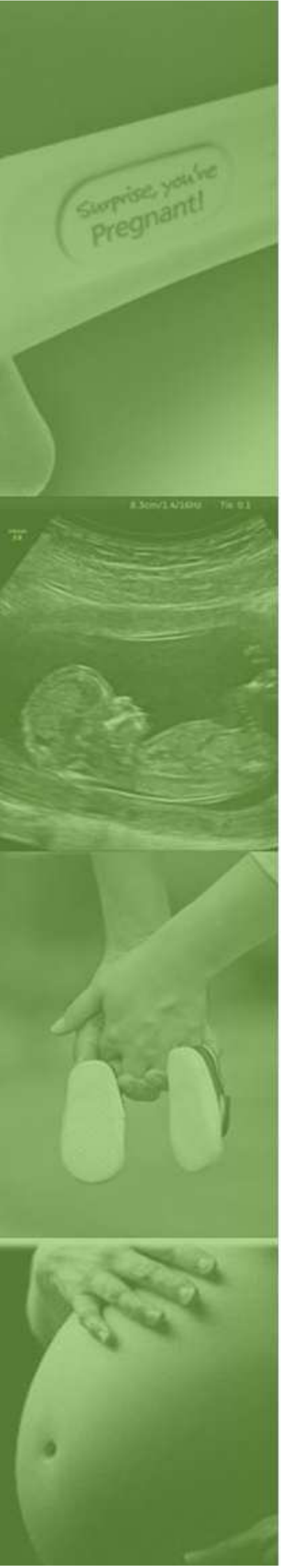
We investigated this further during our research. Women are referred by the hospital to the smoking cessation service provided by The London Borough of Hillingdon. We found that the referral process was not working as efficiently as it could be. After discussing this with the smoking cessation team and the Hospital, work has been undertaken to review the referral process and a new pathway is being developed.

During your pregnancy, did you have a named midwife or midwifery team that you could contact?

The National Maternity Review 2016 states that:

> ''Every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.''

Only 55 expectant mothers of the 156 who responded to this question stated that they had a named midwife or midwifery team. For most women, this did not seem to affect them as they still said the quality of



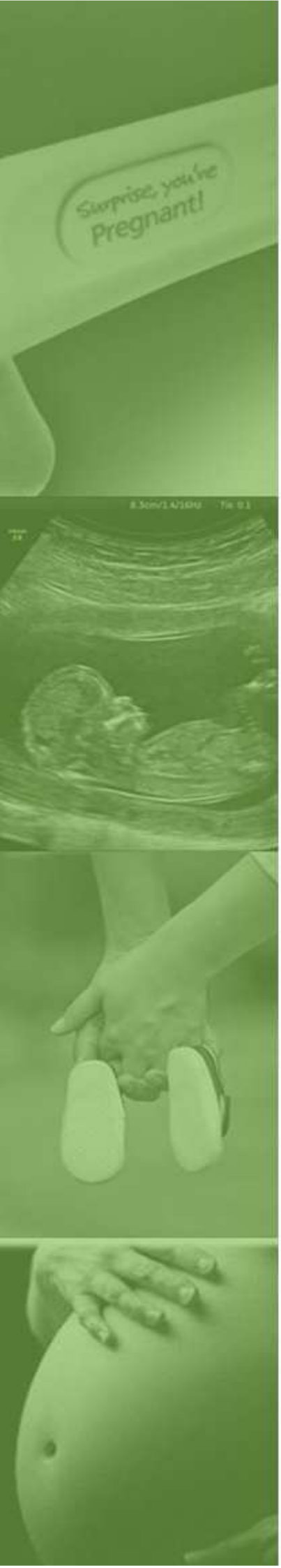
care given at the hospital is of a very good standard. Where this was an issue it was stated that **'I kept getting seen by different midwives which was a little frustrating because I kept having to give my information repeatedly to each one because the information wasn't being passed on to each midwife'.**

Of the women that did contact their midwives during their pregnancy a majority reported that the service they received was **'very helpful'**. In particular, some expectant mothers with high risk pregnancies expressed that '*the staff were really helpful every time*'. Likewise, another expectant mother stated that

> 'I had gestational diabetes during my pregnancy and the team were really helpful with advising me on what to eat and what type of exercises I should be doing so that was helpful'

Did you attend birthing/antenatal/parent education classes?

When we inquired about expectant mothers' antenatal class attendance 67% stated that they did not engage with antenatal classes. The cause of this included factors, such as non-eligibility for non-first time parents, and a general lack of perceived necessity of the classes. For the 32% of mothers that did attend antenatal classes, in particular those held at The Hillingdon Hospital, mothers said that classes '*were very helpful*'.



Did you feel involved in the choices and decisions made about your care?

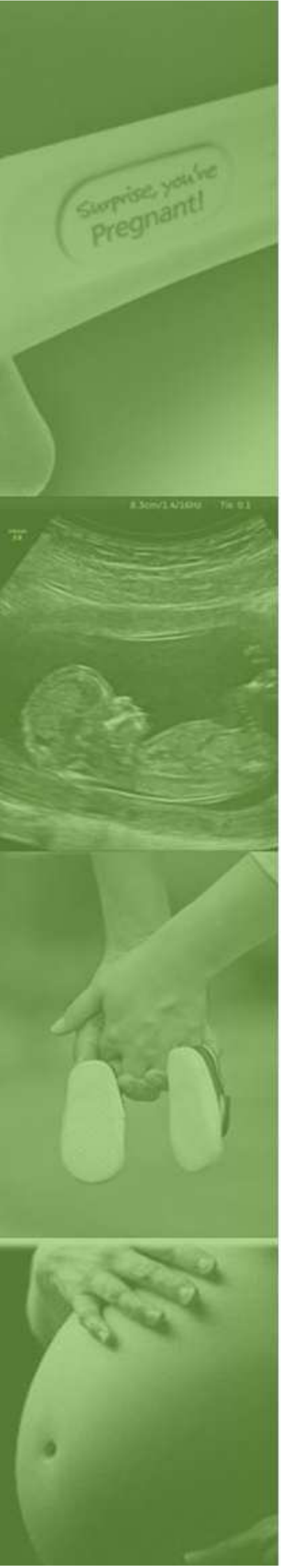
We asked mothers whether they felt that they were involved in the choices and decisions made about various aspects of their pregnancy. The table shows that across many areas expectant mothers highlighted they believed that they were involved and given a choice concerning various aspects. Though our feedback shows that expectant mothers at the hospital are being offered choices, there is more work that can be done to help ensure there is a reduction in the number of mothers who did not feel they had a choice or their choices were not adhered to.

Keeping Women Involved and giving choice	Yes	No
Where to have the antenatal classes	48	11
Where to have screening checks	145	16
The birth plan	120	39
Where to give birth	124	32
What kind of birth to have	129	32
Positions in which to give birth	122	39
How to manage the pain of labour	134	26

Please tell us what went well?

When asked about the helpful factors that made their antenatal experience the majority stated they were very happy with the overall care given by the hospital and community midwives. The Hillingdon Hospital Maternity staff as well as Children Centre staff in charge of antenatal support (such as bump and beyond practitioners). In addition to this, for women who stated that they experienced complications during their pregnancy they specified, that generally staff effectively managed and assisted them throughout the pregnancy giving appropriate support when required.

> "I developed gestational diabetes and the antenatal team were really reassuring and told me what I should and shouldn't be eating and how to stay healthy''
>
> "My wife decided that she wanted a home birth and was very happy with the antenatal care we were given by the home birth team"
>
> "antenatal care had great monitoring, I had pre-eclampsia in my previous and recent pregnancy, when pre-eclampsia symptoms started arising again they admitted me into hospital for a week…"



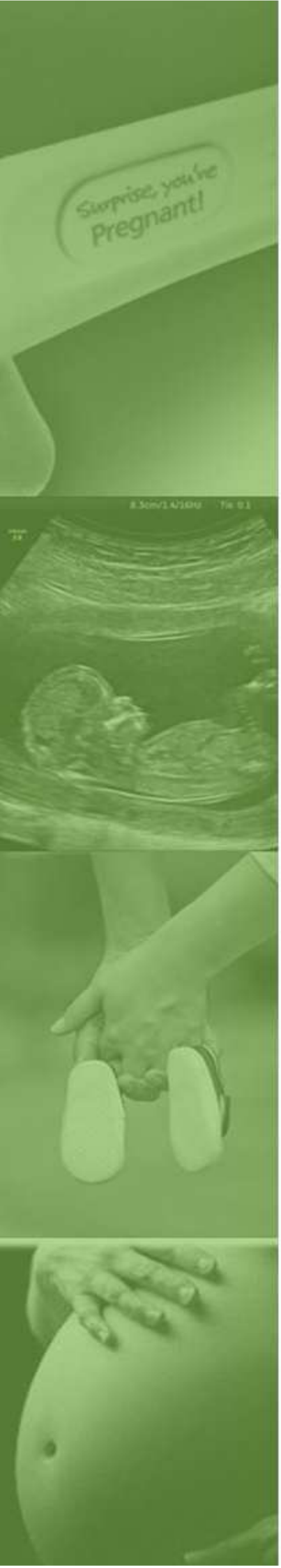
Please tell us what did not work?

Overall, Mothers expressed their satisfaction with the care provision they received. However, there were 63 mothers that expressed their dissatisfaction concerning some areas of their antenatal care service. In particular, 25% commented on excessive waiting times, discomfort and overcrowding in waiting area, 20% in a lack of consistency with health professionals seen, and 30% general lack of effective communication between patients and the hospital.

With regards to waiting times, mothers said that they are rarely seen at their appointed times, with waiting times being more than 2 hours long. In many instances mothers state that there was no communication given to them explaining the cause of the delay or providing information to help estimate waiting time.

For women who had previously delivered at the Hospital many stated that waiting times were significantly worse in comparison to their previous experience. A small minority perceived this change to be due to the influx of women following the closure of Ealing Hospital. Service users described that due to not being seen on time, there were frequent occasions that the antenatal waiting area became excessively crowded and uncomfortable due to the arrival of new appointments clashing with pending appointments. This not only had a negative impact on women's comfort but for some disrupted work schedules and/or child care arrangements. Women who required the accompaniment of a spouse, family member or friend to help with language translation - predominately Ealing/ Southall mothers - said that this often compromised their 'translator's' availability to accompany them, which meant they did not fully understand what was said to them.

> "I don't think that the structure of the antenatal care ward is right, it gets really overcrowded at times because of the long waiting times and it's hard to want to get up and go for a walk because you're scared to miss your appointment. It's a bit frustrating because after waiting hours for your appointment when you are actually seen you're only there for 10/15mins"
>
> "The amount of information I was given seemed fairly limited in comparison to some of the information my friends told me they got, I got given a lot via leaflets would've preferred being spoken to"



A problem associated with these excessive waiting times for a very small percentage of women was the decrease in their desire to attend hospital appointments as they were reluctant to dedicate a whole day for appointments.

A lack of consistency with health professionals seen by expectant mothers was shown to have a negative impact on the information given to them and their continuity of care. Mothers specified that this lack of consistency, inadequate note taking and breakdown in communication between staff caused a discrepancy with the information given to them by the various health professionals.

> "Lack of consistency with the midwives and staff that I saw so I had to repeat information over and over to different staff"

Please tell us what would have made the experience better for you?

When asked to comment on areas of improvement within the antenatal pathway (excluding the requests for a reduction in waiting times and better communication) a few expressed the desire for the hospital to incorporate text messages or alerts that notifies them when they are going to be called in for their appointments. They stated that this would provide them with the opportunity to walk around or wait in a more comfortable environment, if they wished to. Furthermore, mothers explained the desire to be given information verbally concerning issues such as birthing plans, options of pain medication, where to go for antenatal classes provision and what types of birth they could have as opposed to just leaflets. Though these documents contain the relevant information, mothers (particularly first time mothers) stated a preference of speaking through these options with their midwives. Some women explained the frustration of having to wait until subsequent appointments to discuss elements of their care and birth that they had, after reading the literature at home.

> "a lot of information was given to me by leaflets and booklets but would've liked a bit more verbal information"
>
> "would've preferred to have the various options explained to me rather than just given booklets and leaflets

Labour Care

At the start of your labour, did you contact your midwife, hospital or birth centre for advice? If yes, please tell us about your experience when you contacted them?

Mothers were asked whether they contacted the hospital triage or their midwife at the start of labour. Of the 164 responses 58.5% stated that they did and 41.5% stated that they did not. The reasons for not contacting medical advice at the onset of labour varied. A few reasons included; pre-scheduled inductions and personal decision. For the 51 women who told us of their experience of contacting triage, many stated that they had a very positive experience as triage responded to their queries in a timely manner, provided relevant information and admitting them into hospital when needed.

> "Triage were great very informative"
>
> "Triage were amazing, I came in multiple times throughout my pregnancy and they were great every time"

However, approximately 35% fed back that they were unable to access medical advice within a reasonable time- period, many saying that they were left on hold for approximately 30 minutes or more before getting through to triage. This resulted in them coming straight to the hospital. Women also spoke about impoliteness of triage staff, a lack of acknowledgement of the patient's judgement and delays in receiving medical attention.

> "pretty helpful, once I got through to them but that was after waiting on the line for about 30mins"

Though women highlighted their awareness of the current NHS pressures and increasing demands placed on staff, some felt that triage did not have the adequate resources to support them in active labour. This made some women's experiences quite challenging with 10 saying they did not feel fully supported with pain management whilst waiting in triage.

> "I had a very bad experience. I was left waiting in triage without being attended to. I was given no pain medication to assist just gas and air plus it was not very comforting when you're in labour and others around you are just there for appointments"

For a small minority of women, they believed that having a negative experience at the onset of labour had a negative impact on the rest of their maternity experience.

If you had a birth partner, were you both happy with the way they were involved with the birth? Please let us know the reason for the answer.

For women who had birthing partners present during their birth they expressed that health professionals were very efficient with ensuring that both parties were involved with the birth at every stage. 88% of respondents stated they were pleased with the level of involvement that staff gave to the birthing partners.

> "Because I was in a lot of pain I couldn't really understand everything I was told so it was reassuring that they spoke to my boyfriend and gave him the same amount of detail that they gave me so he knew what was going on with me and the baby"
>
> "They were extremely nice to him and supportive of us both"

Did you have skin-to-skin contact with your baby shortly after the birth? If no, was there a reason.

In line with NICE guidelines, 84% of women who delivered at THH had skin-to-skin contact with their babies shortly after the birth. Out of the 15% of women who did not have skin to skin contact a large proportion attributed it to delivering via caesarean section or experiencing medical complications during or after the delivery. In most cases this meant that the new born baby had to be taken away from the mother.

How do you rate the support you received in each of these areas?

Women were asked to rate their experiences on some areas of their maternity care. This included; breastfeeding advice, emotional support, food and drink and advice/ information given after birth. With the exception of breastfeeding, all areas received positive responses with approximately 70% satisfaction rate. In the case of breastfeeding, 59% of women stated that they had a positive experience and received adequate support with the breastfeeding advice given at Hillingdon hospital. Though it is evident that Hillingdon Hospital are currently providing a very good breastfeeding service we believe that some improvements can still be made. The two areas of dissatisfaction that were highlighted were firstly, the inconsistency with breastfeeding information provided by maternity staff created confusion for mothers attempting to learn how to breastfeed. This was particularly daunting for first time mothers as it left them feeling very unsettled and uncertain. Secondly engagement with some mothers, mainly first time mothers, highlighted the desire for more support provided by midwives on the postnatal wards after delivery.

> "the midwives at the hospital were giving slightly different information about how to breastfeed, however one thing that I didn't like was that I was made to overly needy because I actually wanted the midwife to stay with me for an extra few minutes to ensure that I am breastfeeding correctly. My baby latched once and then they were of, they didn't stay so I didn't get a chance to explain that breastfeeding was actually becoming extremely painful"

> "one midwife was really emotionally supportive especially because my baby had jaundice and I was really scared, she really did go above and beyond to put me at ease"

After giving birth, how did you feel about your length of stay in hospital?

Overall 67% of women were happy with their length of stay in hospital after delivery with most stating that they were *'ready to go home'* and others highlighting they were even given the option to stay longer if they wanted to. However, 19% specified they would have preferred to stay in longer with many explaining that they felt rushed out due to





limited bed space. On the other hand, 13% felt their discharge from hospital was too long with a few stating they were waiting to be officially signed off by medical professionals. Others were unaware of the cause of the delay. In quite a few instances women have self-discharged from hospital because of delayed discharge.

> "I want to be discharged but I have to wait for a doctor to sign me off. I've been waiting for hours now.."
>
> "we really weren't there for very long at all after I had my baby maybe just a few hours but baby and I were fine so it was perfectly fine and I was asked if I was happy to leave"
>
> "Midwife that was working on my discharge documents went home and didn't transfer my notes so took a total of approx. of 12 hours to finally discharged"
>
> "I don't feel rushed like I did with my first pregnancy. They are letting me go at my own pace"

12% of women rated their experience on the postnatal ward as poor. Some said that due to the lack of staff availability and support they preferred to be discharged home as they believed that they would receive better support at home.

