Central and North West London NHS
NHS Foundation Trust

Appendix A

Draft Quality Account 2015-16

v.6.0.0

Glossary of terms

CAMHS	Child and Adolescent Mental Health Service
CMHT	Community mental health team
CNWL	Central and North West London NHS Foundation Trust
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
ED	Eating Disorder services
FFT	Friends and family test
GP	General Practitioner
GUM	Genitourinary medicine
HMP & YOI	Her Majesty's Prison & Young Offenders Institution
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
Q4	Quarter 4
SPA	Single Point of Access
SRH	Sexual and reproductive health
TCN	Trust Clinical Network
YTD	Year-to-date; an aggregation of performance data over 2015/16

Contents

Part 1 – Letter from our Chief Executive

This is Central and North West London NHS Foundation Trust's (CNWL) Quality Account for 2015-16.

The Quality Account tells you our quality story for the year, how we have performed against the quality priority that we set through consultation last year, and what we are going to focus on in this new financial year.

We have ended this financial year with 92% of the patients we asked telling us that they would recommend CNWL's services to their friends and family, and 97% telling us they felt treated with dignity and respect. This is truly a testament to our staff, our patients, carers and our public who work in partnership with us to help us continuously improve.

Last year our focus was rightly on learning from our CQC inspection. In February 2015 a team of over 100 CQC inspectors visited 137 wards and teams in our Trust. In June they told us that they had rated us overall as 'Requires Improvement' with our rating for Caring as 'Outstanding.' This demonstrates to us that our staff live the Trust values of Compassion, Respect, Empowerment and Partnership. We had other bright stars: Sexual Health services were considered 'Outstanding,' Mental health services for children and young people were rated good as were our mental health crisis and rehabilitation services for adults, community mental health services for older people, our forensic wards and our Learning disability and autism wards. This is a reminder that we serve some of the most vulnerable in society and our staff do this with such compassion and care. We were disappointed with our ratings for our London adult mental health inpatient services but set about ensuring that we learned from this inspection. We constructed an action plan in response to the 24 areas that CQC said we must take action and every month reported back to the CQC on our progress. We set ourselves some tough challenges and I am pleased to report that we have met these. We've reduced our bed occupancy rates from 116% to just around the 100% mark and whilst the bed problem is a national one I am so pleased that we rarely have anyone wanting more than 24 hours for a bed or 'sleep out' on another ward. We monitor how we use our beds every day because we want to make sure that we are using this resource effectively but we also know that bringing service users into hospital when we can better manage their care at home or in the community can slow down their recovery. We've also taken action to reduce the number of patients who have absconded from our wards and are on track to deliver a 50% reduction. And we've almost halved the number of face down physical restraint incidents on our inpatient mental health wards. This is such important work in terms of patient safety and maintaining patient dignity and respect.

In January this year we sent the CQC our final action plan and we continue to maintain this important work.

Last year having listened to our stakeholders we decided to focus on 'Effective Care and Treatment Planning'. To do this we prioritised three things and heard from over 6,700 patients across the year:

- Involvement in care and treatment planning as we know that the more involved patients are the more likely they are have better health outcomes. Ninety-six per cent told us they felt involved, when we looked at those who said they were definitely involved this was eighty-two per cent.
- Putting patients at the centre of measuring improvement by asking them if their care and treatment helped them achieve

the things that matter to them. Ninety-one per cent told us it did.

- We continue to recognise the impact and important roles carers and families play in helping their loved ones recover and so through our Carer's Council we had a conversation with a number of our carers to ask them what we could do to help them. As a result of this the Carer's Council is holding its first Conference later this year.

But we're not complacent; we know there are some services where we need to improve. We know that some of the big changes we have made to services and some of our recruitment problems have impacted on how patients feel about their care and treatment. This too has an impact on staff and whilst we have some of the best scores on staff engagement, staff recommending us as a place to work or receive care and treatment in the National Staff Survey we are making sure that staff too are at the heart of our quality priorities. We know that if our patients are to experience better care our staff also need to feel better cared for. So this year we are making quality all about our staff, patients, and carers in partnership: the perfect 'triangle of care'. At our Quality Summit in March this year we were privileged to hear from Dr Kate Granger MBE who started the #hellomynameis campaign. Kate told us how this simple gesture that we take for granted has the power to change a patient's experience of care; 'we stop just being the patient and doctor or nurse, we become two humans interacting at a time of great need.' So this coming year we are going to make quality less about metrics and more about cultural change and commitment. We are asking our staff and teams to pledge their support for the #hellomynameis campaign. We know that some of our services in Camden are already signed up and I am going to ask our Trust Board to do the same. Our two big programmes of Staff Engagement and Patient and Carer involvement are each led by an Executive Director and our Quality Account sets out what we hope to achieve and how we will demonstrate the impact of our actions.

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

Claire Murdoch RMN
Chief Executive

May 2016

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 in May 2016]

May 2016

KPMG LLP, Statutory Auditor

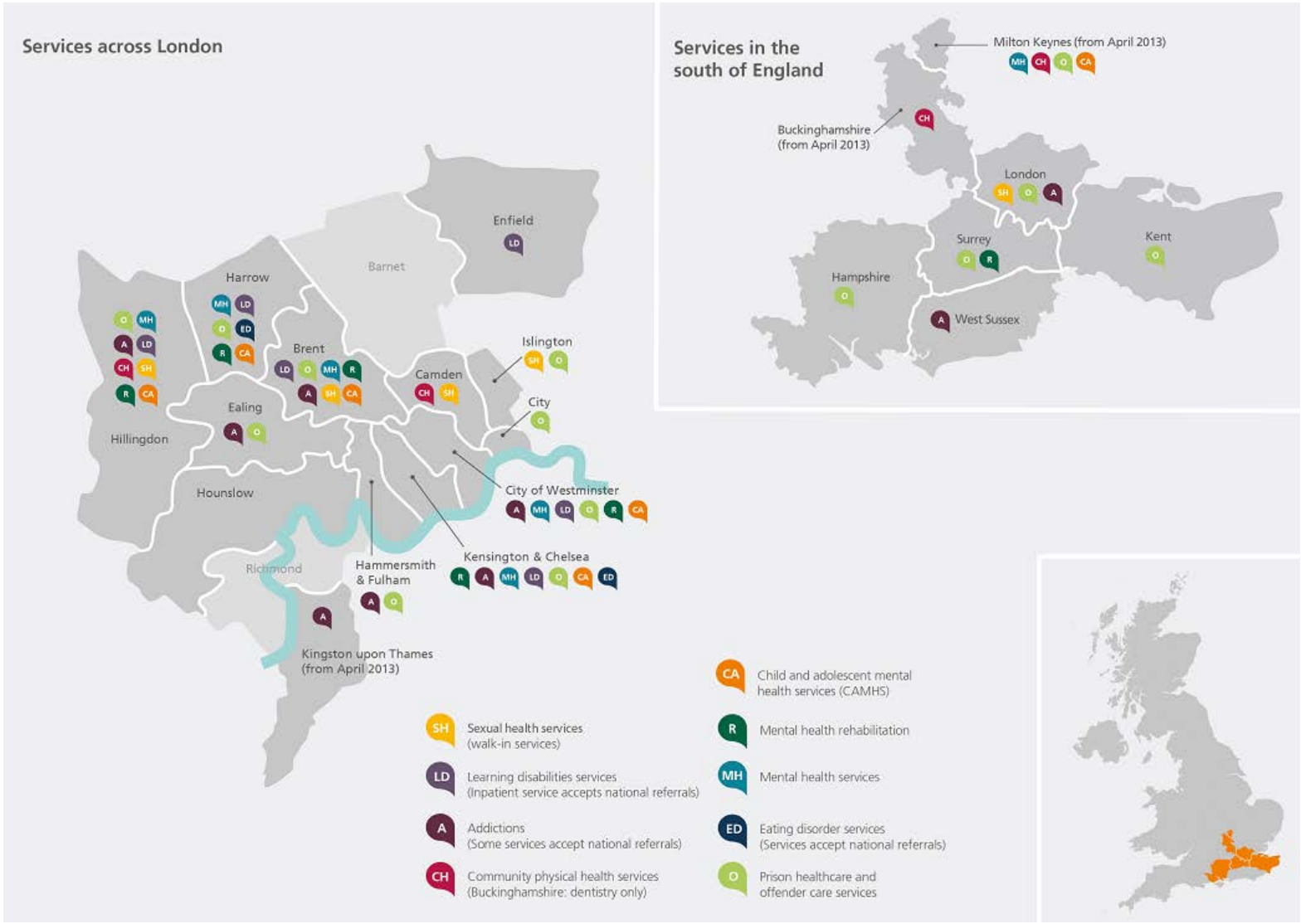
KPMG LLP

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 provide an update on our Quality Priority for improvement which we set last year in partnership with our patients, carers, staff, commissioners, Healthwatch and public. We provide a brief overview of our Trust-wide achievement, which is followed by the more detailed updates from our localities and specialist services.

In Section 2.2 we describe our Quality Priority plans for 2016/17 and include our statements of assurance from our Trust Board.

Two key changes from last year:

This year our Quality Account has been developed to be far more local than ever before.

This is in response to requests from our local stakeholders wanting local information, given the diverse nature of our organisation.

This year we have further developed our approach to support this so in this section we provide brief comment on our overarching achievements, and then a **focus on our localities and specialist services**.

Secondly, this year we present **all our data as 'year-to-date' as standard** which is an aggregation of performance across the four quarters. In previous years some indicators were reported as at Quarter 4. This shift is to make data reporting consistent and easier to understand, and provide a representative picture when the data is broken down by locality or service.

Section 2.1 Quality Priorities 2015/16 – A Trust-wide review of how we did

Our expectation is that the care we deliver embodies our Trust values of compassion, respect, empowerment and partnership; and that our care is **safe**, **effective** and **achieves the health outcomes** that matter most to our patients and their families.

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test.

'Friends and Family Test'

We are pleased to report that by the end of the year 92% of 4,416 patients told us that they would be **likely or extremely likely to recommend CNWL services** to their family and friends. We looked at this further to understand how this compared to similar Trusts: The chart below shows that we are on par with other Trusts providing similar community and mental health services.

Our Friends and Family Test feedback cards:

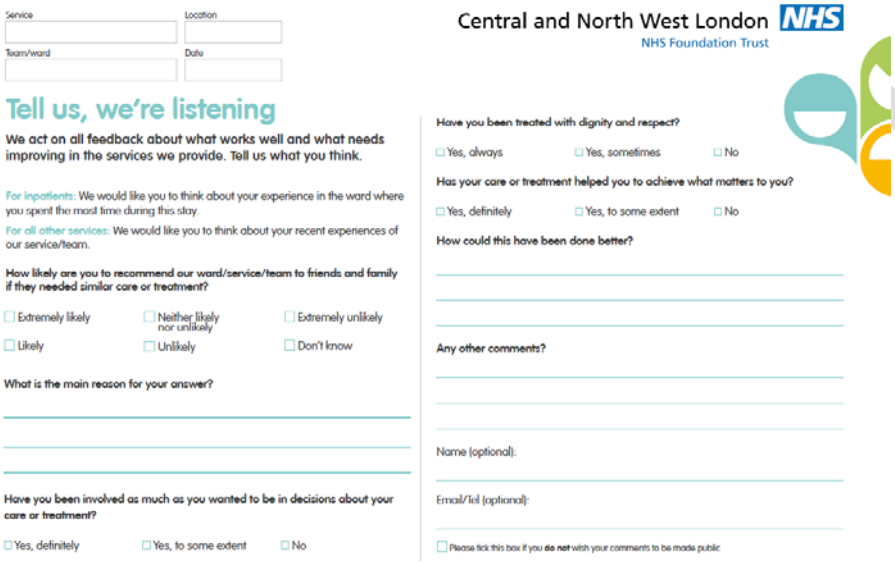
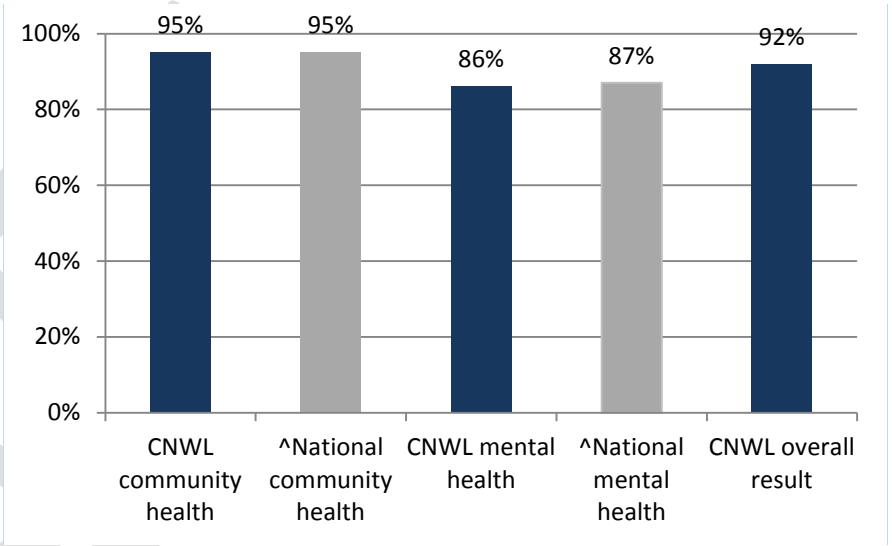


Chart 1. Our patient Friends and Family Test results, compared with the national average



Key: ^ NHS England patient FFT national results (at February 2016, to be updated on 12 May 2016)

Patients told us what they value most and what has the greatest impact on how satisfied they feel:

- *Without doubt our staff are the key to how patients feel about our services – the majority of comments received complimented our staff for being caring, competent and professional*
- *Patients were more likely to be happier when the felt supported and involved in their care and treatment*
- *Patients wanted to better information on their conditions and what their treatment and care would include*
- *Long waits to start care and treatment*
- *More options and flexibility when booking appointments*

These comments are fed back to services to inform local improvement plans and you can find more detail in the local reports on pages 14-70.

Our Quality Priority 2015/16 achievement

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning'.**

To understand whether or not the actions we took were having an effect we tested 3 things:

- *We wanted more than 75% of our patients to tell us that **they felt involved** in their care or treatment*
- *We wanted more than 85% of our patients to tell us that they received the care or treatment that helped them achieve **what mattered to them***
- *We wanted to **support carers** to be involved in care or treatment, and to have the information they needed to best support their loved ones*

Throughout the year we collected feedback from our patients and carers through various surveys, focus groups and meetings and we heard from over 6,700 patients.

Based on feedback, we put in place improvement action and further details are described in the local reports on pages 14-70.

The following provides a Trust-level picture of how we performed against these Quality Priority indicators.

Overall, we are pleased to report that we have achieved our three indicators for 2015/16:

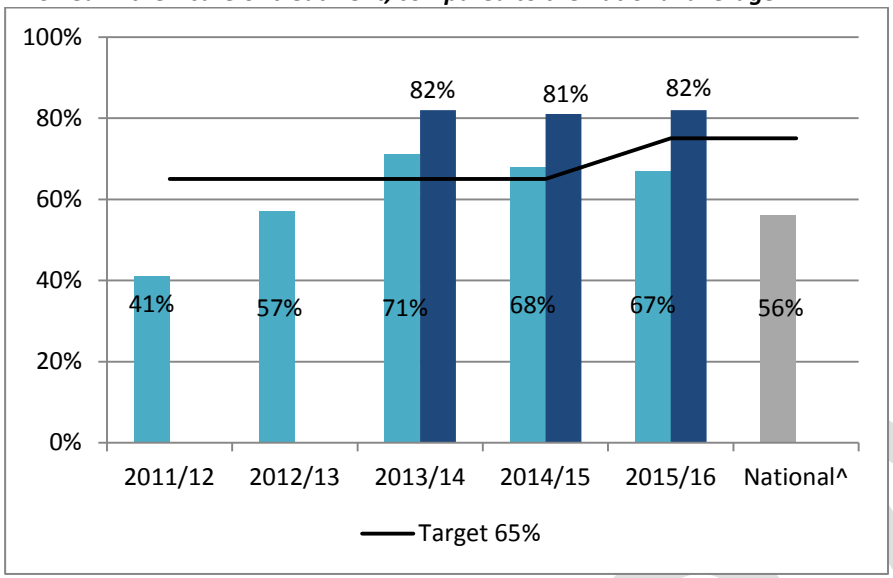
Indicator 1: Patients tell us that they felt involved in their care or treatment

Getting this right means that patients are at the centre of planning, have ownership of their plan, and know what they and health and social care professionals need to do to help their recovery. There is evidence that tells us that the more involved patients are in decisions about their care and treatment the more likely it is that they will experience better health outcomes.

This year we increased the target from 65% to 75%. At year end, 82% of patients told us that they felt 'definitely' involved in their care or treatment; a slight improvement on our performance in 2014/15.

Involvement in care planning is particularly central to the delivery of mental health services, so we have displayed the results for these services separately to show trend information. At year end, mental health services achieved 67%, a very slight decline on last year – suggesting that our initial year-on-year increase has plateaued. We are pleased however, that our performance is well above the 56% national average as reported in the national community mental health survey 2015. Chart 2 displays these results.

Chart 2. The year-on-year results from patients reporting that they definitely felt involved in their care or treatment, compared to the national average



Key: [light blue]: CNWL mental health service results; [dark blue]: CNWL overall results; [grey]: National average from Quality Health Ltd 2015 NHS community mental health service user survey
Note: 2015/16 data is presented as year-to-date (an aggregation of all quarters), while previous years data is reported as at Quarter 4.
— Target 65%, increased to 75% in 2015-16

We also wanted to consider those who told us they felt involved to 'some extent', and so combining these with those who reported feeling 'definitely' involved we achieved 96% Trust-wide; and 91% in mental health.

This tells us that for the majority of patients we are well on the way to getting it right.

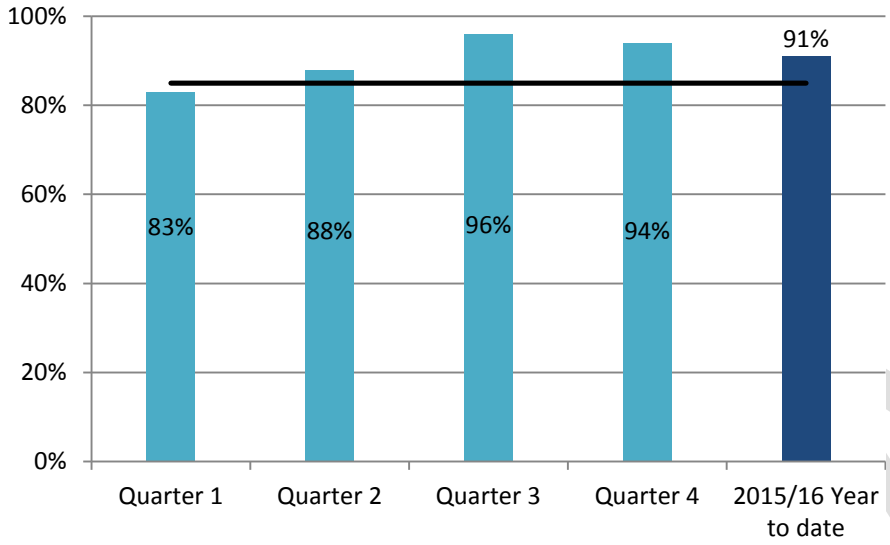
We continue to out-perform the national average, but we recognise the importance of maintaining this position and making sure all of our services deliver to this high standard.

Indicator 2: Patients tell us that they received the care or treatment that helped them achieve what mattered to them

This helped us understand whether the care or treatment planned was effective *from the patient's point of view*.

As this indicator was new for us, we based the target on our performance at Quarter 1: We achieved 83%, and so the target was set at a minimum of 85%. Chart 3 shows our quarter-on-quarter progression, and the final year-to-date reported position.

Chart 3. The quarter-on-quarter and year-to-date results from patients reporting that their care or treatment helped them achieve what mattered to them



Key: [light blue]: CNWL quarterly results; [dark blue]: CNWL 2015/16 year-to-date result
Target 85%

The chart shows an initial quarter-on-quarter increase and an aggregated Trust position of 91% at year end, exceeding our target.

Based on our mental health surveys we achieved 89%, and 92% in our community health surveys; both above our internal target.

Further detail can be found in the local reports on pages 14-70.

Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one

Our Carer's Council has done much work this year to achieve this with the highlights provided below.

CNWL's Carer's Council, chaired by a carer representative, works to improve the carer experience across the Trust, establishing the Trust's annual carer priorities and making sure the carers' collective voice reaches to the heart of the organisation.

The Council has a diverse membership drawn from across the Trust's services and has strong links with community organisations. As well as Carers and Carer Governors, membership includes the Chief Operating Officer, the Associate Director of Quality and Head of Patient and Carer Involvement.

We have listened to our carers and we know there is a long way to go but we are committed to getting it right. The issues raised by our carers have led to key developments in the areas of involvement and information provision over the last year:

Carers wanted more of a voice within the Trust:
The Carers Council co-produced a Carers Survey that we use to gather the views and experiences of carers, and our council members outreach to carer groups and organisations.

We have increased the frequency of our Carers Council meetings this year to make sure we are sharing and acting on this feedback more effectively. The Chair of the Council, a local carer, attended

the Trust Board in January and Non-Executive Directors are supporting the Carers Council with their work-plan.

Carers need more information to support them in their caring role:
We have co-produced a Carers Information Leaflet with our carers. The leaflet contains information requested by our carers as well as support and resources available locally. This is being updated and will be available by May 2016.

Carers want more involvement in the care and treatment of their loved ones:
As reported last year, CNWL staff and carers have co-produced a short film *'The Last Time We Spoke'* to highlight the barriers to inclusion faced by carers and to promote equal partnership working between our carers and staff. Carers are now co-delivering this training resource to our Trust staff as part of our Recovery and Wellbeing College programme.

Carers would like more support from peers, support groups and staff:
A number of local carer forums have been established in our local services including in community, mental health and learning disabilities services. Many of our services now have Carers leads identified and we will continue to roll this out. We are training our Council members to guide and support them in their role as Peer leads.

Carer's Conference 2016:
We are planning a co-produced Trust-wide Carers' Conference to take place in October 2016 in central London that will focus on outreaching to carers requiring support in accessing and engaging with our services, and highlighting the resources and support available. We hope to launch a Carers booklet at the event and kick off a new work programme. Non-Executive Directors from the Trust Board are supporting the Carers Council with this.

What else did we monitor?

There are a number of other indictors against which we monitor our performance to ensure we deliver safe, effective care which is results in a positive patient or carer experience. These include historical Quality Priorities as well as our Monitor targets. Details of these can be found in Part 3.

Patient and carer experience and involvement

Involvement is not just limited to patients' care or treatment planning. In this section we tell you more about our work to engage and involve our patients and carers across the organisation.

Trustwide examples:

- **Recruitment and Selection**

We have a growing database of trained patient and carer interviewers from across the Trust involved in the recruitment, assessment and interviewing of a wide range of staff across our services including administrative staff, clinicians including consultants, team leaders, service managers and directors.

- **Quality Inspections**

In November 2015, CNWL carried out an internal Quality Inspection across the Trust. We organised approximately 140 inspectors, from staff, patients, carers and external stakeholders into teams, and reviewed our services using the CQC's key lines of enquiry.

- **Trust Clinical Network Consultation and Engagement**

In January 2016, the Trust hosted the Clinical Networks Engagement Event to help shape our programme to improve Physical and Mental Healthcare integration across the Trust. Over 50 people including staff, patients, carers and partner agencies attended the event and shared their views.

- **Service User Monitoring Team**

Central to improving the quality of our services is gathering feedback from our patients and carers and responding to it. A diverse team of patient interviewers conduct regular peer-to-peer telephone surveys across the Trust.

Local examples:

- **Community Services**

The Camden Active Living Group (CALG) user and carer group enables people using Camden Community Services to become involved in the planning, design and delivery or services and to play an active role in promoting person centred care.

The End of Life Care Service in Camden has involved patients in 'Discovery Interviews'. Discovery Interviews are a recognised technique designed to improve patient care by listening to their experiences as a way of gaining insight into their needs.

The Diggory Patient Engagement Roadshow took place in November and December 2015 visiting Milton Keynes Community Services and Milton Keynes Mental Health Services. The Roadshow captured evidence of work in progress and outcomes as a result of patient engagement, identified challenges faced by services in relation to patient engagement and gave services the opportunity to make recommendations about patient engagement which are now being taken forward.

- **Sexual Health and HIV**

Sexual Health Services pioneered the quick feedback cards and we receive over 1000 every quarter. In response to patient feedback, early morning appointments are available 4 days a week at Mortimer Market Centre and a Saturday GUM clinic at the Archway Centre is being piloted to improve access for patients who have asked for more flexible access to services. The Bloomsbury Patient Network continued to provide an exemplary peer-led service of free advocacy, advice, workshops and support to people living with HIV to improve the patient experience.

- **Mental Health**

This year saw a significant redesign of our Mental Health services beginning with the launch of our new Single Point of Access (SPA) service.

