Central and North West London Foundation NHS Trust

DRAFT Quality Account 2010/11

For Consultation

Contents

Part 1:

Chief Executive Statement

Welcome to the Trust's annual Quality Account for 2010/11. This Quality Account forms part of our Annual Report for the same period. This document allows us to share with you our ongoing commitment to achieve better outcomes for our service users and carers. This Quality Account provides a summary of our wider approach to quality improvement. It will tell you how we are doing against the priorities we set ourselves last year and describe the process we have gone through with our stakeholders to identify our quality priorities for 2011/12.

We believe that our approach to quality improvement needs to be tailored to our organisation and reflect the views and needs of the local population and service users. As such there has been a real drive within the trust to ensure involvement of our service users, carers, GPs, commissioners, Local Improvement Networks and our staff and Executives in agreeing our priorities for 2011/12. We have used their feedback to help us develop this Quality Account and you will see their views reflected throughout this document.

In 2010/11 Hillingdon Community Health (HCH) integrated with CNWL, and for Camden Provider Services (CPS), this occurred in April 2011. Both HCH and CPS have been working with their stakeholders to identify priorities that matter to them. In this Quality Account we will share with you the priorities decided upon through their consultations.

We have made considerable progress towards delivering against our priorities from 2010/11. In this year's Quality Account we have included a quality overview section to provide a transparent and detailed account of the quality of mental health services that we have provided. Whilst we have met a number of our targets in the priority areas from last year, and in some areas achieved more than the reported national average, we have not achieved all that we wanted to. We would like to thank our staff for dedication and commitment throughout the year that has enabled us to improve our services.

Our priority areas for 2011/12

CNWL mental health priorities	Hillingdon Community Health priorities	Camden Provider Services priorities
1. Access to services when in a crisis	1. Reduction in errors in the administration of medication by Hillingdon Community Health staff	1. Improving telephone access
2. Respect and involvement	2. Increase in number of woman sustaining breastfeeding at 6-8 weeks post delivery	2. Introducing safer ambulatory syringe drivers
3. Physical healthcare	3. Increase in the number of patients who have undergone DESMOND training who state that they are better able to understand and manage	3. Providing intensive stroke rehabilitation in accordance with NICE Quality Standards

	their condition	
4. Carer involvement	4. Increase in the number of patients who are offered and provided with interpreting support where they expressed that they needed the support	4. Communication with GPs about the care of HIV patients

You will notice that the mental health priorities are largely the same areas as last year. We decided to continue prioritising Access, Respect and involvement and Physical healthcare because we haven't achieved all that we wanted to in these areas, which remain important to our stakeholders. These themes also are important nationally, particularly Respect and involvement which features strongly in the Government's White Paper *'Equity and excellence: Liberating the NHS'*.

We have included a new area this year which focuses on working in partnership with carers and promoting carer involvement. We believe that good working relationships between services and carers are fundamental to delivering high quality care and keeping users safe. We want to focus on building these relationships, focussing particularly on identifying the support we can offer the carers to enable them to perform their valuable roles. Throughout the year, and at our stakeholder consultation event in March 2011, we have heard from our stakeholders that this is an area that they want us to develop. We have used their valuable feedback to develop this new important priority area in 2011/12.

In this account we set out what we plan to do to develop all of these priority areas so that we build on what we have achieved to date, and stretch ourselves to continuously improve the quality of the services we provide.

I would like to thank all of you who have contributed to our understanding of where we are and for sharing in shaping our priorities as we continue on our journey to improve outcomes for patients. We believe that ongoing dialogue between us and our stakeholders is really important to shaping our wider approach to quality improvement, all year round, and not just in forming our Quality Account.
This Quality Account represents my commitment to ensuring that we continue to embed quality improvement at the heart of our organisation. I look forward to working with all of you to make this happen.

To the best of my knowledge and belief, this Quality Account is true and accurate. It will be audited by KPMG by 30 June 2011 in accordance with Monitor's audit guidelines.

Claire Murdoch
Chief Executive

Part 2:

Quality overview – a review of our performance in 2010/11 against last year's priorities

Our Quality Account last year identified three priority areas for 2010/11. In this section we will report on what we have achieved in these areas and how this has been done. Where data is available, we have also included our performance from 2009/10 along with the national average to provide context.

1) Access to services when in a crisis - helping service users when they need it most

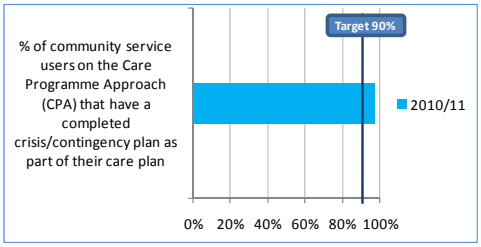
We set the following measures and targets to record our performance:

A. 90% of community service users on the Care Programme Approach (CPA) have a completed crisis/contingency plan as part of their care plan
B. 75% of community service users on the CPA report that they have a phone number to call in crisis
C. 70% of community service users on the CPA who called the crisis number said that they definitely got the help they wanted.