Please tell us what did work?

Generally, women stated gratitude towards the Hillingdon Maternity staff for their support throughout the labour process and their empathetic care. For some women, the support of staff was the key contributor that enabled them to cope with stresses of labour. Many women highlighted that on the postnatal ward most midwives provided very good support with helping them learn how to take care of the new-born, which was particularly helpful for first time parents.

> "was meant to have a home birth but things didn't end up going to plan because my wife became very dehydrated. The home birth team were amazing, can't fault, they made the decision that we should go into hospital and everyone on the labour ward were great"
>
> "This was the best part of my care. From triage to delivery midwives put my fears of having a C-section

> completely at ease. When I told her I'd do anything she'd ask me to do but have a C-section she told me that that was perfectly fine and was extremely positive throughout"
>
> "I was really appreciative with the emotional support I received because, I really needed it to cope with my baby being born prematurely"
>
> "Staff were friendly, and I was happy with the overall experience"

Please tell us what did not work?

The majority of the 84 responses of women's experience of labour and postnatal care within the hospital were very varied. The predominant themes were, staffing levels, breastfeeding and impoliteness of staff. For pain relief 12 women said they did not feel their needs were met during labour. 15 women commented on a lack of staff on the postnatal ward saying, staff were extremely busy and rushed. They felt this compromised the quality of their care with 5 women saying that they felt alone or ignored.

> "on postnatal ward staff seemed very busy and didn't give as much support as they did during labour"

One of the biggest concerns from the 15 women who raised breastfeeding was the confusion that came from being advised differently by health professional on the ward.

> "I struggled quite a bit with breastfeeding, it became even more difficult and emotionally distressing because midwives kept giving me different information"

12 women also commented that they felt staff had been rude to them. We noted that this was equally split between triage and the postnatal ward.

It is also worth noting that a distinction was made between the service provided on the postnatal ward between the day and night staff. With a few women saying night staff were less attentive.

A few women we spoke to in the hospital felt that some members of staff that interacted with them, were slightly culturally insensitive. The focus groups we held with the BME communities in Southall and Hayes Town, for women who had given birth in the last year, also highlighted some similar insensitivities. Although small in number, these women told us that this did negatively affect their experience.

> 'I felt that my culture (eastern European) was not respected and I was spoken down to'

These women also explained that they felt there was a lack of accommodation for women who had difficulties with speaking and understanding English. Some saying they mostly used a personal translator (e.g. spouse or family member) to communicate with staff. However, once that person was required to leave the ward they felt they were unable to seek assistance until their translator returned. They also felt that due to the language barrier some staff members were hesitant in attempting to communicate with them.

Please tell us what would have made the experience better for you?

As previously stated feedback in this section is very varied and is covered in the main by the evidence previously laid out in this section. To summarise, feedback highlights that generally women are receiving very good care during labour, however, it revealed some areas that could be improved. Women and their spouse's feedback requested an increase of hospital facilities in various areas such as more staff and more amenities such as birthing pools. Patients highlighted the desire for more regular checks to reduce the amount of time that women are left unattended or kept waiting, especially in triage. For Ealing women who experienced language barriers they expressed the desire for the creation of language facilities, like those that were provided at Ealing hospital. Women also stated that they would have appreciated it if there was greater uniformity with regards to information given to women and families by members of staff.

Community Postnatal Care

Were you told who to contact if you needed advice or information once you were home with your baby?

Over 80% of women and mothers said that they had a positive experience of various areas of their postnatal community support services such as; midwifes home visit, midwives at children's centre and Health visitors. On average, women also stated having a high satisfaction rate with the standard of information and advice they received 6 weeks post-delivery.

Were you given information about the emotional changes you might experience after the birth; such as tearfulness, depression and anxiety?

With regards to perinatal mental health information provision, over 90% of women said that they had received information concerning these services in some form. However, approximately 48% of women stated that this information was given via leaflets and booklets. They said that these leaflets were included in their discharge package but staff never spoke through the information with them. For some women, this was not a problem and they were fine with this format. However, quite a few stated that they would have preferred if information was spoken through with them as opposed to merely receiving literature. Women expressed the overwhelming amount of information given in the discharge packages made it difficult to process.

Please tell us what went well?

On numerous occasions women voiced their appreciation of many services provided by children centres, as these facilities provided essential support and advice. In particular, breastfeeding support was very welcomed by women who had not felt adequately supported when they were in hospital. They expressed their gratitude of children centre staff creating sufficient time to have one to one consultations with them ensuring that women are completely supported.

"Community support for breastfeeding was great, you can tell that the midwives at the hospital are very busy so maybe cannot have that one on one time with you"

> "The midwife that came to see me at home was great, I have been given all the help and support I needed, I'm very happy with my postnatal care"
>
> "We were under the home birth team and had all our community care from them and they were prefect couldn't fault them they gave us all the information we needed and more"

Please tell us what did not work?

We recognise that tongue tie is rare, as it affects only 4% of new-born babies. However, 5 of the mothers we spoke to advised that the condition was not identified whilst they were in hospital and it was not until they searched for special help, after experiencing a long duration of difficultly breastfeeding, that the tongue tie was not detected. They told us that it would have been useful for information to have been given to mothers about tongue tie whilst in hospital.

The area where the most dissatisfaction was expressed was with regards to a lack of continuity of care with health professionals seen, TB vaccination and problems surrounding a lack of information and uniformity when contacting direct hospital postnatal departments. For women who contacted the hospitals postnatal ward after they were discharged home many experienced difficulties with obtaining comprehensive, uniform advice. Women explained that in some cases they were constantly being referred to different professionals without any resolve.

> "when I went home I was feeling quite a lot of pain in my stitches and when I called into the hospital to ask what to do I felt that I was a bit dismissed and just told to take pain medication, like I hadn't already done that"

> "I felt that the postnatal care was quite poor especially because everyone would give different information"

Some women, particularly those from Ealing, expressed their concern, and dissatisfaction, that their baby did not receive a TB vaccination at the hospital. Many had received this before at Ealing hospital and were told that this was very important due to where they live, being a high-risk area.

In addition, we found that women were being given different and confusing information about where to get the vaccination. Some were told to go to their GP, who then referred them back to the hospital. GPs were also referring women to private sector providers, advising that the vaccination was not available on the NHS.

> "my baby didn't get any BCG vaccinations and my friend who had her baby at West Middlesex did, I'm being told I have to do it privately which I really can't afford"

Though Hillingdon mothers seem content with the number of available postnatal community facility options in the borough, Ealing mothers (who delivered at Hillingdon) do not feel the same. A small minority of Ealing mothers said that they experienced some difficulty accessing what they felt to be limited postnatal community facilities within the area.

> "The only clinic that I was told was available to me for postnatal checks with a midwife was Jubilee Gardens, though the midwife there was very helpful and the appointment was fine it is still quite far for me to get to and takes me 2 bus journeys, when Ealing was open I could just walk to my appointment, which is what I did with my first pregnancy"

Perinatal Mental Health

The 2016 National Maternity Review and NHS England's independent Mental Health Taskforce stated that:

> 'There should be significant investment in perinatal mental health service in the community and in specialist care'

The 2016 National Maternity review further adds that:

> 'Maternity services should ensure smooth transition between midwife, obstetric and neonatal care, and on-going care in the community from their GP and health visitor'

Our engagement with service professionals and service users highlighted that implementing these recommendations are key to women's wellbeing during pregnancy. Patient feedback concerning the current perinatal services indicated the importance and usefulness of the perinatal services. With women indicating that the supportive service was a pivotal factor in them having a successful pregnancy.

> "Given a lot of support throughout the pregnancy which was very helpful given that I had mental health conditions. Perinatal mental health team were very supportive as well as support workers"

> "If it wasn't for Sarah Finnis I don't know how I would have gotten through this pregnancy, I had suffered a still birth a few months prior to falling pregnant again and was in a terrible mental state, I felt borderline suicidal at times and was definitely depressed, but Sarah gave me much support and techniques which helped me through it I honestly cannot thank her enough"

> "Sarah (Finnis) put on my notes that should've had a private room but it wasn't adhered to and it was really difficult hearing all the other women's babies when I didn't have mine at the time"

The quality of care and service provision received unanimous positive reviews from the mothers and expectant mothers who have used the

services. Quite a few women stated that they wanted to use the perinatal mental health service and explained that they were unable to, owing to the extensive waiting list. In most cases this would mean not being seen until post-delivery. For these women, they described the alternative option provided - Talking Therapies – however, they did not believe this provided adequate support.

> "Given that I had a history of mental health issue (depression, anxiety) I didn't like how I wasn't able to see the prenatal mental health specialist when I said I wasn't coping well with taking care of my baby, they said that they would put me on a waiting list but I never got seen, luckily I was able to find groups to go to on my own but I really don't think this was helpful at all because if it wasn't for the groups I went to I would've had an even worse time than I was already having and the talking therapies line that I was referred to was pretty useless if I'm honest."

Health professionals described the immense difficulty they have with providing a service to Ealing women, given that currently there is no clinical pathway to them. In addition, professionals stated they are seeing more women and the waiting list for perinatal services is getting longer. With no increased capacity, the pressure on the service is rising and this compromises the service's ability to adequately meet the NICE quality standards[3].

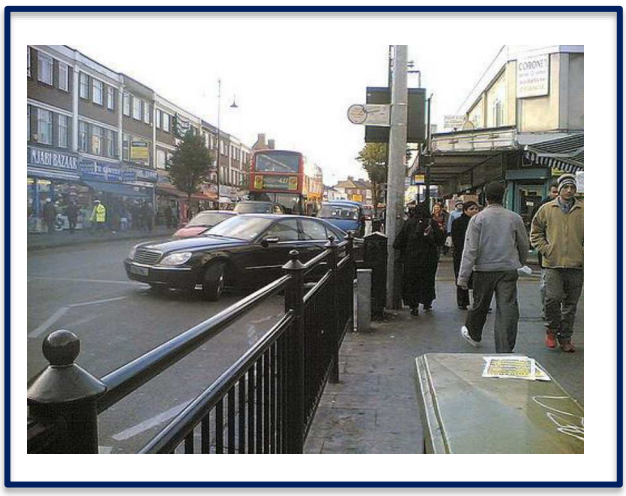
[3] www.nice.org.uk/guidance/cg192/chapter/1-recommendations#providing-interventions-in-pregnancy-and-the-postnatal-period-2

Focus Groups

In attempts to have a holistic view of the impact of the Ealing closure, we conducted 3 focus groups. These were targeted at gathering the experiences of women within various BME communities.

In total, 54 women attended the focus groups that we held. 21 women attended our focus groups targeted at Ealing women who used Hillingdon maternity services. Approximately 95% were members of the BME community. For this focus group, much of the feedback given echoed what we had previously received during our engagement programme. This included anxiousness concerning lack of BCG vaccination provision, lack of language support, wanting to receive more verbal information as opposed to only literature and around accessing the hospital. A majority of Ealing women also said they felt that there was a limited midwifery presence within their local areas. Though all were assigned children centres where they were seen by midwives, some expressed the desire to have more options.

Many of the women in this group explained the difficulty they experienced with getting to the hospital in time for their appointments due to distance and traffic. For many of the women from low income families they said that the extra travel costs were challenging. We can fully understand this frustration because during our engagement programme we experienced severe traffic delays when commuting to women in the relevant Ealing areas from Uxbridge, particularly within the Southall region.



Though many residents are aware of the no control that the hospital has concerning this issue, they explained that better thought should have been taken to understand the impact that the closure would have on Ealing women. Due to these challenges, many of the Ealing women we engaged with deemed that the closure of Ealing maternity hospital was a bad idea.

Two of our other focus groups engaged with women from the BME and Eastern European communities, totalling 26 women. During these sessions, women spoke about their personal experiences of the maternity pathway within the past 12 months, in addition to the experiences of others within their social network and of similar ethnic origin. Approximately 60% of these 26 women expressed their dissatisfaction with what they felt were culturally insensitive statements made by maternity staff. While others stated that they felt that clinical staff were very dismissive of their views, and believed that many of their opinions weren't fully acknowledged. Some thought that this may have been because of language barriers whereas others said it was due to a lack of patience from clinical staff. Though a proportion of the feedback expressed a range of dissatisfaction amongst BME women within the Hillingdon and Ealing borough, some members did state that they received good comprehensive care from the maternity department at Hillingdon Hospital.





What professionals said……

We spoke with various healthcare professionals that work within the maternity department and children centres who engage with expectant and recent mothers. This included community midwives, breastfeeding support workers and children centre staff. We gathered their views on the impact of the Ealing closure and its effects on the service provision at Hillingdon Hospital.

Feedback from the community midwives showed that overall, they believed that the change had not affected the antenatal care provision on a community level. Nevertheless, they believed that there is an overall lack of staffing throughout the whole maternity department. In addition to this, some mentioned that because their colleagues on the postnatal ward tend not to have enough time to fully attend to women after delivery, they discover during home visits that some women are quite ill informed or lack confidence in certain areas due to limited support received during hospital stay, especially with regards to breast feeding. They described that, in the case of breastfeeding, if adequate support is not provided prior to women being discharged, if they encounter difficulties they resort to bottle-feeding. This then increases the difficulty with mother's returning to breastfeeding. Some breast-feeding support workers at children centres described experiences of supporting mothers with babies under 10 days old because some midwives had told new mothers that is where they could get support. However, some of these professionals' state that breastfeeding support for babies of that age should be given by the midwives, as children centre workers have limited knowledge and ability to provide comprehensive support and identify exceptional cases that require special intervention such as tongue tie.

Members of staff within Ealing borough children centres highlighted the inconsistency of Midwives that visit the centres increases the variation of information passed to themselves and patients. They explained the decrease in midwifery presence in South Southall and suggest that this is because of a lack of knowledge of facilities' in the area. They believed that this was triggered by the dispersion of Ealing midwives who were more knowledgeable of facilities within the area. This has resulted in a deficiency of local choices being offered to women in the Ealing borough. It was raised that before maternity facilities were a walkable distance for many Ealing based women, some women now have to take approximately 2 to 3 buses to get to their appointments which is not convenient, especially with women with other small children who have no other mode of transport. They explained that this is problematic for this group of women because a very high proportion of women in Asian communities suffer from pregnancy complications such as gestational diabetes which means they require specialist attention, and more hospital visits. In addition

to this, the travel adds additional cost to women who already have limited financial resources. They explained that a very high percentage of women that live in South Southall are from the BME community and come from low income families. Many of these women are still facing on- going immigration problems so having more transport expenses is added pressures especially given that they have no money coming in.

Area's to Note

Late Antenatal Booking

Late bookings (13 weeks or above) for women's first antenatal appointment was an area of concern identified by the hospital because of the potential risk it carries. Our research revealed that the main reason for late booking was patient availability, and late pregnancy diagnosis.

Antenatal Parenting Classes

Our engagement discovered that only 32% of women and families attended birthing/ antenatal/ parent education classes. Though the majority of the non-attendance was due to choice, many women were not eligible for these classes as they were not first- time mothers. In most cases this was not an issue for mothers however, some of those ineligible mothers expressed their desire to take up antenatal classes and felt it would be beneficial for them and their families to be able to access antenatal classes (e.g. women who have had large time gaps between pregnancies).

Choice of Provider

Though it is evident that limited choice provision is not a key issue at the hospital, evidence would suggest that more work needs to be done with GP's to ensure that women are given the information required to make informed choices.

TB Vaccination

It was brought to our attention by some women that their new-born had not been offered the TB immunisation. This was a concern to them because it had been routinely available at Ealing hospital, due to prevalence of TB within Ealing. We understand that historically The Hillingdon Hospital have not given the TB vaccination to new-borns due to the low risk of TB in the Hillingdon borough.

Now that Ealing women are giving birth at Hillingdon we suggest that the administration of this vaccine be addressed owing to the high risk of TB in the Ealing borough and bordering Hayes area.

Tongue Tie

5 mothers we spoke to advised that their child was diagnosed with tongue tie after they had left the hospital. Although this is small in number given that only 4% of new-born babies are affected by tongue tie, we feel it has a relevance. For these mothers it was a stressful time not understanding why their child was having difficulty breast feeding. These women told us that it would have been useful for better

information to have been given in the hospital about this condition and it is something the hospital may like to consider to improve women's experience.

Triage

Although women's experiences of Triage where relatively good, in comparison to other areas satisfaction rates dipped. Our report has evidenced a number of areas within Triage which if addressed will improve women's experience of maternity care.

We are aware that the hospital has already noted Triage as an area they are looking to enhance and consideration of our evidence will add to the framing of this work stream.

Conclusion

Our engagement programme has provided us with comprehensive feedback. It has given us the opportunity to hear the experiences and views of women, their families and staff, and form a conclusive understanding of our local maternity services.