The SPA User and Carer Reference Group involved patients from across the Trust's mental health services in the development and launch of the new service and co-produced a SPA service leaflet. Service Redesign Events were held regularly in all boroughs inviting local Healthwatch members, service user and carers.

The *Different Voices* Inpatient Involvement Project continued to hold weekly Patient Forums and surveys on the inpatient wards in Kensington, Chelsea and Westminster to make sure patients on our wards have a voice.

- **Learning Disability**

The Learning Disability Service's Care Quality Meetings and Care Quality Inpatient Meetings have regular attendance and input from patients.

Patients are also engaged in weekly *Speak up Forum* meetings at their centres to identify areas they wish to discuss and develop. The service produces a montage of the positive comments received and a list of changes undertaken as a result of patient and carer feedback.

- **Children and Young People**

Innovative approaches are used to involve our younger service users such as a designated *Feedback Week* every quarter in CAMHS services.

- **Addictions and Offender Care**

The inspiring *Head Back into Treatment* Poster designed by a service user was the winner of a competition held at the annual CNWL Addictions Service Users Conference "Engage" in June 2015. It is designed to encourage service users to re-engage with addictions services and get back into treatment. The poster has been printed and laminated and is now displayed in all of our Addictions services.

Offender Care Services are rolling out an adapted version of the Friends and Family test making us one of the first Trusts in the country to use this survey in Offender care services.

Strengthening our learning culture – An update

Last year a theme for action from our consultations was to focus on strengthening our learning culture. We said this would be taken forward as business as usual, and we would like to provide an update on the action we took to support a culture of continuous learning.

Here are some of the things we did:

- We launched our Learning and Improvement Guide in September 2015. This guide describes how we expect learning to take place throughout the organisation from team to board and across services.

- Our Listen, Learn and Act quarterly newsletter shares learning from our patient, carer and staff feedback, incidents, and our performance against standards. To encourage front line staff to share their learning stories we have introduced a prize for the best story which would be show-cased in the newsletter. For example, our Quarter 2 winners were our Serious Incident Investigation Team, who shared learning based on a compliment received for a family which highlighted the importance of keeping relatives informed, updated throughout the sometimes difficult investigation or complaints process.

- We have signed up to the national 'Sign up to Safety' campaign, and our five pledges include the topics of violence and aggression, medication omissions, suicide and self-harm, falls and pressure ulcers. Further detail of this work is described in Part 3.

- Divisions have set up programmes of 'Learning Walks' through which groups of staff form one service review another's, so creating a culture of shared learning. We have seen some great examples where clinical teams have created time and space to reflect and learn from incidents and feedback. Next year we will focus on rolling this out across all teams.

- We set up a Trust-wide internal Quality Inspection in November 2015. This included both corporate and clinical staff, patients, carers, commissioners and Healthwatch. We received very positive feedback from all who were involved as it allowed 'cross pollination' of good ideas and relationship building. Outcomes from the Quality Inspection were fed back to staff in a large engagement event earlier this year. We are proud of this initiative and will continue this next year.

- To create greater understanding, connection and learning between corporate and clinical services we introduced an initiative for corporate staff to spend a day shadowing or supporting clinical teams. This has received positive feedback with staff feeling better engagement. This initiative also needs further development over the next year.

Our plans to continue to embed a culture of learning for 2016/17 are currently under review with our Organisational Learning Group to ensure this important work is maintained and improved upon.

Our performance against our Quality Account Priority and indicators was monitored throughout the year by the Quality and Performance Committee, and overseen by the Board of Directors. These were a key focus for our Divisional Boards and local care quality groups to monitor performance, and design and implement improvement programmes where required.

We also reported our performance externally to our commissioners the Clinical Quality Group. The aim was to facilitate open dialogue; to discuss quality of services, share monitoring information and feedback key messages. Our quality and performance reports were also published on our website.

Section 2.2 Quality Priorities 2015/16 – A locality and specialist service review of how we did

The following pages present **local and specialist service quality information**, from performance against quality measures to themes and learning from complaints and initiatives achieved or planned through the year. Further information and data tables can also be found in Part 3.

Our locality and specialist service page contents

Brent

Our services

We provide a wide range of mental health services in Brent for children and young people, working age adults through to older people. Services include acute, community mental health services, older people's healthy ageing services and psychological medicine services. We also provide addictions and sexual health services in Brent.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	100%	90%
Staff FFT (Target: minimum 66%)	51%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions we have taken to improve:

For our patients and their families or carers

- Quarterly patient and carer events are taking place to facilitate and improve open dialogue and reinforce the importance of carers being involved in care planning and recovery.
- Our Brent User Group (BUG) is running a project to increase awareness of the recovery approach and supports staff to encourage patients to apply for self-directed support funds.
- Work to improve our Adult Community Mental Health Services in Brent took place in 2015, led locally by the Borough Directors from CNWL and Brent Local Authority. A wider audience were involved to redesign our community services - our staff, patients, carers, local authority staff and with Brent's Clinical Commissioning Groups (CCG). The teams have been restructured to form two Community Mental Health Teams (CMHTs): Brent North and Brent South. The teams are now aligned with the GP Practices across the borough. Both teams are fully operational in their new format, and our Brent Early Intervention Service remains unchanged.

For our staff:

- We have a staff engagement plan in place which is being implemented within our existing forums. We have had good engagement with staff regarding the community service redesign. This includes 'back to the floor' for all the management team, and staff focus groups to improve recruitment and retention.
- New Health at Work Activities are planned including massage and reflexology, occupational health involvement, and Zumba classes. These will be advertised within the borough and staff will be encouraged to participate. We are also planning a summer fair with staff recognition awards.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 60% Definitely and to some extent: 86%	Definitely: 81% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	85%	90%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one	For our carer initiatives, see detail below.	

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

The following are initiatives to help us improve:

- Ensuring that every patient has a carer's status recorded so they can be identified. This is monitored and we achieved 91% on average over the year.
- Ensuring every carer is offered a carer's assessment.
- We have agreed key performance indicators around carers with the Local Authority and these will be reported on a monthly basis, for example:
  - Proportion of carers who reported that they had as much social contact as they would like
  - The proportion of carers who find it easy to find information about support
- We have developed a small working group, with Brent User Group (BUG) involvement, to develop new service user and carer surveys, which will be rolled out and feedback collected on a rolling basis. The draft surveys are currently being consulted on.
- Our Picnic Project and exercise program to help with the launch of the smoke-free initiative on mental health wards.
- We are planning to further improve engagement with our carers with quarterly carers events at which we will be listening the carers about what they think works well and what would they like more of. We will have an educational element and a social element to them. The event will have presentations from Health and Social Care, will be looking at we have done already and future plans. A large portion of the meeting will be listening to the patients and getting their feedback on "have they noticed change" what they would like more or less of. We already run a monthly carers group in the evenings attended by many carers.
- We have a planned project with Brent User Group to support patients and staff to access the self-directed support panel and improve the awareness of the recovery model. This will be co-produced and co-delivered, and includes training and mentoring.

Other indicators of quality we report on in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	95%	97%
Community patients whose care plans contain at least one personal recovery goal (Target: minimum 75%)	76%	83%

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Inpatients who have a risk assessment completed and reflected in their care plan (Target: minimum 95%)	90%	90%
Patients who have their carer status identified (Target: minimum 70%)	91%	83%
Community patients report they got enough advice and support for their physical health (Target: minimum 80%)	87%	95.4%
Inpatients who received a physical health care assessment after admission (by both nursing and medical staff) (Target: minimum 95%)	100%	91%
Community patients who report having a phone number to call in a crisis (out of hours) (Target: minimum 85%)	84%	85%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions we have taken to improve:

- Reduction in restrictive interventions and rapid tranquilisation - A number of initiatives have been implemented locally around ensuring all wards have refurbished de-escalation rooms and guidance issued to staff governing their usage.
- We have improved the pathway to the Psychiatric Intensive Care Unit (PICU) for female patients to ensure timely access.
- We have increased training to staff on "reducing restrictive practice" and are monitoring the impact through auditing. All staff have had access to "positive behavioural support" training and improving professional boundaries training. This has led to a significant reduction in restraint and rapid tranquilisation overall in Brent.
- BUG have been training staff on the recovery focus and ensuring that this is embedded with self-directed support.

How we responded when things didn't go as planned

Our incidents: Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents result in low or no harm. Our key themes from our incidents this year have been related to:

- Keeping service users safe – In response we have made sure we have more permanent staff in position to care co-ordinate, improve continuity and communication with patients, carers and between teams.
- We have implemented single sex wards, implemented sexual safety training and the Keeping Safe Project for staff and patients
- We have also invested in our rapid response team, reviewed our policy for when patients miss appointments and the Early Intervention in Psychosis engagement protocol.
- We have worked to reduce restrictive interventions on our inpatient wards thereby supporting the safety and well-being of our patients and staff.

Our complaints: We are pleased to report that all our complaints were responded to within allocated timeframes, and our top five themes related to:

- Clinical Treatment or procedure – We need to better engage with families, offer meetings to resolve issues early and locally,
- Assessment Concerns – We need to reinforce our single assessment approach,
- Attitude of staff – Staff have been seen by the Borough Director and communication has been highlighted,

- Communication with patients, carer/family – We need to get it right first time and offer of regular meeting with senior management where this is needed.

What we've done well and our plans for the year

- Brent received two team awards at Brent Council's Annual Staff Awards: one was for efficiency and the other for innovation. These awards were for the joint work between Brent Local Authority Adult Social Care, Housing and Brent Mental Health services' partnership working within the integrated teams,
- Achieved a reduction in numbers of Brent residents in 'residential' and 'move on' placements which has allowed for patients to move into more independent accommodation with secure tenancies,
- All units have recruited Activity Coordinators and we have appointed a new Sports Technician across the service. This will help with the roll out of the Smoke Free at Park Royal Mental Health Centre in April 2016,
- New Pharmacy Room at Park Royal: Works were completed earlier this year resulting in better access to pharmacy services for patients and staff.

Camden Community Health

Our Services

We provide a wide range of community physical healthcare services for children and adults. This includes neurological and stroke services, podiatry services, diabetes services, wheelchair services specialist community and inpatient rehabilitation and palliative care services. Services for children include school nursing, immunisation, health visiting, looked after children and Camden MOSAIC, an integrated service for children and young people with disabilities, and their families.

All our services are designed to improve the quality of life of patients and their families, supporting people to keep healthy in the community and avoid unnecessary hospital admissions.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16(YTD)	Trust average(YTD)
Patient FFT (Target: minimum 90%)	88%	92%
Staff FFT (Target: minimum 66%)	79%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions we have taken to improve:

For our patients and their families or carers

- We worked on how we get greater responses to our 'Friends and Family test', and we are already seeing a much higher response rate and detailed feedback so that we truly know where to target improvement. For example, we know that patients are more likely to give feedback if there is communication about how it is being used, so we introduced 'You said, we did' information on our notice boards.
- We increased patient-focussed activities and brought in more entertainment options to the inpatient ward. We have trained volunteers to engage with patients on a variety of activities.

- We initiated weekly reviews of patient feedback on our inpatient wards.
- We conducted a detailed user experience project in our children's services using surveys and focus groups to help improve the services we offer for child and families with complex needs. Our focus groups have helped us re-design how we triage and accept referrals
- Our children's school services contact parents at the start of the school year to introduce themselves and provide their contact details and a photo.
- We are developing a patient involvement plan in conjunction with the Camden Active Living Group (discussed further on); including discovery interviews and focus groups, on key themes from surveys.

Here are some of the things our patients have said:

"It was marvellous. Nothing seemed to go wrong. I was really, really completely surprised that it was so good, tremendous - all of them! The whole thing, even in the hospital. I am a writer and I don't say these things lightly. If I get the opportunity to write about it, I will"

"Everyone is working for the welfare of the child and this makes it easier for the parents"

"Great, warm, expert professional approach. Effective, efficient, humane – Thanks"

For our staff:

- Our Borough Director has provided a series of informative road shows for staff and also regularly hosts meetings for new-starters to understand their experience and impression of the Trust and see what we can do to improve services.
- We now include a 'team escalation' section on all team meeting agendas to ensure our staff can raise any concern they have, no matter how small
- We have taken forward a number of actions identified through our staff survey, including staffing reviews, flexible working projects, resilience sessions and individualised team objectives.
- Staff have opportunity to attend senior strategic meetings or shadow staff to better understand the wider Trust strategic position.
- Our children's services have initiated an annual celebration and learning event for all staff.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority Indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 67% Definitely and to some extent: 88%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	86%	91%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one		

Camden Commissioners introduced an initiative on 'care navigators'. These are people who provide support to patients in need of additional carer support. Our Camden services work closely with the Commissioners to identify patients who would benefit from this.

We also link with Camden Carers where appropriate to make use of their counselling services for patients and carers.

In February 2016 we engaged with Camden & Islington Talking Therapies services (IAPT), who provided an overview of mental health support services for patients, carers and staff within Camden. This included providing each team with a "map" of psychological support services within Camden where patients and carers can be directed for support with any mental health needs.

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some of the actions we have taken to improve:

- Our adult services have developed an action plan based on patient feedback designed to further improve our delivery of these targets in 2016/17.
- The patient involvement plan encompasses all aspects of patient engagement and involvement. Some key actions are:
  - Our inpatient services ensure all care plans are signed off by both the patient and the clinical staff.
  - The palliative care service has introduced patient reported outcome scores, which are reviewed and used to inform future treatment. They also routinely encourage patients to make advance care plans of their preferences as their health deteriorates. They also work with patients to develop an individualised end of life care plan.
  - Our children's services are managing a number of projects; including developing shared clinical reports; working with a group of families to develop shared care plans within the service and ensuring family choices are reflected in their children's care plans.

Other indicators of quality we report on in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	98%	97%
Community health patients who report that they got enough advice and support for their mental health (Target: minimum 85%)	80%	78%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some of the actions we have taken to improve:

- How we treat patients with dignity and respect continues to be assessed in a number of ways, such as supervision and teaching sessions, as well as kept under constant scrutiny through our surveys. We also continue to seek other ways to improve a patient's experience in this regard – for example, our adult inpatient services recently introduced dignity packs – clothing packs that are given to patients admitted to our inpatient services, who do not have clothing of their own. We also use funding we raise to buy personal items and patient comforts.
- We are using our Trust expertise in mental health to support the mental health and wellbeing of our patients. We have a mental health nurse specialist and a psychologist to provide advice and support and liaise with other borough services as appropriate.
- Our initial nursing assessment form includes assessment tools to identify any past or present mental health issues, and we provide

training to enhance nursing skills in this area. Furthermore, later in 2016 we will run a full day's training with mental health practitioners from MIND.

- We have recently developed links with the Camden and Islington Talking Therapies service to support patient, carer and staff mental health and wellbeing needs

How we responded when things didn't go as planned

Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents result in low or no harm.

Within our adult services, pressure ulcer incidents remain the highest category (56%) of all reported incidents. A range of learning and actions were identified as a result, including making sure we complete and document assessments fully, team planning around missed visits. We carefully monitor our patients, make sure they have the right equipment and mattresses to support them and making sure GPs have the information they need to care for their patient.

We also identified learning on how to prevent and manage those patients at risk of slips, trips and falls. This resulted in the weekly testing of Careline alarms (these are systems patients can use to get help quickly if they have a fall). Making sure teams have Blood Pressure machines and pulse oxymeters because we know that low blood pressure and low oxygen levels can result in falls. And we are educating our support workers on the impact of patient tiredness and fatigue that can result on falls.

Within our children's services, some of our incidents were about information governance and so we undertook refresher training and reminded staff about being extra vigilant about the processes and safeguards we have in place. Others incidents were about inappropriate administration of vaccines, and some safeguarding incidents. Appropriate learning has been taken forward, for example from the vaccine incidents that all staff have been reminded they must adhere to the consent protocols. With regard to safeguarding the service is well supported by the named nurse for child protection, who links closely with the Local Authority to identify significant learning arising from incidents.

Our complaints in both services were mainly around better communication and clearer information, so some of the things we are doing are: specifically stating how a visit will be followed up
Some parents comment about lack of co-ordination of care and parents wanting more therapy. As a result of this we have engaged parents in focus groups to help us re-design our referral pathways and understand how we can better communicate the service offer.

What we've done well and our plans for this year

This year saw the introduction of the Camden Active Living Group, these are patients employed by the Trust to carry out bespoke pieces of work. They have been very involved in the development and delivery of training modules for staff, learning walks and service inspections, recruitment of staff and designing other mechanisms for patient engagement. They will be very involved in the rollout of the patient involvement plan in 2016/17.

Camden Community Services held a planning event at the end of 2015 and at the workshop we developed our plans for 2016/17 along the following themes:

1. Equality and Diversities
2. Mental Health
3. Learning Disabilities
4. Patient Engagement and Involvement

We were excited that there was such a strong focus on patient engagement, with one of the service leads taking this forward across Camden. The outputs from this piece of work will be shared in our quality account report for next year.

Our services have also begun carrying out discovery interviews, which are designed to elicit more detailed, specific feedback on how patients have experienced our services and been treated by our services. These will be rolled out more widely across services as part of the patient involvement plan.

The CNWL Community Services Patient Experience Survey

Annually since 2013, CNWL has carried out a survey of its community service patients, including Camden. This reviews how patients experienced the service they received, across various metrics. There are a number of headlines from the most recent survey, conducted in 2015 and presented to the March Board of Directors:

- Camden saw increases across all but two metrics related to overall patient experience (one of which remained static). This includes questions such as: were patients treated with dignity and respect; were patients involved in decisions about care and treatment; did patients have enough time to discuss their health needs; and have they had a care review. Camden scored highly in relation to most metrics, and comparably to the rest of the Trust's community services across all metrics.
- Staff related questions also generally saw a positive increase (only one score has worsened since 2014), and again, Camden services scored highly across most of them. These metrics include: did the staff member wear an ID badge; were staff compassionate and kind in their care; and staff knowledge about care and treatment.
- Some particular metrics have increased significantly. In particular, the overall experience was rated as good, very good or excellent by 94% of respondents. This is an increase of 10% from the 2013 survey (84% positive). A table of some key Camden performance indicators is provided below.

Metric	2013	2014	2015
Your overall experience of service - excellent/very good/good	84%	90%	94%
Are you extremely likely or likely to recommend the service	83%	84%	87%
You felt the care or treatment received helped you	-	93%	96%
Staff knowledge about care and treatment (excellent, very good or good)	95%	90%	94%
Staff provide compassionate and kind care	94%	90%	93%
Staff friendliness and politeness	96%	95%	96%
You were treated with dignity and respect	98%	98%	99%
You were involved in decisions about your care and treatment	94%	96%	96%
You had enough time to discuss your health needs with your Health Care Professional (nurse, health visitor, doctor, therapist)	87%	87%	89%

We recognise, however, that there are areas we need to improve, and we should always seek ways to improve patient experience regardless. There are five key areas identified across all CNWL adult community services that will be taken forward as a result of this survey:

- Ensure patients understand that they may not always be seen / visited by the same staff member.
- Ensure we check if patients still have concerns about medications or prescriptions, equipment and transport, and then address those concerns.
- Ensure we are always actively explaining to patients how to give feedback.
- Ensure patients have their care and treatment reviewed appropriately and that we are explaining this fully.

- Continue to make improvements in the number of patient/service users who said they needed to speak in confidence and were offered a private area in which to do so.

We are pleased to receive feedback on our Quality Account and look forward to working in partnership this year with our patients, carers, Healthwatch, local authority and commissioners.

Harrow

Our services

We provide a wide range of mental health services in Harrow for children and young people, working age adults and older people. Services include acute inpatient mental health wards, Home Treatment and Rapid Response Team, Liaison Psychiatry in A&E. We also provide an assessment lounge within the mental health unit to improve the experience of acutely unwell service users as an alternative to waiting in A&E. There are also Community Mental Health Teams which have recently undergone a redesign for adults. In addition there is an Older People & Healthy Ageing Community Mental Health Team, a Memory Service and a Forensic Community Service.

What our patients and staff tell us about our services

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	54%	92%
Staff FFT (Target: minimum 66%)	62%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions we have taken to improve:

- Our community meetings take place daily on the inpatient wards. The inpatient wards have implemented *"you said we did"* process, which provides patients with a written response to changes made following feedback in community meetings.
- Senior managers attend the Harrow User Group and the Carer's Forum to further facilitate feedback and open dialogue.
- Carer surgeries take place monthly which allows feedback on our services and interventions.
- The Psychiatric Liaison service has received universally positive feedback stating that it is quick, friendly and helpful.
- The community services have undergone a significant redesign in order to simplify the care pathway for service users and improve their experience. As part of this, there were a number of stakeholder/user/carer events, workshops and 'task and finish' groups in order to ascertain their views and incorporate into the redesign model.
- We try to help with any practical requests from our in-patients. For example, we ensured batteries were readily available for the electric piano following a request from one service user and are currently looking into the availability of Wi-Fi on the wards for use by patients.
- Following concerns expressed that Harrow's Older Peoples services were located out of borough these were relocated back to Harrow Borough in August 2015. This resulted in more home visits being available for clients.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority Indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 69% Definitely and to some extent: 89%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	86%	91%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one		
The in-patient psychologist has helped Harrow carers develop a psychology service for carers. Psychology assistants are supervised so that they can provide positive psychology interventions and offer courses which help prevent mental health problems among carers. There are also meeting and individual appointments with senior managers for carers. Examples of areas of concern and action taken: • The introduction of a smoke free environment. The Harrow Lead Occupational Therapist has facilitated training and awareness with inpatient and community staff and patients and provided information on available alternative options. • Staff answering the telephone and saying that someone will call them back or declining to speak to them due to 'patient confidentiality'. This has been addressed in team meetings and is included in training sessions. It will remain an on-going area for staff development.		

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some of the actions we've taken to improve:
Inpatient care plans are checked every day to ensure that all new admissions have a care plan and have been given a copy of the care plan. There are also checks to ensure that care plans are produced with the patient and are reflective of the patient's needs and any associated risks. If issues are found during these checks, improvements are made and feedback is provided to individual practitioners.

The last CQC Mental Health Assessment (MHA) focussed visit was positive regarding the co-production of care planning but identified that one-to-one sessions and evaluations are not being recorded as such. These areas have been addressed in staff meetings. Engaging with patients remains a priority for all teams and is monitored throughout the quality based forums within the service.

Much work has been done across the community teams to ensure all clients are sent a plan and that the quality of this plan is good. We maintain this through ad hoc audits of care plan quality locally. There is an issue with patients under lead professional care (outpatients) not recognising the letter they receive as a care plan. Clinical and administrative staff have been asked to ensure they explain this properly at clinics.

Other indicators of quality we report on in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	93%	97%
Community patients whose care plans contain at least one personal recovery goal (Target: minimum 75%)	85%	83%
Inpatients who have a risk assessment completed and reflected in their care plan (Target: minimum 95%)	84%	90%
Patients who have their carer status identified (Target: minimum 70%)	87%	83%
Community mental health patients report they got enough advice and support for their physical health (Target: minimum 80%)	84%	86%
Inpatients who received a physical health care assessment after admission (by both nursing and medical staff) (Target: minimum 95%)	98%	91%
Community patients who report having a phone number to call in a crisis (out of hours) (Target: minimum 85%)	79%	85%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

What we have done during the year:

- Dignity and respect: we respond to any concerns identified by patients or carers via complaints or CQC feedback as a matter of urgency. Following feedback from the CQC, changes have been made in relation to Section 136 mental health assessments and patients are now taken directly to the Section 136 assessment suite without having to go through the main reception.
- Risk assessment completed and reflected in their care plan: the presence of a risk assessment is monitored on a daily basis. There are spot checks on a weekly basis in order to ensure that all risks are addressed within the individual's care plan and that both the risk assessment and the care plan are of an acceptable standard. This is a high priority area for supervision and training.
- Carer status identified: this is monitored on a daily basis to ensure carers are identified for all individuals receiving care within the service.
- Physical health care assessment: the completion of physical health care examinations by both nursing and medical staff is monitored on a daily basis for all new admissions. The Clozapine and Depot Clinic has had additional resources added to it as part of the Community Services redesign and has re-launched as the Psychotropic Medication and Physical Health Care Clinic with an increased focus in the physical wellbeing of service users.
- Results from patient survey/local audits are: discussed at team meetings. Action plans are made to improve performance where appropriate, which are followed up in staff supervision. Follow up audits are planned to ensure improvements made are sustained. For example a recent local audit has been introduced to monitor the timeliness of communication with GPs.
- Risk Assessments: both compliance and quality of plans are of high priority for all community staff for training and supervision.

How we responded when things didn't go as planned

The senior management team in Harrow are committed to ensure we learn when things don't go as planned and hold a monthly 'Lessons Learnt' meeting

where data and themes from incidents, complaints and safeguarding are brought together and discussed to encourage learning and system change. The learning is disseminated to staff via local Care Quality meetings.
One of the most common themes of complaints relates to communication between professionals and service users and carers. The service users and carers naturally would prefer simpler communication without using any professional jargon. This feedback has been acknowledged and we are now making every effort to ensure that our communication straightforward and jargon free. When these complaints relate to specific members of staff rather than being applicable across the service, the concerns are addressed with the individual staff members through supervision processes.