We are reporting our performance against each of these targets.

Measure A

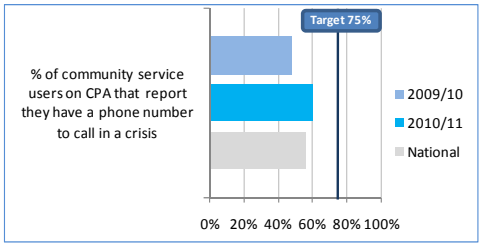
This measure is about assessing if our service users have a documented plan in their notes of what to do if a crisis occurs. It relates to those service users who live in the community on a Care Programme Approach (CPA) form of care planning as opposed to lead professional care.



We are very pleased to report that we have exceeded our 90% target in this area; we achieved 97%. This means that our staff are developing and documenting plans to keep our service users safe. As a service user this means that you know that staff are planning for how to look after you if you do encounter a crisis or emergency.

Measure B

This measure is about assessing if those service users in the community on CPA report that they have a phone number to call in a crisis/emergency. We have a responsibility to ensure that our users have access to a phone number if they are in a crisis so that we have the opportunity to support them when they need it most.



Source: CQC National Community Service User Survey 2010

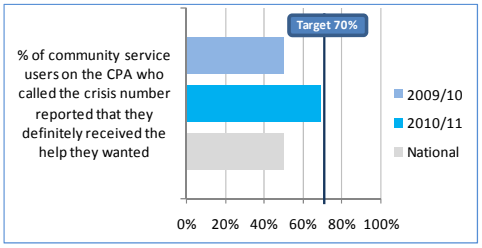
We have not met our 75% target – we achieved 60% – which means we have work to do to improve in this area. In response to poorer performance than expected with crisis cards, a Care Plan folder was developed for Care Co-ordinators to give to service users which included the service user's care plan, crisis card and other helpful numbers. This has led to improved performance in the later quarters of 2010/11. We are committed to improving performance in this area for our service users and provide details of our plans on page 14.

The Trust produced a Trust-wide crisis card some years ago. We are currently working with service user and carer representatives to update it and meet as wide a range of needs as possible.

Measure C

When service users call us in a crisis it is vital that they receive the advice and help they need. We worked hard to meet our 70% target in this area but our surveys found that we narrowly missed it, achieving 69%. One of

the difficulties was that our service user surveys were only able to identify a small number of service users who had called in a crisis. The limited information we were able to get from service user surveys was supplemented by Mystery Shopper exercises which provided invaluable feedback and helped us develop action plans to improve services.



Source: CQC National Community Service User Survey 2010

Our staff providing crisis advice as part of their work in A&E Liaison or Crisis Resolution Teams were briefed on customer care and the range of solutions that could be offered. Mystery shopper exercises have provided invaluable feedback to our staff and helped staff understand how to improve responses.

Feedback from our recent stakeholder workshop supported our thinking that we need to continue to focus improvement in this area in 2011/12 and we have given detail on how we are going to do this on page 14 in the section on Quality Priorities.

2) Respect and involvement - respecting and involving people who use our services

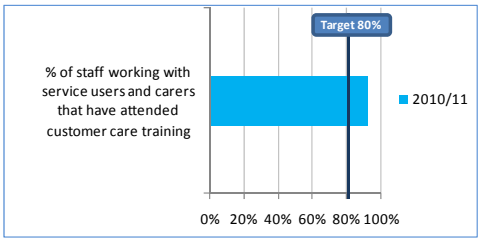
We set the following measures and targets to record our performance:

A. 80% of staff working with service users and carers have attended customer care training
B. 60% of service users on CPA report definitely understanding what is in their care plan
C. 50% of service users on CPA report they have definitely had enough say in decisions about their care.

We are reporting our performance against each of these targets.

Measure A

This measure is about ensuring that our staff receive appropriate training to help them work with our users and the carers of our users. This year we have monitored the completion of training by community staff only (last year we focused on inpatient staff only).

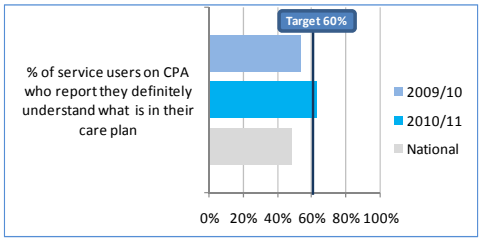


We have exceeded our 80% target this year, with 92% of community staff having been trained. Customer care training is now being embedded in the training delivered as part of each service line, ensuring consistency across the Trust's services and enabling us to sustain our achievement. We will therefore not be reporting on this in future Quality Accounts.

Measure B

This measure is about making sure that our service users who are being managed on the care programme approach understand what the plans are for their care.