Healthwatch Hillingdon would like to congratulate The Hillingdon Hospital Maternity department on the results of our engagement. Our evidence clearly shows that the maternity department is providing an excellent service. We especially want to commend them for the supportive and empathic care given to women and their families throughout their maternity pathway and their excellent skin- to- skin rates.

We believe that generally, the maternity department has effectively adjusted to the changes made by the Shaping a Healthier Future re-configuration. They have managed the transition well and as our evidence shows the care of women has not been negatively impacted during this period.

We acknowledge the work carried out by the Children's Centres. Women told us that they really valued the services and support provided to them and their families. Especially the sympathetic support given to help them with breast feeding.

We would also give a special mention to the Perinatal Mental Health Team. Our feedback identifies the excellent support they are providing and the great benefit this has been to women.

We recognise that not all women have received excellent care, some have not felt fully supported during the pregnancy and not all women have said their experience was positive. It is quite likely from our evidence, that an Ealing women would certainly argue that even if the care is good, the closure of Ealing's maternity unit has definitely impacted negatively upon their personal experience.

Engaging with women and their families about their experiences of maternity care has given us the opportunity to hear about what is important to them. We have been able to listen to their suggestions on what they would like to see change and give them the chance to tell us their ideas of how things can be done differently.

Having analysed all the information received, we have identified 8 recommendations, which we consider will help to make the maternity service even better and improve the experiences of women and their families.

Recommendations

Recommendation 1

An overwhelming number of women explained that they were happy with the amount of information they received and the time it was given. However, our engagement highlighted that a number of women would have preferred for this information to also be explained to them verbally.

- *We propose that there is a review of how information is given, so women are provided with verbal information in addition to receiving printed literature.*

Recommendation 2

We heard from women and families who have difficulties speaking and understanding English. They explained that the language difficulties caused challenges between them and health professionals with understanding and communicating information to one another, unless the women had a personal interpreter (usually a family member or friend) present.

In line with the Clinical maternity standards under The Shaping a healthier future initiative that states:

> 'During labour, birth and immediate postnatal care, all women who do not speak English or women with minimal English should receive appropriate interpreting services'

- *We recommend that a review is undertaken of interpreting services, to support women who do not speak or have little understanding of English to improve the experiences and safety of these women.*

Recommendation 3

The feedback we received showed that only 35% of women had a named midwife or midwifery team. Overall, this had little effect on the quality of the care provided, but a number of women highlighted that not being seen to by the same health professional at each appointment did impact on their experience. This was due to variances in the information they received from different professionals.

The National Maternity Review highlights that:

> 'Improving continuity of carer is not an optional luxury. If we are to improve quality, we must improve this'

- *We therefore suggest that to help decrease the variance in information that women are receiving that the maternity department review the continuity of care between women and their health professionals.*

Recommendation 4

Although we note that smoking is not prevalent amongst the women we engaged with, there were a small number of women who felt they were not adequately supported to give up smoking during their pregnancy. Evidence would suggest that the referral process between the hospital and The London Borough of Hillingdon - who provide the smoking cessation service- could be made more efficient.

- *We recommend that there is a review of the referral process between the hospital and The London Borough of Hillingdon smoking cessation service to help increase the proportion of women and their unborn child benefitting from this service.*

Recommendation 5

Women advised that one of the negatives of their experience was waiting in a crowded antenatal department, where there were not always enough seats available and waiting times could be long, without information of when it would be their turn.

- *We would recommend that the hospital consider introducing a similar pager system to that previously used in out-patients Pharmacy. This allowed patients to leave the waiting area and be called back when their medication was ready.*

  By adapting this system for use in the antenatal department, women would have the choice to wait elsewhere, which would alleviate the overcrowding and improve their experience.

Recommendation 6

Women tell us that when seen by the perinatal mental health team the service provided is excellent. We have however recorded a concern from some women that they are waiting a very long time to access the service.

We know that it is a challenge for the service to meet the high numbers of referrals with its current resource. We discovered during our research some instances where Ealing women were being referred to the Hillingdon service rather than the service provided in Ealing. We also noted that there was a lack of knowledge of the provision in Ealing and there was no pathway in place to refer to that service.

- *To manage the demand on Hillingdon's perinatal mental health services we recommend:*

  a) that there is a review of the referral pathway for Ealing residents.

  b) that in line with NHS England Mental Health Forward View that the Hillingdon CCG review the perinatal mental health service in Hillingdon to see how future provision can be met in line with NHS England Mental Health Forward View and NICE guidelines[4]

[4] https://www.nice.org.uk/guidance/cg192/chapter/1-recommendations#providing-interventions-in-pregnancy-and-the-postnatal-period-2

Recommendation 7

Highlighted in the feedback that we received, over 50% of women indicated that they were not given choices of where to deliver their baby. In most cases this was GPs routinely referring them to Hillingdon Hospital.

The Better Births Review states

> Women 'should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising those choices….'

- *We recommend that all health professionals, particularly GPs, ensure that all women are provided with the relevant information and opportunity to make an informed choice of the maternity services they wish to use.*

Recommendation 8

Our engagement revealed that although Ealing women received a good quality of care within the hospital, the satisfaction rate of their overall experience was lower than Hillingdon Women. Ealing women expressed dissatisfaction with the difficulties accessing Hillingdon hospital due to traffic, the increased distance and limited direct public transport.

Though the service they received at their antenatal and postnatal community appointments were of a good standard, Ealing women told us that the availability of clinics had reduced following the closure of the Ealing maternity department, and this was limiting their options.

- *We understand that the NHS have no control over the transportation issues that some of these women face. However, we recommend that the Hillingdon CCG work with the Hospital and the 'Shaping a Healthier Future' team to review the provision of antenatal and postnatal clinics for Ealing women, to ensure that their needs are met.*

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Appendix D

healthwatch Hillingdon

Safely "home" to the right care

The experiences of Older People being discharged from Hillingdon Hospital and the onward care they received in the community

February 2017

CONTENTS

We have produced a short film of patients lived experiences to accompany this report.

Watch it at: https://m.youtube.com/watch?v=5mgLI37uPzE

A special thank you to Save the Dog productions for volunteering their services to make this film

Save the Dog productions

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HEALTHWATCH HILLINGDON

Introduction

Healthwatch Hillingdon is a health and social care watchdog. We are here to help our residents get the best out of their health and care services, and give them a voice to influence and challenge how health and care services are provided throughout Hillingdon.

Healthwatch Hillingdon has very strong operational relationships with the local NHS, Council and Voluntary Sector organisations. We are an independent partner and a valued "critical friend" within health and social care.

Membership of the Hillingdon Health and Wellbeing Board and Hillingdon Clinical Commissioning Group Governing Body enables us to have considerable strategic input into the shaping of local commissioning and the delivery of services.

As a local partner, we are kept well-informed, can challenge and seek assurances on behalf of our residents, ensure that the lived experience of patients and the public are clearly heard, and are influencing decisions and improving health and social care in Hillingdon.

Reports and Recommendations

Healthwatch Hillingdon produces evidence based reports for commissioners and providers, to inform them of the views and experiences of people who use health and social care services in the London Borough of Hillingdon.

Commissioners and providers must have regard for our views, reports and any recommendations made and respond in writing to explain what actions they will take, or why they have decided not to act. [i]

Healthwatch have a duty to publish reports they share with commissioners and providers, and their responses, in public.

Our reports and recommendations are also shared with:

- Hillingdon Health and Wellbeing Board
- Hillingdon External Services Scrutiny Committee
- Healthwatch England
- The Care Quality Commission

EXECUTIVE SUMMARY

Overview

Nationally there is a recognition that health and social care services face enormous challenges because of financial pressures and a rising in demand, driven by a growing ageing population.

As statutory organisations look to address this challenge several initiatives and strategies are being implemented at differing rates across the country.

In Hillingdon, these include a number of programmes that initially concentrate on the adult population over the age of 65.

- The Better Care Fund
- Whole System Integration (Accountable Care Partnership)
- GP Networks (Federation)

With these local initiatives in their infancy and recognising that the pressures upon Hillingdon Hospital were dramatically increasing - with unprecedented numbers attending A&E and rising numbers of delayed discharges being recorded – Healthwatch Hillingdon decided to look at how this was affecting patient experience.

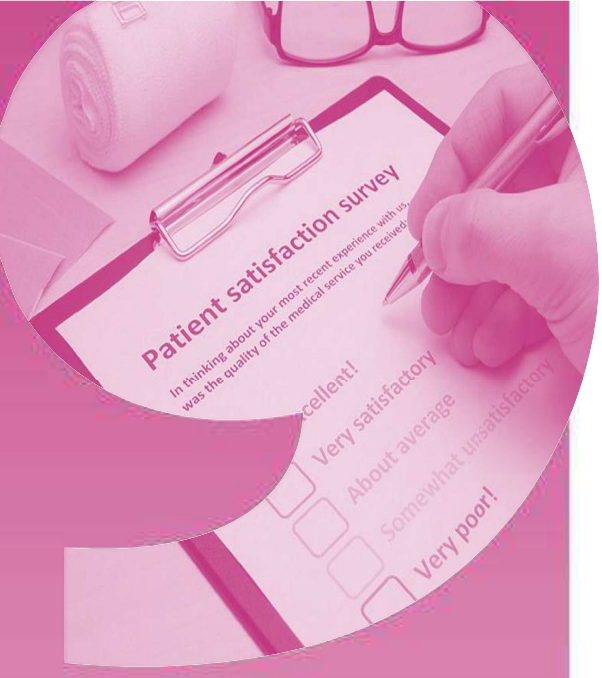
Objectives

Our discharge project set out to engage with Hillingdon residents over the age of 65, who have recently been involved in the discharge process at Hillingdon Hospital.

Through their personal experience, we looked to gain a greater understanding of the effectiveness of discharge processes and the support and care provided to them post discharge, in their home, or another care facility.

We looked to ascertain what works well and outline recommendations where service delivery may require improvement.

The project was also an opportunity to benchmark current service provision. As a tool to evaluate the effectiveness of the new programmes as they are embedded over the coming years.



Methodology

An extensive engagement programme carried out between June and October 2016 saw us interview and survey, 172 inpatients at Hillingdon Hospital, 52 of those patients post discharge and the professionals and staff from over 20 organisations.

Findings

The over 65's express an overwhelming feeling of pride in the NHS and hospital services. They are quick to praise Hillingdon Hospital for their caring and attentive staff, and give individual examples of exemplary conduct.

They are largely from a generation where they just 'get on with it' and 'don't want to cause trouble', and as such some were reluctant to say anything against their care. We found that they were far more comfortable speaking to us after discharge, than they were on the ward.

The satisfaction rate for discharge and the follow up care is varied. Patients expectations differ considerably resulting in polarised views on the same subject.

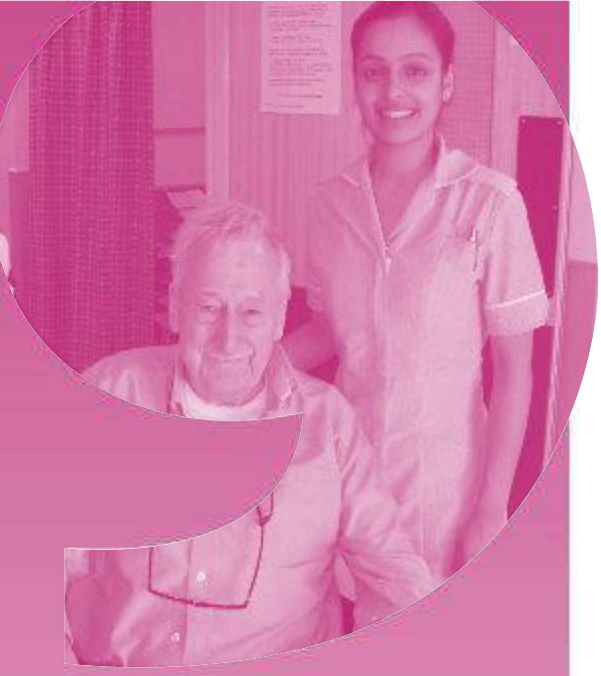
Service delivery is not always consistent and there are a number of areas which we found impacted upon the patient/carer experience.

The professionals and staff we spoke to during our engagement demonstrated that they are committed to providing the best care they can in their role.

They were candid in their responses.

It was sad to note that we found general dissatisfaction amongst professionals and staff. Many expressing frustration, as they highlighted a number of operational barriers and areas along the discharge pathway that required improving.

The evidence provided by both the staff and patients, and the impact upon their experience of the discharge pathway, broadly falls into 3 categories:



Communication and Information

Patient/carers said that they want to be fully informed across the whole pathway. They stated that the communication between them and professionals and the information provided to them is often poor. Many reported that they were not involved in the planning of their discharge and follow-up care and support. They have illustrated where they have been unable to speak to a doctor, have forgotten or become confused about what they have been told, do not know what medicines to take, who is coming to see them at home, or how to arrange a private care home placement, or care package. This leads to them being uncertain and anxious which becomes a barrier between them and staff. This promotes a situation which is not positive for either party. When uninformed, patients/carers persistently seek answers and this increases the number of interactions with staff, which in turn impacts negatively upon already stretched staff, by taking them away from other activities.

Evidence would suggest that by providing clear written information to inform patient/carers and support them to make decisions would empower them to become partners in the discharge process. This will improve outcomes for both patients, partner organisations and their staff.

Recommendations

1. The Trust has a booklet titled 'Working Together'. This was a trust wide initiative which commenced in September 2014 with the aim of issuing this booklet to all admitted patients. This booklet would then be filled in during the inpatient stay, and would be completed on discharge complying with many of the details listed in the NICE requirements[ii].

   We would recommend that this booklet is reviewed and updated to produce a 'Patient Journey' booklet that keeps patient/carer fully informed during the inpatient stay and outlines the details of the follow-up care and support arranged.

This will then act as a clear method of communication between patient/carers and professionals in hospital and in the community.

2. We would recommend that patient/carers are provided with written information about social care and continuing health care assessments in line with the Care Act[iii]. This should clearly outline, entitlement, assessment process, financial implications and support and information to make decisions on the selection of private care.

3. We would recommend that where an individual has substantial difficulty in being involved in the assessment process and their onward care provision, that an independent advocacy should be provided.

Processes and Procedures

Throughout the course of our engagement patient/carers informed us that during their inpatient stay the staff were working hard to provide them with good care.

There was a general observation that they often felt staff were stretched and did not have the time they would like to attend to the patient's needs. They also perceived a variation in care between the day and night shifts, and permanent and agency staff.

The use of agency staff and workforce pressures were also raised by staff in both the hospital and the community.

Several patients reported that they felt under pressure to leave hospital. With some highlighting that they had been told by staff that their bed was needed for somebody else.

Our researchers saw a marked difference in the discharge procedures on each ward and several patient/carers who had experienced multiple inpatient stays also identified this to us. This is exampled by the discrepancy in how patients awaiting medication and transport are processed. Depending upon which ward, patients of a similar condition, could either, wait in their bed, be

asked to sit in the ward's day room, or will be sent to the discharge lounge.

Professionals and staff also echoed concerns around procedures not being uniform across the wards.

From the conversations we had in the discharge lounge, we found that patients often waited for many hours, without hot food or other facilities. This was particularly apparent for those awaiting patient transport.

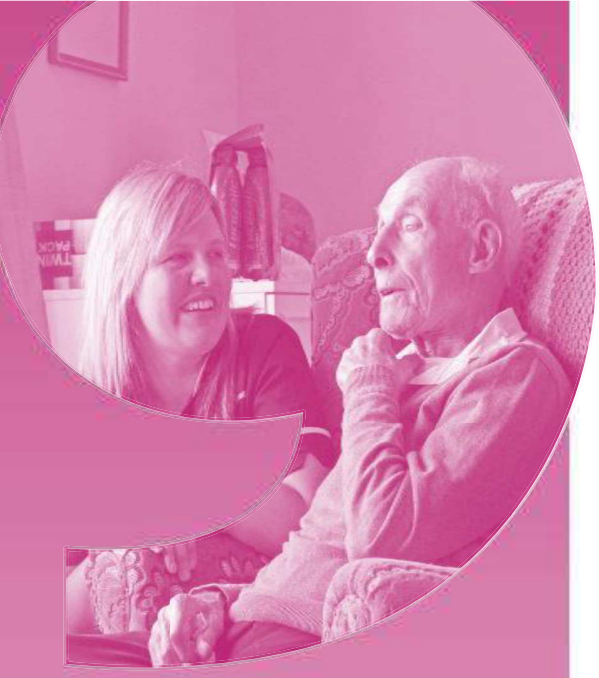
Although waiting for medication at discharge remains a frustration for both patients and staff, on the whole all patients went home with the medication they required. Some patient/carers did highlight to us that they were confused about their medication; especially those who were dispensed multiple drugs at discharge.

Recommendations

4. We would recommend that the hospital looks to standardise the discharge process across all wards. A compulsory uniform process could provide many benefits to improve the patient and staff experience.