Another theme identified through the complaints that we have received concerns waiting times for services. The introduction of the Single Point of Access (SPA) and Rapid Response Team means that those in urgent need can be seen more quickly. Similarly we have changed our community teams so that both CMHTs operate in the same way so we have increased our capacity to see people within the time frames set. With specific regard to the Memory Service, we have been transparent regarding the length of the waiting times and following discussions with the CCG there has been temporary increased investment and discussions are underway regarding the need for the longer term requirements of the service.

Although the majority of our incidents result in low or no harm, we are committed to learning from all our incidents, but especially our serious ones. When a serious incident occurs the circumstances are always thoroughly investigated. The distress caused to carers when a serious incident results in a loved one's death is incalculable. We make sure that family members are contacted and additional support is offered to them. The lessons identified during the investigation process are then discussed in the senior management team and then disseminated to all staff. This is presented in a form of an action plan with an expectation to complete it within a given time. The senior management team ensures that this is done through the local care quality meeting and any service concerns identified and addressed.

What we've done well and our plans for the year

A key achievement over the last year has been the review and redesign of our adult community Mental Health services. The bringing together of the Assessment and Brief Treatment, Community Recovery, Community Rehabilitation and Assertive Outreach teams has simplified the care pathway; and the introduction of daily multi-disciplinary meetings aims to speed up decision making and improve the timeliness of the response of the service. The newly modelled teams have recently moved into a refurbished premises - Bentley House in Harrow and Wealdstone which we are confident will foster good partnership working both between services and with patients and carers. Over the coming year we will be monitoring how the new Community Adult Mental Health services bed down and will be keen to get feedback on areas for improvement.

The Psychiatric Liaison team successfully bid for funding, from the Collaborative Leadership Applied Health Research and Care (CLAHRC) to develop an alcohol pathway for patients treated on medical wards. This project commenced in May 2015 and will be undertaken over an 18 month period. The team are also bidding for funding for a project to improve care planning for older adults with dementia.

We will be undertaking a review of our Older People and Healthy Ageing services to ensure that the resources we have are being used as effectively and efficiently as possible. One specific new initiative which is very near being finalised is new enhanced Dementia Community service which will improve dementia pathway in the community in 2016/17.

Hillingdon Community Health

Our Services

We provide a wide range of community physical health services for children and adults. Our adult service portfolio includes a range of services to maintain independence at home with nurses and therapists, specialist

rehabilitative therapy and long term conditions services, physiotherapy for musculoskeletal problems, inpatient rehabilitation and end of life care.

Services for children include health visiting, children's nursing and infant feeding, as well as paediatric services including speech and language therapy, occupational therapy and physiotherapy services.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	93%	92%
Staff FFT (Target: minimum 66%)	82%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Our actions we have undertaken in relation to patient experience:

- We have continued our 'you said, we did' information displayed on the noticeboard in our inpatient unit.
- Feedback is obtained from patients on the in-patient physical health ward (HICU) on a monthly basis. The ward manager receives feedback and actions are taken where targets are not met.
- Several service specific satisfaction surveys took place in Hillingdon community with some excellent feedback, for example, 100% of patients receiving intravenous antibiotics, 91% from tissue viability and 97% from the bladder and bowel service reported they were either extremely likely or likely to recommend the service. 96% of young people in secondary schools rated the School Nursing service as high.
- The high level of patient satisfaction was confirmed in our Annual Patient Survey where 95% respondents reported they would be extremely likely or likely to recommend community Services which is up from 93% in 2014.
- Below is a sample of responses taken from the Patient Survey 2015 in relation to patient experience:

Patient Experience	Year	Hillingdon CHS
Treated with dignity and respect	**2015**	**99 ▲**
	2014	98
	2013	99
Involved in the decisions about your care and treatment	**2015**	**97 ▶**
	2014	97
	2013	96
Involved in developing and evaluating your care plan? (Definitely and to some extent)	**2015**	**95**
	2014	
	2013	
Encouraged to make choices about your treatment?	**2015**	**94**
	2014	
	2013	
Given a choice (where available) about your care or treatment	**2015**	**86 ▲**
	2014	83
	2013	75
Had enough time to discuss your health needs with your Health Care Professional (nurse, health visitor, doctor, therapist)	**2015**	**91 ▲**
	2014	90
	2013	90
Do you know how to give feedback e.g. compliments, complaint	**2015**	**73 ▲**
	2014	65
	2013	59
Have confidence and trust in the Health Care Professional (nurse, health visitor, doctor, therapist) treating you	**2015**	**96 ▲**

Examples of quotes from our patients in relation to the service they received:

"The person who dealt with me was so helpful and made suggestions which have helped me enormously. She also phoned to see how I was getting on. I wish everyone in the NHS was like (Staff) and didn't make you feel you were a nuisance."

I'd like to thank my wonderful health visitor. I've had a really hard time with my daughter and she has been so great, to mention a few things that helped;
- Always called and visited when she said she would, never let me down
- Fantastic listener, never spoke over me and always had time, I never felt rushed
- encouraging, always let me know she thought I was doing a great job! Any mother who has (Staff member) as their health visitor is very lucky!
Thank you to staff for their warm welcome, help and advice & for being 'caring & efficient people' and for help with advice for appropriate bath aids.

- In response to feedback from our parents we are in the process of purchasing new toys and some replacement chairs for our clinics.
- The Musculoskeletal Service (MSK) held a patient focus group to establish where they could make improvements to their service, for example opening hours and sharing discharge summaries.

In relation to staff engagement:

- Our Borough Director has provided a series of informative road shows for new staff joining the organisation.
- As part of therapies week the MSK team visited staff and gave advice on correct seating postures which was received positively.
- Hillingdon Community Engagement Team has conducted a health awareness drop-in session where they screen staff's blood pressures, blood sugar levels and weight.
- Health Visiting Professional practice event arranged to re-energise the workforce and plan the future direction of the service.
- Our Podiatry Service arranged an away morning with their Camden colleagues to enable the sharing of best practice.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority Indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 82% Definitely and to some extent: 95%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	88%	91%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one		
Hillingdon CCG has invested in our Homesafe Team to enable the number of patients to be supported with early discharge to almost double. We are working closely with four GP practices in the north of Hillingdon to pilot a 'whole systems' model of care. A community Matron and District Nurse are working with practice staff to develop proactive care plans with the aim of reducing unplanned hospital admissions. We have also extended our links with third sector colleagues to enable more patients to be cared for in their own home through the use of service such as night sitting.		
We continue to work in collaboration to deliver on the 7-day working initiative to enable patients to access services equitably across the week.		

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some of the actions we've taken to improve:

- Our adult services have developed an action plan based on patient feedback which is designed to further improve our delivery of these targets in 2016/17.
- Our inpatient service ensures all care plans are signed off by the patient and the clinical staff.
- We have introduced a daily 'skin integrity' form on our inpatient unit to heighten awareness of the importance of minimising the risk of tissue damage and the development of pressure ulcers.
- Following feedback from patients, written confirmation of appointment times are now sent to those patients who have arranged their appointments directly with our contact centre by phone.
- Our School Nursing Service is involved with the development of an asthma pathway for children and young children in partnership with the acute trust to ensure children have an individualised care plan.
- The Child Development Service and the Health Visitors have been working with the Local Authority and Children Centres to strengthen the ASD (Autistic Spectrum Disorder) pathway for younger children.

Our other indicators of quality reported in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	97%	97%
Community health patients who report that they got enough advice and support for their mental health (Target: minimum 85%)	79%	78%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions taken throughout the year:

- How we treat our patients with dignity and respect is kept under constant scrutiny through our surveys – to date we have achieved a 100% against a 95% target in our inpatient unit.
- With regard to supporting mental health we have worked closely with our mental health colleagues in a number of areas for example we were able to provide physical rehabilitation for a patient who had significant mental health problems in our physical inpatient unit. We also continue to have a mental health trained nurse working alongside our Rapid Response Team which accept a wider cohort of patients.
- We have developed links with the Hillingdon Talking Therapies (IAPT) service and their Consultant has visited the community services to raise awareness.
- Due to the increase in the number of young people in secondary school presenting with emotional /mental health concerns to the School Nurse drop in sessions; training from our mental health colleagues has been delivered to school nurses in relation to early identification, highlighting risk factors and where to refer those needing further support.

How we responded when things didn't go as planned

Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents result in low or no harm. Here are our key themes:

- Within our adult services, pressure ulcer incidents remain the highest category (56%) of all reported incidents. A range of learning and actions were identified as a result, including making sure we complete and document assessments fully, team planning around missed visits. We carefully monitor our patients, make sure they have the right equipment and mattresses to support them and making sure GPs have the information they need to care for their patient.

- We also identified learning on how to prevent and manage those patients at risk of slips, trips and falls. We are educating our support workers on the impact of patient tiredness and fatigue and the risks associated with those patients who have cognitive and mobility problems.

- Within our children's services, some of our incidents were about information governance and so we undertook refresher training and reminded staff about being extra vigilant about the processes and safeguards we have in place. Others incidents were about inappropriate administration of vaccines, and some safeguarding incidents. Appropriate learning has been taken forward, for example from the vaccine incidents that all staff have been reminded they must adhere to the consent protocols. With regard to safeguarding, the service is well supported by the named nurse for child protection, who links closely with the Local Authority to identify significant learning arising from incidents. In addition there is a Hillingdon immunisation workshop planned in April 2016 to review the consent process.

- The main theme from complaints was around better communication and clearer information, from which learning has also been taken forward such as appointments to be confirmed in writing where possible, staff to inform patients if they are running late and sharing of information relating to services other than CNWL is clearly identified as third party information.

What we've done well and our plans for this year

The plan for the year ahead in our Community adult services is to continue to expand the whole systems model of care which in turn will mean a redesign of many of our community services to align with the GP Networks.
We have also begun to collect recovery stories from our patients, which aim to elicit more detailed feedback on their personal experiences of being treated by our services.

In October 2015 CNWL Hillingdon were awarded the contract for school aged immunisations in Brent, Ealing and Hillingdon as well as the contract in collaboration with West London Mental Health Trust to deliver the short term rehabilitation element of the Home ward Service in Ealing.
In April 2016 Hillingdon Children Services will be delivering a catch up BCG (Bacille Calmette-Guerin vaccine) programme to babies in Brent, Ealing and Harrow.

We are pleased to receive feedback on our Quality Account and look forward to working in partnership this year with our patients, carers, Healthwatch, local authority and commissioners.

Hillingdon Mental Health

Our services

We provide mental health services across the borough for adults and older people, including a psychiatric intensive care unit at the Riverside Centre and two adult inpatient mental health wards, which offer a safe and therapeutic environment for people with acute mental health problems. Also based at the Riverside Centre is a Liaison Psychiatry Team delivering significant mental health support to the A&E department and wards at The Hillingdon Hospitals NHS Foundation Trust. Our Home Treatment and Rapid Response Team are designed to support patients safely at home during crisis. There is also a Section 136 Suite at the Riverside Centre. These are for people who require a health-based place of safety while experiencing a mental health crisis.

In addition we provide integrated adult community mental health services, including Community Mental Health Team's (CMHTs), an Early Intervention in Psychosis Team, a Primary Care Mental Health Team, and a Community Rehabilitation Service.

Our Older Peoples Services (over 65-years) are based at The Woodlands Centre and they comprise of an inpatient Ward, a Community Mental Health Team, an older people's Home treatment Team, and a Memory Service.

We provide a small perinatal service across Hillingdon and have a Clinical Health Psychology team who work with many services run by Hillingdon Hospitals Trust.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16(YTD)	Trust average(YTD)
Patient FFT (Target: minimum 90%)	71%	92%
Staff FFT (Target: minimum 66%)	60%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

The borough response rates and results of the Friends and Family Test were disappointing. This was partly because 2015 has been a year of great change for both our staff and patients as we completed community care service redesign.

We know we need to do better and have taken action over and above the redesign, which is having positive outcome.

- To improve our patient and carer experience and ensure that views are heard we have introduced a peer-led patient and carer involvement meeting co-chaired by two patients. This group has identified three targets for all teams, which are monitored on a monthly basis. The group has said this has improved engagement with the services.
- We have started a monthly carer's surgery, where any carer can come along to discuss any concerns they may have about care provided with a member of the senior management team. Our older adult service offers a similar initiative and carers can meet with the consultant psychiatrist for support.
- The inpatient wards hold weekly meetings between patients and staff and have suggestion boxes. We then have a 'you said we did' board on the wards to share the actions taken from the feedback received.
- To increase staff engagement, the borough director produces a weekly newsletter, which focussed initially on community service redesign but has evolved into a service wide update.
- The Borough Director meets all new starters in the borough within eight weeks of starting work with the Trust to welcome them and to listen to any immediate feedback or concerns.
- We are creating a monthly staff engagement forum to have a two-way communication channel between front line staff and senior managers.
- We have been assessing a pilot in another borough aimed at increasing the response rates by both patients and staff to the FFT. Initial feedback is positive and, if successful, this will be implemented within Hillingdon this year.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority indicators 2015/16	2015/16(YTD)	Trust average(YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 65% Definitely and to some extent: 91%	Definitely: 82% Definitely and to some extent: 96%

Quality Priority indicators 2015/16	2015/16(YTD)	Trust average(YTD)
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	95%	91%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one		
"The staff here are very helpful and take the time to listen to you". This carer statement is indicative of our staff's commitment to care and to ensuring patients are involved in their care. Carers are invited to be involved in all or any aspect of their loved ones care and are offered support to do this. Community and inpatient services offer regular opportunities for carers to join reviews and contribute. Carers' forums are held at the unit and carer surgeries are held at the Civic Centre attended by staff. Through the community redesign we have addressed concerns about access to urgent care. Community teams will be able to identify and be more responsive to patients who are in crisis by introducing a way of deciding what level of support a patient needs. We have also introduced a Rapid Response Team to the existing Home Treatment Team, which responds to urgent and emergency referrals.		

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

We have changed some of our processes to ensure our service users and their carers have more involvement in care planning to improve the quality of the care we provide.

In community services, our patients and their carers are encouraged, during Care Programme Approach (CPA) reviews and outpatient clinics to contribute to their care plans. The CPA is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

In the inpatient services, nursing staff sit with patients immediately following admission and together formulate the initial care plan. This is reviewed in the ward rounds with the patient and where possible, requested and appropriate, carers are invited to contribute. The ward rounds are done daily and slots are offered to carers to join the ward rounds and participate in the treatment and care planning. Discharge planning is also discussed with patients and carers to ensure all are aware of the crisis contacts. Most importantly recovery goals are now identified in the care plans by patients.

Our other indicators of quality reported in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	96%	97%
Community patients whose care plans contain at least one personal recovery goal (Target: minimum 75%)	88%	83%
Inpatients who have a risk assessment completed and reflected in their care plan (Target: minimum 95%)	100%	90%
Patients who have their carer status identified (Target: minimum 70%)	85%	83%

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Community patients report they got enough advice and support for their physical health (Target: minimum 80%)	89%	86%
Inpatients who received a physical health care assessment after admission (by both nursing and medical staff) (Target: minimum 95%)	81%	91%
Community patients who report having a phone number to call in a crisis (out of hours) (Target: minimum 85%)	93%	85%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

As part of our commitment to excellence in care delivery, the adult community service has undergone a redesign to create a seamless service, which is more responsive. We have an overarching Single Point of Access service which offers triage, support and crisis intervention through the Urgent Care pathway and is accessible to service users, carers, GPs, voluntary sector, Police and local authorities. Our Liaison Service is well established within the acute hospital, ensuring that anyone presenting there is seen promptly and offered the support needed.

Co-production of our services forms an important part of our strategy, and we have a number of Peer Support Workers in our services.

The Primary Care Mental Health Team works closely with our GP colleagues and Community Mental Health Teams, to foster better working relationships and ensure patients are seen in the most appropriate setting. It also ensures that patients move from secondary mental health services, in a timely and safe manner. The success of this recent initiative has seen a total of 282 patients now being cared for in this setting.

Inpatient services continue to improve and recent comments of our older adult wards indicate this: "It is more like a homely service and not like a hospital".

How we responded when things didn't go as planned

Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents result in low or no harm.

Themes that have arisen from our complaints and serious incidents this year have been predominantly around interfaces between the various teams in the services and communications between them being slow to respond and confusing for our patients, carers and stakeholders.

We believe that the community service redesign will address many of these issues by integrating teams and engaging a more multi-disciplinary approach. This will allow us to offer a more responsive and streamlined service, with care being delivered either at home or nearer to home for the patient. The teams are integrated with health social care mental health services.

What we've done well and our plans for the year ahead

The major change this year was completing the community care service redesign, which we firmly believe will benefit our patients, carers, stakeholders and our staff once fully embedded into every day practice. We involved our patients, carers and stakeholders in the redesign planning and immensely valued their support and ideas.

We will build on this work to continue to support the delivery of care closer to home as our rapid response mental health services and single point of access embed this year.

We are delighted that our primary care mental health team continue to increase their work across the borough and this will be a continued focus for

2016 as we continue to provide education and direct support to GPs in relation to mental health services in the community

We are pleased that our Talking Therapy Services (IAPT) saw in excess of 4,600 people in the last year and exceeded all targets around the access and recovery for the people that they treated.

We are proud of our older people's matron being accredited as a 'Care Maker', part of a national initiative to embed "Compassion in Practice". We will be building on her expertise to review our community older adult teams this year to drive improved models of integration, to support improved patient experience and more joined up care across physical and mental health services.

Kensington and Chelsea

Our services

We provide a wide range of mental health services in the borough of Kensington and Chelsea for both adults and older adults. Services are offered across both the north and south of the borough with our acute services being delivered from St Charles Hospital and the South Kensington and Chelsea Mental Health Centre where we have six adult inpatient wards and two older adult inpatient wards that provide a safe and therapeutic environment for people with acute mental health problems. Other services in the borough include: adult and older adult liaison psychiatry services, home treatment services, early intervention services, both older adult and adult community mental health teams, and primary care liaison services.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	79%	92%
Staff FFT (Target: minimum 66%)	58%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

We actively include and consult with both staff and patients in order to improve the experience patients have of our services and have meaningful engagement with staff. We have undertaken the following actions to make this happen:

- Workshops led by the senior management team for both staff and patients and their carers to provide a forum for open feedback and discussion.
- The roll out of a survey which was co-produced with patients (RBKC Community Redesign Survey) to get patient feedback– Patient Reported Experience Measure (PREM).
- Monthly feedback forums for patients on our wards at St Charles Hospital delivered by the advocacy project on.
- Wards at St Charles Hospital implemented Team Recovery Implementation Plans which keep patient recovery focused thinking at the heart of the work of our teams.
- Regular meetings with carers, carer organisations, Borough managers and staff.
- Regular attendance to the Kensington and Chelsea Mental Health Carers meeting (team managers attend from the Single Point of Access, Home Treatment Team, Community Mental Health Team and the Deputy Borough Director).

What our patients said:

"Great treatment, kind and helpful atmosphere"

"As a former nurse myself, I recognise good care when I see it. The staff at 3 Beatrice Place are well trained and respect the residents, treat them with dignity and make their lives as varied and interesting as possible. This is not an easy task for this group of clients. It takes patience, courage and a degree of self-restraint in many situations of care, to maintain the residents' humanity and the staffs' on-going capacity to care. I am also encouraged by the good relations the staff maintain with relatives and friends and am satisfied with the amount of communication and dialogue there is."

"I have received help above and beyond the call of duty from staff member X, the service has saved my life. I am enormously grateful, for her and her team"

"Your input has helped me think I can do something again"

"The K&C Recovery College course has given me a new insight and how to develop myself and be in control of my recovery"

What carers said:

"The attendance of CNWL staff at our mental health carers meetings is very informative and keeps people up to date. It helps us understand the system and helps carers help the person they look after"

"The carers interface meeting is particularly helpful. The staff are hands on and from a range of roles within the borough"

"Attending the Service Redesign meeting is a great opportunity to be on the inside, meet professionals and understand how services fit together"

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority Indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 67% Definitely and to some extent: 91%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	90%	91%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one		
In recent years, we have pioneered various initiatives for carers. Including two new recovery and wellbeing college courses specifically for carers of people with bipolar disorder and psychosis. These have been, and will continue to be delivered as part of the CNWL Recovery and Wellbeing College spoke in Kensington and Chelsea. We also run Carer's Art Therapy Groups. This year we plan to pilot a cinema club and a mural project at St Charles for patients and carers. Here is what some carers said: "Learning from a person with Psychosis has dramatically increased my understanding of my son's problems" "Thanks, CNWL and the therapist, I had no idea how those weekly two hours would be helping me so much. But I know there are many more suffering, isolated carers who could benefit from these types of initiatives. I think they are much needed and judging from our group, they can promote a sense of wellbeing and I would be as daring as to say, prevent ill health."		

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some of the actions we've taken to improve:

- This year we secured funding to deliver a series of 'Recovery Workshops' facilitated by a Senior Consultant for staff working within the inpatient services at St Charles and both adult community mental health teams. These workshops provided valuable training for staff in the effective delivery of recovery focussed care and treatment planning.
- We have worked in partnership with the CNWL Recovery and Wellbeing College to deliver snapshot courses on the wards at St Charles and to increase the take up of CNWL Recovery and Wellbeing College courses by the local community. This has increased access to the courses on offer and continues to support patients to access the necessary skills and to build their confidence and knowledge to be able to feel more in control of decisions related to their care and treatment.
- Kensington and Chelsea North Community Mental Health Team Personal Health Budget Pilot is being run in partnership with West London Clinical Commissioning Groups, Kensington and Chelsea Mind, the Local Authority and NHS England. The pilot to date has engaged 15 people offering greater patient choice and control and shared decision making approach to care planning. There is a focus on individual patient defined outcomes and flexibility in how to achieve them. A detailed evaluation of the pilot will be completed in June 2016 and it will include recommendations for future proposals.
- Effective links with third sector partners; examples include introducing an extended service with a peer support worker working in SMART Recovery (a science-based programme to help people manage their recovery from any type of addictive behaviour) at weekends in the south of the borough. Bridging workers from Hestia (a housing and support charity) are also aligned to the north and south community mental health teams to support patients who are transitioning from secondary to primary care services. A 'Positive Steps' group is run by Kensington and Chelsea Mind on inpatient mental health wards to support the patients journey from the inpatient setting into the community.
- Community partnerships: we work with community partners in many ways including formally established multi-agency groups in partnership with police/criminal justice, housing, social care, other NHS providers and community groups such as:
    - MARAC (Multi Agency Risk Assessment Conference): co-ordinating responses to domestic violence
    - JAG (Joint Action Group): developing problem-solving approaches to anti-social behaviour
    - MAPPA (Multi Agency Public Protection Arrangements): co-ordinating management and
    - Integrated Offender Management Meeting: cross-agency responses to crime and reoffending threats faced by local communities.
- We are an active participant in the London-wide group working to develop formal multi-agency Anti-Social Behaviour Risk Assessment Conferences and are part of a current project developing awareness of local resources and care pathways supporting the Earls Court community.

Our other indicators of quality reported in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	97%	97%

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Community patients whose care plans contain at least one personal recovery goal (Target: minimum 75%)	83%	83%
Inpatients who have a risk assessment completed and reflected in their care plan (Target: minimum 95%)	88%	89%
Patients who have their carer status identified (Target: minimum 70%)	80%	83%
Community patients report they got enough advice and support for their physical health (Target: minimum 80%)	87%	86%
Inpatients who received a physical health care assessment after admission (by both nursing and medical staff) (Target: minimum 95%)	72%	91%
Community patients who report having a phone number to call in a crisis (out of hours) (Target: minimum 85%)	88%	85%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Overall we are pleased that we have exceed the target and improved on last year's performance across a number of indicators. Here are some actions taken throughout the year:

- Effective senior leadership and positive role modelling for all staff within each service area.
- Roll out of appropriate training where staff skills gaps have been identified with on-going support available for staff through supervision and appraisal.
- Team managers will continue to closely manage their teams' performance by regularly monitoring internal performance targets using existing reporting systems.
- Borough-wide physical health steering group that will continually monitor performance of the recently established community wellbeing clinics and inpatient physical health care initiatives such as the SHINE project.

How we responded when things didn't go as planned

Our incidents: Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents result in low or no harm.

The Clinical and Borough Directors are leading on thematic review and learning from incidents that have happened in the borough over the last 18 months. This work will be to identify any themes and specific service areas with a view to improved learning and practice. This work will conclude in May 2016 and the findings will be shared in a wider forum including patients, carers, commissioners and other relevant parties.

We identified learning within our older people services about how to better manage the risks of slips, trips and falls through reviewing incidents. Sharing the learning from incidents relating to medications has helped to decrease these types of incidents.

To ensure our inpatients remain safe during difficult times we have introduced environment changes to reduce the risk of detained patients absconding from the wards, as well as introduced measures to ensure that prone restraint and rapid tranquilisation is utilised as a last resort, and when

there is a need for patient seclusion that they receive on-going nursing and medical reviews. Monitoring of this is completed weekly by the matron.

Our complaints: Key themes from our complaints this year have been about concerns regarding detention under the Mental Health Act, poor communication, and professionalism of staff. In response we will be focussed on responsive engagement and local resolution following any patient concerns, review and improve our administration processes to ensure information is forwarded to other agencies, including GPs, in a timely manner, and emphasise the importance of staff behaviour and the impact it has on patient experience.