We are pleased to report that we have met our 60% target and our performance (63%) is above the national average (48%). We think it is important that we ensure care plans are explained to patients in a way they can understand and, where possible, that the plans are co-designed with patients.

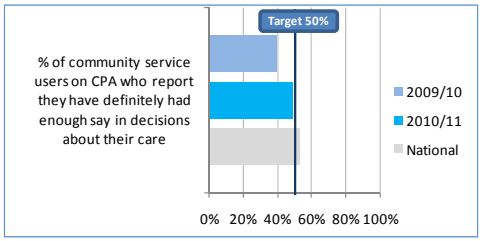


Source: CQC National Community Service User Survey 2010

A significant advance in this area is that the Trust now issues a Care Plan Folder to our service users. This contains a copy of the care plan which is explained to service users. It also advises service users on who to contact if they do not understand or have any queries about their care plan. We plan to continue to monitor and improve our performance in this area, though it will not be a priority area for us in 2011/12.

Measure C

This measure assesses if our service users who are on a CPA report that they have been involved in decisions about their care.



Source: CQC National Community Service User Survey 2010

Whilst we have seen an improvement in our performance since 2009/10, our performance (49%) still falls slightly below our 50% target, and is below the national average (53%). This means we need to do better. We believe that service users should have as much involvement as possible in decisions about their care. Furthermore, this is a national priority following the Government's White Paper ('No *Decision Without Me'*).

We have revised our CPA policy and provided an intensive training programme focused on the need to develop care plans in partnership with service users and support their involvement in decision making. In addition, we are undertaking a sustained programme of training for staff on how to apply the Mental Capacity Act.

The Trust will make improving this area a priority for 2011/12. We will also stretch our

targets to reflect that this is an important area for us, our users and their carers. Further details can be found on page 15.

3) Physical healthcare - taking care of physical health as well as mental health

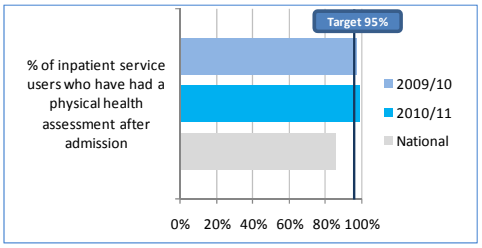
We set the following measures and targets to record our performance:

A. 95% of inpatient service users have had a physical health assessment after admission
B. 55% of inpatient service users said that they got enough care for their physical health
C. Establish a baseline for community service users (% of service users who said that mental health services gave them enough support in getting help for any physical health needs they had.

We are reporting our performance against each of these targets.

Measure A

When service users are admitted to our mental health wards it is important that they have a physical health assessment to identify any physical health needs and problems the users have. This measure assesses whether this occurs.



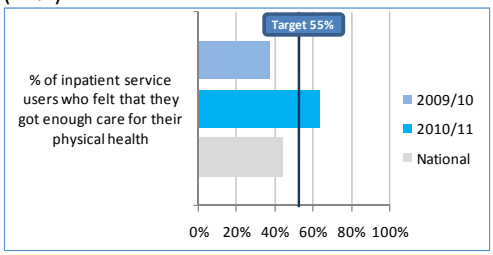
Source: CQC National Inpatient Service User Survey 2009

We are delighted that we have exceeded our 95% target and the national average (86%) in this area; we achieved 99%[1]. This was supported by the work on the form used for inpatients following a national recommendation from NICE (National Institute of Clinical Excellence), which has contributed to this achievement. Following this, staff were trained on the revised form and rationale for the change.

Measure B

This measure assesses whether our inpatients report that they have received the help they needed with their physical health.

We are pleased to report a significant improvement against last year's performance in this area; our performance (63%) exceeds our 55% target and the national average (44%).



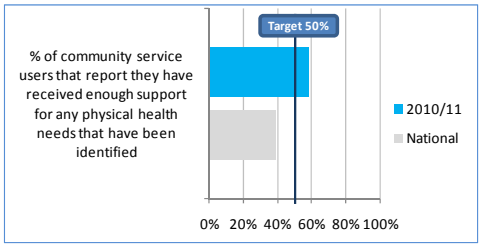
Source: CQC National Inpatient Service User Survey 2009

We have promoted better communication about physical healthcare issues about patients to GPs by sending out prompter discharge notifications and summaries. Our physical healthcare nurses also run sessions each week where they visit wards to give advice and support on assessments and specialist treatments.

We will continue to focus on ensuring that, following the physical healthcare assessment, action plans are made to support all of our users get the help and advice they need for any physical health issue identified. More details can be found in the section on Quality Priorities on page 17.

Measure C

This measure is the same as measure B but refers to community service users. We used quarter 1 of 2010/11 to collect data to create a baseline, and then used this baseline to set ourselves a target (50%).



Source: CQC National Community Service User Survey 2010

We are pleased to report that we are exceeding our target and the national average (39%); we achieved 59%.