   When identical and consistent, a process becomes natural and this can only positively affect the pressures on staff. Applying the same process may also assist the hospital in its compliance with the 'Safer Staffing' initiative. Staff and agency staff can seamlessly transfer between wards. Resulting in bank staff able to work on any ward with confidence, agency staff training and induction becomes easier, returning agency staff become familiar, and escalation wards can be opened quickly. This in turn may help with staff recruitment and retention and positively affect the quality of care provided to patients. As staff have more time and opportunity to care for patients in the way they want to. Possibly improving staff moral and encouraging agency staff to become substantive.

5. We would recommend a review of the discharge lounge be carried out, to assess how effective it is in meeting the needs of patient/carers who are waiting there. Without any pre-emption of this assessment,



we would suggest the scope includes looking at facilities/amenities available to patients, food and drink, and timely information on their medication or transport.

6. We would recommend that in addition to written instructions for those patients being prescribed multiply medications, that the hospital also looks to provide Dosette boxes, or blister packs. This will mitigate against possible unintentional overdose, improve patient safety and could avoid some readmissions.

7. We would recommend that when discharging an older person that it becomes standard practice to proactively refer to Hillingdon Carers for further support, especially when:

   - the patient is the carer for their partner.
   - the partner is the sole carer for the patient.

Closer integration and joined up working

We have already spoken about communication and how written clear information is needed to aid patient/carers in the discharge process. Patient/carers also pointed out to us that organisations do not necessarily communicate with each other well, or work as closely together as they could. They have told us about their GP not receiving a discharge summary, not being accepted on transfer to intermediate care and being sent back to the hospital. Assessments being carried out separately by social services and hospital staff, not all relevant partners being invited to multi-disciplinary team meetings and domiciliary carers not knowing how to contact district nursing.

Timely communication between organisations is something the 'system' has been striving to achieve for some time. Patients tell us it is something they want too. The 'Patient Journey' booklet we propose could go part way to connecting organisations who are currently providing care for an individual, but more work needs to

be done to connect the whole 'system' and for the 'system' to have a joint way of keeping patients/carers involved and informed.

Ensuring the organisations that will be providing care, are all involved in the discharge process is a key element for patients and their ongoing care. Patients and their families do not always see this and that needs to be embedded in the discharge process. Patients/carers tell us they want this to include domiciliary care agencies and care homes directly.

Although not picked up in our conversations with patients it should also be noted that our researchers were told of confusion amongst ward staff of the function of the Joint Discharge Team, and it was questioned whether it was being fully effective.

Organisations need to know about each other's services and know how to signpost patients/carers effectively to each other.

The Accountable Care Partnership is an opportunity to deliver this closer understanding of the different organisations and improve our joint working but again close working relationships need to be built with organisations providing 'social' care.

Recommendations

8. We would recommend that serious consideration is given to the proposed ***single point of access for discharge***.
    - As a possible solution to providing wrap around and integrated care for the patient/carer.
    - And; as an information hub for professionals to greatly improve communication between organisations and the understanding of each other's services.
9. We recommend that there is an evaluation of the Integrated Discharge Team. To review membership and effectiveness.

Rising demand for services, combined with restricted or reduced funding, is putting pressure on the capacity of local health and social care systems. The number of people aged 65 and over in England is increasing rapidly. The relative growth in numbers of older people is important. The number of older people with an emergency admission to hospital increased by 18% between 2010-11 and 2014-15. In 2014-15, the percentage of older people admitted to hospital after attending accident and emergency (A&E) was 50% compared with 16% for those aged under 65.

Although overall length of stay for older patients following an emergency admission has decreased from 12.9 to 11.9 days between 2010-11 and 2014-15 - suggesting improved efficiency - the overall number of bed days resulting from an emergency admission has still increased by 9% from 17.8 million to 19.4 million days.

Put simply, without major change, these recent trends indicate that the more older people there are, the more pressure there will be on hospitals.

While NHS spending has grown by 5% in real terms between 2010-11 and 2014-15, local authority spending on adult social care has reduced by 10% in real terms since 2009-10

Extract from "Discharging older patients from hospital" published by the National Audit Office May 2016[iv]

England

With a growing population, people living longer and a rise in the number of people living with one or more long term conditions, the need for the health service and social care support is increasing.

30% of the population have one or more long-term condition and these conditions account for £7 out of every £10 spent on health and care in England.[v]

Currently, people aged over 65 represent 18% of the total population, up from 12% in 1966. It is projected that by

With the continued rise in demand, against a backdrop of financial pressures, it is nationally recognised that health and social care services face enormous challenges.

2039[vi] nearly a quarter of the population will be over 65, with 1 in 12 people being over 80.

It is reported that over 5 years there has been an 18% increase in emergency admissions for older people.[vii]

Nearly two-thirds of people admitted to hospital are over 65 years old. Accounting for almost 70% of emergency bed days.[viii]

On average, the over 65's tend to stay longer in hospital and they are more likely to have their discharge delayed, after they are clinically fit to leave.

In the last 2 years there has been an increase of 55% in the average number of delayed transfers of care that are attributable to social care.[ix]

For older people, longer stays in hospital can have adverse effects. They can quickly lose mobility and the ability to live independently. This can increase their long-term care needs and worsen their health outcomes.

In real terms 81% of local authorities have cut their spending on social care for older people over the past five years.[x] With a 30% drop in older adults receiving publicly-funded community based services, 18% fewer receiving home care and 50% less, day care.[xi]

With the continued rise in demand, against a backdrop of financial pressures, it is nationally recognised that health and social care services face enormous challenges.

Hillingdon

The challenges in Hillingdon are no different.

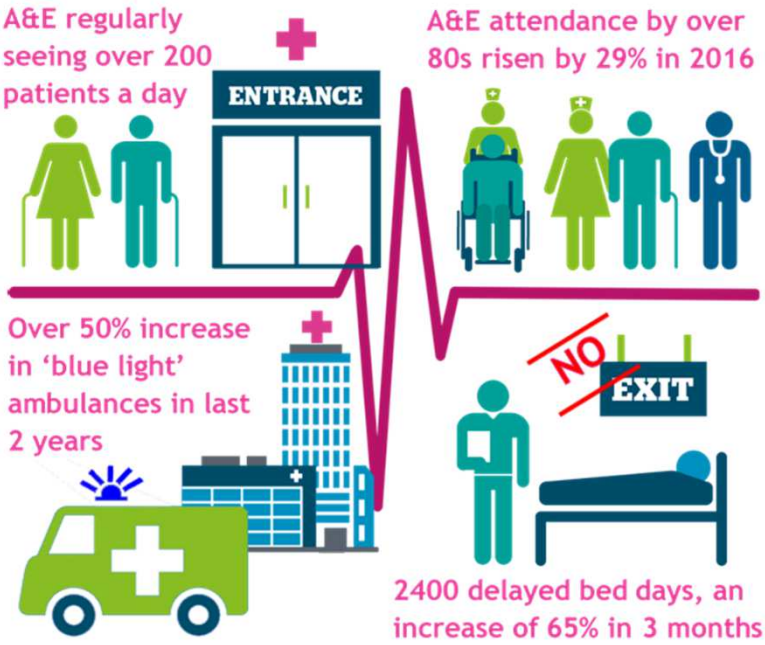
The Hillingdon Hospital's A&E department has a calculated daily capacity for 160 patients and is regularly seeing over 200.

In the last 2 years there has been an increase of over 50% in the arrival of 'blue light' category 1 emergency ambulances – who carry the sickest patients.

Attendance at A&E by older people is rising. Most noticeably in the over 80s which has risen by 29% in the last year.

With the development of Ambulatory Care Clinics[xii] the number of over 65s admitted into Hillingdon Hospital has actually reduced by 6% in 2016. However, delayed discharges of medically fit people have risen sharply. During the period of our engagement they rose 65%. With over 2400 delayed bed days recorded in that quarter (July to Sept 2016).

Although 15% of these delays are due to patient choice, the majority - 70% - are attributed to finding placements in residential or nursing homes.



For Social Services and NHS Continuing Health Care, securing sufficient capacity, in care homes and domiciliary care, to meet current need is a definite challenge in the borough.

And; for all care providers in Hillingdon the recruitment and retaining of staff continues to be difficult and is compounding their pressures.

Strategic Plans

There is a view shared by many that to address these new challenges, the NHS needs to adapt and change.

In the NHS England, Five Year Forward View[xiii] the NHS' national leadership outline a clear strategic vision for the NHS to meet these challenges.

A plan to improve the nation's health, transform the quality of care delivery, and make the NHS financially sustainable[xiv]

The vision concentrates on prevention, supporting people to take control of their own health, GPs working together at scale and for new models of care.

A future, where organisational barriers are broken down and NHS organisations work closely, in collaboration, with the council, voluntary sector and local people to improve health and care for their population.

Local Plans

It had long been recognised that to improve the local health and social care system in Hillingdon, care would need to delivered differently.

Led by Hillingdon Clinical Commissioning Group and the Local Authority there have been a number of strategic initiatives that have been started in Hillingdon. The majority of these have concentrated on the care provided to Hillingdon's older residents:

- Integrated Care Programme
- Better Care Fund
- Whole System Integration - Accountable Care Partnership
- GP Networks

These work streams have all focused on collaboration and organisations working closely together, to change the way in which care is delivered.

This has led to mature relationships being built between organisation and Hillingdon being in a good place to build on the current initiatives as part of the Sustainability and Transformation Plan.[xv]

INTRODUCTION

Discharge processes cut across the responsibilities of multiple agencies and have long been recognised, as an indicator to assess the effectiveness of care in a local health and social care system.

In a 'perfect system', multi-agency working and collaboration is seamless. People are appropriately supported at home. Hospital activity is planned and when admitted to hospital for emergency unplanned activity, the patient is timely discharged back to being supported in the community.

The Healthwatch England report 'Safely home: What happens when people leave hospital and care settings?'[xvi], published in July 2015, provides evidence that health and social care systems across England are far from 'perfect'.

Healthwatch Hillingdon had already recorded many patient's stories relating to discharge and the provision of care and support in the community, for residents over 65. Through our strategic involvement, we were using this information to inform the change programmes.

With pressures upon Hillingdon Hospital dramatically increasing - with unprecedented numbers attending A&E and rising numbers of delayed discharges being recorded. Healthwatch Hillingdon decided to look at how this was affecting patient experience.

Our discharge project set out to engage with Hillingdon residents over the age of 65, who have recently been involved in the discharge process at Hillingdon Hospital.

Through their personal experience, we looked to gain a greater understanding of the effectiveness of discharge processes and the support and care provided to them post discharge, in their home, or another care facility.

We looked to ascertain what works well and outline recommendations where service delivery may require improvement.

The project was also an opportunity to benchmark current service provision. As a tool to evaluate the

effectiveness of the new programmes as they are embedded over the coming years.

We worked closely with The Hillingdon Hospital NHS FT and we would like to thank them for facilitating access to the patients and staff we have spoken to during our engagement program.

We would also say thank you to all the organisations who we engaged with and the staff we spoke to. Their insight gave us a greater understanding of the patient journey, from hospital to 'home' and a further dimension to understand what works well and what could be improved.

We also express a special thank you to all the patients and their carers or families that have taken the time to tell us about their experiences.

The Patient and Carer experience outlined in this report has been shared with local Partners who either commission or provide care to give them an opportunity to:

- assess the quality and effectiveness of discharge and the follow-up care we provide in the community
- consider how this evidence can inform current work streams
- consider how we can use this evidence to develop better services for Hillingdon's residents.

During our research, we have identified possible solutions and outline these as recommendations for Partner organisations to consider.

If implemented, these recommendations may help towards improving:

- the patient/carer experience
- staff experience and job satisfaction
- quality and safety of care
- length of stay
- readmissions

METHODOLOGY

Stage 1

172 patients were interviewed and completed a survey on 17 different wards (including the Discharge Lounge), over a period of 2 months. Patients gave written permission for Healthwatch to follow up the survey with another survey once they had been discharged from hospital. The second survey would ask about their experience of the discharge and how they were coping post discharge.

The survey was sometimes completed by a patient's advocate, and permission was given for us to follow up with this contact.

The survey data was then recorded into a database for analysis.

Stage 2

Patients interviewed on the wards, or their advocates, were then phoned at home 30 days after their original interview. This contact asked how the discharge process had gone, and if adequate care was in place for their needs.

This was a more challenging aspect of the project as some patients were still in hospital, some had died, and some were no longer at the contact number.

52 discharged patients/advocates completed the second survey. These were recorded into the database for analysis.

Stage 3

We met with over 20 local organisations who commission, or provide care services for the over 65's in Hillingdon, within hospital and the community. This engagement, with senior managers and frontline staff, looked to

identify and understand the processes and procedures involved in discharge; and the factors, barriers and enablers that contribute to providing patients with a safe transfer from hospital to being cared for in the community.

Views were canvassed from the following:

- The Hillingdon CCG
- Continuing Health Care
- Hospital staff and managers
- London Borough of Hillingdon Social Care
- Age UK Hillingdon
- Hillingdon Carers
- Care homes
- CNWL Community Services
- GPs
- H4ALL
- Domiciliary care agencies

DIGNITY, CARE AND COMPASSION

Older patients arriving at THH are from a generation who express pride in what they regard as 'their' NHS.

They are largely from a generation where they just 'get on with it' and 'don't want to cause trouble or be a nuisance'. They endure, and don't like to complain. They feel vulnerable as many have lost confidence with age.

81% of patients said that they were either satisfied or very satisfied with the way they were treated overall. They said staff were caring and trying their best, but wards were very busy, which led to lengthy waits in being attended to, long waits for medication and poor communication. It was no surprise therefore when asked what could be improved, 31% of these said they felt the hospital was understaffed and needed more doctors and nurses.

Of the 19% of patients who said they were dissatisfied or very dissatisfied with their care. The reasons given for their dissatisfaction were:

- requests made to staff were not completed
- no continuity of care
- night staff are less caring than day staff
- agency staff are not as good as permanent staff
- never see the same face
- having to frequently move wards
- personal care not carried out, like cleaning dentures
- anxiety over toileting and not being assisted to go
- not understanding what is happening to them

The professionals and staff that we spoke to also recognised that there is an inconsistency of care. Hospital staff pointed out that this is not helped by the high turnover of staff and the need to use agency staff, who lack a clear understanding of hospital procedures. They also recognised the lack of consistent discharge processes for staff to follow across the wards. Set processes and procedures are often not followed. Instead, organic procedures have developed on each ward.

10% of patients and their families expressed deep dissatisfaction in what they consider to be a major failure in the discharge pathway, again siting staff under pressure as being the reason for poor communication and procedures. Many felt under pressure to leave the hospital as they were very aware of the urgent need for beds. Professionals that we spoke to concurred with the view saying that they felt under pressure to discharge patients, as the hospital is under huge pressure from the demand coming through the doors.

Pain relief was a concern of patients, with many saying they had to wait lengthy periods to obtain authorisation from unavailable doctors for medication to be administered. This is an issue also recognised within the hospital, again attributed to pressure of demand and lack of available doctors and nurses.

COMMUNICATION

30% of patients and/or their carers referred to poor communication and lack of understanding about their condition. Professionals and staff also recognised the need for better communication and explanation for patients and families/carers, but see the need for better processes and management to be able to free up 'fire-fighting' time in order to invest in the necessary commitment to clearer communication.

Patients and families/carers wanted an understanding of their situation from a member of staff. They were often told they needed to speak to a doctor for this, but that could mean waiting a considerable time. Professionals and staff also felt there is a need for a communication process consistently applied. Some wards seem to allow an appointments system with doctors, others do not. It seems to be very hard to get any time with a doctor.

Patients sometimes forget, don't hear or get confused about what they have been told. This can lead to the family /carers being uninformed, which leads to family seeking information from staff which is often time consuming and frustrating. Patients and their families/carers would therefore like information from doctors explaining the current situation and what would happen next, written down.

Staff told us that this would also help them, as much of their time is taken up with enquiries from families, and not all staff roles are aware of the full situation on a patient to be able to effectively give an update.

Patients also felt confused by conflicting information from staff on their discharge. Physios may have told them one thing, the Occupational Therapist another, ward staff something else. Discharge dates kept changing, expectations were raised then dashed. Through all this patents felt they weren't communicated to adequately or listened to. Families/Carers felt anxious and didn't understand what diagnosis, prognosis or treatment had taken place or how to avoid the condition in the future. There was no one they could talk to who could tell them the whole co-ordinated picture.

65% of patients, carers or family members felt they were not given the chance to raise any concerns they had about their discharge or going home. They would have liked the opportunity to talk about their concerns and have information on how to manage their condition after going home. Many felt advice on nutrition would have helped but this wasn't necessarily available.

Families/Carers say there is poor communication of what 'Continuing Health Care' means, and what help they can get for their loved ones when they come out of hospital. Professionals and staff echoed this confusion and saw part of the solution as being a clear user friendly published discharge policy, which everyone can follow and refer to. Staff said that they are aware that families think they are not told about continuing health care options as the NHS wants to 'save money'. Transparency is key, and staff would welcome a clear process to guide patients/families through all the options for leaving hospital care.