What we've done well and our plans for this year

- Our Early Intervention Service introduced the access and waits standard for patients with suspected first episode psychosis (FEP). The new standard has no age limit and requires patients presenting as suspected FEP to commence NICE concordant treatment within 2 weeks of referral. This means our patients are seen promptly and receive the most effective care.
- A review of skill mix has successfully led to the recruitment of a senior peer support worker and the introduction of two employment specialist posts within both the north and south community mental health teams to provide more support to patients. We plan to increase the number of peer support worker posts within both adult and older adult services. We also plan to expand the Individual Placement Support employment model.
- There are plans to increase access to the CNWL Recovery and Wellbeing College spoke courses in the borough and plan to develop our relationship with the local Kensington and Chelsea College so that we can run courses from their campus.
- Effective link with the Trust peer bank to continue and build upon co-production initiatives within the borough.
- An IT dictation initiative will be piloted within the borough, the overall aim being to reduce bureaucracy and increase face-to-face interaction between staff and patients.
- Kensington and Chelsea community mental health team and Pharmacy are working on the introduction of Point of Care Haematology (PocHi) Analyser into the North Kensington Clozapine Clinic, which is located in Pall Mall. Clozapine is a medicine that cannot be given to patients unless blood tests are done and the results available. The introduction of the PocHi blood testing systems will mean patients will be able to have their blood test and collect their Clozapine medication on the same day because blood results are available within five minutes.

We are pleased to receive feedback on our Quality Account and look forward to working in partnership this year with our patients, carers, Healthwatch, local authority and commissioners.

Milton Keynes Community Health

Our services

We provide a wide range of community health services for children and adults with physical health problems in Milton Keynes (MK). Services include Community Nursing, Universal Children's Services such as Health Visiting and School Nursing, Podiatry, Intermediate Care, Dental Services and Specialist Therapies ranging from Speech and Language to Neurological Rehabilitation.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	96%	92%
Staff FFT (Target: minimum 66%)	76%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year

Here are some actions we have taken to improve:

- Our Windsor Intermediate Care Unit has developed a successful traffic light system with walking frames. This was as a result of feedback where patients indicated they were being asked unnecessarily if they should be walking around attended, unattended or not at all. The team developed a colour coded system by which one of the 3 traffic light colours hangs from the frame to indicate the level of the patient's ability to use the frame.

- The Family Nurse Partnership Service has successfully improvised in involving its patients by hosting a themed annual review which brings together nurses, supporting organisations, display boards showcasing patient's journey and also offers service users to present and share their patient stories.

- Within the Adult Hearing Team a 'Story Wall' was set up where service users were offered the opportunity to describe their experience. This 'Story Wall' is in prime position in the waiting area where a 'Story of the Month' is displayed.

- Whilst the results exceed both the target and the Trust average, we also recognise that one in four of our staff are, in some way, not as happy as they could be in their workplace and we do not want to lose sight of this. During 2016 we will be engaging with staff more frequently, and at a team level, so we can respond more specifically for ways of improving and ensuring that staff have a rewarding and fulfilling time at work.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 83% Definitely and to some extent: 96%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	84%	96%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

The Service works hard to ensure that patients feel involved as much as possible in all decisions relating to the care and treatment offered to them. An innovative approach to treatment planning is evidenced by the

Buckinghamshire Priority Dental Service who put together an illustrated story board that describes a patient journey for children and adults with complex needs. The story board aims to ease the fears of the patient with complex needs who is set to have an operation, as well as the parents, by explaining the process in easy to understand terms. The story board was such a success that it is now being adapted to help paediatric patients going for a dental general anaesthetic.

Achieving what matters to patients is pivotal in Specialist Therapy Services where many approaches have been established to support patients. A Multiple System Atrophy Support Group has been set up for patients (and carers) of the disease; created in response to the emergence of three new cases of this rare disease for patients who were isolated. Two Specialists began, and now facilitate a Social Support Group which meets monthly to support patients with an Acquired Brain Injury; this includes demonstrations and guest speakers.

Our other indicators of quality reported in the Quality Account
These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	100%	97%
Community health patients who report that they got enough advice and support for their mental health (Target: minimum 85%)	73%	78%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

MK Community Services consistently exceed the targeted priorities and are especially proud where 100% of our patients express being 'treated with dignity and respect'; this demonstrates the caring nature embedded in the culture that underpins the service delivered to our patients. We aim to continually embed this positive culture through 'Meet the Director' sessions for all new staff, regular supervision, and provide staff with the opportunity to speak up and make change.

The Service recognises that it needs to strengthen the advice and support given to the community patients about their mental health needs and plan to develop a strategy through 2016 to address this.

How we responded when things didn't go as planned

Our incidents: Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents result in low or no harm.

Pressure Ulcers remain the highest reported category of incidents within Community Services. In response to this our Tissue Viability Team has delivered training sessions, in addition to the specific to role training which is provided each month. These targeted training sessions were provided to specific locations where a cluster of pressure sores were identified, where a particular incident had resulted in a more serious nature or where improvement in communication between team members had been identified. These targeted sessions focussed on accountability and good record keeping. This training will continue through 2016 with the adaption of training presentations as and when additional key learning is identified.

Our complaints: Complaints received are limited for our services but we value each and every one. Following a thematic analysis it was found that when people do complain this is usually about treatment and communication. One of the ways we are addressing this, is to review patient leaflets and service information that is made available, and to ensure it is clear what services we do provide. We are also looking at other ways of communicating with our patients as an alternative to a reliance on letters. The texting of appointments is speedy but we want to make sure this is what our patients want.

What we've done well and our plans for next year

- The High Impact Team is successfully working with local care homes to reduce the need for residents to go into hospital as 'unplanned' emergency admissions by proactively managing their health and care needs and focusing on prevention. The service was piloted in Milton Keynes and saw a 31% drop in older people being admitted to hospital from care homes. It is now being rolled out to 28 care homes.

- The 'Children with Complex Needs' won the annual GEM award for Team of Year 2015, clearly demonstrating commitment, passion, professionalism and care whilst providing care to children with life-limiting and complex medical conditions. This team recognise the importance of supporting the whole family and others involved in the child's care; and provide an out-of-hours on-call service to families to make sure that parents and carers can speak to someone they know for advice about their child's medical condition at any time.

- Hillingdon Dental services are now working closely with 18 local Children's Centres to promote the "Brushing for Life" program for children aged between 0 – 5 years where parent/carers receive free toothbrushes/toothpaste and education on keeping teeth healthy.

Milton Keynes Mental Health

Our services

Most of our services are community-based and provide help to support, care and treat a wide range of mental disorders, such as severe anxieties and depression, psychotic illnesses, such as schizophrenia and bipolar affective disorder, personality disorders, and dementia. Services include our Assessment and Short Term Intervention Team (ASTI), Acute Home Treatment Team; Specialist Therapies Team, Specialist Memory Services, CAMHS, Recovery and Rehabilitation and Talking Therapies (IAPT).

We also provide inpatient services within three units; The 38-bedded Campbell Centre, which provides care to working-age adults who require a hospital admission when suffering from a mental health problem; the six-bedded Cherrywood Mental Health Rehabilitation Unit, which provides short term residential rehabilitation to help people with severe and complex mental health problems gain or regain confidence and skills in everyday activities and return to independent living; and TOPAS (The Older Persons Assessment Service) unit, which is a 20-bedded unit providing assessment and treatment mainly for older people who have complex or acute mental health needs to help them to return to independent living wherever possible.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	87%	92%
Staff FFT (Target: minimum 66%)	67%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year

Patient FFT: We recognised the need to continue to improve and maintain both the response rate and satisfaction rate for the FFT from patients, service users and carers throughout the year.

Monthly FFT reports are discussed at individual service team meetings to ensure both negative and positive feedback is recognised and shared; and actions implemented. Overall FFT reports are presented at monthly senior

managers meetings, the Care Quality and Innovation Forum and Operational Managers meetings.

All services continue to offer the FFT in its various formats at all times, where appropriate to encourage patients' feedback.

In addition, our services continue to engage with our patients on a wider scale. For example:

- Service themed Mental Health Forums: Open public forums giving service users and carers an opportunity to share their experiences about receiving local mental health services. These events were well publicised throughout our services and with partner organisations and agencies including Healthwatch, MIND, Re-think and through GP practices. They were led by our service managers and attended by supporting staff, patients, carers, and external stakeholders. For the first time, attendees were asked to complete a feedback form which asked whether they found the Forum useful, how it could be improved and whether the Forum meet their expectations. Evaluation indicates useful discussions; better channels for promotion; greater number of patient representation and the need to improve relationships with local education providers (e.g. Milton Keynes College) to provide information, support and counselling for young people.
- TOPAS (The Older Persons Assessment Service): Community meetings are held each week to enable patients to have an opportunity to feedback about their care and discuss any improvements they would like.
- Campbell Centre: A psychologist-led patient engagement group was held for the designing of the 'My Care Plan' which is a more personalised care plan aiming to engage the patient early on in their care and consider what they want to achieve. Equally, the 'key worker' system in which a named nurse is responsible for one person's care planning has been successfully trialled. The new care plans are now being configured on our patient information system to ensure they become an integral care planning tool. If the pilot is successful this will be used for all patients at the Campbell Centre.
- Specialist Memory Services: Most care and treatment pathways have successful patient groups. Commendable work was undertaken by two of the service's Assistant Psychologists with the "life stories" project. This involves talking about past activities, events and experiences using prompts such as photographs, household and other familiar items from the past from which they can put together a booklet of the patient's life story. The books are then used as talking points for reminiscence and to assist others in talking about the person's life with them.

Staff FFT: We have improved two-way communications with staff. Existing staff are encouraged to attend a staff surgery to give feedback about their experiences of working in the local service.
Our new staff now meet with the Service Director early on in their career with CNWL to discuss how they are settling in. Both developments aim to encourage the development of on-going dialogue between staff and senior managers.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority Indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 70% Definitely and to some extent: 93%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	88%	91%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one	Our carer information DVD for Campbell Centre induction is being developed and is currently being costed prior to fully launching the project. We have also re-launched the Carer Forum at Campbell Centre, and hold Carer Feedback events. We are also working with our carers on what information they would find most useful so we can provide this.	

Key: "YTD" – results year-to-date, which is an aggregation of results over the year

The table identifies that we need to improve on those reporting a definite involvement in decisions about their care and treatment – however considering those who respond 'definitely and to some extent' we achieve 93% which is well above our target. In order to support improvement the pilot of the 'My Care Plan' is underway, and the care plans at TOPAS have been amended to be more specific around their particular client group. Further actions taken to foster patient involvement are detailed above. Work is being carried out with a group of carers at the Campbell Centre to scope what information would be useful to them and a DVD is being developed to provide this information, alongside an improved Welcome Pack.

Other indicators of quality reported in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	98%	97%
Community patients whose care plans contain at least one personal recovery goal (Target: minimum 75%)	81%	82%
Inpatients who have a risk assessment completed and reflected in their care plan (Target: minimum 95%)	74%	90%
Patients who have their carer status identified (Target: minimum 70%)	51%	83%
Community patients report they got enough advice and support for their physical health (Target: minimum 80%)	80%	85%
Inpatients who received a physical health care assessment after admission (by both nursing and medical staff) (Target: minimum 95%)	85%	91%
Community patients who report having a phone number to call in a crisis (out of hours) (Target: minimum 85%)	89%	85%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year

Here are some actions we have taken to improve:
More patients are now reporting that they are being treated with dignity and respect and there is an increase in the number of care plans detailing at least one personal recovery goal.

We are working with staff to improve recording in the care plan and that the risks identified in the risk assessment are better articulated in these. This will hopefully be developed as part of the 'My Care Plan' initiative currently being trialled at the Campbell Centre as detailed above.

Training sessions are being rolled out across all services to better equip mental health nurses with the knowledge, skill and confidence to monitor and record physical health issues to a better standard. This is an important issue within mental health services.

We have also been reminding staff of the importance of recording carer status by having lead carer roles in the inpatient areas and regular reviews/audits of records. We work closely with the Care Service employed by Milton Keynes Council who are co-located in one of our community teams.

How we responded when things didn't go as planned

One of the themes that has been highlighted as a result of the complaints that we have received has been around engagement with carers. As a result of this the Carers Forum held at the Campbell Centre has been re-launched and work is being carried out to film a DVD explaining the patient's journey and what can be expected whilst at the Campbell Centre. This will show the environment within the Campbell Centre and the sort of activities that take place and hopefully allay any fears that carers may have regarding the admission process and experience for their loved one.

The complaints process has also been reviewed and there is now much more emphasis on meeting with the complainant early in the process and again once the investigation has been completed. This allows for the issues to be discussed at a face to face meeting and helps resolve the issues much faster and to everyone's satisfaction.

We have also learned that more training is needed for our staff around the recording and monitoring of physical health conditions of our patients following two incidents. This work has started and is being rolled out across the services.

What we've done well and our plans for next year

• Specialist Memory Service - 2015 MSNAP accreditation: MK Memory Assessment Service received their MSNAP (Memory Services National Accreditation Programme) accreditation
• Street Triage - Received the 2015 GEM Award for Project of the Year. The project has also received further funding following a successful pilot; and has successfully reduced the number of Section 136 detentions by over 50% since it began. It was also nominated for an HSJ award. A Section 136 detention is where a person is taken to a health based place of safety for a mental health assessment.
• Campbell Centre - The Campbell Centre has recently been audited as part of the Accreditation for Acute Inpatient Mental Health Services (AIMS – there are some minor pieces of work being carried out before this is achieved but the Domestic Team received excellent feedback during this audit).
• Psychological Therapy Service, Medium Term Team and Complex Needs Service amalgamated to form the "Specialist Therapy Service" compromising of approximately 30 members of staff and including the Eating Disorders pathway.
• The Memory Assessment and Support Service and the Community Dementia Service merged to form the "Specialist Memory Service."
• Dr Reg Race, Managing Director of Quality Health, presented "Mental Health Services: Service Quality Change as Seen by Service Users 2005-15", Dr Race gave an overview of the exceptional performance by MK Mental Health services as per results of the 2015 Annual Community Mental Health Survey.

Our plans for next year:
• To continue to develop our services in line with the additional funding received
• To continue with our patient forums to maintain open dialogue and improve engagement
• To develop the Urgent Care Pathway
• To improve access into our mental health services
• To increase engagement with community groups
• To improve recruitment and retention of all staff groups
• For Campbell Centre to achieve Accreditation for Inpatient Mental Health Services (AIMS)

We are pleased to receive feedback on our Quality Account and look forward to working in partnership this year with our patients, carers, Healthwatch, local authority and commissioners.

Westminster

Our services

We provide a wide range of mental health services in Westminster for adults and older people. Services include acute mental health services, community mental health services, home treatment rapid response services and therapies services. Unique to this borough are the Forced Migration Trauma Service and Joint Homelessness Team. We have three adult inpatient wards located at the Gordon Hospital.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	67%	92%
Staff FFT (Target: minimum 66%)	54%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions we have taken to improve:
We regularly engage with our patients and staff through various means. Many of the borough teams hold regular patient and carer focused meetings, for example at the Gordon Hospital, the Service Manager meets with the advocacy workers quarterly to get updates and briefings from them about what patients and carers have fed back to them about our services. Inpatient wards hold patient meetings and forums where patients raise issues, and they are responded to by the ward staff. Patients from the wards are invited to be part of the monthly inpatient Care Quality meeting where they have a regular slot. At this meeting they share and discuss their experience of the service with the management team, who respond to all feedback in a meaningful way. We involve patients in decision making that affects their care, as far as possible. This was evident during a review of the catering contract at the Gordon Hospital where patients were asked for their feedback and it identified the need for a greater choice of healthy options and snacks to be available aside from meal times. As a result, fruit is now provided to the wards twice a day as well as a wider range of healthy snacks.

A monthly partnership meeting is held with local Learning Disability services at which there is a regular session for the Project Worker (from the Advocacy Project) and patient representatives to feedback the work they have been doing particularly at the Gordon Hospital. As a result of this engagement, patients are now working with colleagues in the Learning Disability service to provide some bespoke awareness training to our inpatient staff.

At the Butterworth Centre meetings with carers are held every six weeks during which carers are provided with feedback and asked for their input. If

carers are not able to attend, including those abroad, they are sent copies of the meeting minutes and asked for their feedback by email.

We have redesigned the way in which community services are delivered in Westminster. As part of this process monthly workshops for stakeholders were held which were attended by patients, carers and staff from services directly affected by the re-design and more widely across the borough. The workshops have been well attended and feedback was received from staff saying how valued the workshops were, and that staff had felt engaged with the process; reflecting that they were part of the re-design process and did not felt that the redesign had been done to them. The Borough Directors have presented this work at several other forums across the borough throughout the year including the Healthwatch Public and Patient Forum.

Staff told us they valued face-to-face briefing and feedback sessions so we have developed a staff engagement plan covering a range of initiatives including; a monthly 'get to know you' coffee for new staff to meet with the senior management team. Quarterly staff engagement activity in the Borough/service areas which may include training events, staff meetings, a health and wellbeing initiative with occupational health input and listening events. These events will be held in different sites across the borough. The first monthly 'get to know you' coffee for new staff to meet with the senior management was held in February and was very successful.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 61% Definitely and to some extent: 90%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	86%	91%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one	This year the borough has focused on ensuring that the carers data reflects the work being undertaken in the teams. For example, The Butterworth Centre holds a six-weekly carers group, to hear from and feedback to our carers.	

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Performance on patient engagement in their care and treatment has disappointedly not reached the level expected. Teams are aware of this and robust local plans have been implemented to improve performance. Structures are now in place to ensure that performance against the quality indicator is regularly discussed and reviewed in team meetings and learning is shared across teams by the community service manager has ensured that learning is disseminated across all relevant teams.

As part of the community service redesign a new model of care has been introduced to give greater focus to recovery and working with patients to develop individual care plans which identify their personal recovery goals. The new service model places a greater emphasis on the team approach with proactive engagement in the care planning process with frequent and regular reviews to better support people to move to greater independence.

Work is also underway to review the care planning documents that are used to improve their functionality, make them shorter and more user friendly for patients.

Our other indicators of quality reported in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	94%	97%
Community patients whose care plans contain at least one personal recovery goal (Target: minimum 75%)	81%	83%
Inpatients who have a risk assessment completed and reflected in their care plan (Target: minimum 95%)	78%	89%
Patients who have their carer status identified (Target: minimum 70%)	80%	83%
Community patients report they got enough advice and support for their physical health (Target: minimum 80%)	85%	86%
Inpatients who received a physical health care assessment after admission (by both nursing and medical staff) (Target: minimum 95%)	93%	91%
Community patients who report having a phone number to call in a crisis (out of hours) (Target: minimum 85%)	80%	85%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some of the actions taken throughout the year:

The newly re-designed community services have systems in place to deliver against and monitor all quality and performance indicators to ensure consistency and timeliness of approach. A new service model has also been introduced into the inpatient wards which includes the new approach to quality and performance. We will build on the improved performance seen in some areas, for example, care plans containing at least one personal recovery goal, and address performance in areas where the borough has not achieved the target.

A significant amount of work has been done in the community teams to ensure that information about carers has been updated and reflected on the clinical system, and that carer assessments are reviewed and updated in a timely manner.

Following the introduction of the new Single Point of Access (SPA) in November 2015 the Service Manager and Community Team Managers have made sure that patients, staff and carers have the information they need about what the SPA does and how to contact the service.

How we responded when things didn't go as planned

Our complaints: Key for the past year has been what we learn from complaints and how we share the learning. Anonymised complaint feedback forms part of our quarterly quality newsletter to staff and learning is shared among teams as part of local care quality meetings. It is also important to

recognise that services have also received a number of compliments and the learning from these is also shared. There have been no outliers in terms of complaint themes or any area receiving significantly more than another. Our incidents: Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents result in low or no harm. Structures for sharing the learning from serious incidents have been embedded across all service in Westminster. A monthly Clinical Review Meeting (CRM) is held with service managers to review the learning from incidents. Clinicians are invited to attend serious case discussions. These meetings are replicated across all services and teams where the lessons and actions are discussed with staff and the necessary changes made where appropriate. There have unfortunately been a number of deaths in the borough which have been attributed to natural causes and a review is being undertaken to provide a greater understanding of the issues and to identify the learning.

What we've done well and our plans for this year

A major focus of this year has been to re-design our community services which has brought significant change to the team structures and service model for community mental health services, including psychological therapies and inpatient services, where a new inpatient model was introduced.

The introduction of the Single Point of Access, Home Treatment Rapid Response Team and Centralised Approved Mental Health Professional Service have involved changes to the way we work across all the services. The positive engagement by staff and their flexible approach to the changes have been notable, where they have maintained the focus on the patients whilst implementing significant changes.

The next year will bring opportunities to embed the new model across all the services, developing our workforce and continuing to support patients to achieve their recovery goals. A key area for further development is closer working with third sector, local authority and primary care partners to support the transitions between primary and secondary care.

We are pleased to receive feedback on our Quality Account and look forward to working in partnership this year with our patients, carers, Healthwatch, local authority and commissioners.

Our specialist services

Addictions

Our services

Community Addictions provide a range of clinically evidenced substance misuse services for drugs and alcohol across six London boroughs, including, Barnet, Brent, Ealing, Hackney, Harrow, and Hillingdon. The directorate also provides a specialist Club Drug Clinic and leads the response to the New Psychoactive Substance (NPS) issue, and the National Problem Gambling Clinic primarily commissioned through the Responsible Gambling Trust. We also provide a range of smaller services that include Alcohol Liaison at UCLH and specialist integrated working with Hepatology services at St Marys Hospital, and a clinic with sexual health at Chelsea & Westminster Hospital.

Community Addictions also provide peripatetic nursing services to homeless individuals through targeted GP practices across Westminster and Kensington and Chelsea and a Family Therapy Parenting service in Hammersmith & Fulham.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	94%	92%
Staff FFT (Target: minimum 66%)	72% *	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year. *Figure is for Addiction & Offender care

Patient Friends and Family test results:
We are proud that 94% of our patients would recommend our Addiction services to family or friends if they needed similar care or treatment, achieving our target and out-performing the Trust average.

This result was associated with a number of positive comments such as staff care, support and understanding, and staff respect of confidentiality and sensitive issues. Two patients' comments were: "*the service provided is of a very high standard, and the benefits for me have been instant', and "Service is excellent. Has been of great help stabilising me and returning a degree of normality".*

Themes from our negative responses were that scripts take too long to get, not all staff feel well informed about addition issues, and general comments that the service could be 'better'. To deliver improvements the following actions are in place:

- A review of the delays in wait times for prescriptions based on feedback from our local service user forums, and amend local systems to ensure wait times are minimised,
- The majority of Addiction services were retendered and mobilised from July 2015 resulting in a number of new staff teams. All services are working through a programme of staff training to ensure that all staff understand service procedures as well as being skilled and competent to deliver clinical and recovery care. Our teams also ensure that all staff have regular supervision so that training needs can be identified and provided.
- To identify areas where the service could improve further, services employ a variety of methods for collecting service user feedback and responding, for example Service User Forums, suggestion boxes, annual surveys and 'you said we did' boards.

In November 2015 Addictions completed a peer-led annual survey of 430 service users. The survey tool was developed with members of the Strategic Service User Group, and had two key outcomes for improvement: Patients recognising their care plan when they had been given one and helping service users identify treatment goals. As a result we now provide and work through the care plan document at all key worker sessions, and key workers are to set shorter 'stepped' goals every few weeks with progress followed up.

Staff Friends and Family test results:
Addictions achieved the Trust target and out-performed the Trust average for staff recommending our services. Positive responses included 'patients are treated with compassion and respect, and are involved in the decision processes', 'this is a good NHS Trust with good standards of care', and 'our doctors and nurses *work under a code of conduct for which they are accountable for their practice'.*

The key areas for improvement highlighted was 'staff engagement' as a result of much service change such as re-tendering and acquisition processes which has caused a level of stress and disruption for our staff. Actions taken as a result:

- The Addictions Director holds 'Meet the Director' sessions with new staff coming into CNWL. Forum for staff to feedback about the transfer and recruitment processes, and service issues. These are fed back to local management to inform improvement plans.

- Services in Hillingdon also held a Welcome Staff Sports Day in August 2015 following the transfer of new staff into the service that was very positively received.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 70% Definitely and to some extent: 95%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	93%	91%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one	We continue to closely monitor our recording of carers details on our clinical systems for appropriate follow-up, and to date achieved this in almost 90% of cases. Our Hillingdon service continues to provide carers assessments and interventions; and in our other services this is a contracted function of our partner agencies.	

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions we have taken to improve:

- The Addictions service has a focus on improving care planning and patient involvement using a visual mapping processes that uses diagrams to facilitate working with the service user and developing their care and treatment with them.
- The Addictions Pharmacy team are delivering 'best practice' training to include training on involving the patient in decisions about their care and treatment including medication; and for to be evidenced in the progress notes.
- We will use the on-going feedback from our FFT cards and repeated annual Peer Audit both which ask if patients feel involved in decisions of their care plan as a way to monitor this.