[1] Service users that have had a physical assessment by either Nursing or Medical staff

The Trust has met a number of CQUIN[2] (Commissioning for Quality and Innovation) targets on physical healthcare. We do recognise that this is still a key concern for users and carers and will continue to work with them to improve quality in this area.

The Learning Disabilities Service

We would also like to tell you about the work that we have been doing in the Learning Disabilities Services area.

The Learning Disabilities Services core purpose remains the delivery of improved quality for our service users, by improving safety, effectiveness and service user experience. In achieving this we have focused upon developing effective service user measures through an easy read questionnaire. This was developed within our 'Making it Happen' carer and service user engagement group with joint participation from our independent advocate and the learning disabilities multi-disciplinary team.

The resulting questionnaire has been developed to include 14 questions for 2010/11, with results showing satisfaction at an average of 73%.

Our plans for the financial year 2011/12 are to continue to gather service user feedback on a quarterly basis and to blend this with staff experience findings.

Results of our surveys help to drive service improvements and meeting our customers' needs better and faster.

[2] Further detail on CQUINs is contained in the *What is a CQUIN and how do CQUINs relate to our priority areas?* section on page 10

Introduction to our mental health quality improvement

In this section we describe the quality improvements we intend to make to the mental health we provide in 2011/12, and why we have chosen to make these a priority. We are proud of the breadth of our quality improvement plans and have ensured they encompass the three domains of quality as described in High Quality Care for All (2008); safety, clinical effectiveness and user experience.

We have produced priorities to reflect the range of mental health that CNWL provides. Notably, as a result of our integration with Hillingdon Community Services in February 2011 and Camden Provider Services in April 2011, we are also able to present to you the priorities that they have been developing with their stakeholders. Their priorities reflect that they provide services with a physical healthcare focus.

How we have decided on our quality priorities for 2011/12

- We reviewed our performance against our quality priorities from last year along with national and other indicators we use to measure our performance
- We reviewed data available on how others are performing (benchmarked our performance to inform our target)
- From the above, we identified areas for improvement
- We engaged leaders in our organisation to design a quality improvement agenda that reflects the needs of our local population and service users
- We engaged with commissioners to check that our proposed priorities align and complement, where possible, the CQUIN scheme agreed with commissioners. Our Commissioners also consulted with service users and carers on areas of interest or concern.
- We consulted with our service users and tested our suggestions and asked them to tell us what other areas they wanted us to focus on. Following the consultations we have endeavoured to feedback the outcomes of the engagements so that people know what has happened as a result of their ideas.

priorities for 2011/12 and why we have chosen them

You will also notice, as you read through the next few pages, that we have described how consulting with our stakeholders has helped us decide on, and shape our priorities for 2011/12.

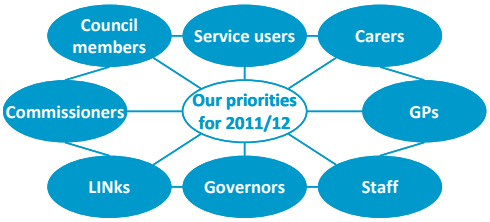
We have engaged our stakeholders throughout the year...

We have talked to and involved our stakeholders throughout the year through formal and informal means to ensure that we arrive at the right quality priorities for our organisation.

Formal	Informal
• CQUIN consultation event • User focus monitoring group • Stakeholder consultation event • Council members' meetings • Service user surveys • LINks Mental Health Leads meetings • Reviewing incident reports	• Local carer forums • Local service user groups • Contact with LINks • Service line management stakeholder events

We held a successful consultation event in March 2011 involving various stakeholder groups including service users and carers, council members, LINks, commissioners, GPs, our staff and executives.

The purpose of this event was to consult on our priority areas and the measures and targets we use to assess our performance in these areas. Stakeholders were invited to provide their feedback on our proposal to roll forward our priority areas last year and to suggest any additional areas they wanted us to focus on.



The feedback received from stakeholders at this event has been reflected throughout our Quality Account for 2011/12, from the inclusion of an additional priority area focussing on the involvement of carers to increased targets for some priorities. We are proud of the success of the event, echoed through the feedback we received regarding the event itself from stakeholders, and would like to thank all of those that attended for their input into shaping our Quality Account in 2011/12.

Key themes and suggestions from our stakeholders

A key theme in the quality overview section is that although we have made considerable progress in achieving our targets, there is still work to be done to deliver all that we want to. We firmly believe that we should not retire priorities that remain important and where more still needs to be achieved. We therefore proposed to our stakeholders at our consultation event in March 2011 that we keep the priority areas of Access, Respect and involvement and Physical Healthcare as priorities for 2011/12.

The majority of our stakeholders agreed that these areas still remain important to our service users and require further improvement. Therefore we will continue to focus on these quality priority areas. We also checked what other areas our stakeholders would like us to focus our quality improvement efforts on this coming year.

