Appendix A

Central and North West London NHS
NHS Foundation Trust

Draft Quality Account 2016-17

v.4.0

Glossary of terms

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

Contents

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

Part 1 – Letter from our Chief Executive

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

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

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

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

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

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

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

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

We hosted our first Carers Conference and set up our Staff Carers Network. We set up special events to listen to our staff and as a result developed our work plan that demonstrates we've listened.

We refreshed our Health & Wellbeing plans, are working on our leadership programmes and are particularly focussed on the development of our BME staff. I am proud to report that we were accredited by the Mayor of London's office with the Healthy Workplace Charter.

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

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

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

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

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

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

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

Claire Murdoch
Chief Executive

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

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

May 2017

KPMG LLP, Statutory Auditor

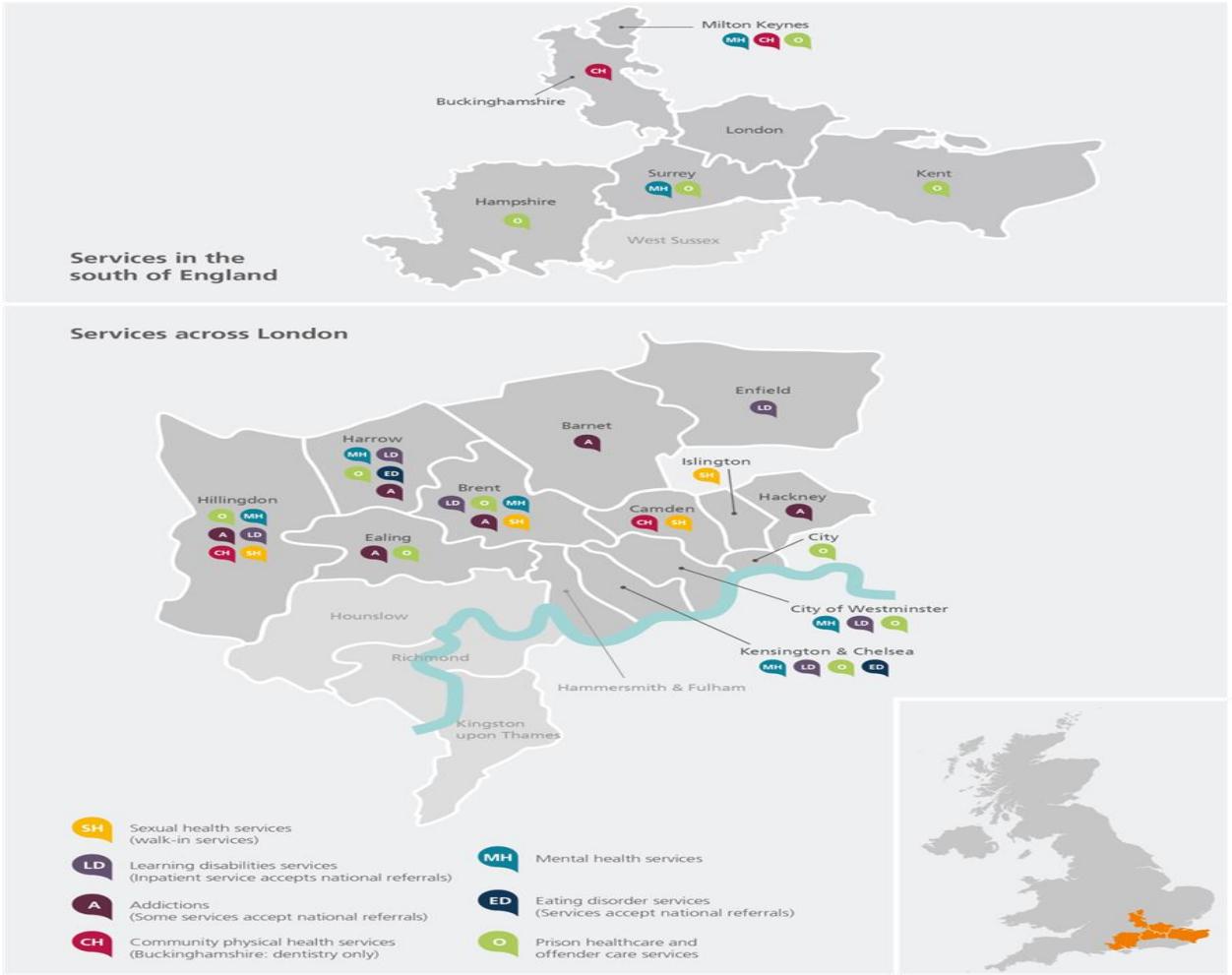
KPMG LLP

15 Canada Square, London

E14 5GL

Overview of our services

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



PART 2 - Our priorities for improvement

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

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

Section 2.1 Our Quality Priorities 2016/17

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

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

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

- Patient & Carer Involvement
- Staff Engagement.

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

2.1.1 Quality Priority 1: Patient & Carer Involvement

What we achieved

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Involvement to Influence

-Patient and Carer Involvement in Recruitment and Selection:

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

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

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

-The Patient Reference Group:

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

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

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

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

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

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

2.1.2 Quality Priority 2: Staff Engagement

What we achieved

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

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

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

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

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

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

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

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

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

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

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

The National Staff Survey

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

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

2.1.3 Measuring and testing our actions

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

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

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

Staff Engagement- Indicators for measuring the impact of our actions

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

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

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

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

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

Patient & Carer Involvement Indicators

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

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

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

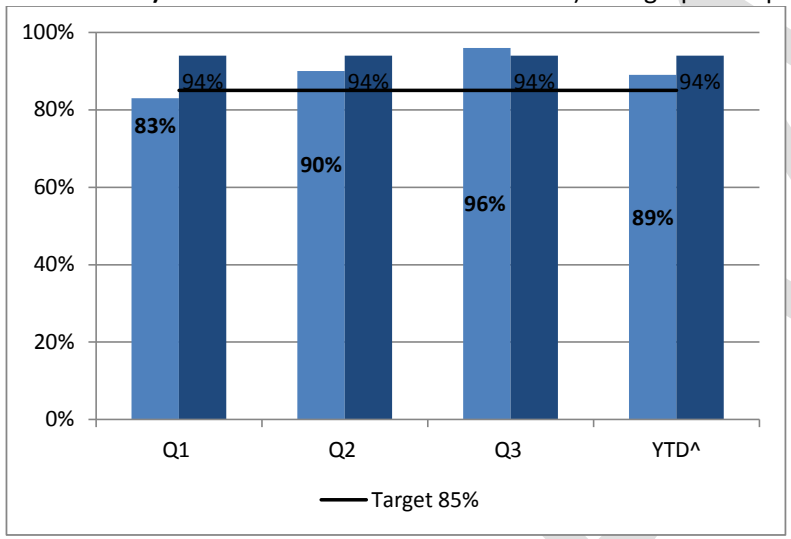


Chart 1

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

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

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

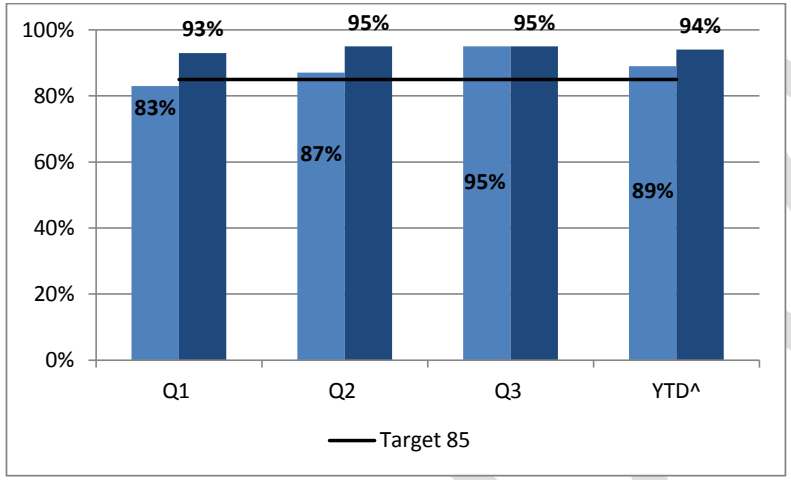


Chart 2

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

Staff Engagement Indicators

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

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

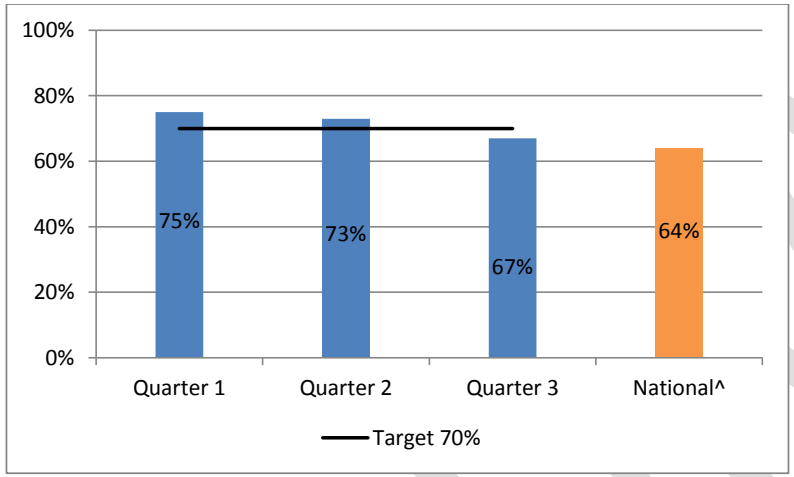


Chart 3

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

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

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

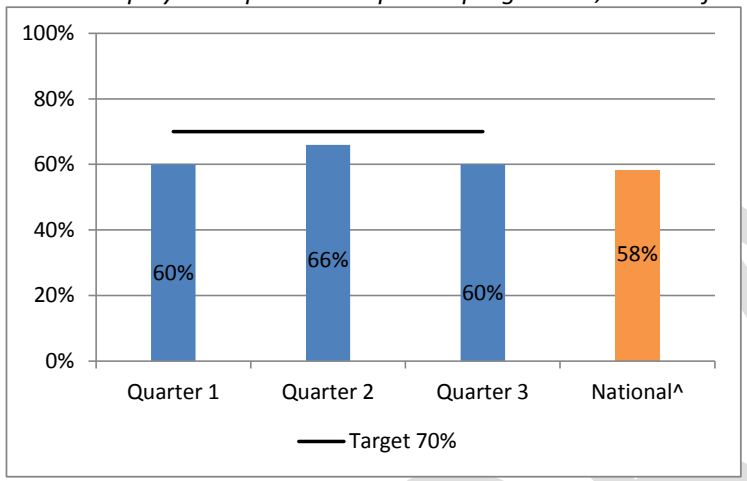


Chart 4

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

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

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

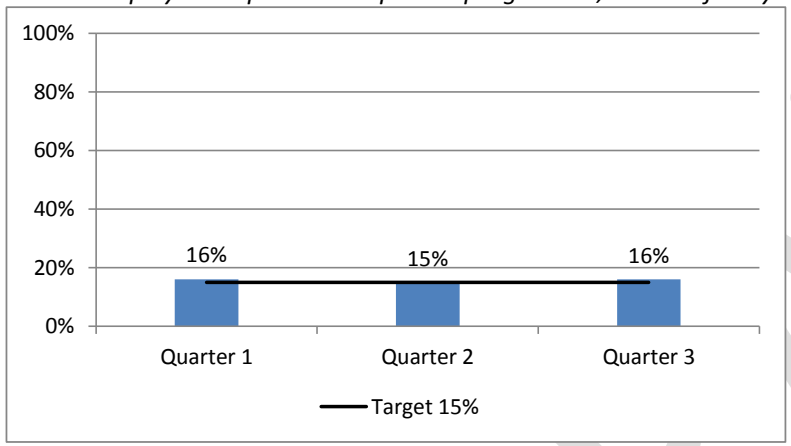


Chart 5

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

What else did we measure?