Our other indicators of quality reported in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	98%	97%
Patients who have their carer status identified (Target: minimum 70%)	89%	83%
Community patients who report having a phone number to call in a crisis (out of hours) (Target: minimum 85%)	75%	85%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions we have taken to improve:

We are pleased that we have achieved our target and out-performed the Trust average for patients reporting feeling treated with dignity and respect,

and our recording of the details our patients' carers for follow-up support. We need to get better at ensuring our patients all have a phone number to call out of hours in case of crisis. The service has included this indicator as one of the key priorities for 2016/17: Our services are using Additions Crisis Cards and developing a crisis leaflet to hand out to clients at treatment start and have available in patient areas. Services will also re-check crisis information as part of the 3-month care plan review and will also develop disengagement plans with patients that include crisis contact numbers.

How we responded when things didn't go as planned

Our complaints: The themes from the complaints made to Addictions services are about access/admissions, clinical assessments and treatments, consent/confidentiality, medication administration, supply and advice, and staff issues. The key lessons we have learned from these have been:

- More timely communication to patients to explain their treatment.
- Checking that patients understand discussions about their treatment.
- The need to review of the management of benzodiazepine addiction and those misusing pain killers, as these have been a source of complaints. This will be discussed for action in our May 2016 Strategic Care Quality Meeting.

Our incidents: Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents result in low or no harm.

Our older patient population are increasingly presenting with long term and complex physical health conditions; primarily cardiovascular conditions and respiratory conditions like Chronic Obstructive Airways Disease or pneumonia. As a result the follow actions have been taken:

- Addictions priorities for 2016/17 include risk assessment and risk management plans; care planning; crisis planning; communication with GP; optimising treatment; prescribing relapse prevention medication, so this can be closely monitored and acted upon,
- Introducing nursing health checks for all prescribed patients,
- All services have a standard to contact patients on the day that they 'do not attend' and continue to follow up daily until contact is made; this includes home visits.

What we've done well and our plans for next year

Addictions experienced service changes during 2015/16: Two existing services were re-tendered and were retained. We also acquired a further three new services in Hackney, Harrow and Barnet that started on 1 October 2015.
In February 2015 the Trust's Care Quality Commission inspection included a pilot inspection of four Addiction services. This was not reported as part of the overall Trust rating, however all services were reported to be rateable as 'Good' with commendable patient user involvement.

The 5th CNWL Addictions Service User Conference was held in May 2015, and was organised by Addictions Strategic Service User Group. The theme was 'Re-Engage' and was attended by 130 patients, carers and staff from across CNWL Addiction services and partner agencies. This year we are planning another conference in September 2016 themed 'Connect'.

We have also developed a 'Leadership and Succession Planning Programme for band 6 and 7's with our Divisional Head of Education. This was rolled out in March 2016 with 17 staff in attendance.

Child and Adolescent Mental Health Services (London)

Our Services

We provide CAMHS services in the London boroughs of Brent, Harrow, Hillingdon, Kensington and Chelsea, Westminster. We provide a specialist Tier 4 national inpatient CAMHS service, Collingham Child and Family Centre in Kensington. Coombe Wood is our NHS England commissioned inpatient perinatal unit for mothers and babies located in Brent.

Our CAMHS services include children's community mental health services, children's inpatient services, mother and baby inpatient services, perinatal services and borough specific services such as CAMHS in Youth Outreach Team, gang work and liaison in acute hospitals.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	87%	92%
Staff FFT (Target: 66% minimum)	74%*	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year. *Figure is for CAMHS & Eating Disorders

Patient feedback is valued and welcomed and we are pleased with the feedback from the Friends and Family test during 2015/16. Patient and carer feedback is gathered via our on-line survey, FFT feedback cards, audits, patient and parent group meetings as well as from complaints and any incident investigations.

Although above the Trust average, we are disappointed with the Staff Friends and Family Test during this year. The merger of the management structure between CAMHS and Eating Disorders services was challenging and also occurred at a time of service changes in the various boroughs which, we recognise, was unsettling for staff. In addressing this, the service line management team has worked with staff from across the service line to develop an improvement plan. We are introducing 'Meet the Directors' aimed at members of staff in the first months of a new role.

The CAMHS service continues to offer specialist training and expert supervision for staff as a means of continuous quality improvement and motivation for staff. The service has planned a series multi-disciplinary team clinician away days to consider service provision, pathways and clinical engagement. The senior management has also recruited a wider range of clinical representatives into a Clinical Effectiveness Group to support change to practice and engagement. Improving the quality of appraisal and learning opportunities is also part of the service line's workforce plan.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority indicators	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 93% Definitely and to some extent: 93%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	93%	91%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions we have taken to improve:
During 2015/16 the CAMHS services worked with children and young people user groups to develop a care plan template, and to agree how they would

like to be involved in developing their care plan. The process drew on the principles of Children and Young People's IAPT (Improved Access to Psychological Therapies), namely:

- Meaningful Participation and collaboration
- Evidence-based practice including NICE approved interventions
- Clinically relevant session-by-session outcome measures

Our other indicators of quality reported in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	100%	97%
Inpatients who have a risk assessment completed and reflected in their care plan (Target: minimum 95%)	99%	90%
Patients who have their carer status identified (Target: minimum 70%)	86%	83%
Inpatients who received a physical health care assessment after admission (by both nursing and medical staff) (Target: minimum 80%)	93%	91%
Community patients who report having a phone number to call in a crisis (out of hours) (Target: minimum 85%)	92%	85%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

We are pleased to report that we have achieved our quality indicator targets and out-performed the Trust average. We know that children and young people recognising their care plans and the planning process remains an area of concern. This is an area being addressed through the work of the CAMHS & Eating Disorders Service Clinical Effectiveness Group. Apart from the work already described, we plan to review the new arrangement in during 2016/17.

How we responded when things didn't go as planned

Our complaints**:** Of the small number of complaints received, a theme of staff attitude and approach has come up. This has been dealt with through feedback and clinical supervision. The service continues to make use of specific reflective supervision of its staff to raise awareness of good communication with our service users. Secondly access and waiting times particularly in our outer London services is a theme. The issues relating to access were linked in Harrow to the lack of commissioned tier 2 services. This is being addresses through close work with our commissioners and measures to develop services are actively being put in place for2016/17 through CAMHS transformation monies. Hillingdon commissioners have invested in a new Crisis and Complex Care Team to work with young people with urgent presentations as well as a new learning disability service to address capacity and gaps in service provision.

Our incidents: Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents result in low or no harm.

The community perinatal service had one serious incident in the last year. The importance of good clinical leadership in management of referrals and consistent skilled administration to support the clinical system was the key message from the learning from this incident. As a result, the management and administration processes have been reviewed for the service there have been incidents of information governance breaches where identifiable

information has been sent to the wrong team via email. The members of staff involved have all revisited their Information Governance training.

During the last six months of the year, there have been continual difficulties in accessing tier 4 services for children and young people. Access to specialist urgent access tier 4 services for children with a moderate to severe learning disabilities or autistic spectrum disorders have also been of concern. This has been raised internally in the Trust as well as at North West London Care Quality Meetings and with NHS England. The service will continue to work with commissioners to develop and influence other options as the opportunity arises.

What we've done well and our plans for this year

The Coombe Wood Mother and Baby Unit have successfully maintained its accreditation by The Royal College of Psychiatry Quality Network for Perinatal Mental Health Service. The service will work to maintain its accreditation during 2016/17.

The Collingham Child and Family Centre have successfully maintained its accreditation by The Royal College of Psychiatry Quality Network for In Patient CAMHS. The service will work to maintain its accreditation during 2016/17.

The service line is developing a CAMHS Eating Disorders service as part of the national CAMHS transformation strategy. The new service will be collocated and delivered alongside the existing eating disorders service. The multi-disciplinary service, once up and running, will aim to deliver against the ambition of treating young people using the latest evidence based family based treatment models which is ageless, flexible and has the capacity to manage transitions well, where this is necessary, for young people with the most complex eating problems.

Other initiatives include the Multi-System Therapy Team (MST) which has gone from strength to strength. The service is managed in CNWL and provides the MST approach to the Tri Borough. This is an evidence based approach for 10 – 17 year olds who have challenging behaviour and are known to Children's social care or youth offending services. We successfully received funding until 2017 when the service model and impact will be evaluated.

Eating Disorders Services

Our Services

CNWL's Eating Disorders Service is known as Vincent Square Eating Disorder Service (VSEDS) and located at South Kensington and Chelsea Mental Health Centre with a satellite service at Northwick Park Hospital in Harrow. The Eating Disorders service is commissioned by NHS England and national referrals are accepted for inpatient, outpatient and day patient services.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average.

	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	100%	92%
Staff FFT (Target: minimum 66%)	74%*	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year. *Figure is for CAMHS and Eating Disorders.

We are pleased with the feedback from the Friends and Family Test during 2015/16. Patient feedback as part of the care delivery is valued and welcomed via audits, community meetings as well as complaints. Overall

patients were positive about their experience at VSEDS. They reported feeling listened to and supported; finding staff friendly and approachable. They also talked about their satisfaction of the therapy they received and feeling confident in overcoming their eating disorder. They found the books recommended by staff helpful. Inpatient groups were also described as helpful.

There were some areas indicated for service improvement. Several patients commented that reception staff were not always welcoming and polite in South Kensington. To address this, we have reviewed our administrative structures and are recruiting into permanent roles alongside beginning to plan training and development for this important group of staff. Patients also commented on struggling with long wait times and the lack of communication whilst waiting saying they would like some communication to let them know they have not been forgotten. Patients would also like more key worker sessions on the ward.

Quotes from our patients:

Patient: 'I would like to give extra thanks to the staff for their continued commitment and caring attitude toward all the patients here. I particularly enjoyed attending recovery talks from guest speakers, providing motivation for us all. Additionally, I found self-catering to be a useful experience for practicing outside the ward.'

Patient: 'I've only had one therapy session but I've been impressed with the process so far. The 4 month wait for treatment was challenging but am happy with the staff and experience so far'.

We are disappointed with our results in the Staff FFT during this year, although we have achieved the target and done better than the Trust average. Staff feedback has been affected by the merger of the management structure between CAMHS and Eating Disorders Services which has been a challenge for all concerned. This coincided with a high rate of experienced staff turnover in the service due to relocations and retirement. To address this, the service line management has worked with staff from across the service line to develop improvement plan around this area. We are also introducing a 'Meet the Directors' scheme for all new starters within the first months of a new role.

There are reflective practice sessions in place to provide support to people working in our services. In addition, the service has also had a whole service away day to look at service provision and how the team works together. The senior management has also recruited to crucial roles such as the Matron who will be key in supporting staff on a day to day basis. Improving the quality of appraisal and learning opportunities is also part of the service line's workforce plan.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 58% Definitely and to some extent: 90%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	80%	91%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one		
In the Autumn of 2015 a Carers Skills Workshop was facilitated on the Unit, led by the Family Therapist and Nursing staff. The purpose of the workshop		

was to help parents gain a better understanding of Eating Disorders and equip them with the skills to manage the illness at home with their family. Below is what some of the attendees said about this workshop:
"The workshops have taught me new skills to help with my relationship with my loved one with an eating disorder".
"The workshops have made me more confident in how to approach issues with my loved one with an eating disorder".
In addition we are currently developing a Carers Assessment which will be used within the Service in helping support families with Eating Disorders, this is been developed in conjunction with a carer.

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Other indicators reported in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	94%	97%
Inpatients who have a risk assessment completed and reflected in their care plan (Target: minimum 95%)	98%	90%
Patients who have their carer status identified (Target: minimum 70%)	91%	83%
Inpatients who received a physical health care assessment after admission (by both nursing and medical staff) (Target: minimum 95%)	100%	91%
Community patients who report having a phone number to call in a crisis (out of hours) (Target: minimum 85%)	92%	85%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

The service has performed well against the main areas in the quality account. It is key that inpatients receive a physical healthcare assessment after admission and this is a particular area which will be prioritised in the service next year. All new members of staff have induction and objectives set that inform their role as a means of ensuring focus on these targets.

As part of care planning and a partnership approach to treatment expectations of treatment are discussed and agreed with service users. The staff receive regular feedback and take part in local care quality groups and highlights/trends are discussed in the service line Care Quality Group.

How we responded when things didn't go as planned

Our complaints: There have been very small numbers of complaints this year. However, staff attitude and approach has come up as a theme in complaints this has been dealt with through feedback and clinical supervision. The service continues to make use of specific reflective supervision of its staff to raise awareness of good communication with our service users.
Our incidents: Incident reporting has much improved over the year. DATIX (the system used to report incidents) has been reviewed and issues discussed in local care quality meetings. There is no one theme but incidents have demonstrated that the service is working with patients who present with complex issues and challenges that require staff being well trained in de-escalation and negotiation skills.

What we've done well and our plans for this year

The service was successfully assessed and accredited by The Royal College of Psychiatry Quality Network for Eating Disorders (QED). The service will work to maintain its accreditation during 2016/17.

The service line is developing a CAMHS Eating Disorders service as part of the national CAMHS transformation strategy. The new service will be co-located and delivered alongside the existing VSEDS service. The multi-disciplinary service, once up and running, will aim to deliver against the ambition of treating young people using the latest evidence based family based treatment models which is ageless, flexible and has the capacity to manage transitions well where this is necessary for young people with the most complex eating problems.

Learning Disability Services

Our services

We provide services to people with learning disabilities and mental health services who require specialist assessment and treatment. We deliver community and inpatient assessments, treatment and recovery services for people in the London area and we accept national referrals to our inpatient facilities. CNWL's learning disabilities services include an Autism Diagnostic Service, psychosexual assessment services, community learning disability services and inpatient learning disability assessment and treatment services.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	63%	91%
Staff FFT (Target: minimum 66%)	61%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions we have taken to improve:

- Following the introduction of the Friends and Family Test (FFT) easy-read card we found that our response rate fell which is an indication of how difficult it is to survey our client group. We believe that a higher return is possible by including the Friends and Family Test questions on our 'Learning Disability Service User Questionnaires' to obtain a more robust and representative sample. We plan to do this next year to increase our response rate, and share the learning from this approach.
- Our source of feedback from staff has been primarily through the staff survey and this approach will be reviewed to help better understand staff perceptions, get more detailed feedback to be able to work together to solve issues.
- Through the year we received many quotes related to the satisfaction felt by patients and carers. Some of these are highlighted below:

From our community teams:

- "Very helpful and supportive and able to identity and offer solutions"
- "The team was nice and patient and very helpful"
- "Very happy with the way the meeting went and the result. I would always go back again."

From our inpatient teams:

- "Kingswood centre is a very nice, friendly place. I like coming here"
- "Good communications to the family" and "Good caring support to young people at Seacole"
- "I like activities here. I like Speak Up. I'll be chairing today."
- "It's OK here. Staff try their best you know."

Inpatients' carer feedback:

- "The best thing is the staff. All the medical staff including the doctors and consultant were very helpful and approachable. Always met us when asked. The Nurses and carers were exceptionally good, providing care, love and support for X under challenging conditions."
- "Safe and secure unit with excellent staff. It must really be a lifeline to other parents and carers whose relatives needs are best met in such a setting."

How we did against out Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested a variety of things in our Learning Disability Service using amended Quality Priority questions as appropriate. The table below shows how we did:

Learning Disability inpatient questions asked:	2015/16 (YTD)	Trust average (YTD)
"Are you happy with your Big Meeting / your CPA?"	80%	n/a
"Are the staff good at listening to you?"	82%	n/a
"Are you treated fairly in hospital?"	79%	n/a
Learning Disability community questions asked:	**2015/16 (YTD)**	**Trust average (YTD)**
"Did you find the meeting helpful?"	92%	n/a
"Did they [staff] listen to you?"	100%	n/a
"Was it easy for you to talk to them?"	93%	n/a
Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one:		
We have engaged carers through a variety of events where both carers and patients were present. These ranged from BBQ's on our inpatient sites, themed events where carers were invited to topic specific workshops relevant to them. Additionally the community teams accessed carers and patients through community events organised by Mencap in their relevant borough. These events allowed us to engage carers and patients to find out what they think of our services and how we can better meet their needs.		

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

We will review our patient questionnaire approach in the new financial year to develop learning disability specific questions to support the monitoring, action and achievement of our quality indicators, as well as gain a greater response rate from the new approach.

Other indicators of quality we report on in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Inpatients who have a risk assessment completed and reflected in their care plan (Target: minimum 95%)	94%	90%
Patients who have their carer status identified (Target: minimum 70%)	79%	83%
Inpatients who received a physical health care assessment after admission (by both nursing and medical staff) (Target: minimum 95%)	94%	91%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions taken throughout the year:

The missed target for "Inpatients who have a risk assessment completed and reflected in their care plan" and for "Inpatients who received a physical health care assessment after admission" is being addressed by the Lead Consultant. Discussions are underway with respective Consultants about how to make sure their Doctors, or the Consultant, complete the risk assessments on time ensuring that the managers are also engaged in checking that tasks are completed using the checklist on the clinical system. Support will be offered to staff if needed to help prevent recurrence of failing to capture data at the right time.

How we responded when things didn't go as planned

Our incidents: The Learning Disability Service routinely record all incidents that happen across the service and share all learning from them. We record, capture and review incidents at our senior managers meetings on a monthly basis. All managers can now run their own reports using our information systems so teams of clinicians caring for patients can now start to look at patterns from data. This also means that patterns can be identified from incidents, trends, and risk behaviours so that further lessons can be identified and shared across the service.

A new member of staff has been brought in to help reduce patients' challenging behaviour. This new role will apply Positive Behaviour Approaches across the staff base and all front line staff will be trained to use this method (which is applied together with de-escalation techniques) when patients exhibit challenging behaviour. This approach has been well received by staff trained to date.
Our complaints: Complaints relating to eight different patients have been received and all have been resolved. Our lessons learnt:

- We will continue to be transparent with families about the care their family member receives
- We will maintain good communication channels with them and address issues as they arise
- We will continue to encourage participation in care planning meetings and one-to-one meetings with all our clinicians and independent advocates.

What we've done well and our plans for this year

We have engaged with both patients and carers through setting up events such as the "Garden Meditation" held in May 2015 at the Kingswood Centre. This event was attended by 50 people including carers and patients. A meditation walk through the gardens at the unit helped patients to learn about meditation and mindfulness while carers attended a pharmacy

presentation about medication from our Pharmacist. A BBQ to round off the event was enjoyed by all with 100 per cent of feedback showing everyone enjoyed the event. Feedback quotes included: "...all staff that I spoke to were friendly and approachable", "staff were brilliant", "cooking different BBQ meat like Halal and also for vegetarians' was very good", "more events like this event as it was very good".

For this year's Learning Disability Week our services paired up with Mencap and delivered various events. Staff at the Kingswood Centre held a 'hear my voice' group session with about 12 patients who said what changes they wanted to see from the 2015 General Election. Considerable information was gathered from the patient perspective which was shared with newly-elected politicians and people in a powerful position, so that they can also help to tackle the myths and misconceptions about learning disability that help to fuel prejudice and inequality. Feedback from the event showed that all participants felt engaged and enjoyed the workshop.

We are pleased to receive feedback on our Quality Account and look forward to working in partnership this year with our patients, carers, Healthwatch, local authority and commissioners.

Offender Care Services

Our services

CNWL Offender Care is an experienced provider of a wide range of healthcare services within criminal justice settings. Our services span:

- 10 prisons (London, Hampshire, Kent & Milton Keynes)
- 1immigration removal centre (Heathrow)
- 1 secure training centre (Kent)
- 4 Magistrates' Courts (London)
- 2 Crown Courts (London)
- 3 community forensic teams (London)
- 2 low-secure forensic in-patient units (London)

Offender Care operates healthcare systems as lead contractors. For example, prisons are run by Her Majesty's Inspector of Prisons (HMP) and we provide the healthcare support. We sometimes sub-contract partners to provide services (e.g. psychosocial services in HMP Winchester). As `lead provider' we directly provide and/or manage: primary care, GP and nursing; administration; mental health; substance misuse; sexual health; allied healthcare e.g. podiatry, optometry, pharmacy, and dental services; clinical waste; escorts and bed watches; dental radiology; health promotion and continuity of care.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test results	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	60%	92%
Staff FFT (Target: minimum 66%)	72%*	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year; * Represents Addictions and Offender Care

- Our patient FFT results relate to our patients' experience on Java House and Tasman Ward (a forensic step-down rehabilitation and low secure unit respectively). Key feedback from our satisfaction surveys from Java and Tasman Wards has been that patients feel treatment and therapy is 'good', the service is responsive ("when you ask for something you normally get it"), and positive feedback about ward activities and the games room. Negative comments have included

waits to be taken out and the introduction of smoke-free environments. We have a system whereby patients attend a 'plan your day' meeting first thing in the morning to allow them to book their leave but the availability of staff to escort can be a limiting factor at times depending on the demands of the ward. As a result of feedback we have adjust our approach to more frequent, but shorter smoking breaks. Our FFT lead reads through all of the completed FFT cards received and follows up any issues or concerns. This is recorded on the prisoner's electronic records.

This year we have co-produced and rolled out a new paper-based survey to our prison services, and included the FFT question so we can begin collecting this. The standard FFT wording is not appropriate for prison services and so we have adjusted this slightly. We aim to begin gathering this information from April 2016.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority indicators 2015/16	2015/16 (YTD)	Trust average(YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 50% Definitely and to some extent: 79%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	85%	Definitely and to some extent: 96%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one	See detail below:	

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

Here are some actions we have taken to improve:

- Tasman Ward/Java House now has an established carer's support group which meets on a monthly basis. The group is firmly linked in to the local Brent Carers Support Service, who have attended the evening and provided participants with information about services available to them.
- The development and regular facilitation of the carer's evenings has led to a culture where carers are an essential part of the multi-disciplinary team, for example, carers are regularly invited to attend the local governance meetings or take part in activities on the ward, such as cooking sessions with their loved ones and attend the patients' Christmas party.
- Service managers and directors attend the regular local carers support group which has led to carers being able to give feedback directly to leaders and fostered robust organisational change.
- We have assigned a dedicated local carers lead which has helped with the firm integration of carers in the patients treatment planning.
- Going forward we have a number of focus groups planned with representatives from Health and Justice to engage service users.

Other indicator(s) of quality reported in the Quality Account

These indicator(s) are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	93%	97%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

The following actions have been identified to improve patient involvement and ensure that they are treated with dignity and respect:

- We provide relevant information leaflets to patients to explain their medication and its side effects, and provide information about the care planning process and people's roles in planning their care,
- We have developed and share diagrams of the care pathway,
- We have posters are on display on how to raise a concern or make a complaint,
- As well as patient feedback forms being completed the all prisons hold regular focus groups with their patients to discuss healthcare processes and allow prisoners the opportunity to voice concerns. These are co-facilitated with prison operational staff.

A recent patient feedback report for HMYOI Cookham Wood found 82% of young people reported that they were happy with the care they received from the Health and Wellbeing team, 91% stating that they thought staff members were helpful and listened to them and 82% agreeing or strongly agreeing that they were treated with dignity and respect.

How we responded when things didn't go as planned

Our incidents: There has been a good incident reporting culture noted in a majority of Offender Care services. However, in some areas we have identified access to reporting systems and staff training as potential barriers to achieving this across the board. This action is currently being progressed across our services and monitored via our system of Care Quality and Divisional Board meetings.

Overall, the highest numbers of incidents in Offender Care pertained to the administration of medication. While in the majority of cases our patients came to no harm we have made considerable changes in services, such as in our immigration and removal centre at Heathrow to improve the management of medicines.

In addition there have been unexpected deaths and suspected suicides within Offender Care services which we are concerned about. Significant actions are being taken by the Offender Care team in relation to any Self-Inflicted Deaths in Custody (DICs):

- We have set up an Offender Care Internal Task and Finish Group which reports and is accountable to our Offender Care Quality Meeting. The aim of this group is to review all DICs and put in robust improvement action to address areas of concern. To date five key priority areas have been identified and are being worked on. These include strengthening the initial mental and physical health assessment screen on arrival; reviewing and improving the patient healthcare journey throughout their time in the prison; strengthening our processes to manage death in custody to ensure a more consistent approach is taken and an immediate focus on mitigating actions, and full root cause analysis investigations and resulting actions are taken and lessons are shared.
- We have completed a thematic review of self-inflicted DICs at HMP Woodhill which have resulted in recommendations and an action plan has commenced.
- We have completed review of HMP Winchester Mental Health services in January 2016 and an action plan has commenced.

To date we have made a number of improvements in our services. For example:

- We have reviewed internal and external best practice assessment screens, and based on this are incorporating changes to strengthen our initial screen and assessment across our prisons and immigrations and removal centres.
- Together with the prison service we have strengthened the prison-led ACCT process (care of people at risk of self-harm) to ensure greater attendance of healthcare staff at all reviews. We have also employed more mental health nurses to support these reviews, resulting in safer, more effective patient reviews.
- We have included an e-learning training package on suicide and self-harm as part of the Offender Care mandatory training and this has been implemented,
- We have designed, built and piloted an online learning development package for health and prison officer staff in the care of people who may self-harm. This is being rolled out across our prisons, and being presented nationally: We are in discussions with NHS England and National Offender Management Service about the availability of this training nation-wide.