The main additional areas that our stakeholders wanted to see improvement are as follows:

- Supporting and involving carers
- Sharing information with GPs
- The quality of staff to deliver high quality care
- Recovery of service users.

They also reported that developing shared priorities in the future, which encompass improvements across both mental health services and community services, is important to them.

Each of these areas is important to us and we intend to look at how we can improve and embed quality in these areas in the future. We have captured those that we feel confident we can measure and improve upon this year in our Quality Account. We will look at how we can incorporate the remainder in future Quality Accounts.

As a result of our feedback from our stakeholders we added a new priority area on carer involvement. We have also added some indicators on staff satisfaction; though these are not priorities as such (Please see Part 3 of this account for more information).

What is a CQUIN and how do CQUINs relate to our priority areas?

The CQUIN payment framework makes a proportion of our income conditional on quality and innovation. It helps ensure that quality is part of the commissioner-provider discussion. CQUIN measures and targets are developed in conjunction with service users and are set by our commissioners.

Under each of our priority areas, we have set ourselves measures and targets that we will monitor our performance against during 2011/12 (more detail on how we will do this is contained in the following paragraphs). Where possible, we have aligned our measures and targets to the CQUINs set by our commissioners. This ensures that we are measuring priorities that service users have said are important to them via our commissioners.

How we will record our performance

Over the next few pages we set out how we intend to record our performance in these quality priority areas and introduce the targets we have set ourselves for 2011/12.

The measures and targets we are using under each priority area broadly fall into one of the following three categories:

1) The measure and target are the same as last year
For priorities where we did not achieve the target we set in our Quality Account last year and need to continue to work towards achieving it this year

2) The measure is the same as last year but with stretched targets
For priorities where we have achieved the target we set in our Quality Account last year and want to stretch ourselves to achieve even higher quality this year

3) The measure is new this year
For priorities that we did not measure as part of Quality Account last year but want to measure in order to improve quality of our services this year.

There are some priorities from our 2010/11 Quality Account where the target we set ourselves has been achieved and we have decided not to keep them as quality priorities this year. We will, however, continue to monitor, measure and develop these and act on any issues relating to performance as part of our ongoing commitment to ensuring change is sustained.

How we will measure our performance

We collect data on how we are performing against our priorities by a number of different methods. These include performing spot checks on documentation, undertaking local service user and carer surveys and participating in national service user and staff surveys.

How we will monitor our performance

Every month our performance is reviewed by a Care Quality Management Group which is made up of service directors, clinical directors and executive directors. Plans are made at these meetings to resolve any issues shown in the data. Sub-committees of the Board also meet to review performance and quality. These make recommendations to improve services, where appropriate.

How we will report our performance

We report on our performance every quarter on our public facing dashboard. Our stakeholders have told us that they like to see performance by borough. We provide a wide range of service across a large geographical area and we agree that borough-by-borough reports give a much more informed account of what is happening and what needs to be improved. We have therefore included borough-by-bough performance against our priorities in our Quality Account this year in Annex 4. We have presented our performance at the Trust level in the body of our Quality Account to keep the flow of the document and not to overload our readers with too much detail. We will be seeking new ways to present lower level, borough-by-borough performance detail in the body of future Quality Accounts.

We are also exploring new methods of data collection to improve data quality...

We have concentrated a lot of effort into defining ways to improve the quality of the data we collect so that it is more accurate and reliable, enabling us to get the maximum value from the data.

In 2011/12, we will be substantially increasing the numbers of service users who we survey each quarter. We will primarily use telephone surveys and some face-to-face surveys where appropriate. Face-to-face surveys will still feature as we value the richness of information th at can be obtained using this methodology. We will ensure that we prioritise the correct service user groups to survey to make maximum use of our resources. We will also seek further validation of the data by working with our service users in focus groups and checking that they feel the data is representative. Members of our focus groups and user forums will be discussing the data with the staff in their boroughs and this co-working will help inform locally tailored action plans.

The following pages give a bit more detail on why we have chosen these priorities and how we are developing quality improvement capacity and capability to deliver these priorities.

Mental health Priority 1:

Access to services when in a crisis - helping service users when they need it most

We acknowledge that service users may from time to time experience a crisis meaning they need urgent support from mental health and specialist services. We and our stakeholders feel that ensuring we help service users when they need it most is of paramount importance to the safety of our service users and those who care for them. This is why access is one of our priority areas for 2011/12.

What are our measures and targets for 2011/12?

Measure	Target 2011/12	*Target 2010/11*	Measure is a CQUIN this year	Measure and target same as last year	Measure same as last year but stretched target this year	New measure this year
A. % of patients who are discharged from hospital or who are on CMHT caseloads have been given a crisis card with details of who to contact and what phone number to use in a crisis	**85%**		✪			✪
B. % of community service users on CPA report that they have a phone number to call in a crisis	**75%**	*75%*	✪	✪		
C. % of community service users on CPA who called the crisis number report that they definitely received the help they wanted	**75%**	*70%*	✪		✪	

Why have we set these targets?