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

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

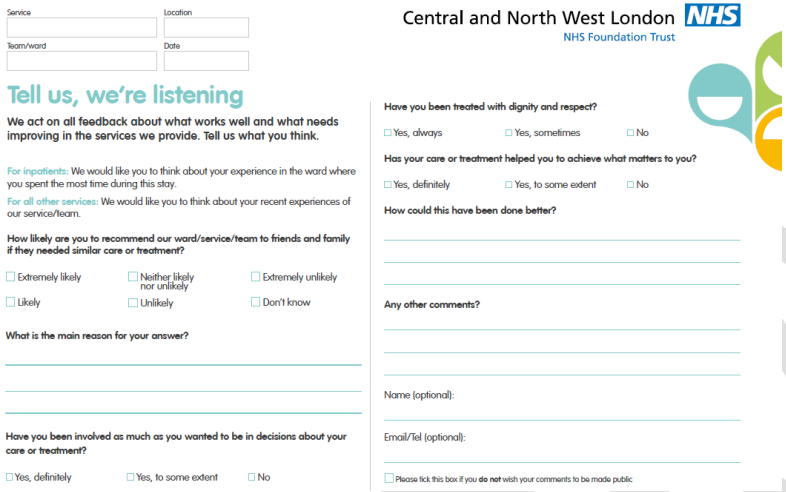
Like our quality priority indicators, two of these are patient reported. The third indicator (one relating to risk assessments linking to care plans in mental health), is audit based. We are pleased to report that we have met or exceeded our targets every quarter.

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

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

2016/17 Friends and Family Test

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



Service | Location
Team/ward | Date

Tell us, we're listening

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

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

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

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

What is the main reason for your answer?

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

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

Central and North West London NHS
NHS Foundation Trust

Have you been treated with dignity and respect?

☐ Yes, always ☐ Yes, sometimes ☐ No

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

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

How could this have been done better?

Any other comments?

Name (optional):

Email/Tel (optional):

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

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

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

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

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

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

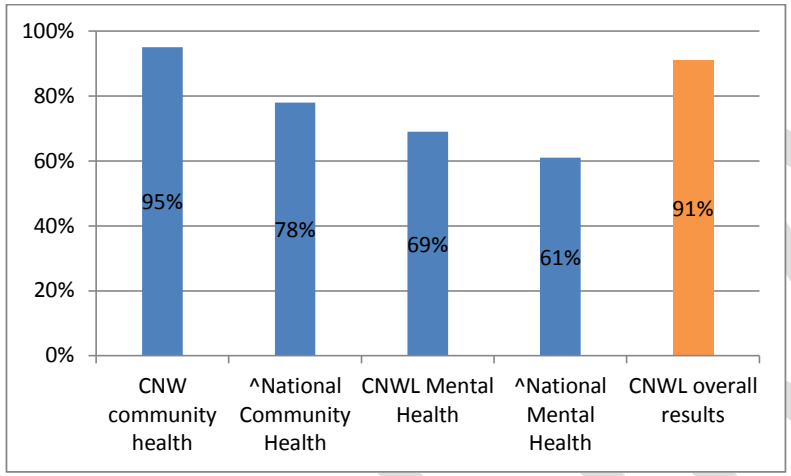


Chart 6

Key:

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

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

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

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

Learning from Feedback

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

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

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

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

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

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

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

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

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

Section 2.2 Quality Priority Plans for 2017/18

How we agreed our Quality Priorities for 2017/18

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

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

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

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

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

Participants told us that Quality means…….

They described Quality as:

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

"Having a stable motivated workforce"

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

"Giving choice and preserving dignity"

"Doing it right the first time"

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

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

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

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

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

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

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

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

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

What do we want to achieve?

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

Why are we doing this?

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

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

What will we do? Our plans for the year:

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

How we will know?

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

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

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

What do we want to achieve?

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

Why are we doing this?

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

What will we do? Our plans for the year:

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

How we will know?