PATIENT NEEDS ASSESSMENT

Relatives of patients expressed a desire to be included in discussions about their loved ones when the patient is incapable of contributing to an assessment of their needs. They felt that an assessment may not be accurate when relying on confused information from an unwell patient. Professionals also raised concern that both

families/carers, and the right skillsets were not always present at meetings to fully inform a decision on care needs. Quite often, daily home carers who know the patient intimately are not asked for any input into understanding the patient's on-going needs. Professionals also pointed out that the lack of joined up IT systems meant that not all the information is always available to make a fully informed decision.

Professionals also felt that sometimes needs could be met for patients at home by community services, but what may be available for a patient is not always understood. A better awareness of community services at the assessment stage could expedite an earlier discharge.

There was confusion amongst professionals about whose responsibility it was to find out the financial situation of a patient in need of continuing care. It was felt that staff required a greater understanding and training on the roles and responsibilities at assessment.

We found that assessments can be carried out on the same patient, by the hospital, social services and a care home. Which leads to confusion for patients and their families and disagreement between organisations.

Patients and their families/carers wanted to understand how the assessment was conducted and the conclusions arrived at. Families also wanted clarity around who makes the decisions on care going forward for the patient.

Families have told us about meetings that they have attended where recommendations for care packages have been made by medical staff but overridden afterwards by social workers. This we have found is also frustrating for professional staff who told us that their expertise and advice is overridden.

Patients and families/carers want accurate information on assessments and their entitlements. They feel the whole funding entitlement rules are very confusing. Many were worried that they must attempt to sell their parent's house while they're still in hospital, in order to pay for care when they come out.

Clear understandable written information explaining options would go a long way to alleviating the stress on families at such a difficult time. Professionals concurred with this view, and agreed that funding rules are complex and difficult to explain.

Finding a care home is particularly difficult regardless of funding, especially if the patient has dementia and behavioural problems. Relatives expressed anxiety over lack of help procuring a home, and the time it takes to get their loved ones placed.

Professional staff expressed frustration over families refusing care home placements which led to beds being unavailable for acute medical need.

They felt that having a joint placement board for patients needing a care home would be more efficient than the Local Authority and Clinical Commissioning Group working separately. A joint board would stop duplication of effort and competition for a scarce resource.

When asked to determine whether they can meet the needs of an individual, care homes are sent a FACE assessment form[xvii], outlining the care and support the patient requires. Care homes felt that the process could be made more efficient and it would benefit patients, if the assessment form did not contain acronyms, and was always dated to confirm it was current.

CARE PLANS AND DISCHARGE INFORMATION

Although the NICE[xviii] regulations state that a patient leaving hospital in need of on-going care should have a fully documented plan, this rarely happens. Only 14% of our sample said that they had been given anything that explained what care they would be getting on discharge.

Staff told us that they would welcome a consistent template for providing discharging patients with a plan, as currently there is a mixture of different methods: some provide written advice for the patients, while most just issue the discharge summary.

Patients who left with a 'Discharge Summary' said it probably meant something to their doctor but it meant very little to them as it is written in medical language.

Care professionals told us that in the absence of anything else the Discharge Summary was a useful document, but found it to be inaccurate in some cases, and often written too early and therefore not documenting recent issues.

A Discharge Summary document is given to the patient and a copy sent to the GP. However, there are other services caring for the patient in the community that would benefit from having this information. On occasions patients are attended at home for the first time without any prior knowledge of a person's condition.

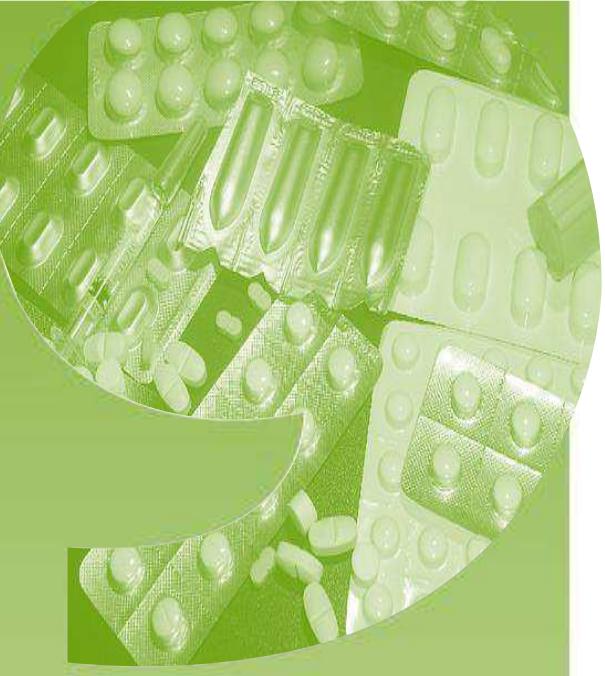
Care homes told us that they would welcome a clear plan, arriving with the patient, written in plain English, without acronyms. They saw inconsistency in the information they received with a discharged patient, with some wards giving care homes no information, making it difficult to provide initial effective care.

Some families said they were shocked at the care package received, not being what was agreed at discharge meetings, and would have challenged this had there been a published care plan in place.

We found that little regard, or help, is given to the family carers of the patients returning home. No support or signposting is offered. Quite often carers are not aware of the help they can get and are often the frail elderly partners of the patient. Or, the patient is the carer themselves, returning home whilst still in need of recovery to look after a partner with a chronic condition.

Professionals told us that a referral for a carers assessment at the point of discharge would ensure that the family carer was contacted and offered support. Lack of joined up communication and processes were often given as examples of where the 'system' is failing the discharging patient and their family carer.

Whilst some treatment areas of the hospital are good at providing information on discharge and on how to manage a condition, this is not consistent throughout the



hospital. Many patients/family/carers say they left not knowing how to manage a condition, or what to do. Professionals concurred that information was patchy.

Patients/families/carers would like written information at discharge which clearly shows:

- the details of the patient's condition
- what has been done to them in hospital
- who they can contact if they have a problem
- medicines needed and frequency
- what support they can expect when they get home
- who will be providing this support
- how they can contact the support
- what they can do to manage their condition
- details of useful community and voluntary services who can support them

Professionals felt a care plan on the discharge of a complex case was invaluable, but advised that there needs to be just one unified plan. Currently the patient can be provided one by both the NHS and Social Services. We were given an example, where assessments are carried out in hospital for patients who are already known to Social Services and on a plan. This is confusing for patients and felt to be a duplication of resource.

MEDICATION

Medication is a big issue for patients. Whilst 95% of patients said they were discharged with the necessary medicines, many were unclear about dosage or frequency.

Many commented on being given a big bag of tablets which they had no idea how to cope with. Many elderly patients do not have the memory to manage tablets as prescribed.

Medication is also confusing for care agency staff, who often rely on family members (who are also confused) to administer the correct medication.

> I think provision of an updated dosset box by the hospital will be the single most improvement in quality of care for this elderly group of patients.

Relatives who have a good relationship with their local pharmacist told us that they were too concerned about giving the wrong dosage to their loved ones and so took the bags of tablets to their local pharmacist, who have in many cases sorted out Dosette boxes to help.

Two patients had been previously admitted for inadvertently overdosing on their loose tablets.

It was the general consensus of all parties, that blister packs, or Dosette boxes, should be provided at discharge to ensure that patients take the right medicines and the correct dosage.

Under the current process, blister packs and dosette boxes are prescribed by GPs and not stocked at the hospital. Hospital staff told us of a number of occasions where discharges were delayed by days, whilst a blister pack was obtained.

One GP said **"I think provision of an updated dosset box by the hospital [at discharge] will be the single most improvement in quality of care for this elderly group of patients."**

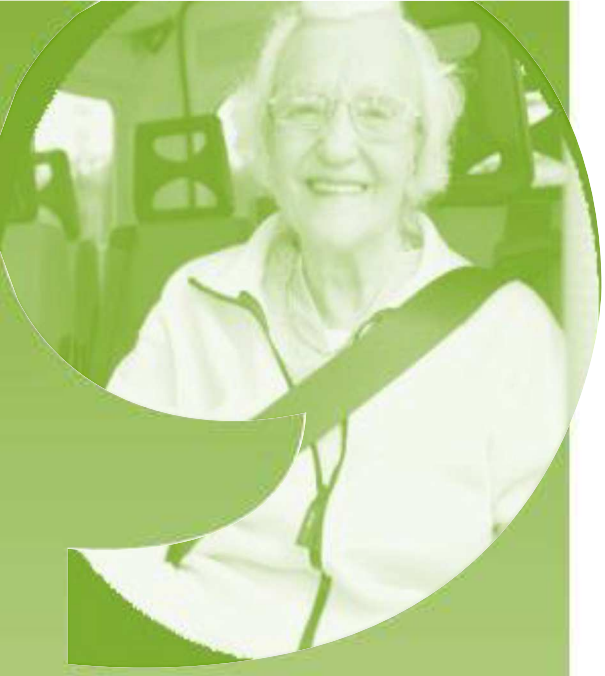
Patients, families and carers also want to fully understand what the medicines are for.

Many were confused about old medicines used before their hospital admission, whether they should continue to take them alongside the new medication prescribed. This is again also confusing for both family carers and carers from agencies.

Another big issue is medication not being ready when a patient is ready to leave the hospital. This can mean a patient is waiting for hours in the discharge lounge, day room, or their bed.

Patients want a discharge process where the pharmacy is fully aligned with time of discharge. This of course is impacted by finding a doctor to sign off medications needed for discharge.

Both patients and professionals highlighted incidents where inefficiencies in providing medication led to patients, who were medically fit, staying in hospital longer.



Professionals in the hospital recognise timely medication at discharge as being an issue. A frustrated staff member cited “like many issues, due to the demands, there isn’t the time to stand back and address the processes”.

There is also a clear consensus that the pharmacy should have opening hours to match the hours of demand, especially at the weekend.

Finding an available doctor to sign off medication is also an issue for patients needing medication during their stay. Pain relief is often delayed awaiting doctor sign off.

TRANSPORT

Half of our patients surveyed after discharge went home by hospital transport. Many of them commented on the long wait times for transport.

Those waiting in the discharge lounge commented that there are no facilities for long wait patients. There is no entertainment (TV or magazines), no hot meal provision, Professionals and staff in the hospital raised with us this issue and were equally concerned that it had no provision for patients who cannot sit in a chair and need to lie down, and support for confused patients who wander.

If patients want a co-ordinated discharge process which means they do not have to wait for up to 8 hours for a vehicle to take them home. They want a seamless discharge process where medication and transport comes together in time for a patient to go home. Especially when family, or agency carers, have been informed and are there waiting to receive them.

Families and care homes described transport to transfer patients being arranged for late in the evening. Care homes spoke about patients arriving as late as 11pm which isn’t good for the resident, or the care home. A few expressed concerns that patients can arrive unannounced when they are not prepared for a new admission.

Again, professionals in and out of the hospital recognise that the transport process is ‘poor’. It is expected to be ‘unreliable’. They give examples of poor joined up working and communication, which often results in

delayed discharges, as patients miss their ‘slot’ and must wait another day(s) for re-scheduled passage home.

The more experienced transport crews do communicate with the care agencies directly, to ensure they rendezvous with carers when taking a patient home. But this is not standard process and vulnerable patients can be left at home without carers present.

Poor communication has been cited for transport turning up to collect patients for follow-up outpatient appointments, when the appointment was the following or previous week, or the patient was now deceased.

Hospital transport is currently being retendered and is under review. This opportunity needs to be taken to ensure that, the service for patients at discharge is safe, efficient, and that methods are devised for timely communication between the transport, and family or carers when the patient is being taken home.

DISCHARGE

42% of patients thought it was the right time to leave hospital when they did and were extremely grateful for ‘fantastic medical treatment’.

36% of patients felt they left hospital too early, some felt this was due to the hospital’s urgent need for beds. Patients want to be discharged when, and only when they are medically fit. They want to be discharged when everything is in place for a safe return home. They wanted to feel that their own health situation is the primary concern, not the need for their bed.

Professionals felt that individually each hospital department was working robustly to ensure a timely and safe discharge. It is acknowledged that most staff are working flat out, under great pressure to care for patients and ensure they go ‘home’ with a positive outcome. However, staff acknowledged that this has led to a ‘blame culture’ where patients and families are being told ‘we’ve done our bit, we are now waiting on them” and they are not seen as a united team. This is giving patients a negative impression and a perception that their care is disjointed.

Both patients and families/carers felt that there needs to be more joined up working between the hospital and social services as there are delays and confusion over what care is being provided and who will be providing it.

Patients want to know when they are going to be discharged and for the date/time to be met, not postponed. They want a seamless service, to leave on time without waiting, and they want to leave with a care plan and clear written advice on what is going to happen next. Professionals also want a more effective discharge service. They want discharges spread evenly over a 7 day week, and a discharge plan for all professionals to see and work towards.

POST DISCHARGE

68% of patients felt the right care was in place on leaving hospital. However, 32% felt care was only partly in place or not in place at all.

Patients wanted to be discharged to a safe place with the supporting equipment implemented before they got there. This wasn't always the case.

They wanted to know exactly what the expected care package was, and what community services they would be receiving, when these were going to arrive and how to contact them if they didn't.

Professionals in the community also said that although the GP is provided with a copy of the discharge summary it would help them to receive a copy to have more understanding of the patient's condition and circumstances.

Relatives and patients were unsure of what happened when re-enablement care finishes. They were anxious about who would care for them and whose responsibility it was to arrange.

They wanted to understand what outpatient appointments they would need to attend, and when, and how they would get there.

They also wanted to know who they could contact if they found themselves in difficulty after leaving the hospital.

Going forward patients and relatives/carers wanted to know how to manage their condition so that they could avoid hospital admissions in the future.

Professionals who gave their view on post discharge services, agreed that agency carers require better training to help them identify signs of deterioration in the person they cared for, administer medication more effectively, and be able to seek relevant help from the right agencies to prevent a hospital admission.

It was acknowledged that some care agencies provide a robust training programme for their carers, but sadly this is not always the case. Regulations to ensure carers are sufficiently trained and given the tools to do the job effectively, would be welcomed by some.

Professionals inside and outside the hospital also felt that there needs to be greater education for relatives of dementia patients, to understand the end stage of the disease and how it can be eased with palliative care at home rather than in a hospital setting.

It was felt that this also applies to Care Home staff who need training to better understand end of life stage of dementia and support to have confidence that the home can provide the palliative care and hospital intervention is not required.

Professionals felt the post discharge planning process could be improved by better co-ordination of GP and community services to ensure a patient has a considered plan of care available to them.

RECOMMENDATIONS

Communication and Information

1. The Trust has a booklet titled 'Working Together'. This was a trust wide initiative which commenced in September 2014 with the aim of issuing this booklet to all admitted patients. This booklet would then be filled in during the inpatient stay, and would be completed on discharge complying with many of the details listed in the NICE requirements.

   We would recommend that this booklet is reviewed and updated to produce a 'Patient Journey' booklet that keeps patient/carer fully informed.

   This will then act as a method of communication between patient/carers and professionals in hospital and in the community.

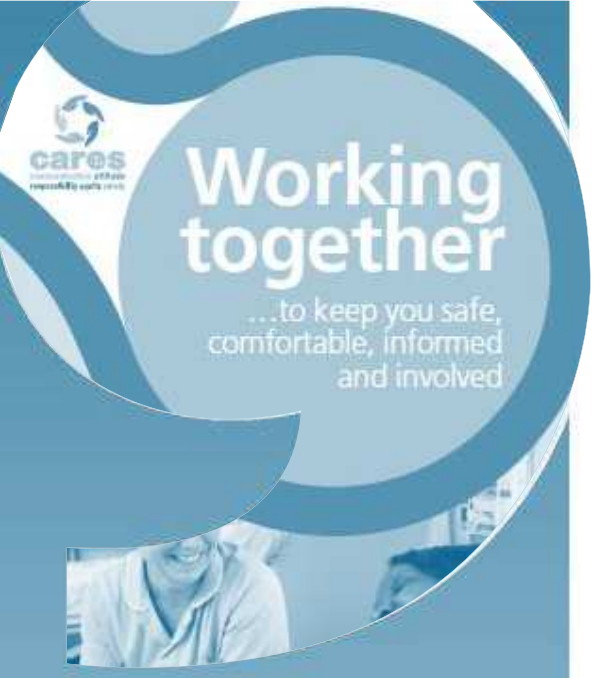
2. We would recommend that patient/carers are provided with written information about social care and continuing health care assessments in line with the Care Act. This should clearly outline, entitlement, assessment process, financial implications and support and information to make decisions on the selection of private care.

3. We recommend that an independent advocacy service should be provided for individuals who have substantial difficulty in being involved in the assessment and discharge planning process.

Processes and Procedures

4. We would recommend that the hospital looks to standardise the discharge process across all wards. A compulsory uniform process could provide many benefits to improve the patient and staff experience.