Measure A is a new measure for us this year. It is important that service users on CMHT caseloads know who to contact in a crisis and we need to ensure that we are providing service users with a crisis card routinely when they are discharged from hospital. This measure will ensure that improvement in this area is prioritised and the target we have set is in line with that set for the CQUIN by our commissioners.

The target was set for measure B to be the same as last year because although last year's performance against this measure was improving, the target was not reached and we need to further improve our performance in this area.

The target was set for measure C to stretch our performance on last year, which did not always hit the target. Our stakeholders also informed us that they wanted a higher target to be achieved.

How are we going to achieve them?

- We will monitor the distribution of crisis cards so that we know which users need to be given one and can arrange for this to happen
- We will be rolling out and supporting our staff to complete the discharge check list that has been developed within the Trust. This checklist will ensure that patients are given a crisis card before discharge as it will prompt staff and require them to record that they have provided a card to the service user. This process will also require staff to explain the purpose of the card to our service users to ensure they understand when and how they should use it
- We will repeat the 'mystery shopper' exercise to identify good practice and area for further improvement. This exercise involves selected individuals calling the crisis line and reporting on the standard of response they received.

Mental health Priority 2:

Respect and involvement – respecting and involving people who use our services

The White Paper *'Equity and excellence: Liberating the NHS'* has placed a renewed emphasis on patient involvement and sets out the ambition to see the principle of shared decision making - no decision about me without me - become the norm. We have a particular responsibility as a mental health provider to make sure that our service users do not become disadvantaged as a result of this statement. We want to ensure that we provide information to service users in a way they can understand, and support and empower service users to make decisions about their care and recovery as far as possible. This is why respect and involvement is a priority area for us in 2011/12.

What are our measures and targets for 2011/12?

Measure	Target 2011/12	*Target 2010/11*	Measure is a CQUIN this year	Measure and target same as last year	Measure same as last year but stretched target this year	New measure this year
A. % of community service users on CPA report that they were definitely involved as much as they wanted to be in decisions about their care plan	**65%**	*50%*	✪		✪	
B. % of community service users on CPA report that they had been given (or offered) a written or printed copy of their care plan	**80%**		✪			✪
C. % of patients reported that they felt safe during their most recent stay in hospital	**75%**		✪			✪

Why have we set these targets?

We exceeded the target we set ourselves for measure A last year and were just behind the national average recorded in the CQC National Community Service User Survey in 2010. Thus we have decided to stretch the target we are setting ourselves this year.

We were measuring our performance against measure B last year as it was a CQUIN. We want to focus on driving quality in this area this year and have therefore made it a quality priority in 2011/12. Our performance exceeded the CQUIN target of 65% last year and we have therefore, in line with feedback from our stakeholders, set ourselves a higher target of 80% this year.

Improving patient experience is a key focus for CNWL and ensuring that patients feel safe during their admissions stay with us is instrumental to us delivering that. We have already been monitoring our performance internally against measure C in 2010/11 (we achieved 71%). This measure is a CQUIN and in setting our target for 2011/12, we have taken on board feedback from our stakeholders and set ourselves a stretch target of 75%.

How are we going to achieve them?

We will achieve the targets we have set ourselves by building on the good work completed in 2010/11 and by:

- Embedding Protected Engagement Time to ensure that issues of patients' perceptions of their safety is addressed
- Sharing results of service user surveys with inpatients on wards to facilitate dialogue between

staff and service users about what can be done to address their concerns

- Being responsive to feedback from service user surveys and using this feedback to generate action plans to address issues raised by service users
- Recognising the carer role and promoting carer involvement. This is captured under our Carer Involvement priority area later in this section.

Mental health Priority 3:

Physical Health - taking care of physical health as well as mental health

Our service users may have physical health problems as well as mental health problems. There is considerable evidence to suggest that mental health patients are at increased risk of physical health problems. We will work together with our service users and primary care colleagues to detect physical health problems and ensure our service users are supported in accessing the advice and support they need to address any physical health concerns.

What are our measures and targets for 2011/12?

Measure	Target 2011/12	*Target 2010/11*	Measure is a CQUIN this year	Measure and target same as last year	Measure same as last year but stretched target this year	New measure this year
A. % of inpatients have had their medications cross-checked against more than one source within 72 hours of admission	**75%**		✪			✪
B. % of service users on CPA report that they got enough advice and support for their physical health	**65%**	*Inpatients: 55% Community : 50%*			✪*	

*We have set the same target this year for all service users on CPA, inpatients and community service users.

Why have we set these targets?