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

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

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

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2.3 Monitoring and sharing how we perform

Reporting our performance and achieving our targets

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

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

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

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

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

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

Benchmarking

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

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

2.4 Statements relating to the quality of NHS services provided

Review of services

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

These included:

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

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

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

Participation in clinical audit

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

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

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

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

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

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

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

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

The national clinical audits and national confidential enquiries that CNWL participated in, and for which data collection was completed during 2016-17, are listed below alongside the number of cases

submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

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

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

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

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

Action

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

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

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

Action

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

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

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

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

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

Action

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

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

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

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

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

Action

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

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

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

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

Action

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

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

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

Additional Trust wide clinical audits:

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

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

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

Action

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

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

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

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

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

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

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

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

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

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

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

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

Local Clinical Audit Programmes:
The reports of over 500 local clinical audits were reviewed by the provider in 2016/17 and local services have taken action following audit outcomes to both sustain and improve the quality of healthcare provided. Local quality governance structures are in place across the organisation to monitor, and take action on the results of audits. Through these groups, the results of clinical audit reports are discussed, and any actions required to improve practice are identified.

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

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

Action

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

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

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

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

Action

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

Sexual Health:

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

Cervical Cancer Screening in Mental Health Patients:

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

Action

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

Liaison psychiatry:

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

Action

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

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

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

Action

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

District Nursing Records spot check audit:

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

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

Action

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

Pre-school special needs and early years:

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

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

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

Action

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

Assessing and managing referrals for Challenging Behaviours in Dementia:

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

Action

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

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

Research

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

Goals agreed by commissioners

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

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

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

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

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

CQC Reviews of Compliance

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

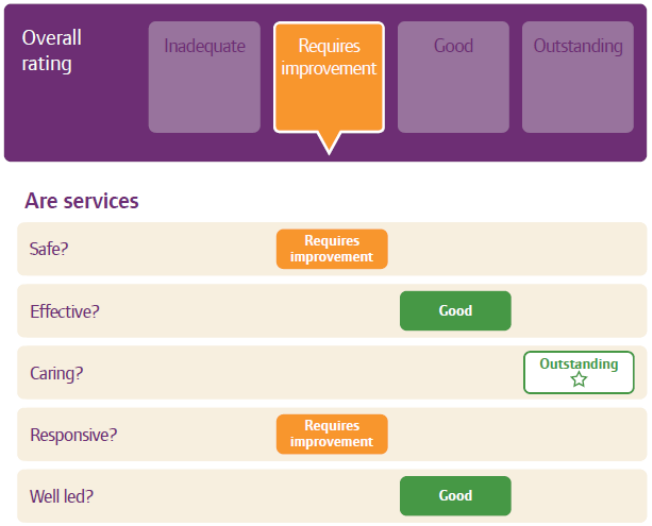
The CQC has not taken enforcement action against CNWL during 2016/17.

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

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

CQC Reviews of Compliance during 2016/17:

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



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

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

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

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

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

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

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

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

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

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

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

Data quality

NHS number and General Medical Practice Code Validity

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

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

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

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

Information Governance Toolkit attainment level

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

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

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

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

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

Clinical coding error rate

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

PART 3 – Other information

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

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

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

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

ALL WILL BE UPDATED AT THE CLOSE OF THE YEAR

3.1.1 Patient Safety

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sign up to Safety Campaign / Patient Safety Improvement Work

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

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

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

- Reducing restrictive interventions

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

Duty of Candour

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

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

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

3.1.2 Clinical Effectiveness

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

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

Key:

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

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

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

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

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

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

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

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

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

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

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

3.1.3 Patient, carer and staff experience

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

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

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

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

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

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

Measure 3 Care/ treatment plans:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2.1. Clinical Safety

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

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

3.2.3 Clinical effectiveness

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

Key: n/a: Measure not applicable;

3.2.3 Patient and Carer Experience

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

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

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

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

Our commissioners

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

Our local Healthwatch

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

Our Overview and Scrutiny Committees

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

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

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

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to March 2017
  - papers relating to quality reported to the board over the period April 2016 to March 2017
  - feedback from commissioners dated XXX (closing date of the Quality Account 30-day consultation)
  - feedback from governors dated XXXX (closing date of the Quality Account 30-day consultation)
  - feedback from local Healthwatch organisations XXXXXX (closing date of the Quality Account 30-day consultation)
  - feedback from Overview and Scrutiny Committee dated XXXXX (closing date of the Quality Account 30-day consultation)
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;
  - the 2016 national patient survey
  - the 2016 national staff survey

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

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

[signatures]

Claire Murdoch
Chief Executive
27 May 2017

Prof. Dorothy Griffiths
Chairman
27 May 2017