   When identical and consistent, a process becomes natural and this can only positively affect the pressures on staff. Applying the same process may also assist the hospital in its compliance with the 'Safer Staffing' initiative[xix]. Staff and agency staff can seamlessly transfer between wards. Resulting in bank staff able to work on any ward with confidence, agency staff training and induction becomes easier, returning agency staff become familiar, and escalation wards can be opened quickly. This in turn may help with staff recruitment

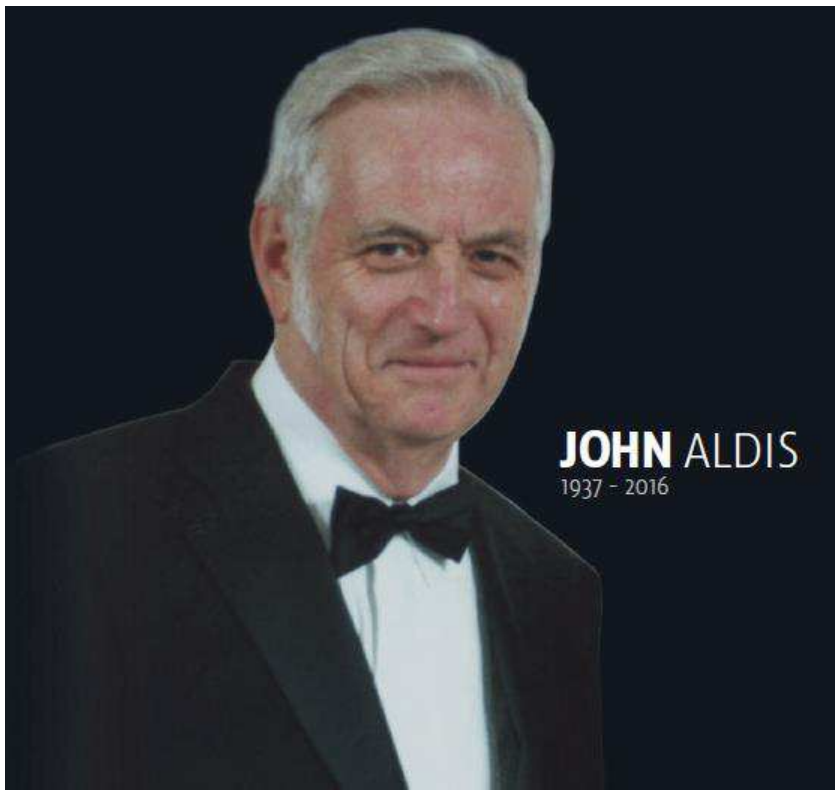


and retention and positively affect the quality of care provided to patients, as staff have more time and opportunity to care for patients in the way they want to. Possibly improving staff moral and encouraging agency staff to become substantive.

5. We would recommend a review of the discharge lounge be carried out, to assess how effective it is in meeting the needs of patient/carers who are waiting there. Without any pre-emption of this assessment, we would suggest the scope includes looking at facilities/amenities available to patients, food and drink, and timely information on their medication or transport.
6. We would recommend that in addition to written instructions for those patients being prescribed multiply medications, that the hospital also looks to provide Dosette boxes. This will mitigate against possible unintentional overdose and improve patient safety.
7. We would recommend that when discharging an older person that it becomes standard practice to proactively refer to Hillingdon Carers for further support, especially when:
   - the patient is the carer for their partner.
   - the partner is the sole carer for the patient.

Closer integration and joined up working

8. We would recommend that serious consideration is given to the proposed ***single point of access for discharge***.
   - As a possible solution to providing wrap around and integrated care for the patient/carer.
   - And; as an information hub for professionals to greatly improve communication between organisations and the understanding of each other's services.
9. We recommend that there is an evaluation of the Integrated Discharge Team. To review membership and effectiveness.



My Big Brother John

Background

First of all, let me offer some background information and my opinion as to what led to his premature death.

Around six years ago, my brother suffered a stroke from which he never fully recovered. This led to mobility issues which became more evident approximately six months ago. He was often having falls inside his home which inevitably led to hospital admissions ...and they were becoming more frequent. There were also very early signs of dementia setting in.

Just after his 79th birthday in January, I suggested to him that he took out a Lasting Power of Attorney for his Health (LPH) naming his only next of kin (me) as his executor. I also asked him did he wish to stay in his own home for the remainder of his days. He replied "Yes". I also explained to him that the LPH would not kick in until he was mentally unable to make his own decisions. He said he would think about the LPH.

By April, he was back in Hillingdon with a urine infection. He was incontinent (mainly because of his mobility

*Stories are of the lived experience of patients and their family members. They are their own accounts and written in their own words. Some names have been changed to protect anonymity.

issues) and prone to this kind of infection. By this time Social Services had decided he need full time care which was duly implemented. 4 visits by two carers every day. By this time, I had also asked Age UK to take care of his house cleaning (one hour a day, Monday to Friday). They had taken care of his shopping once a week for the last two years. John also asked me to apply for the LPH which I did.

For the next two months he was often getting into difficulties getting up and down stairs and suffering falls as a result because his mobility was getting worse. So, I had some of the downstairs area cleared and a hospital bed and hoist were installed by the district nurse's department of Social Services. His doctor paid him a visit and diagnosed that he had rheumatoid arthritis in his hands and arranged for him a visit to the hospital for some time in July. The rheumatoid arthritis condition made it difficult for him to hold things plus he was pretty much a "dead weight" with his limbs. He never got to that appointment because the doctor's practice (Medical Centre in Ruislip) forgot to mention that he couldn't walk by himself to the hospital transport that had come to pick him up! I contacted the practice to discuss my brother's health and to get the transport changed so he could meet his appointment at a later date. I did say that I would soon be getting the LPH - their answer was they would not discuss my brother's health and would only discuss it once I had it in my possession and they had proof that I in fact had the LPH - not very helpful to say the least.

We are now into late July and I noticed that my brother had an irritable cough, but thought no more of it. Approximately three weeks later I went to visit him again and he still had the cough - but he said he was OK. A few days after that I get a call to say that John was admitted to hospital (Friday 12th August I think) because he had slipped off his chair (which sets off an alarm) and the attending carers noticed that his urine was a really dark colour.

The following is mostly from conversations I had with Ward Staff at Hillingdon Hospital and other parties:

So, he was in Hillingdon Hospital for the urine infection.

His stepson had a call about this time from the hospital to ask whether he was a heavy drinker because of the colour of his urine. John had not touched any alcohol by choice soon after his Wife died some four and a half years earlier. It is more like dehydration!

The Discharge Fiasco

The urine infection got cleared up in about four days. On the Wednesday, a doctor who noticed his cough, checked him out and diagnosed that he had the early signs of pneumonia. His throat had swollen up as a result and his diet had to be changed to soft foods.

The medical staff at the hospital suggested that he recover in his own home and would be discharged the next day (Thursday) taking with him medication from the hospital pharmacy. Hillingdon Hospital notified Social Services who in turn notified John's carers that they would be "back on" as he was coming home on the Thursday.

Well, he never got there. Why? Because pharmacy didn't have the medication that was prescribed. Meanwhile the carers were at the house, but no John.

The next day (Friday), pharmacy supplied the medication required. The carers showed up again. However, Hospital Transport couldn't spare anyone until nearly 11pm at night. I was told he should get home around midnight. I said to the ward nurse she must be joking because who was going to get him into the house as there wouldn't be anyone there to greet him. She said OK, it'll have to be Monday now.

(I would suggest: that unknown to me, he was getting no antibiotics for the pneumonia condition, because the ward staff saw him just as a patient waiting to go home. It is conjecture, but I 'm putting two and two together and making four. Of course, there is another scenario - he was getting the medication, but despite him getting worse, they still discharged him because all they were interested in was the availability of his bed - if that was the case then I don't know how the management can sleep at night)

Monday changed everything. Finally, he got driven home by Hospital Transport, with his medication. Problem was, John was gasping for breath because he could hardly breath. It was also the hottest day of August. The driver noticed the difficulties my brother was having and pointed it out to the two awaiting carers at his home. They took one look at him and called for an ambulance. The ambulance got there within 30 minutes. The Paramedics took a look at him and were heard to say 'which idiots let this one out'. They tried to take him back to Hillingdon but were informed there were no beds available. So they took him to Northwick Park Hospital where he was transferred into the intensive care ward.

He was on near enough, pure oxygen for four days. But a patient cannot stay on pure Oxygen forever. So he was transferred out of there to another ward where he was put on half-oxygen.

(Sunday, 28th August) That was the last time I saw John alive. To be honest he seemed quite cheerful but struggling to speak. I thought 'he's over the worst; he'll get better and through it OK'.

I kept in touch with Northwick Park just about everyday from that point onwards. Towards the end of that week the staff at Northwick Park were saying that his heart was becoming a problem because of the pneumonia and that if he got into difficulties they would not try to revive him. By the Sunday (4th September) the hospital said he was in pain from breathing difficulties and that they were going to administer Morphine. When hospital staff tell you they are going to administer Morphine, you know it's the beginning of the end but you live in hope.

Thursday 8th September

John died at 7am on the morning of Thursday 8th September of Bronchial Pneumonia. Northwick Park had obviously tried to contact me early in the morning, but I hadn't picked up. So they phoned John's stepson in Wigan. He sent me a text to say that I should call "Vill" at the hospital. I did so about 8.30am to enquire what the problem was with John. He told me "John has expired". I didn't quite catch the last word and asked him to repeat it. He repeated it: "John has expired".

No-one at Hillingdon seems to talk to each other. It's not that they don't care, I'm sure they do, it just seems that no-one is working off the same page. If they had been, my brother would probably still be alive today!

That made me so angry, I replied "He's not a Packet of Cornflakes or a robot -he's a human being! Try died, deceased or passed away, not frigging expired!" Shocking to speak to the bereaved like that!

I said I wanted to see him to say good-bye to the body. He said "How quickly could you get here". I said "It takes approximately one and a half hours but I probably won't get there until 12 noon and please do not leave him in the ward - because they were going to until I got there. I said it's unfair to the other patients".

Oh incidentally, one more thing- The LPH came through on the 8th September, the day he died.

No-one at Hillingdon seems to talk to each other. It's not that they don't care, I'm sure they do, it just seems that no-one is working off the same page. If they had been, my brother would probably still be alive today!

Mary's Story

My Mum was in Hillingdon hospital for 7 and a half weeks. She was moved during this time from one ward in the hospital as they needed the bed, to Hawthorne. On the day she was moved to Hawthorne, they said there was a referral for my Mum to go there but that they hadn't accepted her, and so didn't know why she had turned up. There doesn't seem to be any joined-up communication.

Whilst in Hawthorn mum had to be sent to A&E at Northwick Park. Mum stayed in a ward there for a few days and then was discharged back to Hillingdon's Stroke Unit. Yet again a ward she was being moved to who were not expecting her, another breakdown in communication, this time between hospitals.

Before Mum came home for a home visit I asked to speak with the doctor. I was told that there was no need to speak with a doctor as she wasn't being discharged, it was just a home visit to assess how she would cope at home.

Mum came home for a visit with the OT who was assessing her, and she stayed home that day. There was no discharge, the ward didn't realise she was going to stay home. So, I had to go back to collect her medication and a commode. I asked to see a doctor as I had questions but there wasn't one available.

The ward eventually gave me a discharge summary note which a doctor had written under the heading 'Under relevant legal information'- "I have not seen or assessed this patient, I have only been involved in preparing this discharge summary from medical notes".

There were no adaptations or equipment in place, no medication ready and the care hadn't been confirmed. I am caring for my mother but I won't be able to do it by myself forever. I tried to speak with a doctor as I have not had an update on Mum's condition or how she has been treated or why she was discharged so abruptly. I was told to ring at 9am the following morning, but there was no doctor to talk to.

I was told that Mum needs physio but that there was a 6-week waiting list of physio which Mum needs.

As it turns out Mum's unplanned early discharge meant that she came home with an infection level that was increasing again (something that had been monitored since 10th Aug). Her own GP got the rapid response team to do further tests, which showed the infection level had increased further and mum was put on antibiotics. Surely, she shouldn’t have been discharged with a growing chest infection???

An outpatient’s appointment was sent to us for her to attend the Elderly Day Hospital clinic with arranged hospital transport. I rang the hospital transport the day before to check what time they were coming.

When I phoned up I was told that she wasn't on the list to be picked up for any appointment. The upshot of this was that Mum couldn't have a new appointment for another two weeks. The ironic thing was the hospital transport turned up at our home the next day to take her to the appointment. There is just no joined up thinking.

> Mum was in Hillingdon Hospital in September this year, where she received fantastic care and attention from the staff there.

Kate's Story

My Mum was in Hillingdon Hospital in September this year, where she received fantastic care and attention from the staff there. She had been in Hillingdon before this incident and had to stay in for an extra 10 days while the care package was sorted out. This was a long time for her to be in there just waiting.

Mum went in again in September this year with fluid on her lungs. While this seems to have been addressed, I kept asking to speak to a doctor to find out what had been done, and how we can avoid it again. It seems the actual Doctors have no intention of speaking to family members and certainly make it impossible to speak to them, I never got to speak to a doctor, I kept asking but one never updated me with any information.

Mum was given the Friday as a discharge date. I arranged with the hospital that she would be brought home in the hospital transport ambulance at 4pm as I had arranged for 2 carers to receive her at her house. This was necessary as Mum cannot walk, is very deaf, diabetic and needs support. For some reason the hospital transport ignored this instruction and took her home at 2pm. They took the key out of her key safe and let themselves in, dumping my Mum on the bed. They left her alone without a drink or any support.

She rang my Aunt who lives far away. My Aunt tried to get hold of the carers to go around straight away but they couldn't, so she was left disorientated and alone for 2 hours. I'm really not happy about this as my Mum is 80 years old and it is disorientating enough coming out of hospital, but to be dumped on a bed and just left is not how an elderly person with multiple health conditions should be treated.

Harry's Story

My mother-in-law was in Hillingdon Hospital for 3 months this year following a stroke. The outcome of her current condition is that she cannot eat food unless it is pureed

as there is a risk of choking. In considering her discharge, we went to a discharge planning meeting where I thought we would be discussing her needs and deciding what would be best for her on her return to home.

The meeting had multidisciplinary staff there, and on the advice of an OT, it was decided that my mother-in-law would need carers 3 times a day. This would ensure she is fed and cared for appropriately. This is the understanding that I had on leaving the meeting.

However, on the day that my mother-in-law was discharged it became clear that a carer would only be visiting twice a day. I was very concerned about this and thought they had made a mistake, as it wasn't what was agreed at the planning meeting. I rang the hospital and was told that Social Services who did not turn up at the planning meeting, had overridden the planning meeting decision, and had changed the care package to a carer twice a day.

It seems that Social Services had done their own assessment without any of my mother-in-law's family being present. As her main carer, and the one who knows her best, I feel that my concerns about my mother-in-law were not taken into account. After contacting Social Services on the day of discharge and explaining that care at mealtimes was essential, the care package was amended to 3 times a day, but we shouldn't have had to go through that stress to ensure my mother-in-law was discharged safely. The carers visiting my mother-in-law were the re-enablement carers who attend for 6 weeks after discharge. Social Services Manager arranged for a Care Agency to take over after 6 weeks as it was clear that my mother in law was not going to cope on her own. We were given no advice where to go for private carers if this agency was not suitable. I was not given any advice on support for carers which I desperately needed as I was overwhelmed with all the different arrangements that needed to be sorted out. I think that the hospital should do an automatic referral to Hillingdon Carers as this would trigger a contact to enable some support.

My mother-in-law left hospital with no care plan explaining her condition and what care she would get or who to contact if we had a problem. If she had left with

Things have gradually become more “normal” over the last few months but it has been a very long and tortuous journey which could have been made so much simpler if the correct support had been there from the very beginning.

a care plan we would have known immediately that the package of care was inadequate.

Another thing that concerned me was the medication. My mother-in-law has to take a variety of tablets at different times of the day. It's confusing for anyone to administer, I don't know why Hillingdon Hospital couldn't put them in a blister pack. I had to dispense her medications into a Dosette box myself crushing them up before giving them to her. Eventually, I managed to get her GP to arrange for the blister packs with a new pharmacy.

Things have gradually become more “normal” over the last few months but it has been a very long and tortuous journey which could have been made so much simpler if the correct support had been there from the very beginning.

Geoff’s Story

Over a period of three years I have been in Hillingdon Hospital twice for operations to remove cancers in my bladder, both operations went extremely well and I cannot fault the professionalism of the surgeons and the immediate after care staff.

After the first operation I was taken to a ward to recover where I was told to keep drinking several litres of water to flush out blood and clots until my urine ran clear, a doctor who was supervising me at the time advised me to call for him if my urine turned bloody and painful which it did during the night so I asked the duty nurse to call for the doctor, after waiting for at least 1 hour nobody came so I asked the nurse again as I was becoming anxious, after another hour a pharmacist turned up and gave me a bag of medications which puzzled me as I had not asked for this, he insisted it was for me, however I noticed the medications were addressed to a polish sounding name and suspected this medication was for the foreign sounding patient in the next ward who had been screaming 'Pain' all night, the pharmacist did apologise for the mix up.