Measure A is a CQUIN. Medicine reconciliation involves a healthcare professional (usually a pharmacist) checking the medications that the service user is on with the GP and/or other sources, to ensure that service users do not come to harm as a result of medication errors. Our service users reported that 72 hours is quite a long time to wait, however the reason the CQUIN cannot be set less that 72 hours is that the GPs would be unable to provide this information on weekends. We have set ourselves a target of 75% based on feedback received from our stakeholders during the consultation event. It is worth noting that this is a stretch on the performance we achieved (68%) according to the POMH-UK (Prescribing Observatory for Mental Health) audit for 2010.

The reason the target for measure B is set at 65% is that our current performance for inpatients was 63% and community service users was 59%. This was discussed at our consultation workshop and our stakeholders told us they wanted to see a higher target.

How are we going to achieve them?

- We will establish a process for auditing medicine reconciliation with our doctors and pharmacists to ensure that we have a systematic approach for measuring whether or not we are achieving our target. Through this work we will promote the importance of medicine reconciliation amongst our staff
- We have developed new general assessment documentation which includes a much stronger emphasis on physical health and which is more service user led. This will promote the diagnosing and reporting of the physical health needs of our service users and enable these to be acted upon. We have piloted this in Westminster and will roll it out to Kensington and Chelsea and Brent this year. Our plan is to have this fully rolled out across all boroughs in the next two years.

Mental health Priority 4:

Carer involvement – working in partnership with carers and promoting carer involvement

Carers are those who provide support to family, friends or individuals who could not manage without this help. They could be supporting someone who has an addiction, physical or mental health problem or a combination these. We believe that good working relationships between services and carers are fundamental to delivering high quality care and keeping service users safe. We want to focus on building these relationships, focussing particularly on identifying the support we can offer carers to enable them to perform their valuable roles.

What are our measures and targets for 2011/12?

This is a new area for us and whilst we have in the past collected some data in this area, there is work to do to establish robust baselines against which we can measure improvement.

A. Establish a baseline for the % of service users that have a carer identified

B. Establish a baseline for the % of carers recorded as having been offered a carer's assessment

C. Establish a baseline for the % of carers that report feeling involved in crisis care planning for the person they care for.

What are we doing in this area?

We are already doing work to involve and support carers. For example, each of our local boroughs has a Carer Strategy that they are working to and have established Carer Forums where carers meet with CNWL staff to discuss any questions, issues and concerns they have, along with sharing information and experiences. We run 'information sharing' and 'carer awareness and assessment' training for our staff to enable them to provide effective support to carers. We provide these and other training and information sessions for carers to support them in their caring role. We involve carers in training for our staff where possible, and carers are members of local and Trust-wide governance forums. A carer survey was conducted in 2009 and another is planned for 2011. A new project is currently being designed for mystery shopping to ascertain the reception and support of carers by inpatient services.

How are we going to achieve them?

We will set and achieve our targets by:

- Establishing a process to systematically record where there is a carer involved and the care that they provide (Quarter 1 of 2011/12)
- Collecting data using this new process and through our local surveys to establish a robust baseline against which we can measure quality improvement in this priority area
- Enhancing the carers survey to provide a qualitative evaluation of what mental health services do to support carers currently, identify any unmet needs of carers and to understand what needs to be done to meet any unmet needs of carers
- Running a mystery shopper exercise to understand the carers' view of the reception and support they receive by inpatient services.

Introduction to our community health quality improvement priorities for 2011/12 and why we have chosen them

Part A - Hillingdon Community Provider

Hillingdon Community Health (HCH) is committed to providing high quality, value for money, responsive and clinically effective services. HCH joined with CNWL on 1st February 2011. However, for this year's Quality Account, we have decided to include separate quality priority areas for HCH, which represent the journey HCH has gone on with its stakeholders. It is of course going to be important that, over the coming year, we all work together to establish development themes that are common to our community physical health users and mental health service users. This will ensure that our priorities in future years represent a shared vision for the new CNWL.

HCH has identified four priorities for 2011/12, which align with the key principles of quality in healthcare: safety, clinical effectiveness and user experience. These are as follows:

	Topic	Relevant quality domains
Priority 1	Reducing errors in the administration of medication by Hillingdon Community Health staff	Safety
Priority 2	Increasing the number of women who sustain breastfeeding at 6-8 weeks post delivery	Clinical Effectiveness
Priority 3	Supporting service users with diabetes to better understand and manage their condition (through DESMOND[3] training)	Clinical Effectiveness
Priority 4	Offering and providing interpreting support to service users when they express a need for it	User Experience

How have we decided on our priorities for 2011/12?

Our quality improvement priorities have emerged as a result of the following:

- A performance review of all our clinical services in line with national and local indicators and performance targets
- Engagement with our clinical service leads, service team leaders and the Business Performance team to discuss our performance and identify areas for development
- A review of the 2010 Patient experience survey
- Engagement with stakeholders via a joint consultation event with CNWL
- Engagement with the Chair of Hillingdon's LINks.

The following pages provide more detail on these priority areas and what HCH is planning to do.

[3] Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND). Further information on this can be found later in this section under Community service Priority 3.