Further more detailed action plans are in place to ensure improvements are made to improve mental and physical health care of Offender Care patients and reduce self-inflicted death.

Our complaints: A common theme from Offender Care complainants was the need to improve consistent access to health care services to ensure physical health care needs are met and health is improved. This work has been progressed throughout the year in partnership with the prison authorities. Also, work continues to ensure that the NHS complaint management process is well advertised and works in effective partnership with the prison complaints process.

In March 2016 we also had a visit from the Care Quality Commission to our Immigration and Removal Centre at Heathrow. The visit resulted in three improvement notices being issued in the following areas: providing person-centred care, receiving and acting on complaints, and staffing issues – specifically around skill mix and recruitment difficulties. Although some immediate action has already taken place, we are currently developing our action plans and monitor checks to ensure these issues are rectified as soon as possible, and these will be shared with the CQC.

What we've done well

- Tasman Ward and Java House have continued building strong links with the local adult education service, "Brent Start", who now facilitate in-house skill based and vocational courses on a regular basis. Examples of this are: a 10-week Employability Course, an Introduction to Painting Course and the delivery of a Level 2 Food & Hygiene course, which enabled patients to apply for jobs in the service industry.

  The impact of this service development has been that patients have been able to enrol onto further courses with the adult education college, whilst being an inpatient.

- The development and roll-out of our new, adapted FFT feedback card. This will allow for consistent feedback from across our many different sites to be reviewed, benchmarked and responded to with improvement actions as is needed.

Rehabilitation Services (mental health)

Our services

Rehabilitation services provide long-term care and support to patients with on-going mental health needs in 24 hour in-patient settings. The Trust provides services across London and also at Horton Rehabilitation Services in Surrey.

Additionally we deliver Talking Therapies Services across Brent, Harrow, Hillingdon, Kensington and Chelsea and Westminster.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test indicators	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	73%	92%
Staff FFT (Target: minimum 66%)	60%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

We encourage service users and staff to take the test, so that we have a more representative response. Surveys were conducted in November and January and as a result of the results, a number of actions have been put in place:

- Teams have been given telephone survey detailed feedback including comments to help shape and improve service delivery
- As part of keyworker sessions, the key worker will continue to ask if we could improve one thing in the service, how/what would it be
- We undertook a pilot aimed at increasing the response rates by both patients and staff to the FFT. At the time of going to print, the findings of this pilot are being assessed and initial feedback is positive. If the pilot is proved to be successful it will be implemented across Rehabilitation services during 2016.

A patient involvement group has been set up at Horton, facilitated by an independent user group. Themes this year have been: Staff approach, observations, and the approach to medication. Patients are happy with the approach to medication but would welcome a more personalised approach to observations, which has now been implemented. Observations are carried out according to individual patient need and risk.

A booklet of recovery stories was produced by Colham Green in Hillingdon. The booklet includes stories from patients giving feedback on how the Rehabilitation service has given them hope and enabled them to overcome challenges in order to move on and live in their local community.

There are regular quality inspections in all units and patient feedback about staff has been generally very positive.

To encourage staff engagement and lesson sharing, a monthly newsletter goes out to all staff, highlighting service developments and good practice in rehabilitation units. The senior managers regularly visit all units and talk to staff and service users about current issues.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did and how we compared to the Trust average.

Quality Priority indicators 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%)	Definitely: 50% Definitely and to some extent: 85%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	77%	91%
Indicator 3: Supporting carers to be involved in care or treatment, and to have the information they need to best support their loved one	The rehabilitation service engages with families and significant people for service users on an individual basis, and have regular carers' groups in Harrow and Hillingdon. There is less demand for carers' groups in other areas, but we set them up as the need arises.	

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

We have introduced the following initiatives to support the achievement of 'effective care and treatment planning':

- **Outcome measures**. Lead professionals have had a series of meetings with the patient representative to develop outcome measures which reflect the outcomes patients want from the rehabilitation service.
- **Embedding the recovery approach in practice.** Following a series of recovery workshops all inpatient sites have Team Recovery Implementation Plans (TRIPS) co-produced with patients which they are working towards.

Outcomes from these initiatives include:

- Increased numbers of patients choosing to personalise their rooms
- Increased numbers of patients and staff attending Recovery and Wellbeing College courses
- Patients sharing their recovery stories
- Development of the Recovery Centre at Horton where staff and patients can access Recovery College and Wellbeing Courses on a term time basis
- Development of a peer support worker post at Horton

Other indicators of quality reported in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	90%	97%
Inpatients who have a risk assessment completed and reflected in their care plan (Target: minimum 95%)	100%	89%
Patients who have their carer status identified (Target: minimum 70%)	100%	83%
In-patients who received a physical health care assessment after admission (by both nursing and medical staff) (Target: minimum 95%)	97%	91%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year.

A system is in place to ensure that the minimum data on recorded new admissions is complete; this check includes carer status. Regular links are

made with teams to advise and support them in updating records and data management.

Services have a local admissions checklist to help them identify all the steps and timeframes involved in admission and discharge processes.

Core values of the service are embedded into delivery – dignity and respect are essential for offering and delivering successful recovery focused rehabilitation programmes.

How we responded when things didn't go as planned

Our incidents: Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents were minor and result in low or no harm. However, there were three serious incidents: assault on a member of staff; a service user injured during restraint; the death of a patient with cause of death as yet not identified.

Although staff members have training, incidents are rare and so techniques can be forgotten. In order to maintain skill levels regular mock role plays of restraint and managing violence and aggression take place. The service works with the restrictive interventions group to improve and learn from Trust-wide lessons. The Rehabilitation service also has an integrated physical and mental health approach to identify physical health concerns at the earliest stage. Common themes include:

- **Patients not returning from leave on time:** the learning is that clinicians should not respond with a more risk adverse approach, as the rehabilitation philosophy is to work towards independence with a positive risk taking approach. Clinicians talk to patients about keeping to agreements to facilitate prompt step-down to community services.
- **Patient smoking in their rooms:** A trial of banning smoking led to more incidents and compromised safety, so is not being taken further at this stage. Smoking is allowed in designated outside areas.
- **Minor assaults and verbal abuse:** This is addressed in community meetings and by the service user engagement programme at Horton.

What we've done well and our plans for this year

The Rehabilitation Employment Specialist has supported three service users into paid work and one into a work placement. Self-directed support was used to fund two courses for a patient. Three Horton patients were identified for paid roles, and further opportunities are being developed with Epsom Volunteer Centre.

We plan to work towards accreditation for Inpatient mental health services (AIMS-Rehab) and there is representation from the Rehabilitation service on the standard setting group.

We are piloting a multimedia application to develop health and wellbeing plans, and staff will support individuals to utilise them on our units.

During 2016, we will continue to progress work with patients and commissioners on our rehabilitation pathway of care so that we are able to continue to adapt our services to meet the needs of our patients, providing care through more innovative models in order to deliver support long-term recovery and independence.

Sexual Health Services

Our services

CNWL's sexual health and HIV services include STI testing and treatment (Genito-Urinary Medicine, GUM), contraception (Sexual and Reproductive Health, SRH) and HIV treatment and care. Our three main centres are Mortimer Market Centre, Archway Centre and Margaret Pyke Centre. We also provide SRH services in health centres across the boroughs of Camden, Islington, Hillingdon and Brent, together with outreach services in the latter

two boroughs. Overall the services undertake more than 150 000 appointments per year.

What our patients and staff tell us

Our overall test of how we are doing is through the feedback we receive from the Friends and Family Test (FFT) from our patients, carers and staff. The FFT asks patients, carers and staff how likely they would recommend our services to friends or family if they needed similar care or treatment. The table below demonstrates these results and are compared to the Trust average:

Friends and Family Test results	2015/16 (YTD)	Trust average (YTD)
Patient FFT (Target: minimum 90%)	93%*	92%
Staff FFT (Target: minimum 66%)	83%	70%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year; * Represents HIV services results only

HIV & Hepatitis Service - The majority of patients seen within these services were satisfied and would recommend the services to friends and family. Results also showed a high satisfaction rate for involvement in decisions about care and treatment, as well as being treated in a respectful manner. Most patients also reported that waiting times were acceptable, with many reporting they did not have to wait at all to see their clinician.

GUM/SRH Service also collects FFT feedback from patients, although by asking a slightly amended and more appropriate question for this cohort of patients. We are pleased to report that results for this feedback are equally high.

We are proud of our staff FFT result, out-performing the Trust average, especially during a time of service reconfiguration. We have kept in close contact with the staff through service-wide meetings and involving them in the service re-design process (re-modelling clinical and administrative pathways), to maintain engagement and respond to key areas of concerns.

How we did against our Quality Priority

Last year, having listened to our stakeholders we said that by involving patients, helping them achieve the outcomes that matter to them and by including carers in partnership we would aspire to deliver **'Effective Care and Treatment Planning.** To understand the effectiveness of our actions we tested three things. The table below shows how we did, and compares this with previous years and the Trust average.

Quality Priorities 2015/16	2015/16 (YTD)	Trust average (YTD)
Indicator 1: Patients report they were involved as much as they wanted to be in decisions about their care and treatment (Target: minimum 75%	Definitely: 89% Definitely and to some extent: 99%	Definitely: 82% Definitely and to some extent: 96%
Indicator 2: Patients report their care or treatment helped them achieve what matters to them (Target: minimum 85%)	92%	91%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year

All clinics have feedback cards available for comments, suggestions concerns and complaints. Any received are reviewed by managers and patients are contacted immediately if a response if required. All teams receive patient feedback and 'lessons learned', plus themes are discussed monthly at our operational and strategic meetings.

In order to continue receiving high satisfaction rates, HIV patients are encouraged to join the Bloomsbury Patient Network, which is an advice, support and advocacy group for the 4600+ cohort of patients registered at Mortimer Market. Not only do the Patient Representatives work directly with patients, through 1-2-1 appointments and events such as the Newly Diagnosed Course, but they also attend the monthly multi-disciplinary HIV

service meeting, thus providing an invaluable link between patients and clinicians.

Other indicators of quality reported in the Quality Account

These indicators are quality priorities that we have reported on in previous years and help us to get a fuller picture of quality in our service.

Quality indicators	2015/16 (YTD)	Trust average (YTD)
Patients who report being treated with dignity and respect (Target: minimum 95%)	96% *	97%

Key: "YTD" – results year-to-date, which is an aggregation of results over the year; * Represents HIV services results only

Although there has been a slight drop in the number of patients who report being treated with dignity and respect, no specific issues have been identified through our Patient Representatives. However, as detailed below, staff attitude is highlight as a theme from our complaints and we have customer care training in place for all our reception staff to address this and will continue to monitor. Any feedback we receive is reviewed by our managers and patients are contacted where a response is required.

How we responded when things didn't go as planned

Throughout the year we record and monitor all our incidents to identify learning, trends and response actions to ensure our patients and staff are kept safe. The majority of our incidents result in low or no harm.
However, an increased number of incidents were raised in three areas:

- Information Technology (IT): Specifically staff difficulties in accessing the clinical system while seeing patients in clinic. The CNWL IT upgrade will eliminate these problems by delivering a faster and more reliable network and a new network will be in place by the end of April 2016.
- Infection prevention and control: The infection prevention incidents were mostly related to staff needle stick injuries. This is the accidental puncture of the skin with an unsterilized instrument. This resulted in a review of the sharps management processes, in conjunction with the Infection Prevention Control team, to reduce this risk.
- Clinical assessment incidents: Clinical assessment incidents were mainly due to test results being missing or unavailable; and most were rated as no or low harm. The numbers of these incidents have dropped as the new clinical system has embedded in the service.

Only one serious incident occurred following a whistle-blowing email. An investigation was instigated to determine whether hepatitis A and B vaccines were kept outside the vaccine fridge during clinic hours. The incident was rated as level 3 (moderate/significant) as a number of patients may have received a less effective hepatitis A and B vaccination. All affected patients were contacted and offered a repeat vaccination.
All the complaints received were investigated, with the largest number relating to staff attitude. Customer care training is an on-going process for all reception staff in order to further reduce the low number of complaints.

What we've done well and our plans for next year

The over-riding highlight for the services was receiving an overall 'Outstanding' rating from the CQC for being effective, caring and responsive, and 'Outstanding' overall.
The CQC said:

"Patients were receiving safe care from appropriately trained, qualified and skilled staff. An extensive programme of training was in place. Staff confirmed that this prepared them for their roles and responsibilities."

"The services were a centre for national and international research and innovation. This meant that patients were benefitting from this work and

receiving the latest treatment from staff who were committed to improving care and treatment for patients across the world."

However, financial challenges will continue in 2016/17 as local authorities reduce the tariffs for GUM and the block contracts for SRH will also reduce in value. Considerable savings have already been achieved and work is on-going to reduce the clinical workforce safely and the cost of overheads, administration and spends on pathology and pharmacy.

Section 2.3
Our Quality Priorities for 2016-17

In this section we describe the journey we have taken to develop and agree our Quality Priorities for 2016-17. We include the rationale for their selection, and how we will measure, monitor and report on them.

How we agreed our Quality Priorities for 2016-17

Learning from our CQC inspection in February 2015 we have been considering the things that make the biggest difference to patient health and care. In reviewing all the sources of information available to us over the year – from our incidents, complaints, survey feedback, and outcomes from our internal learning walks or inspections - on what keeps patients safe, effectively cared for and treated with dignity and respect, it comes down to two main things:

The first is patients and carers feeling involved, supported and taking ownership of the decisions about their care.

Evidence tells us that as a therapeutic intervention in both physical and mental health care, *involvement* results in better concordance, engagement, ownership and ultimately *better health outcomes.*

The second is that to deliver this we need a workforce which is committed, well-trained, well-supported, and *above all, engaged*.

Evidence tells us if our patients are to experience better care our staff need to feel better cared for. This is supported by the Health Foundation (2014) who state "When staff feel supported by colleagues, appreciated and empowered this spills over into greater empathy and compassion in the care they provide. The evidence for this has been growing over the last few years and is very strong".

Last year our focus was on patients and carers, this year. So this year we are making quality all about our staff, patients and carers in partnership. This approach is endorsed by the 'Triangle of Care, Carers Included'.

The Triangle of Care – Carers included

Launched by the Carer's Trust in 2010, the Triangle of Care is the result of research with carers into the information and support that they need from service providers to best support their loved one.

Carers are often the only constant in the patient's care journey, and so understand the needs and conditions of the patient well and are there during times of crisis. They are therefore a valuable partner in care.

The aims is for professionals to recognise the support that carers give patients and acknowledge them as a key partners, so patients receive better support on their journey to recovery and well-being.

We developed, tested and shaped this approach through our early consultation events, and received the final endorsement at our annual all-stakeholder consultation event on 4 March 2016. This included patients, carers, staff, commissioners, Healthwatch representatives and others.

This year we were privileged enough to have Dr Kate Granger MBE who began the **#hellomynameis** campaign to speak at our event. Kate reminded us that this simple gesture, and 'the little things we take for granted' as the power to influence a patient's experience in a very positive way.

In developing our priorities we agreed a number of key principles:

- *Fewer areas of focus to ensure greatest impact*

- *Priorities which must reach all parts of the organisation*
- *Priorities which are not all linked to metrics but include commitments too*

Based on the discussions our two Quality Priorities of '**patient and carer involvement**' and '**staff engagement**' were refined, and are presented below.

Thank you!

While we would like to thank all those who participated, we would like to extend a **special thanks to Dr Kate Granger**, consultant in elderly medicine and **#Hellomynameis** founder, who attended to present the #Hellomynameis campaign.

Kate's moving and inspiring talk can be found on our website. The #Hellmynameis initiative received huge support and so forms the cornerstone of our Quality Priorities for 2016-17.

Quality Priority 1: Patient and carer involvement

What do we want to achieve?

• For patients and their carers to be actively involved in their care or treatment so they feel partnered with, informed and ownership; and feel their care or treatment helps them to achieve the health outcomes which matter to them.

Why are we doing this?

- There is a growing body of evidence which supports the model of the Triangle of Care – that when **patients, carers and staff work together** to plan the care or treatment, we are more likely to see better recovery and health outcomes for our patients.
- We know that there are additional benefits to focussing on the involvement of our patients and carers: that they are **more likely to be treated with dignity and respect**, and experience **better overall satisfaction** with their care or treatment.
- We continue to work on this priority because we believe it is the one that matters most to patients and their carers; and we know that when we do this **well staff engagement and motivation increases too**.

What will we do? Our plans for the year:

- **#Hellomynameis campaign:** This year our main focus will be to begin the roll-out of the **#hellomynameis** campaign to all our services. This initiative will take careful planning to get right: A project task and finish group will be set up involving a CNWL service which already have this initiative successfully embedded in their practice, and will involve patients, carers and staff. Our aim for this powerful initiative will be to do it *together with staff*, and not a top-down approach. We will encourage staff to pledge their support and bring the values that underpin this campaign into their daily practice. This will be supported by a communications plan which will include road-shows to our services, commitment messages by our leaders, and the use badges or stickers, photographs and video clips to encourage and sustain up-take. We will report on our progress in next year's Quality Account on the impact this has had.
- **Patient and Carer Stories:** We will begin a programme of gathering and using Patient and Carer Stories across the Trust to inspire, challenge, connect and lead to learning and change. Evidence shows that these stories can be a powerful training tool, giving real insight into patient and carer experience, building partnerships between staff and patients and carers and improving quality and outcomes. We will report on our progress next year.
- **Carers Council:** We will take forward the initiatives from our Carer's Council work-plan including our first Carer's Conference, more involvement of carers in training through our Recovery and Wellbeing College, and the roll-out of our refreshed and co-produced Carers Information Leaflet. We will report on progress made next year.
- **Involvement to Influence:** We will strengthen our approach to hearing feedback from patients and carers, taking action in response to what you tell us and feeding back the improvement actions taken in response to the feedback we have received using the *You Said, We Did* model.
- **Involvement for better Care Planning:** We will redesign our approach to Care planning for our adult mental health users in community services to ensure that the processes and systems we use enable better engagement and involvement, create for service users and their carers a better sense of personalisation, empowerment and ownership.

How we will know? *Our outcome measures which will test the impact of our actions quarterly*				
Measure	**Method**	**Target**	**Roll-forward from 15/16?**	**Rationale**
1. Patients report feeling involved as much as they wanted to be in decisions about their care or treatment	Patient survey	Minimum 85% Increased from 75%	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. Next year our focus will be on both those who answer 'definitely' and 'to some extent' as this will help us better identify where we need to focus our improvement actions. We have increased our target to 85%.
2. Patient report that their care or treatment helped them to achieve what matters to them	Patient survey	Minimum 85%	Yes	This measure tests the overall effectiveness of the care or treatment, and follows the same rationale as the measure above.

What is the #Hellomynameis campaign?

This national initiative was founded in 2013 by Kate Granger, a doctor with terminal cancer. During her care she made the observation that many staff looking after her did not introduce themselves before delivering care. *"It felt incredibly wrong that such a basic step in communication was missing. I firmly believe it is not just about common courtesy, but runs much deeper. Introductions are about making a human connection between one human being who is suffering and vulnerable, and another human being who wishes to help. They begin therapeutic relationships and can instantly build trust in difficult circumstances. In my mind #Hellomynameis is the first rung on the ladder to providing truly person-centred, compassionate care."*

Kate decided to start the campaign to encourage and remind healthcare staff about the importance of introductions in healthcare, and has gone on to write a book about her experiences, "The Other Side".

Hellomynameis campaign asks staff to make a pledge to always introduce themselves to their patients. The campaign has made over 1 billion impressions since inception, with an average of 6 tweets an hour.

Hellomynameis was also advocated in the Government response to the Francis Report (page 36). Today, over 100 NHS organisations – comprising more than 400,000 staff – have signed up to support this campaign to improve patient experience.

Quality Priority 2: Staff engagement

What do we want to achieve?

Our aim is to achieve a workforce which:

- Feels engaged, motivated and valued, to give their best or go the extra mile for colleagues, patients and carers
- Thinks and acts in a positive way about their work, the people they work with and serve
- Adopts a supportive, inclusive leadership style and demonstrates the Trust's values of compassion, respect, empowerment and partnership.

Why are we doing this?

We are doing this because we've heard from our staff the impact that change and resourcing across the NHS is having on front line care. We know that we like many other NHS trust face significant recruitment and retention challenges. We want to be the employer of choice for new recruits and we want our present staff to feel that they have much to give and gain from working at CNWL. We want to encourage and nurture our talent, promote leadership at all levels, and continue our open and inclusive approach to communication and dialogue. We want our staff to feel they have a stake in the future of the Trust and we want to include them in big decision making,

Our objective is evidence-based: a valued, engaged workforce in turn promotes greater motivation, empathy and compassion in staff behaviour, whether they are clinical or non-clinical.

What will we do? Our plans for the year:

We know that this will take longer than a year but we've started and want to make this public commitment to our staff through our Quality Account. This year we are focussing on:

- Refreshing our Workforce Strategy and Implementation Plan. This includes staff engagement.
- Developing our Health & Wellbeing Plan in line with NICE guidance.
- Building on our work to include and develop staff from minority groups with a special focus on our staff from black and minority ethnic groups. We want to improve our ratings on the national Workforce Race Equality standards
- We have already audited ourselves against the NICE standards and aim by May 2016 for our Board to sign off on the strategy and implementation plan that spans 2016 to 2020.
- We are aiming for commitment to the London (and other regions) Healthy Workplace Charter by October 2016.
- We will work with our commissioners to delivering the national CQUIN on health and wellbeing.
- Our Board are leading this work and have scheduled a Workforce Planning Day and through the Quality & Performance Committee will be monitoring progress. We will have clear plans with agreed timescales and will report on our progress regularly.

Some programmes in development are:

- Refreshing our induction programme and appraisal processes so that all staff know how we 'live and breathe' our Trust values through our work

- Quarterly leadership roadshows
- Multi-disciplinary leadership programmes
- Review of our staff benefits package
- Systems to get regular feedback from our staff and to communicate back to them on how we have acted on their feedback.

How we will know?

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

Measure	Method	Target	Roll-forward from 15/16?	Rationale
Staff recommend the Trust as a place to work	Staff FFT survey	tbc	No	The Friends & Family Test for patients and staff have been introduced as an overall marker of quality and will provide an indication of the outcomes of our work through the year. We are already reporting on these and so have systems in place to collect this rich quantitative and qualitative information. In this year we need to work to improve our response rates and demonstrate much more overtly to staff that we have listened and acted on their feedback.
Staff recommend the Trust as a place to receive care or treatment to a friend or relative		tbc	No	
Staff turnover	Internal database	17%	No	This indicator demonstrates whether or not our actions are having an effect. Our turnover rate is approximately 19% and we know that to provide good care, imbued with our Trust values, we to reduce our staff turnover.

2.4 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 Monitor 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 the Prescribing Observatory for Mental Health (POMH-UK), and participate in their national programme of audits focussing on medication and side effect monitoring. CNWL is benchmarked against all other similar participating Trusts, and performance is monitored by our Medicines Management Group with actions for improvement agreed and implemented.

2.5 Statements relating to the quality of NHS services provided

Review of services

During 2015-16 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 2015-16 represents 100% of the total income generated from the provision of NHS services by CNWL for 2015-16.

Participation in clinical audit

The schedule to the regulations requires providers to complete the following statements:

During 2015-16, 9 national clinical audits and 2 national confidential enquiries covered NHS services that CNWL provides.

During that period, CNWL participated in 100% (9/9) of the national clinical audits and 50% (1/2) of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that CNWL was eligible to participate in during 2015-16 were as follows:

- National Audit of Intermediate Care
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
- Sentinel Stroke National Audit Programme (SSNAP) (data collection throughout 2015/16) - CNWL does not participate directly but assists Hillingdon Hospital
- UK Parkinson's Audit
- National Audit of Cardiac Rehabilitation
- National Audit of Early Intervention Psychosis
- Prescribing for ADHD in Children, Adolescents and Adults
- Topic 15a: Prescribing for BPAD – the use of sodium
- Topic 14b: Prescribing for substance misuse - alcohol detoxification
- National Confidential Enquiry Study of Sepsis
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCISH)

The national clinical audits and national confidential enquiries that CNWL participated in, and for which data collection was completed during 2015-16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Confidential Enquiry / National Audit	Cases submitted
National Audit of Intermediate Care	Organisational Data: 38% (227/591) cases submitted. Service User Questionnaire: 50% (300/600) of cases submitted
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	85% (33/39) of eligible cases submitted
Sentinel Stroke National Audit Programme (SSNAP)	194 cases from Camden services
UK Parkinson's Audit	97% (68) cases from six services
National Audit of Cardiac Rehabilitation	Data not available
National Audit of Early Intervention Psychosis	100% (100) of eligible cases submitted
Prescribing for ADHD in Children, Adolescents and Adults	98 submissions from 13 teams
Topic 15a: Prescribing for BPAD – the use of sodium valproate	422 submissions from 13 teams. The report from POMH is expected in March/April 2016.
Topic 14b: Prescribing for substance misuse: alcohol detoxification	67 submissions from 14 teams. The report is expected in June 2016.
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	We have received 23 suicide questionnaires and have returned 14 (61%) to date. We have received 1 homicide questionnaire and returned this: 100%.