In my opinion we cannot fault the work of our Doctors and Nurses but it is obvious to us all that they are overwhelmed with work and shortage of beds and staff

After the second operation three years later due to the same cancer returning I was again taken to a ward to recover and drink lots of water, when my urine ran clear I was surprised to be discharged early to return home, I suspected the hospital was desperately short of beds.

After being at home for several hours and drinking lots of water I began to experience pain and the urge to urinate but discovered that even using all my strength I could only squeeze out a few drops of blood.

I then started to worry that all the bloodied urine would be forced back up to my Kidneys or my bladder would burst causing further complications so in desperation I rang 111 who called me an ambulance to take me to A&E.

I was readmitted where the clots were removed and after an overnight stay I was discharged home wearing a catheter and urine bag for one week supervised by community nurses.

I have since completely recovered.

In my opinion we cannot fault the work of our Doctors and Nurses but it is obvious to us all that they are overwhelmed with work and shortage of beds and staff, even some staff who cannot speak English.

Vera's Story - "Isn't it ironic……."

Isn't it ironic…that towards the end of my research as Healthwatch lead on the Hospital Discharge project my 83 year old mother-in-law, Vera, fell breaking her hip. This meant that I got to see at close hand, the end- to-end process of the elderly patient journey and share the experience with those I had interviewed.

I'd just like to say that I have a long and proud association with Hillingdon hospital having lived in Hillingdon all my life. I was born at Hillingdon Hospital, I had my children there, and my parents died peacefully there. I have nothing but respect and admiration for the men and women who work there and strive every day to restore health to the sick and the broken: they saved the life of my 3 year old daughter when she had a burst appendix, and they saved my friend whose organs failed due to infection. I have much to thank them for.

In carrying out research for the project I was able to see the immense pressure the hospital is under. They work relentlessly to deal with the hundreds of thousands of people coming through the door. There is no let up, no period of calm before the storm, it storms all the time.

It cannot be unexpected that the service has become almost completely reactive. There is little time to stand back and see the wood for the trees. Processes do not necessarily flow as originally planned, and this is what I saw when my mother-in-law started on her journey.

Monday 5th December 2016

We were away when we received a call explaining that Vera had fallen in her kitchen making a cup of tea. She doesn't remember falling. She was admitted and operated on in the same day which we thought was excellent.

When we saw her the next day she was sitting up and although high on pain killers was relieved to have been fixed, she was very comfortable and happy with the care she was getting from 'terrific' nurses. She has previously had a stroke in 2013 but had recovered well and just needed a carer once a day to help her shower safely.

After a few days, physios had her up attempting to walk again which was great. On the third day of being there she had her hairdresser come in and set her hair. She was positive and looking forward to going home. We were pleased with her care, there were things like her teeth not being cleaned, or hearing aids not being put in but we were there every day and were able to do this for her. What was reassuring was the thoroughness of the staff to establish what caused the fall, her heart was tested and she was scanned.

As the days went on it became clear that surgically she was fixed and therefore could go onto the rehabilitation ward before going home. It wasn't clear how long she would be there, but the days turned into weeks. She was very distressed when she realised that she was going to be in hospital for Christmas but in the event the staff there were fantastic. They bent over backwards to make it a happy event for all patients.

We visited her twice a day whilst she was there, 3 times on Christmas day but never had the opportunity to speak with a doctor or clarify what was happening. We were told by a nurse that she had broken her hip and had had a hip replacement. We were told by the Occupational Therapist (OT) that she had broken her femur at the top and not her hip, and that it had been pinned. We were told by the physiotherapist that she had a partial hip replacement.

She seemed to be doing well, and the physio had her up and walking daily but apparently, the delay for discharge was due to a urinary tract infection - UTI, and the fact that the Civic hadn't allocated her a social worker. It was also delayed for the need to ensure the home environment was safe for her.

They were following the instructions for hip replacement care and therefore all seating at home had to be 2 inches higher than her knee to floor measurement. We had to measure all the furniture at home and provide annotated drawings of heights.

The OT said her sofa was too low and had to be raised by a company that comes in and does it. She also said a perching stool would be necessary for Vera to rest on her

way to the bedroom. And a commode would be necessary for the first few weeks. We asked if we could take her home in the car, but was told the seat would be too low and could cause damage to her hip, so hospital transport would be arranged.

We were told that at the ward meeting the UTI was discussed and identified 4 days before any medication was administered as it had taken time to get a doctor to write the prescription. During this period of no treatment Vera had frequently asked to go to the toilet. One night a nurse on duty refused to take her to the toilet causing her much distress. We raised this with the ward manager the next day and he was appalled that this could have happened.

On Wednesday 28th December the OT told us that they were still trying to get hold of the Civic to sort out a social worker and ask about re-ablement care. We were asked for her current care agency as they would ring them and sort out care for her.

We heard nothing more until Friday 30th at 11:30 when we received a call when we were out of the Borough from the OT asking for the keysafe number for her paperwork. During this conversation it became clear that Mum might be coming out on this day.

First Discharge

We received another call at 2pm from a nurse telling us Mum would be coming out at 5pm. We asked how this was possible when no alterations had been made at home, she didn't have any outdoor clothes to come home in, and no care was in place. We were told that she had a dressing gown that she could come home in, that care from Harlington Hospice had been arranged, and there was no mention of alterations at home.

We took clothes up to the hospital and sat with her until 5pm. There was no sign of any transport. We went to her flat at 6:30 to wait to receive her. At 7:45 the hospital transport eventually brought her home. She had missed an evening meal as she was supposed to leave at 5pm. My husband went to the hospital transport to greet her only to find her on the floor of the vehicle. The driver said she had fallen and was about to ring for an

ambulance. My husband helped her up and got her into the flat. She was fine but very shaken. It would have been safer to bring her home earlier in the car! This was reported the Ward Manager on Tuesday 3rd January but there was no record of this incident.

Care After First Discharge

The care that had been arranged from Harlington Hospice had called twice earlier to an empty flat as it had not been communicated to them that there was a delay.

As there had been no alterations or OT home assessment, Mum's sofa was too low and her bed too high. This resulted in her falling during the night on 31st December whilst she was trying to transfer from her commode to her bed. Careline called us out.

Carers from Harlington Hospice were great, although due to scheduling pressures she was not helped out of bed until 10am which she found distressing. Before breaking her hip/femur she would have got out of bed herself, had a cup of tea and waited for her carer to help her shower, but after spending 26 days in hospital it was noticeable how weak she had got, and how her confidence has depleted, especially after falling in the hospital transport.

She had physio for 5 days after leaving hospital, which was extremely beneficial but not long enough to help her replace the decline in strength over her hospital stay. She did not qualify for re-ablement care although no logical explanation was given and we were never told who the assigned social worker was. No alterations were ever made to her flat to help her with the height of furniture. No phone call was made by the hospital to her care agency as we were led to believe, we sorted that out.

As a family we replaced the mattress to the right height, and we also bought her a new chair which was the right height. We did this as we were financially able to. Had there been conversations at the hospital, and we were there twice a day, we could have agreed between us what would be done before she came home, and who

was going to do it in preparation for her to be safe on arrival.

As it was she came home to an unsafe environment. It took us a few days to procure a new mattress and riser chair for her. During this time she had her first fall on New Years Eve at 11pm transferring from her bed to the commode. She sank to the floor and no longer has the strength to get herself up. This now happens 3-4 times a week which is really distressing for her and us. She no longer has the confidence to go into the kitchen or do the things in the flat that she used to do before going into hospital.

There was also confusion over her medication. She left with a paper bag full of several different boxes of tablets, but a call from the ward after discharge informed us that she shouldn't take one particular tablet at all.

She is surgically fixed but the 26 days in hospital has put back her capability to live a fulfilled independent life. We are now faced with an elderly lady who keeps sinking to the floor. We have requested an OT assessment through the GP, but don't know if we are doing the right thing, or how long it will take to get help and advice. Unfortunately, my mother-in-law was readmitted to hospital within 30 days of her discharge.

Readmission - Saturday 28th January 2017

A week after her 84th birthday, she had the possible symptoms of a stroke, and a painful foot. We weren't too sure what was going on and so rang 111 for advice.

They talked us through diagnostic tests and said a paramedic would be on the way. 2 hours later there still wasn't a paramedic and we were getting further concerned as she was becoming more distressed. The operators on 111 upgraded the call to a 999 call and the ambulance arrived shortly after.

The lovely Hillingdon ambulance crew took us to Northwick Park as they said the stroke unit there was second to none. We arrived at 10pm and she was immediately assessed, had a cannula inserted, and assigned to a High Dependency Unit (HDU). From there

she was taken for a CT scan, a foot xray and other tests. The speed of initial action was impressive. We waited for her to return from the scan/xray. She returned distressed as she has asked to urinate whilst away and her request had been ignored causing her to wet herself.

We waited then until 4:30am when a doctor came to update us on what was happening. The CT scan was clear, it didn't look like a stroke but he explained in detail how something else maybe going on in the body presenting stroke symptoms. We asked how her foot was as she said she couldn't put weight on it. He said he hadn't seen the xray so didn't know.

She was admitted onto the stroke ward at 5am on the Sunday morning, 7 hours after we arrived. On the Monday the consultant pulled up a chair and gave us a very positive account of what would happen. Mum would be dressed in her day clothes and frequently encouraged to walk about and gain mobility, she would have speech therapy and they would work hard on her rehabilitation to get her out as soon as she could walk to the toilet and back. We were very impressed with the level of care and energy that was being invested in her.

Wednesday, four days into her treatment there was a bit of a set back. Someone had at last looked at Mum's xray and the worsening bruising on her foot, and realised that she had in fact broken and possibly dislocated her big toe. There was another incident of a night member of staff chiding her for wanting to urinate again, which distressed her greatly, but on the whole her care was good. She wasn't in fact strong enough to walk to the bathroom and back but they had done all they could medically. It was explained that it is important to get an elderly person home so they don't loose further muscle function/get an infection/become institutionalised.

Second Discharge

Vera was due to be discharged on Monday 6th February, 8 days after her admission. We were hopeful that she had the right care in place. The hospital seemed very aware of the effect of an elderly stay in hospital and were extremely proactive in keeping her mobile on the ward,

and ensuring that she would receive a course of rehab at home.

So everything was arranged, Vera was coming home at 1pm. We had got all her food in for the week, flowers etc and we were feeling positive. We received a call from the hospital discharge coordinator asking what time the carers were arranged for? I explained that I didn't know, as I was told twice by the hospital I did not have to worry about carers, as they would be arranging for us like the last time she was discharged. At Hillingdon Vera had received a supported discharge and we were under the impression this would be reinstated. The coordinator advised me Hillingdon Hospital have just told her Vera is a self-funder, so I needed to arrange something quickly today! I tried the carers who had been looking after Vera but they were not available until the following Saturday. I explained this to the coordinator, but was told if Vera doesn't come home today, they will be transferring her to Hillingdon Hospital.

Why no communication with Hillingdon Hospital before the day of discharge? I do not know. I am still not sure what assessment was done to see what Vera can afford. What I do know is that we do not want her going back to Hillingdon, when she is fit to go home, and I will be my mother-in-law's carer 4 times a day until permanent carers are arranged.

Shirley Clipp
Healthwatch Project Lead - Hospital Discharges

The Hillingdon Hospitals NHS
NHS Foundation Trust

Thank you so much for sharing the findings and recommendations from the Healthwatch Hospital Discharge Project 2016. This detailed project has provided our older patients and their carers an objective, supportive conduit to provide feedback regarding their experiences of discharge from the Trust. The information contained in the report is invaluable and will be used to help us improve discharge processes, and the support available for patients and carers, during this key part of the patient journey.

It was very pleasing to read in the Summary Findings that "the over 65's express an overwhelming feeling of pride in the NHS and hospital services" and that they are "quick to praise Hillingdon Hospital for their caring and attentive staff". Thank you for sharing this positive feedback.

However, it was disappointing to read that a significant number of patients experience poor communication regarding their discharge, and that many did not feel they were involved in the plans for their discharge. It was also concerning to read that some patients perceived a variation in care between day and night shifts and between permanent and agency staff. All our staff are expected to adhere to our "Cares" values and behavioural framework: the quality of care should not vary across different periods of time. The senior nurses for each division are giving this matter their close attention. We also noted the report highlighted marked variation from ward to ward in how discharge processes are implemented, and that inter-agency working is not always joined-up. These areas need addressing to ensure patients are empowered partners in care and that they experience a seamless transition from the hospital to their discharge destination.

We are keen to work in partnership with Healthwatch, Care Partners and other key stakeholders to progress the very helpful recommendations you have made in this report. Specific work already underway includes:

- Redrafting of our Working Together leaflet to encompass suggestions in the report.
- Developing written information for patients and carers in relation to NHS Continuing Healthcare Assessments.
- Continuation of work in progress to review and revise discharge processes and procedures including prescribing and issuing of TTA medication and the format of Multi-Disciplinary Meetings to aid discharge planning.
- Developing an in-house survey to capture patient and carer feedback and satisfaction scores following discharge.

Other initiatives will be scoped and taken forward over coming months.

In conclusion, The Hillingdon Hospitals NHS Foundation Trust welcomes the findings of this report and looks forward to working with colleagues and service users in implementing the recommendations it contains to improve patient and carer experience.

Theresa Murphy
Director of Patient Experience and Nursing

Hillingdon Health and Care Partners

Thank you for sharing the Healthwatch Discharge Project - evidence report for local partners, at the last Older Peoples' Strategy meeting.

I have agreed to provide you a response on behalf of the Hillingdon Health and Care Partnership (HHCP) Accountable Care Partnership (ACP).

This is made up of:

- The Hillingdon Hospitals NHS Foundation Trust (THH)
- Central and North West London NHS Foundation Trust (CNWL),
- H4All CIC, a federation of voluntary sector partners – Hillingdon Age UK, Harlington Hospice, DASH, MIND Hillingdon and Hillingdon Carers
- Hillingdon four GP networks, due to become Hillingdon GP federation from April 2017

Whilst providers may do their own individual responses (assume THH will be responding with regards to their specific in patient issues) the following input has been given from the HHCP partners with particular consideration of their work as part of an ACP.

The report sets out the key areas for consideration:

- Assessment of the quality and effectiveness of discharge and the follow-up care we provide in the community
- How the evidence can inform current work streams
- How we can use the evidence to develop better services for Hillingdon's residents

The recommendations fall into three categories:

1. **Communication and information**

- Working Together booklet – produce 'Patient Journey' (THH)

- Written information about Social services and continuing health care assessments (THH)

2. **Process and procedures**

- Standardising the discharge process across all wards (THH)
- Review of the discharge lounge (THH)
- Additional written instructions – for multiple medications (THH)
- Provision of Dosette boxes (THH)

3. **Clear integration and joined up working**

- Clearer communication between providers – 'Patient Journey' booklet (ALL)
- Joined up approach across all providers in coordinating discharge (ALL)
- Confusion of staff on who and when to refer to services – no signposting (ALL)

We are obviously very concerned to read of some such disappointing experiences people have had in the Hillingdon discharge system but we welcome the recommendations in the report as this provides material on which we can base our service design for older people. Through Hillingdon Health and Care Partners (HHCP), an Accountable Care Partnership (ACP), we have the opportunity to particularly improve the integration of services and provide patient centred care for older people in Hillingdon.

The aim of HHCP is to establish a truly integrated health and social care system. The areas we have identified we need to achieve:

- Addresses individual needs in a holistic way
- Offers more care in the community and in people's homes rather than in acute hospitals
- Invests in prediction, prevention, early intervention and out of hospital services

- Joins up services across organisations and across care settings
- Adopts evidence based pathways
- Concentrates acute services to enable delivery of care in the most appropriate setting
- Offers better overall value for money

The discharge report clearly identifies some significant areas where the experience of people being discharged from hospital requires improvement and the recommendations will be used to influence the work streams that are currently being developed. We are really keen to see the ACP partnership tackle many of the issues you have highlighted that relate to the interface between hospital and the community and we are already working in some areas that we think will be helpful.

Since 2012 there have been developments within the intermediate care pathways and improvements in the admission avoidance (Rapid Response Team -RRT, intermediate care beds) and early supported discharge (RRT, Homesafe, Falls, Take Home & Settle, Early Stroke Discharge and respiratory outreach). However further work can be implemented to continue to build on improving community care with co-ordinated care planning and advance care planning.