The reports of six 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 Audit of Intermediate Care:** In Hillingdon community services the audit results have been discussed at the Hillingdon Clinical Effectiveness and Professional Advisory Group (CEPAG) and the results have been disseminated to the participating services, community Rehab teams and Hawthorne Intermediate Care In-Patient Unit. These services have reported to CEPAG group that recommendations from the report have been reviewed with an action plan in progress. In Camden community services the audit results have been shared with the Inpatient Service and Rapid Response and the findings discussed. A presentation is also to be made to the Camden CEPAG. The audit results have been shared with the teams that were involved in this audit and recommendations from the report are currently under review.

- **Epilepsy 12 Audit (Milton Keynes):** Epilepsy12 is a UK-wide multicentre collaborative audit which measures systematically the quality of health care for childhood epilepsies. The '12' refers to the 12 measures of quality applied to the first 12 months of care after the initial paediatric assessment and care is compared to National Institute of Clinical Excellence (NICE) Guidelines. The audit is in its second stage from 2012-2014 and our Paediatric Team continues to participate in this audit and have implemented the recommendations from the first round.

- **POMH-UK Audit Topic 11b: POMH-UK Lithium Audit:** Findings of this audit have been circulated to relevant Service Directors, Clinical Directors, the Trust's Clinical Safety Group and all teams that have participated in the audit. CNWL submitted data for 455 patients over 23 clinical teams. The majority of data submitted was from Community Recovery Services and they have considered the results and developed an action plan.

All patients audited had documented evidence that potential underlying causes of BPSD were considered prior to antipsychotic prescription. 97% (national sample: 96%) had documented evidence of the clinical indications for initiating the current antipsychotics medication.
32% (national sample: 53%) had documented evidence that a risk/benefit analysis was carried out prior to antipsychotic prescription while 68% (national sample: 61%) had documented evidence that the risks/benefits were discussed with the patient and/or carer prior to antipsychotic initiation. 57% (national sample: 75%) had a documented medication review in the past six months addressing therapeutic response to antipsychotics while 35% (national sample: 54%) had a documented evidence of medication review in the past six months addressing antipsychotic related adverse events.

- **POMH-UK Audit Topic 13b: Prescribing for Attention Deficit Hyperactivity Disorder (ADHD) in Children, Adolescents and Adults:** The audit findings have been circulated to Service Directors, Clinical Directors, and all teams that have participated in the audit. CNWL submitted data for 98 patients, vast majority were children. CAMHS are developing an action plan.

  Overall, results of the audit shows that recording of heart rate, blood pressure, weight and height remains an area for improvement for all patients receiving ADHD medication during initiation or maintenance treatment across the trust. Physical health monitoring during the initial stages (three months) of ADHD medication was has improved. However, routine physical health monitoring in children and young adults receiving long term ADHD medication fell below baseline results.

- **National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme:** Overall the Camden programme is performing well against national guidelines in terms of organization and content of programme referrals and outcomes. A presentation of the findings is to be made Camden CEPAG.

- **POMH-UK Topic 9c: Antipsychotic prescribing in people with a learning disability:**
  CNWL submitted data for all in patients with LD in both specialist and non-specialist inpatient wards were included. Community LD teams from Brent, Harrow, Hillingdon and Milton Keynes all participated in this audit.

  CNWL performed in line with the majority of the participating trusts with few patients (less than 10%) prescribed antipsychotics with no record of a psychiatric diagnosis or were treated for the NICE-approved target symptoms.

  Approximately a quarter of patients in the trust sample were prescribed an antipsychotic and had specific diagnoses of a psychotic and/or affective disorders recorded as indication.

  100% of patients for whom antipsychotics were prescribed for more than 12 months the continuing need for antipsychotic medication were reviewed. This was an increase from last year's audit.

Local Clinical Audit Projects

The reports of approximately 300 local 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:

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. Examples of these are provided below:

Community services in Camden

End of Life Care Pathway Audit (all patients on the District Nursing team's caseload are required to have an end of life care pathway in place)
Actions:

- Audit co-ordinator to inform localities which patients are not on "co-ordinate my care"
- Team Leaders to work with Palliative Care teams to ensure patients are present on the system;
- Teams to organise training sessions on Co-ordinate My Care to increase Community Nurses' skills in entering information onto the system

AMBER Care Bundle Follow –up Audit

Aim was to assess care received by patients cared for by the AMBER care bundle. The AMBER care bundle provides a systematic approach to manage the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months. It is an intervention that can fit within any care pathway or diagnostic group for patients whose recovery is uncertain), to consider whether the service is meeting patients' preferences in care, 30 day Emergency Readmission rate, and whether the service was establishing, documenting and communicating patients' preferences and wishes for the future.

Actions:

- *Earlier intervention -discussion/plan of preferences and future care and documentation (Preferred Place of care/death)*
- *Ensure information from discussions passed on to teams when patients repatriated to ensure continuation of discussions/plans.*
- *Use of re-launched 'Excellent Care in Last Days of Life' for patients dying at UCLH*
    - *Documentation of plan being agreed with Nursing staff*

Community services in Hillingdon

Nutrition Screening Audit
The primary aim was to evaluate nutritional screening practices among the Community Adult Rehabilitation Service (CARS) team prior to training on the nutritional screening tool and post training.)
Actions:

- To include nutrition screening as a prompt in assessment forms for the CARS team
- To save the nutrition screening resources such as diet sheets on the shared drive for staff to access including the nutrition screening tool
- Further training of nutritional screening among CNWL staff
- Present a GP Masterclass on Nutritional screening practices

Audit: Stratified Back Care (Stratified back care aims to match patient to treatments based on prognosis or risk of poor clinical outcome. Start one of the approaches used, for example, has been shown to significantly decrease disability from back pain, reduce time off work and save money by making better use of health resources.)
Actions:

- The results showed that current practice is aligned to the guidance, in terms of number of sessions offered and received by patients.

However the sample size was very small and the results are to be interpreted with caution. A re-audit of a larger sample in six months is recommended.

Re-audit of self-catering activities

The audit was to inform the Rehabilitation service line of current self-catering activities and facilities that are available to service users across the inpatient services, across the service line, and to assist in developing and improving these services further in the future. The re-audit found improvements in several areas.

Actions:

- To benchmark Rehabilitation Services catering facilities against AIMS standards.
- To have clear actions plans in place for units that are working towards increase self-catering, agreed by staff and service users and reviewed in six months.
- To review OCS provision (facilities management & maintenance) where appropriate and utilise budgets in order to increase self-catering.
- To ensure Food and Hygiene Training is a basic requirement for staff and that all units keep a log of training.

Milton Keynes Services

Handover Audit

BMA guidance (Safe handover, safe patients) states "good doctor to doctor handover is vital to protect patient safety and that "systems need to be put in place to enable and facilitate handover." There was a perceived problem with handovers and the data collected during the audit supported that the quality of handovers were inconsistent. As a result of the Audit the following actions have been implemented:

Actions:

- Junior Doctors Training Committee met and discussed the issues
- Sub-group formed to draft a new local procedure which has been implemented
- Trainees consulted and informed
- The process has helped to improve the quality of handovers which has been evidenced by further data collection

Joint Audit of coverage of the health surveillance for children with Down Syndrome

The Royal College of Paediatric Child Health (RCPCH) proposed new service standards for children with Down syndrome. The rationale for the audit was to evaluate the quality of service provided locally through both audit and parent/carer satisfaction survey, and to assess coverage of surveillance against current DSMIG (Down Syndrome Medical Interest Group) guidelines and the proposed new standards from the RCPCH with the view to identify any gaps in current service provision.

Actions:

- Produce information packs in collaboration with local support group and seek their views on what sort of support would be helpful.
- Explore feasibility of having dedicated Neonatal Nurse /HV input at time of diagnosis/on-going input at dedicated clinic respectively.
- Offer early appointments with Community paediatrician (ideally within 4 weeks)

Mental Health London

Observation and Engagement Audit

This audit looked at whether those carrying out observations have appropriate training, staff knowledge of the patients they are observing, and whether staff felt properly supported to carry out observations. Overall the review showed that staff are well informed about close

observation and are able to translate this into practice in order to manage risk and engage patients.

Actions

- Provision of observation and engagement training for bank and agency staff should be reviewed to ensure that it is available.
- Staff to be reminded of the need to document the outcome of their time spent on close observation in the care record.

Sexual Health Services

Audit of Prescribing Errors
The main audit findings were that the number of errors has decreased sharply compared to the results of the previous two years. Many of the errors appear to be repeat errors - uncorrected from previous prescriptions.

Actions

- Future audits will be prospectively undertaken and will include home delivery prescriptions.
- Incorrect prescriptions will be corrected electronically to reduce mistakes with repeat prescriptions.

Audit of Initial Consultation for Emergency Contraception (EC)
The audit was undertaken to determine that documentation in patients' notes demonstrates compliance with local and national guidelines for the provision of EC. The results showed that all patients were appropriately offered emergency contraception where a pregnancy risk was identified.

It was noted that EllaOne was used infrequently (12% of EC prescriptions) during the period audited. It had been recently introduced and after the audit period the pathway for provision of emergency contraception was updated in relation to ellaOne which will likely increase its use where appropriate.

Documentation in relation to offering an IUD could be improved.

CNWL Medicines Management Audits

Controlled Drugs (CDs) Audit
This audit is carried out by pharmacy staff on quarterly basis across all sites and services where CDs are supplied, delivered or stored. This is to ensure compliance with legal requirements of practice and minimise risks associated with the use of CDs across the trust. Data collectors discussed any identified areas of non-compliance immediately with ward/unit managers or nurse in charge and action plans were developed and submitted to the audit team.

All CD cupboards are locked and secured to the wall or floor. The running total in the CD record book tally with the actual stock of CDs i.e. CD balances are correct and the registered nurse in charge or registered delegate either possesses keys for access to CD cupboard or keeps the key in a secure key safe. There is not any inappropriate storing of high-strength morphine, diamorphine or midazolam preparations across the trust

Main shortfalls in practice were regarding; frequency of CD balance checks, crossing out of entries in the CD register and recording of all elements required in the CD record book and registers.

Actions

- Circulate results to Divisional Governance Leads, Divisional Directors of Nursing for consideration and discussion at Divisional Governance Board Meetings.
- Borough Lead Pharmacists to present findings at borough care quality groups, circulate results to all teams and services who have

participated in the audit and to follow up with local managers of wards/units to address local areas of non-compliances identified.
- Associate Chief Pharmacists to present results at Divisional Governance meetings.
- Pharmacy audit team to review and monitor action plans submitted to ensure complete compliance.
- Ensure processes are embedded in to practice to that the on-going use of CDs adheres to the legal requirements and the trusts operational policy on CDs, to avoid diversion and misuse.
- Re-audit

Antimicrobial Audit:
This on-going monthly audit monitors the antimicrobial prescribing trends and quality indicators across the trust in order to guide training and development of healthcare staff and to optimise prescribing practice and minimize antimicrobial misuse and therefore resistance.

Overall there is good compliance with the allergy status and specification of a stop date.
The main areas for improvement are appropriate course lengths and treatment choices which are in line with microbiology advice and guidance. These aspects of antimicrobial prescribing have already been included in on-going initiatives to improve antimicrobial prescribing and usage across the trust.

Actions
- Circulate report to all Prescribers, Pharmacists and Divisional Medical Directors to discuss at respective quality and governance meetings. Also present findings of the audit to each divisional Infection Prevention Control subgroup and Infection Prevention Control Committee.
- Antimicrobial lead pharmacist to use monthly monitoring data to drive up antimicrobial stewardship across the trust in line with the trusts 2016 Antimicrobial Stewardship Strategy.

Safe and Secure Handling of Medicines Audit
This annual audit is conducted by pharmacy staff across all sites and services where medicines are kept or stored. The aim is 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. Data collectors immediately discussed any identified areas of non-compliance with ward/unit managers or nurse in charge, and action plans developed and submitted to the audit team.

Results show there is awareness of the safe and secure handling of medicines across the trust and the level of compliance with the majority of standards measured has improved compared with 2014 results. Main shortfalls were regarding management of pharmaceutical waste (specifically cytotoxic and cytostatic) and checking and recording daily temperatures of the room and medicines fridge.

Actions
- Circulate results to Divisional Governance Leads, Divisional Directors of Nursing for consideration and discussion at Divisional Governance Board Meetings.
- Borough Lead Pharmacists to present findings at borough care quality groups, circulate results to all teams and services who have participated in the audit and to follow up with local managers of wards/units to address local areas of non-compliances identified.
- Associate Chief Pharmacists to present results at Divisional Governance meetings.
- Pharmacy audit team to review and monitor action plans submitted to ensure complete compliance.

- Associate Chief Pharmacists to present results at Divisional Governance meetings.
- Re-audit

FP10 Prescriptions Audit

The aim of this annual audit is to ensure high standards of practice, minimise risks associated with the use processes of using FP10s and to ensure the Trust follows the NHS Security Management Service Security of Prescription Forms Guidance. FP10 prescription is a prescription written by a doctor which is taken to any community pharmacy for dispensing.

Results of the audit demonstrate that there is awareness of the FP10 procedures across all services audited. All services audited have a named Responsible Person (RP) for overall management of FP10 prescriptions. All FP10 prescriptions in-use are kept secure i.e. they are locked away when not in use in an area where patients and the public do not have access. However, the main shortfall was regarding recording of all elements required in the log-in and record books.

Actions

- Circulate results to Divisional Governance Leads, Divisional Directors of Nursing for consideration and discussion at Divisional Governance Board Meetings.
- Borough Lead Pharmacists to present findings at borough care quality groups, circulate results to all teams and services who have participated in the audit and to follow up with local managers of wards/units to address local areas of non-compliances identified.
- Associate Chief Pharmacists to present results at Divisional Governance meetings.
- Pharmacy audit team to review and monitor action plans submitted to ensure complete compliance.
- Ensure processes are embedded in to practice to that the ongoing use of FP10 prescriptions adheres to the legal requirements and the trusts standards operational procedures to avoid diversion and misuse.
- Re-audit

Research

The number of patients receiving relevant health services provided or sub-contracted by CNWL in 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 1648. Throughout the year, the Trust has been involved in 44 studies; 30 were funded of which 8 were commercial trials, and 14 were unfunded.

Over the past year researchers associated with the trust have published 232 articles in peer reviewed journals.

Goals agreed by commissioners

A proportion of CNWL's income in 2015-16 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 2015-16 and for the following 12 month period are available electronically at www.cnwl.nhs.uk.

In 2014-15 CNWL achieved 88% of its CQUIN goals, securing the total CQUIN income of £3.81m.

For 2015-16, CNWL's CQUIN income equates to approximately £5.99m. 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 2015-16 CQUINs have resulted in positive change for CNWL:

- **Domestic Violence, Camden Community:** Formal pathways for identifying, referring and providing interventions to people who experience domestic violence have been put in place. In delivering this CQUIN scheme service users have information in accessible places, as well as formal pathways for referral and agreed protocols for data sharing with agencies and supporting hard to reach communities
- **Sexual Health - Hepatitis C Networks:** Evidence now indicates that CD4 count has little or no impact on treatment plans for patients who are stable on treatment with an undetectable viral load. 'CD4 count' is the estimated number of functioning CD4 cells (immune system helper cells) per cubic millimeter of blood. In light of this, the CQUIN aimed to reduce the number of patients who were unnecessarily tested, ensuring that eligible patients attending in 2015/16 had no more than one CD4 count performed within a nine month period. The target of 90% was exceeded with 99.9% having no more than one count performed.
- **Hillingdon Community CQUIN, Improving the Emergency Care Pathway:** CNWL, The Hillingdon Hospital (THH) and Hillingdon Clinical Commissioning Group set targets on reducing readmission and attendance rates for a group of 30 highly complex patients for quarters three and four. CNWL and THH put in place joint care plans to manage these patients and successfully reduced the number of admissions.

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 2015/16.

CNWL has participated in special reviews or investigations by the CQC relating to the following areas during 2015/16: See table below for details of the Trust locations inspected by the CQC.

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

CNWL has made the following progress by 31st March 2016 in taking such action: See table below for details of the Trust's response to CQC inspections.

CQC Reviews of Compliance during 2015/16:

Location	Outcome of Review	Progress with actions
Immigration and Removal Centre - Harmondsworth	No requirement notices issued, however areas for improvement were noted in the environment, access to nurse or GP services, care plans, and medicine management.	This inspection took place in March 2016. An improvement action plan has been developed and is in progress at the time of printing.
Immigration and Removal Centre - Colnbrook	Three requirement notices were issued. Improvements were required in person centred care, receiving and acting on complaints and staffing, relating to appropriate skill mix and recruitment difficulties.	This inspection took place in March 2016. At the time of printing the Trust's improvement action plan was being internally agreed and shared with the CQC.
HMP & YOI Bronzefield	Fully compliant	None required.
HMP Holloway	Currently awaiting the outcome of the inspection report.	

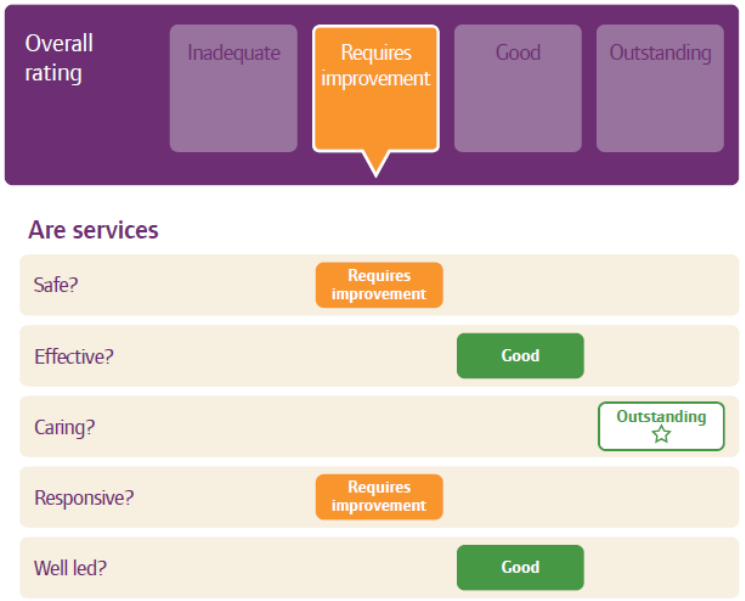
CNWL's comprehensive CQC inspection – February 2015

CNWL was subject to a comprehensive inspection by the Care Quality Commission in February 2015. The CQC's assessment of CNWL following that review was 'requires improvement'.

The CQC rate services across five domains, or 'key lines of enquiry', by assessing the extent to which services are safe, effective, caring, responsive and well-led.

The CQC found that as a whole the Trust was rated Outstanding for caring, reflecting the individualised care provided, especially in our community dental and sexual health services. Trust services were also rated Good for being effective and well-led; and improvements were needed for services being consistently safe and responsive.

The outcome of CNWL's CQC inspection in February 2015:



The CQC findings showed that the Trust had worked hard to meet the needs of diverse communities, providing care which was sensitive to cultural backgrounds of patients, and that CNWL worked well with our statutory and voluntary sector partners. Many good examples of innovation

change were noted, and that opportunities for research and development were made.

In summary, sexual health services were rated as Outstanding, community health services were rated as Good, and areas for improvement were identified in our mental health adult acute and older adult wards, and mental health adult community services.

The CQC issued 24 Must Do areas for action and a number of Should Do recommendations. Our action plans were shared with the CQC, commissioners, Healthwatch and public at our Quality Summit on 18 June 2016. We reported progress monthly to the CQC and commissioners, and updates were provided on our website via our public Board papers. In January 2016 we reported full compliance with the 24 Must Do compliance areas.

Examples of our key Must Do actions and the outcomes:

- *Inpatient bed pressures for mental health patients of working age:*

The CQC identified the pressure on our mental health wards that admit people of working age as their key concern. This included availability of beds for people returning from leave, patient ward moves or sleep-outs, and sufficient management oversight. We are pleased to report that our bed occupancy is down from 116% in March 2015 to around the 100% mark since November 2015, and we are reporting no sleepovers since September, down from 32 in March 2015, or adult admissions to our older adult wards. We also hold twice per week bed management meetings with our bed managers with clear lines for escalation and contingency plans, and positions are monitored weekly by our bed management team and monthly by our Operations Board and Quality and Performance Committee.

- *Improvements to our estate:*

Parts of our estate required improvements to support the dignity, respect and comfort of our patients. We are pleased to report that inpatients have been provided with lockable space, ward blind spots have been addressed, works to enhance single sex accommodation are completed, separate entrances to our Section 136 suites have been built, and interview rooms at St Charles have been sound proofed.

- *Reducing the risk of patients absconding from our mental health wards (AWOL):*

A variety of actions from estates improvements to staff training have been completed to reduce the risk of people absconding from our mental health wards. As a consequence, we are well on track to meet our annual 50% AWOL reduction target by April 2016, and report just one AWOL during the month of March.

- *Medicine management:*

Improvements were found to be required in the safe and secure storage of medicines in some of our older people mental health wards. These issues were immediately addressed, and are compliant.

- *Best practice patient restraint:*

All relevant inpatient staff have been trained in most up-to-date supine restraint techniques, and we have consistently met our annual 50% reduction target for the use of prone restraint by July 2016.

For further detail, including our full inspection report, please see http://www.cqc.org.uk/provider/RV3

Data quality

NHS number and General Medical Practice Code Validity

CNWL submitted records during 2015-16 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 11):

- 95.8% for admitted patient care;
- 98.9% for out-patient care; and

- N/A for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice code was (at month 11):

- 99.1% 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 2015-16 was 86% and was graded green (satisfactory), meaning that the organisation achieved at least level 2 in all the requirements.

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

- Progress is monitored across Divisions against nationally set measures and provide a holistic view of services covered including HR, Finance, Quality and Performance via the Divisional Integrated Dashboard, ensuring indicators are reported at service and team level with any data quality concerns discussed and resolved appropriately with all appropriate parties
- We continue with QIS (the Trust's business intelligence system) reports daily to support the business's ability to audit and validate reports against the clinical systems and provide assurances to relevant stakeholders
- We continue to engage and consult across services to ensure business rules continue to comply with national guidance and any Data Set Change Notifications (DSCN's) to ensure standardisation and compliance
- We use internal and external benchmarking information to monitor data quality and support improvement. Participate in national benchmarking work, such as the NHS Benchmarking Network, to ensure favourable comparison with leading mental health and community service providers
- We continue to publish reports monthly on the intranet against the MHMDS published reports and benchmark performance against national average and other London Trusts
- We have established the Trust's Clinical Action Group (CAG) to lead the provision and development of Trust-wide efficient clinical systems including accurate and timely data recording.

Clinical coding error rate

CNWL was not subject to the Payment by Results clinical coding audit during 2015-16 by the Audit Commission.

PART 3 – Other information

The following section describes how we have performed against indicators required by NHS England, Monitor's (our regulator) Risk Assessment Framework, 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 includes the historic Quality Priorities and how these are broken down 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. In some few cases this is a change from previous year's reporting and where this is the case it is identified in the following tables as "(Q4)". This shift is to make data reporting consistent and easier to understand, and provide a representative picture when the data is broken down by locality or service.

To continually challenge ourselves and strive for better quality services, we increased our targets at the start of the year against a number of measures. These are indicated in the tables below.

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

3.1.1 Patient Safety

Measure		Data Source	Target	2015/16	2014/15	2013/14	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 M11)	Clinical system scan	95%	96.6%	97%	96.1%	National Avg: 96.9% National Max: 100%; National Min: 86.4%

Measure		Data Source	Target	2015/16	2014/15	2013/14	Benchmark (where available): National average; and highest and lowest scores
2. Risk assessment and management	What percentage of mental health inpatients have had a risk assessment completed and linked to their care plans?* (YTD M12; n=761)	Internal audit	95%	90%	87% (Q4)	92% (Q4)	Not available
3. 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 M12)	Internal database	Year on year reduction	7	5	2	Not available
4. Patient safety	Mental health patients reported that they felt safe during their most recent inpatient stay # (YTD M12; n=87)	Patient survey	75%	78%	86%	80%	Not available
5. Access in a crisis	a. Community mental health patients report that they have a phone number to call in a crisis** (YTD M12; n=953)	Patient survey	85% Increase from 65%	85% (YTD)	85% (Q4)	75% (Q4)	69%^
	b. Patients report that they received the help they wanted from the CNWL urgent advice line when they contacted them **+(YTD M12; n=150)	Patient survey	75%	80% (YTD)	75% (YTD)	84% (YTD)	75%^
6. Incidents	a. Number of patient safety incidents for the reporting period (01/04/15 - 31/03/16);	Datix scan	N/A	15,207	18,210	15,702	Not available

	b. Percent of patient safety incidents that resulted in severe harm or death	Datix scan	N/A	132 (0.87%)	129 (0.70%)	113 (0.71%)	Not available

Key:
^ Source: Quality Health 2015 NHS community mental health service user survey
* This was a QP for 2009/10
** 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 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, 96.6% 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 Risk assessment and management: This measure monitors that inpatients' have up-to-date risk assessments, and that management or mitigation plans are reflected in the care plan. This was achieved in 90% of cases audited year-to-date, missing the target. This is an increase from our quarter four position reported last year (87%). Action taken has included weekly case note reviews to identify gaps in risk management planning. The importance of risk management as part of care planning has also been raised at team meetings, clinical supervision and in our Trust-wide Listen, Learn and Act newsletter. This indicator was a Quality Priority in 2009/10 and is solely related to our mental health services. In refreshing our quality indicators to provide a more balanced view of the Trust and its diverse services, performance will be monitored via our Divisional Boards and not reported in the Quality Account next year.

Measure 3 Infection control: We have a duty of care to ensure that our patients do not get any avoidable healthcare acquired infections (HCAI's) while in our services. At year end we are pleased to report that we did not acquire any MRSA bacteraemia cases. Seven 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), lapses in care were not identified across CNWL. In other 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:

- 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 where this is required
- All IPC polices were reviewed and kept up to date in 2015/2016, and new policies were developed, for example Bare Below Elbows (BBE) and the multi-resistant Gram Negative Bacteria Policy
- Mandatory IPC training programme for staff

Updates and audit reports are reported via the Divisional Infection Control Subgroups and main CNWL Infection Control Committee, chaired by the Trust Director of Infection Prevention and Control.

Measure 4 Patient safety:
We wanted to understand our mental health patients' sense of safety on the ward as this impacts on their care experienced and satisfaction of our services. We have achieved 78% against our 75% target. As response rates were low, we have not reported this by locality. This is a key priority for our newly established

Sign up to Safety campaign over the coming year, and more detail is described under Measure 6 below. This measure was a Quality Priority in 2011/12 and has been consistently achieved and so will not be reported in the Quality Account next year.

Measure 5 Access in a crisis:
We wanted to monitor that our community patients have a phone number to call in a crisis to ensure they get help when they need it most. Last year we increased our target from a minimum of 65% to 85%, and are pleased to report that this has been achieved. Our performance has also exceeded the national average of 69%. This is through making sure that our patients have the right access number via the distribution of our crisis contact cards and care plan folders, for example, to contact our newly established Single Point of Access (SPA) team.

We also wanted to ensure that patients who accessed the SPA got the help or support that they need, and so we asked patients who had been in touch to assess this. Results show that 80% said that they did get the help that they wanted from the SPA, achieving our 75% target and performing 5% better than last year and also out-performing the national average of 75%. As this service is largely a sign-posting service and a central point where patients can go when in urgent need of advice, information or the arrangement of urgent follow-up care, the help needed may come subsequently from a different source. Our SPA are currently reviewing and improving their feedback and monitoring mechanisms to understand where improvements need to be made for the variety services that they offer and people who get in touch. This measure will not be reported in the Quality Account next year.

Measure 6 Incidents:
We take reported incidents very seriously at CNWL. The incident data for 2015-16 reflects the recent organisational changes within CNWL, the development of the divisional structures and the establishment the trust's new reporting system (Datix), which went live on 1st April 2015 in all services apart from Hillingdon Community Services, which commenced use of the system on 1st July 2015. The system now provides an integrated reporting function across the whole trust. Use of a whole reporting system provides greater ease, visability and standardisation, objectivity and accuracy in relating to collating data across the Trust.

Incidents are graded, analysed and, where required, undergo a root cause analysis investigation to inform actions, recommendations and learning. The Trust has formed a Serious Incidents Investigation Team that undertakes investigations and provides specialist advice and guidance to investigating teams. Our divisions provide quarterly information and learning from their serious incidents for central analysis and reporting to the Board. This information is also reviewed for action at the Mortality Review Group, and analysed alongside other data from complaints, compliments, patient and staff feedback at the Trust-wide Organisational Learning Group for the production of our quarterly organisational learning themes, and 'Listen, Learn and Act' newsletter.

This measure indicates the total number of safety incidents reported during 2015-16 and, of these, what number and proportion resulted in severe harm or death. **CNWL reported no 'never events' during 2015-16**.

CNWL considers that measure number 6 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. The Trust has now established a central root cause analysis investigation team which has strengthened the arrangements for investigation and reporting within the Trust;
- Conducting non-executive director chaired panels of inquiry into the highest level incidents. The reports are reviewed by the Board of Directors, along with the action plans into the recommendations;
- The Trust's Clinical Risk Assessment and Management Policy has been reviewed in the past year, with strengthened timescales, a focus on care planning and risk assessment being linked and immediate risks being entered onto progress notes;
- The Trust has invested heavily in addressing potential ligature risks at the Campbell Centre in Milton Keynes. We have removed a large number of potential ligature points from this inpatient facility acquired in April 2013;
- The Trust has undertaken multi-discipline reviews of all in-patient areas to further reduce the number of potential ligature risks.
- The Trust has led a London-wide benchmarking process with all other providers of Mental Health services in the London area into probable suicide over a 3 year period.
- The Trust has invested heavily in improving potential points of exit to prevent patients from going AWOL (absent without leave) and points that could be used to smuggle illicit substances into secure environments.
- A project has been established on an acute inpatient ward to improve compliance against all levels of the Incident Reporting Policy by 50% by June 2016. Key areas of learning will be shared across all clinical areas.
- Incident reporting user guides have been revised to support governance and clinical staff. An incident reporting training programme including Datix webinars is in place for governance and clinical teams.

Sign up to Safety

The Trust has signed up to the national campaign by describing the actions we will take in response to the five Sign up to Safety Pledges. This commits the Trust to continually learn from incidents and improve and sustain patient safety through the application of a patient safety model and quality improvement methodology. The Trust's Sign up to Safety Group meets monthly; membership includes governance and speciality leads and divisional practice leads from each of the divisions in order to ensure representation from the many diverse services across the Trust.

Analysis of reported incidents, themes and trends has supported the identification of the Trust's five key clinical priorities in relation to patient safety. Co-production with patients and carers under pins each of the projects and will shape our improvements.

The five Trust clinical priorities:

- **Violence and aggression** - reducing use restrictive practice including prone restraint and use of seclusion, developing skills in de escalation, use of team recovery implementation plans (TRIPS). The Trust is on target to achieve a 50% reduction in this area.
- **Medication omissions -** implementation of Medication Competency Assessments, introduction of the mental health safety Thermometer to identify 'hot spots' and areas of good practice
- **Suicide and self harm -** ongoing safety initiatives in relation to support a reduction in AWOL incidents, improving security through physical controls and raising awareness of the staff in relation to the risks, introducing a Failure to Return to the Ward projects in conjunction with the Oxford PSC to commence 4th April 2016, establishment of a Suicide Prevention Group to focus on vulnerable patient groups, review of the Trust's Clinical Risk Assessment and Risk Management model, development of a Clinical Risk work book for all staff
- **Falls -** the Falls Prevention Project is underway. The aim of the project is to ensure that all staff supporting older people across the trust have user friendly best practice falls prevention tools available to them for use in clinical areas
- **Pressure ulcers -** the establishment of a Pressure Ulcers project to ensure that best practice is in place to reduce the incidence of avoidable pressure ulcers across the Trust.

The Trust's Safety Improvement Plan is in the process of being developed and supports the Trust's strategy for the next 3-5 years in relation to quality and safety. The over arching project plan outlines the detail of the work streams and the practical steps we will take to achieve the objectives.

Additionally the Trust is engaged with the central London (Imperial) and Oxford Patient Safety Collaboratives (PSCs). The PSCs provide invaluable input to the Quality Improvement Projects in terms of supporting the model to embed improvements and change through use of PDSAs and process statistical control charts.

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.

In terms of the practical implementation of the duty of Candour, we have issued guidance to all staff on the requirement to provide an apology and explanation in each case where there has been significant harm. We are further refining our Datix Web (incident reporting system) to enable us to collect data

on the completion of the duty of candour both so that we can issue automatic reminders to staff and to make checking and reporting on compliance more straightforward. We have audited our progress in implementing the duty of candour and as a result are revising our guidance into a more comprehensive policy which will capture both the practical elements of compliance along with the qualitative values of openness and transparency.

3.1.2 Clinical Effectiveness

Measure		Data Source	Target	2015/16	2014/15	2013/14	Benchmark (where available): National average; and highest and lowest scores
1. Re-admission rates	What percentage of patients were re-admitted to hospital within 30 days of leaving? (YTD M11)	Clinical system scan	<8.1%	5.0%	4.2%	4.5%	National Avg: 9% National Max: 16%; National Min: 1%
	a. For patients aged 0 - 15: b. For patients aged 16 or over:			a.1.5% b.5.0%	a. 0% b. 4.2%	a. 0; b. 4.5%	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 M11)	Clinical system scan	95%	96.8%	99.7%	96.2%	National Avg: 97.4% National Max: 100%; National Min: 24.6%
3. Early Intervention	Did our Early Intervention Psychosis Teams meet the commitments (set by commissioners) to serve new psychosis cases? (YTD M11)	Clinical system scan	95%	100%	100%	100%	Not available
4. Mental Health Minimum Data Set (data completeness)	a. Identifiers (YTD M11)	Clinical system scan	97%	99.4%	99.1%	99.5%	Not available
	b. Outcomes (YTD M11)	Clinical system scan	50%	86%	92.6%	98.1%	Not available

Measure		Data Source	Target	2015/16	2014/15	2013/14	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 M11)	Clinical system scan	50%	77.5%	88.5%	-	Not available
6. Physical health checks	a. The percentage of mental health inpatients with physical health assessment after admission (Nursing)** (YTD M12; n=748)	Internal audit	95%	97% (YTD)	98% (Q4)	94% (Q4)	Not available
	b. The percentage of mental health inpatients with physical health assessment after admission (Medical)** (YTD M12; n=748)	Internal audit	95%	93% (YTD)	94% (Q4)	96% (Q4)	Not available
	c. Patients on CPA report that they got enough advice and support for their physical health # + (YTD M12; n=319)	Patient survey	85% Increase from 65%	85% (YTD)	89% (YTD)	86% (YTD)	65%^
7. Mental health checks	Community health patients report that they got enough advice and support for their mental health (YTD M12; n=180)	Patient survey	85%	78%	Not available	Not available	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 30 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 5%. 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 resolution gate-keeping: Our crisis resolution teams assess patients when they are in crisis to quickly determine if they are suitable for home treatment rather than being admitted to hospital. It is important to treat our patients in the most appropriate settings to ensure their safety and that they receive the effective treatment.

We are proud that we have done well on this measure for three years running, achieving 96.8% 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 month 11 we achieved 77.5%, exceeding the national 50% target.

Measure 6 Physical health checks for mental health patients: Measure 6a and 6b indicate the percentage of patients who have received nursing and medical physical health assessments after their admission to a mental health inpatient unit. The medical health assessment includes a physical examination however the nursing assessment does not. Both the nursing and medical health assessment will ask about allergies and both will ask open-ended questions throughout the assessment which allow the patient to report on any physical side effects they may be experiencing. Where side effects are identified on the ward, these are raised with the Home Treatment Team (HTT) to follow up once under their care. While a patient is under the care of HTT they will be primarily under the care of their GP, and HTT's will liaise closely with GP's regarding any outstanding physical healthcare issues.

Year to date we achieved the completion of 97% of our nursing physical health assessments, and 93% of our medical physical health assessments post admission. In some services medical physical health assessment target was narrowly missed, for example in Hillingdon and Kensington and Chelsea. Actions have included the communications amongst the teams to remind staff members of the importance of fully completing these assessments, frequent checks to identify where assessments are still to be completed and the introduction of a checklist to be used in handover.

Measure 6c is a patient reported measure, seeking the views of community mental health patients and if they feel they have received enough support for their physical health care needs. At the beginning of this year we increased our target from 65% to 85%. We are pleased to report that we have achieved this and the previous two year's targets, as well as performing 20% better than the national average.

Measure 7 Mental health care checks for physical health care patients: This year we also asked our community patients in Camden, Hillingdon and Milton Keynes whether they felt they got enough support for their mental health, where this was applicable. We are pleased that almost 80% of 180 people told us that they did. We will continue this work locally and will not report this indicator in the Quality Account next year.

3.1.3 Patient, carer and staff experience

Measure		Data Source	Target	2015/16	2014/15	2013/14	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 M11)	Clinical system scan	<7.5%	4.5%	4.4%	4.7%	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 M11)	Clinical system scan	95%	96.6%	98.0%	96.1%	National Avg: 78% National Max: 99%; National Min: 14%
3. Care/ treatment plans	a. Quality Account Priority 2015/16: Patients report that they were *'definitely'* involved as much as they wanted to be in decisions about their care and treatment (YTD M12; n=6758)	Patient survey	75% Increase from 65%	Trust: 82% MH: 67% CH: 87% (YTD)	81% (Q4)	82% (Q4)	56%%^
	b. Quality Account Priority 2015/16: Patient report that their care or treatment helped them to achieve what mattered to them (YTD M12; n=6472)	Patient survey	85%	Trust: 91% MH: 89% CH: 92% (YTD)	n/a	n/a	93%^
	c. Percentage of patients that have a 'carer status' identified (YTD M12; n=1990)	Internal audit	70%	83% (YTD)	77% (Q4)	68% (Q4)	Not available
	d. Patients on CPA whose care plans contain at least one personal recovery goal+ (YTD M12; n=548)	Internal audit	75%	83% (YTD)	90% (Q4)	81% (Q4)	Not available

Measure		Data Source	Target	2015/16	2014/15	2013/14	Benchmark (where available): National average; and highest and lowest scores
4. Access for people with a learning disability	Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability (YTD M12)	Internal database	8/8	8/8	8/8	8/8	Not available
5. Dignity and respect	Patients report that they were treated with dignity and respect (YTD M12; n=3534)	Patient survey	95% Increased from 90%	Trust: 97% MH: 96% CH: 98% (YTD)	98% (Q4)	-	93%^
6. 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	92%	93%	-	93%^
	b. Were you given enough time to discuss your needs and treatment?		n/a	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	86%	85%	-	86%^
	d. Did you feel that you were treated with respect and dignity by NHS mental health services?		n/a	91%	90%	-	93%^
	e. Were you involved as must as you wanted to be in discussing how your care is working?		n/a	92%	93%	-	93%^

Measure		Data Source	Target	2015/16	2014/15	2013/14	Benchmark (where available): National average; and highest and lowest scores
7. 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 M12; percentage of 'likely' and 'extremely likely' responses; n=4416)	Patient survey	90%	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)	66% (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 2015	n/a	3.71/5	3.68/5	n/a	* National Avg: 3.63/5 National Max: 4.04/5
8. Equal opportunities for progression or promotion	Staff believing that the organisation provides equal opportunities for career progression or promotion	National Staff Survey 2015	n/a	85%	87%	n/a	* National Avg: 84% National Max: 93%
9. Staff experience of bullying or abuse	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	National Staff Survey 2015	n/a	22%	21%	n/a	* National Avg: 22% National Max: 16%

Key:
^ Source: Quality Health Ltd 2015 NHS community mental health service user survey
^^ Source: NHS England national patient FFT results (February 2016)
^^^ Source: NHS England national staff FFT results (Quarter 2; to be updated)
* Source: NHS National Staff Survey 2015
# 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
"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 4.5% against a <7.5% target.

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 and exceed the national average by more than 18%.

Measure 3 Care plans:

a) **Involvement in care and treatment:** This was a Quality Account Priority for 2015/16 and is explained in Part 2. We are rolling this forward as a Quality Account Priority for next year, and will report this in the 2016/17 Quality Account.
b) **Patients report their care or treatment helped them achieve what mattered to them:** This was a Quality Account Priority for 2015/16 and is explained in Part 2. We are rolling this forward as a Quality Account Priority for next year, and will report this in the 2016/17 Quality Account.
c) **Carer status identified:** This measure took a sample of patients across our mental health and specialty services each quarter to assess the extent to which staff were recording whether or not our patients had the involvement of a carer. This is important because it enables us to engage with and offer support to the patients' carer who are partners in the care recovery process and also may know the patient best. We are pleased to report that our focus on carer involvement has paid off: We achieved our target and have demonstrated year on year improvement, and so this mental health specific indicator will be monitored via our Divisional Boards and local care quality groups and not reported in the Quality Account next year.
d) **Care plans include recovery goals:** For the last four years we have audited our patients' care plans to assess the extent to which care plan goals were personalised and recovery focussed, to further support our aspirations of patient involvement, partnership and empowerment. We are pleased to report that we continue to achieve this target across our boroughs and for the last three years. We will monitor this internally and will no longer be reporting on this measure in future Quality Accounts.

Measure 4 Access for people with a learning disability: This measure assesses whether those with a learning disability have the same access to care rights as those who do not, to ensure they are not disadvantaged and receiving the care they need. The assessment is by seven questions based on the recommendations set out in 'Healthcare for All' (2008), the Independent Inquiry into Access to Healthcare for People with Learning Disabilities. We are proud to report that we achieved the maximum score (eight out of eight) at year end for this measure.

Measure 5 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. This is also why we raised the target from 90% to 95% at the start of this year. We are pleased to report that overall we have achieved 97%, achieving our target. In mental health services this was 96%, out-performing the national average of 93% from the national community mental health survey 2015. Our community health services achieved 98%.

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 2015.

CNWL considers that these indicators are as described for the following reasons: Overall, the Trust's 2015 results were positive compared to the previous year and when compared to the national average. In particular, Milton Keynes in particular saw significant gains, their results improved from being amongst the lowest nationwide to amongst the highest. The Trust showed improvements across the majority of areas, 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 reported improvements in staff listening, giving time and understanding their mental health needs. This is supported CQC rating Care at the Trust as **outstanding,** noting:

The staff we spoke to across the Trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard working, caring and compassionate staff. In many services we saw great attention being given to providing care that was meeting the individual needs of each patient.

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 have nominated the first of our Quality Priorities for 2016/17 as patients and carers feeling involved, supported and taking ownership of the decisions about their care. This this will remain a key focus for us over the coming year.

- **#Hellomynameis campaign:** We will begin the roll-out of the **#hellomynameis** campaign to all our services. This initiative is all about treating patients and carers with Respect and Dignity. We will encourage staff to pledge their support and bring the values that underpin this campaign into all interactions with patients and carers.

- **Patient and Carer Stories:** We will use Patient and Carer Stories across the Trust to inspire, challenge, connect and improve experience. Our Carers Council have already designed training for staff and we will grow this model with our patients and carers to develop co-produced training and experience based learning to improve quality and outcomes.

- **Involvement for better Care Planning:** We will redesign our Care Planning approach in adult mental health community services making sure our staff work in partnership with patients to put their needs and goals are at the heart of all Care Planning.

- **We will continue to listen to our patients and carers and, more importantly to act on this 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 92% of our patients would be likely or extremely likely to recommend Trust services, achieving our target. Breaking this down, we achieved 86% for our mental health services and 94% for our community services, both just below 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.

Also, considering CNWL's results from our National Staff Survey, we achieved 3.71/5, 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: Patients and service users are seen as the organisations top priority by three quarters of the workforce with 91% of staff feeling that their role makes a difference to patients and service users and 83% 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 58% would recommend CNWL as a place to work this is a slight improvement on last year and we benchmark more favourably with other similar NHS trusts.

CNWL has taken the following actions to improve this score, and so the quality of its services by ensuring the new divisional structures introduced last year are embedded through strong leadership, governance and accountability. Each Division has had to develop a staff engagement plan and provide examples of key actions taken. Key actions include:

- Quarterly leadership road-shows
- Multi-disciplinary leadership programmes
- Cross-divisional learning walks
- Nurse rotation programmes
- Review of staff benefits
- Delivery of the staff charter
- Equalities and diversity initiatives and training
- Inclusion of Trust values in appraisals

Our challenge this year is to improve further on these measures and we will do this by creating a Workforce Strategy and action plan that builds on Divisional workforce plans; and refreshing other key strategies such as the Staff Engagement Strategy (2014 – 2018); Recruitment and Retention Strategy (2014 – 2018); Staff Health & Wellbeing strategy (2014 – 2018).

The key workforce objectives this year include: Improving recruitment rates through flexible and innovative approaches; dramatically reducing agency usage and improving workforce productivity; 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 8 and 9 Staff career progression and experience of harassment: These measures represent our performance from the National Staff Survey 2015. Measure 7 shows that 85% of our staff feel that there are equal opportunities for career progression or promotion and staff, and this compares favourably to the national average for similar Trusts. Measure 8 shows that 22% of our staff experienced harassment or bullying from staff in the last 12 months which is on par with the average for similar Trusts. Our actions to be taken to improve these results further are captured in Measure 6 above.

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

The following three tables reflect the data presented in Section 3.1 broken down, where possible, by 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	What percentage of mental health inpatients have had a risk assessment completed and linked to their care plans? (YTD M12; n=761)	95%	90%	84%	100%	88%	78%	74%	99%	94%	100%	98%	n/a	n/a	n/a	n/a	n/a	n/a	**90%**
3. Access in a crisis	Community mental health patients report that they have a phone number to call in a crisis (M12; n=953)	85% Increased from 65%	84%	79%	93%	88%	80%	89%	92%	n/a	94%	92%	75%	n/a	n/a	n/a	n/a	n/a	**85%**

Key: "-": Not measured or no response received; n/a: Measure not applicable; "n=" denotes total sample size;
"YTD M12" denotes year to date at month 12; "Q4" denotes results at quarter four

3.2.2. Clinical Effectiveness

			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
4. Mental health physical health checks	a. Inpatients with physical health assessment after admission (Nursing; YTD M12; n=749)	95%	100%	100%	94%	91%	100%	87%	97%	100%	99%	100%	n/a	n/a	n/a	n/a	n/a	n/a	**96%**
	b. Inpatients with physical health assessment after admission (Medical; YTD M12; n=749)	95%	100%	100%	85%	74%	93%	94%	97%	94%	97%	100%	n/a	n/a	n/a	n/a	n/a	n/a	**93%**
	c. Patients on CPA report that they got enough advice and support for their physical health (YTD M12; n=391)	80% Increased from 65%	87%	84%	89%	87%	85%	80%	100%	n/a	86%	100%	100%	n/a	n/a	n/a	n/a	n/a	**85%**

Key: "-": Not measured or no response received; n/a: Measure not applicable; "n=" denotes total sample size; "YTD M12" denotes year to date at month 12; "Q4" denotes results at quarter four;

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 'definitely' involved as much as they wanted to be in decisions about their care and treatment (YTD M12; n=6758)	75% Increased from 65%	66%	69%	65%	66%	61%	70%	93%	58%	n/a	50%	70%	50%	67%	82%	83%	89%	**82%**
	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 M12; n=6758)	75%	86%	89%	91%	91%	90%	93%	93%	90%	n/a	85%	95%	79%	88%	95%	96%	99%	**96%**
	b. Quality Account Priority 2015/16: Patient report that their care or treatment helped them to achieve what mattered to them (YTD M12; n=6472)	85%	85%	86%	95%	90%	86%	88%	93%	80%	n/a	77%	93%	85%	86%	88%	96%	92%	**91%**

Measure		Target	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
	c. Percentage of patients that have a 'carer status' identified (YTD M12; n=1990)	70%	91%	87%	85%	80%	80%	51%	86%	91%	79%	100%	89%	n/a	n/a	n/a	n/a	n/a	**83%**
	d. Patients on CPA whose care plans contain at least one personal recovery goal (YTD M12; n=548)	75%	76%	85%	88%	83%	81%	82%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**83%**
4. Dignity and respect	Patients report feeling they were treated with dignity and respect (YTD M12; n=3534)	95% Increased from 90%	95%	93%	96%	97%	93%	98%	100%	94%	n/a	89%	98%	93%	98%	97%	100%	96%	**97%**
5. Service satisfaction/FFT	Patients: How likely are you 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=4416)	90%	79%	54%	71%	79%	67%	87%	87%	100%	63%	73%	94%	60%	88%	93%	96%	93%	**92%**
	Staff: How likely are you 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)	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 M12" denotes year to date at month 12; "Q4" denotes results at quarter four

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

[Included at close of 30-day consultation 9 May 2016]

Our commissioners

Our local Healthwatch

Our Overview and Scrutiny Committees

Annex 2 – 2015-16 Statement of directors' responsibilities in respect of the Quality Account

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  o board minutes and papers for the period April 2015 to 27 May 2016

  o papers relating to quality reported to the board over the period April 2015 to 27 May 2016

  o feedback from commissioners dated 9 May 2016 (closing date of the Quality Account 30-day consultation)

  o feedback from governors dated 9 May 2016 (closing date of the Quality Account 30-day consultation)

  o feedback from local Healthwatch organisations dated 9 May 2016 (closing date of the Quality Account 30-day consultation)

  o feedback from Overview and Scrutiny Committee dated 9 May 2016 (closing date of the Quality Account 30-day consultation)

  o the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;

  o the 2015 national patient survey

  o the 2015 national staff survey

  o the Head of Internal Audit's annual opinion over the trust's control environment dated 27/05/2016

  o CQC Intelligent Monitoring Report dated February 2016

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

☐ the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

[signatures]

Claire Murdoch
Chief Executive
27 May 2016

Prof. Dorothy Griffiths
Chairman
27 May 2016