Some of the key work areas within our clinical design work include:

- **Information sharing** to prevent the repetition of basic information to several teams (with initial work around due to lack of joined up IT). Some improvement in information sharing from community has recently been noted through access to GP records for hospital staff via Hillingdon Care records.
- **Development of the ICP and development of fifteen care connection teams**

  A centralised care plan is key to coordinating care. The model for the Care Connection Teams (CCT) is based on this principle. Where a patient attends or is admitted to hospital for information is automatically

transferred from the hospital to GP via Docman. These patients are then discussed with the CCT and GP with a view to need for telephone contact / visit to ensure they are stable. This might include proactive calls to the hospital team from the Guided Care Nurse where the patient /family were well known and this information would support safe planning of discharge. In complex cases when a discharge summary was accessed suggesting changes in physical status, care needs, medication and need for follow up (blood tests / clinics / GP review), the patient was contacted.

The new Guided Care Matron (GCM) role enables a holistic review (in the patient home if needed) to ensure understanding of the changes and follow through on actions. This review includes medication reconciliation and compliance (an area being focussed on with hospital pharmacy and community pharmacy support), follow up with other services to support if problems became more apparent post discharge (care connection team / voluntary sector especially) and advice and update of care plan with GP and when needed geriatrician / other specialist. With reduced lengths of stay the requirement for improved timely community support is essential and this service provides a contact and link which was much appreciated by patients as per the pilot feedback.

We will look to promote co-ordinated and advanced care planning.

- We are also supporting THH with **'Patient Journey' booklet** and how this can be successfully implemented and used across all providers

- **Medications issues;** One of the key aspects of concern highlighted in the report is around understanding of new health problems, medications and ongoing follow up post discharge plus physical support / social care input. Whilst there are clearly processes and communication within the hospital trust to improve on, some of this work will be captured through the role out of care connection teams across the borough especially for those complex patients with longer stays.

- **Escalated care plan and workstreams** are based upon the initial Whole systems integration work in the North of the borough and patient voice input about less repetition of story, increased collaboration between differing service and simplification of processes. As a result, those receiving care will have an improved experience and seamless transition between services according to need. Those delivering it will also better understand how to provide optimal care and refer to other services and support appropriately, ensuring less silo working and greater confidence in services available.

- **Review of the current Rapid Response service and step down beds** to be able to support patients with more complex needs, creating access to timely diagnostics and exploring intravenous treatments – the introduction of the geriatrician posts is a start but exploring further options especially around diagnostics and OOH support. We are already seeing a closer working between rapid response team and the hospital for both admission prevention and supported discharge.

- **Streamlining pathways and establishing single point of access (SPA) for community support services including rapid response.** This will include increased ability to provide escalated care in the community (intravenous antibiotics, blood tests) and safely avoid unnecessary admission, assist early discharge. We hope a single contact will make it easier to give patients details of where to call, should they have any problems with access to community services after discharge. We aim to simplify the number of different commissioned Rapid Response pathways to enable the service to take patients according to their needs rather than fitting pathway criteria.

- **Increased community support for patients with more complex needs through enhanced RRT service, ambulatory care pathways and rapid access clinics.**

- **Increased frontline geriatrician support at interface (ED and AMU, telephone support for GP and RRT).**

- **Better integration of intermediate care services** within the borough to enable patients to flow more seamlessly through the pathway. The introduction of a Single Point of Access proposed as part of the escalated care work stream will help in providing a solution to wrap around and integrated care for the patient/carer and act as an information hub for professionals.

Through implementing the above key areas of improvement we aim to have an overall positive impact on the delivery and quality of care for Hillingdon's residents. The key words we need to keep focused on to ensure this succeeds are – Communication, Integration, Ownership and Responsiveness.

We believe that HHCP will be able to offer a really positive contribution to those issues raised in your report relating to the interface between acute and community care and look forward to getting more feedback following redesign.

Jo Manley: ACP Programme Director on behalf of Hillingdon Health and Care Partners

HILLINGDON
LONDON

Thank you for sharing your report at November's meeting of the Older People's Strategy Group and I think that this will be helpful in supporting the drive for change within the local health and care system.

The purpose of this letter is to respond to some of the key issues raised that are pertinent to Adult Social Care.

PRE-DISCHARGE

Patient Information

The report reiterates importance of having available clear information for patients about the discharge process so that they know what to expect and what choices are available to them.

You will be aware from the November meeting of the Joint Hospital Discharge Pathway Group that a task and finish group is being established that will look at the information available and how this can be improved, including the development of a 'Patient Journey' booklet. The level of detail about access to social care to be included in this, including an explanation of the National Eligibility criteria and also about the fact that social care support is subject to a financial assessment, is something for this group to consider. What is clear is that we collectively need to ensure that clear information is available and distributed in a consistent way to patients.

Processes and Procedures

The need to standardise discharge processes across all wards has been acknowledged by health and care partners and there is work in progress through the Hospital Discharge Pathway Group to develop a formal procedure intended to support patient choices that will provide clarity about roles and responsibilities across all partner organisations. The aim is to have this sign-off by partner organisations by the end of 2016/17.

Joint Discharge Team

It is interesting that some staff expressed confusion about the role of the Integrated Discharge Team and again identifies communication issues. The intention for 2017/18 is for the Hospital, the Council and the CCG to work together to secure a decision about funding in Q4 2016/17. This will then provide an opportunity to ensure that staff are fully briefed to avoid continuing confusion going into 2017/18.

POST-DISCHARGE CARE

There were a number of points highlighted in your report about post-discharge care that I think can be summarised under the headings of information and communication, roles and responsibilities and the local homecare market. I will address each of these in turn.

Information and Communication

The issues identified in your report about people being supported by the Reablement Team not knowing what would happen to them after their period of reablement and also people not understanding what package of care to expect relates very much to the general theme about the availability of suitable information and also about communication. This is something that will be looked at as part of the patient information task and finish group referred to above.

Roles and Responsibilities

The Council has noted that for some service users the number of care workers providing their care and the frequency of attendance did not match their expectations. We believe that this relates to the blurring of lines of responsibility between medical and social work staff. The new policy and procedure referred to earlier will help to clarify the decisions that properly sit with the respective professionals and this should assist in relieving scope for service users being left confused.

Local Homecare Market

Your report identified an issue about care workers not attending at times that fitted in with service users' routines. This is not an unreasonable request from

service users and the Council has done a lot of work with homecare providers to improve capacity and stabilise the local market to help deliver this. Unfortunately, where a lot of people require calls at particular times of the day, e.g. early morning, this is not always possible, especially as priority has to be given to those whose circumstances necessitate calls at specific times of the days, e.g. because of medication needs.

The Council will continue to work with providers to improve the capacity and quality of homecare provision and Healthwatch will continue to have a vital role in providing feedback on the service user experience of care. However, you will be aware that the nature of the homecare market in a high employment area such as Hillingdon means that this is not an easy issue to address.

The final point in respect of homecare was about care workers not staying for the allocated time. This is an issue when the care worker charges for care that has not been delivered; if they manage to complete what is required within a shorter period of time and only charge for the time present then this is not an issue. Where a care worker claims for time delivering care that has not been provided then this is likely to constitute fraud and there have been criminal prosecutions in Hillingdon in recent years where this has occurred. Where the Council becomes aware of these instances we will liaise with the Police to ensure that there is a thorough investigation and prosecution where there is sufficient evidence.

Going forward all of the Council's homecare providers will be required to use electronic call monitoring systems and this means that they will then only be paid for the time recorded. This should reduce the scope for this to occur in the future.

I hope that you have found this information useful and please do not hesitate to come back to me if you have any further queries or if you think there are any points that have not been addressed.

Gary Collier
Health and Social Care Integration Manager

CONCLUSION

The evidence we have collected during our research has provided us with a valuable insight into older people's experiences of being discharged from Hillingdon Hospital, and the care and support provided to them in the community.

We acknowledge that health and social care services are under extreme pressure. However, we believe that to maintain high quality services in these challenging times, it is even more important to focus on patient experience.

By engaging with our residents we have provided a rich source of information for commissioners and providers to gain a better understanding of the care delivered to Hillingdon's older residents, and how local people feel the quality of their care can be improved.

Our insight suggests that it is overwhelmingly clear that better information and communication between patients, care staff and organisations, are key if services are to be developed and improved. It could be argued that achieving this maybe the most important factor to transforming care services in Hillingdon.

Organisations have responded positively to our report and have acknowledged that improvement is needed.

A number of the recommendations outlined in the report have already been implemented.

Our evidence has also informed the Better Care Fund and additional actions have been added to the delivery plan, which is monitored at the Hillingdon Health and Wellbeing Board.

We look forward to continually working with, the public, commissioners and providers to improve care for our older residents.

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EXTERNAL SERVICES SCRUTINY COMMITTEE - WORK PROGRAMME 2016/2017

Contact Officer: Nikki O'Halloran
Telephone: 01895 250472

Appendix A: Work Programme 2016/2017
Appendix B: Work Programme 2017/2018

REASON FOR ITEM

To enable the Committee to track the progress of its work in 2016/2017 and forward plan its work for the new municipal year.

SUGGESTED COMMITTEE ACTIVITY

1. To agree (in principle) the proposed Work Programme for 2017/2018, attached at Appendix B, and make any amendments as necessary. This Programme will be subject to review once the new Committee has been appointed at Annual Council on 11 May 2017.

INFORMATION

1. This is the penultimate meeting of the Committee during this municipal year.

2. Members are asked to suggest possible future review topics for consideration by the External Services Scrutiny Committee during the next municipal year.

3. The new membership of the Committee for 2017/2018 will be appointed at Annual Council on 11 May 2017. The Committee has previously requested that a Working Group be set up to review Community Sentencing and has agreed the scoping report and membership for the review. The scoping report will be resubmitted to the new Committee at its meeting on 14 June 2017 for Members to decide whether or not they wish to proceed with the review. Should the new Committee not wish to proceed with the topic suggested by the previous membership, it may agree an alternative topic for review.

BACKGROUND DOCUMENTS

None.

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APPENDIX A

EXTERNAL SERVICES SCRUTINY COMMITTEE

2016/2017 WORK PROGRAMME

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

Shading indicates completed meetings

Meeting Date	Agenda Item
15 June 2016	**Health** To receive the following updates: 1. North West London Collaboration of CCGs - NWL mental health 'Like Minded' strategy 2. Strategic service delivery plan for Out of Hospital Care
12 July 2016	**MEETING CANCELLED**
15 September 2016	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon **Health** To receive a performance update and the annual report of Healthwatch Hillingdon.
6 October 2016	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. London Fire Brigade 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (CCG) 8. Public Health **London Fire Brigade** To receive an update on the impact of hoax calls and action being taken to deal with hoax callers. To identify whether or not there is provision for the Fire Brigade to provide medical services in the absence of the ambulance service.

Meeting Date	Agenda Item
15 November 2016	**London Ambulance Service** - update on the action plan following the CQC inspection
12 January 2017	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon **Major Review 1 (2016/2017) - Community Sentencing**: Consideration of a scoping report and the formulation of a Working Group to undertake a major review on behalf of the Committee
15 February 2017	**Child Sexual Exploitation (CSE)** Update on the work being undertaken by the Council to prevent CSE.
15 March 2017	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. Metropolitan Police Service (MPS) 2. National Probation Service 3. Youth Offending Service
26 April 2017 (*additional meeting*)	**Quality Account Reports & CQC Evidence Gathering** To receive presentations from the local Trusts on their Quality Account 2016/2017 reports and to gather evidence for submission to the CQC: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Central & North West London NHS Foundation Trust 3. Healthwatch Hillingdon
27 April 2017	**Quality Account Reports & CQC Evidence Gathering** To receive presentations from the local Trusts on their Quality Account 2016/2017 reports and to gather evidence for submission to the CQC: 1. Royal Brompton & Harefield NHS Foundation Trust 2. The London Ambulance Service NHS Trust 3. Hillingdon Clinical Commissioning Group (HCCG)

Possible future single meeting or major review topics and update reports
1. CAMHS - possible joint major review with Children, Young People and Learning POC in 2016/2017. 2. Fire Brigade / LAS - the impact of hoax calls and action being taken to deal with hoax callers. Is there provision for the Fire Brigade to provide medical services in the absence of the ambulance service? 3. First responders - is consideration being given to introducing these in Hillingdon? 4. Community Sentencing - how many community sentences are given out, how effective is community sentencing, how does community sentencing work, what type of work is involved in a community sentence? 5. Safe and Sustainable - update on the proposal to withdraw paediatric congenital cardiac services from the Royal Brompton Hospital. 6. Child Sexual Exploitation - update on the partnership work being undertaken in the Borough to address CSE. 7. Domestic Abuse - the provision of mental health support services available to victims. 8. Utilities - to look at the strategic provision of utility services for a growing population in the Borough. 9. Community Policing / Ward Panels / Safer Neighbourhood Board - update. 10. London Ambulance Service - update on the action plan following the CQC inspection.

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APPENDIX B

EXTERNAL SERVICES SCRUTINY COMMITTEE

2017/2018 WORK PROGRAMME

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

Shading indicates completed meetings

Meeting Date	Agenda Item
14 June 2017 ***Report Deadline**:* *3pm Friday 2 June 2017*	**Update on the implementation of recommendations from previous scrutiny reviews:** • Alcohol Related Admissions Amongst Under 18s **Major Review (2017/2018):** Consideration of scoping report.
11 July 2017 ***Report Deadline**:* *3pm Friday 30 June 2017*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
14 September 2017 ***Report Deadline**:* *3pm Monday 4 September 2017*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. London Fire Brigade 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (CCG) 8. Public Health
11 October 2017 ***Report Deadline**:* *3pm Friday 29 September 2017*	**Major Review (2017/2018) - Community Sentencing:** Consideration of final report from the Community Sentencing Working Group **Minor Review (2017/2018):** Consideration of scoping report.

Meeting Date	Agenda Item
14 November 2017 ***Report Deadline**:* *3pm Thursday 2 November 2017*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
11 January 2018 ***Report Deadline**:* *3pm Tuesday 2 January 2018*	
13 February 2018 ***Report Deadline**:* *3pm Thursday 1 February 2017*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. London Fire Brigade 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (CCG) 8. Public Health **Update on the implementation of recommendations from previous scrutiny reviews** **Minor Review (2017/2018):** Consideration of final report from the Working Group.
14 March 2018 ***Report Deadline**:* *3pm Thursday 1 March 2018*	**Quality Account Reports & CQC Evidence Gathering** To receive presentations from the local Trusts on their Quality Account 2016/2017 reports and to gather evidence for submission to the CQC: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Central & North West London NHS Foundation Trust 3. Local Medical Committee 4. Public Health 5. Hillingdon Clinical Commissioning Group (HCCG) 6. Care Quality Commission (CQC) 7. Healthwatch Hillingdon
Possible future single meeting or major review topics and update reports	

PROPOSED MAJOR SCRUTINY REVIEW (WORKING GROUP)

Members of the Working Group:

- Councillors Allen, Dann, Edwards, Higgins, Khatra and Palmer

Topic: Community Sentencing

Meeting	Action	Purpose / Outcome
ESSC: 14 June 2017	Agree Scoping Report	Information and analysis

Working Group:
1st Meeting -
w/c 26 June 2017
	Introductory Report / Witness Session 1	Evidence and enquiry:
		• Magistrates
		  ○ How many community sentences given? For what duration?
		  ○ How many repeat offenders?
		  ○ Magistrates' expectations of community sentences?
		  ○ Standards expected from offenders (e.g., behaviour, attendance)?
		  ○ Do Magistrates think community sentencing works well? How could it be improved?

Working Group: **2nd Meeting -** 20 July 2017	Witness Session 2 (Management)	Evidence and enquiry: • Community Rehabilitation Company • National Probation Service ○ How does the management split work in practice?
Working Group: **3rd Meeting -** w/c 31 July 2017	Witness Session 3 (Operational)	Evidence and enquiry: • Community Rehabilitation Company ○ What community sentence work is done in LBH and how often? • ASBIT
Working Group: **4th Meeting -** w/c 18 September	Draft Final Report	Proposals – agree recommendations and final draft report
ESSC: 11 October 2017	Consider Draft Final Report	Agree recommendations and final draft report
Cabinet: 16 November 2017 *(Agenda published 8 November 2017)*	Consider Final Report	Agree recommendations and final report

Additional stakeholder events, one-to-one meetings and site visits can also be set up to gather further evidence.

MINOR SCRUTINY REVIEW (WORKING GROUP)

Members of the Working Group:

- Councillors TBA (4 Conservative / 2 Labour)

Topic: TBA

Meeting	Action	Purpose / Outcome
ESSC: **TBA**	Agree Scoping Report	Information and analysis
Working Group: **1st Meeting - TBA**	Introductory Report / Witness Session 1	Evidence and enquiry
Working Group: **2nd Meeting - TBA**	Witness Session 2	Evidence and enquiry
Working Group: **3rd Meeting - TBA**	Draft Final Report	Proposals – agree recommendations and final draft report
ESSC: **TBA**	Consider Draft Final Report	Agree recommendations and final draft report
Cabinet: **TBA** *(Agenda published TBA)*	Consider Final Report	Agree recommendations and final report

Additional stakeholder events, one-to-one meetings and site visits can also be set up to gather further evidence.