Community service Priority 1:

Reducing errors in the administration of medication by Hillingdon Community Health staff

Why is this one of our priorities?

Reduction in medication administration errors by HCH staff has been identified as a priority area as this represents a significant service user safety issue. It is also a national priority. Eliminating preventable medication errors will protect service users from harm, and lead to more affordable, effective, and equitable care. There has been important progress already in this area but we feel that further improvement is required to further embed quality improvements and good practice in medication administration at HCH.

What is our measure and target for 2011/12?

- 10% reduction in medication administration errors by HCH staff

Why have we set this target?

HCH staff reported 70 medication administration incidents for 2010/11. HCH believe that a reduction of at least 10% is achievable This issue has been discussed with HCH clinical service leads and team leaders, Hillingdon LINks Chair and the Quality Governance Group which has lay representation.

How are we going to achieve this?

HCH will:

- Develop a sustainable medicines management training programme and work to ensure that all staff administering medication attend medicines management training
- Recruit a dedicated Community Health Services Pharmacist to work with HCH staff
- Gather, implement and communicate the lessons learnt from any incidents that occur and complaints we receive in regard to medication administration errors.

How will this be monitored?

The data for this target will be captured through online incident reporting and manual collation of any complaints relating to medication administration errors. The incident trend will be reported to, and monitored by, both the HCH Quality Governance Group and CNWL's Medicines Management Committee on a quarterly basis.

Community service Priority 2:

Increasing the number of women who sustain breastfeeding at 6-8 weeks post delivery

Why is this one of our priorities?

Sustained breastfeeding for 6 weeks and longer has been proven to have long term health benefits for both mothers and babies, and HCH has a duty to encourage and support women to breastfeed for at least 6 weeks, where it is possible. This is also an improvement priority set by NHS London. HCH has met the NHS London target last year as a result of a significant focus of resource and awareness in this area. HCH believes that a sustained focus in this area is required in order to continue to improve and deliver this national priority.

Through focusing on improvement in this area, HCH will also be driving improvement in the effectiveness of cross organisational working between local maternity services, GP services and HCH health visiting services, as teams from these services will need to work together in order to achieve performance improvement.

What is our measure and target for 2011/12?

- 57% of women sustaining breast feeding at 6-8 weeks post delivery.

Why have we set this target?

The target (57%) has been set for HCH by NHS London against HCH's performance at Quarter 2 2010/11. HCH exceeded the target in Q3 2010/11 (58%) however the target will be a challenge to sustain due to the requirement for HCH to work with a large number of organisations such as local GPs and hospital maternity units in a coordinated manner to promote and support mothers to breast feed.

How are we going to achieve this?

In order to achieve this target, HCH will:

- Continue to develop its working partnership with Community Engagement Project team, promoting the return to work of breastfeeding mothers. This will be achieved through working in partnership with local businesses
- Continue to support the promotion of breastfeeding in public places; this work will be led by HCH's Breastfeeding Coordinator. HCH's Breastfeeding Coordinator will also continue to develop partnership working with Children's Centres to promote breastfeeding and make breastfeeding support accessible and sustainable in local communities
- Ensure that all new HCH staff attend the two-day breastfeeding management course within six months of commencing their post , and receive annual mandatory training
- Ensure that health visitor staff, having completed the two day course, attend an annual breastfeeding update training course
- Work towards fully implementing the UNICEF Baby Friendly Standards (Community initiative) and will build on the lessons learnt from the annual breastfeeding audit by implementing any required actions.

How will this be monitored?

Data on whether a mother is breastfeeding or not will be captured by the GP practice following the 6 - 8 week postnatal assessment and during reviews by health visitors. Performance will be monitored quarterly by Commissioners from NHS Hillingdon and NHS London, and in conjunction with the Department of Health.

Community service Priority 3:

Supporting service users with diabetes to better understand and manage their condition (through DESMOND training)

Why is this one of our priorities?

There has been a significant increase over the last decade of service users being diagnosed with diabetes. The World Health Organisation has indicated that it believes that this will be a sustained increase. HCH is committed to supporting and empowering service users with diabetes to manage their long term conditions and therefore reduce their dependence upon secondary care services.

DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) is a NHS training course for people with type 2 diabetes that helps them to identify their own health risks and to set their own goals. The DESMOND sessions are delivered by HCH's Diabetes Specialist Nurse Team. They are aimed at empowering service users with diabetes to manage their conditions more effectively themselves, optimise their health and reduce the long term complications associated with the diabetes.

What is our measure and target for 2011/12?

- 65% of service users who having undergone DESMOND training report that they are better able to understand and manage their condition.

Why have we set this target?

This target has been identified through consultation with Hillingdon LINKS Chair, Diabetes Specialist Nurse, HCH Senior Management Team and a review of the performance data to date. The effectiveness of the DESMOND service has not been captured or systematically evaluated in the past. However, as a key tool in supporting service users to manage this long term condition, it is important that we evaluate, and where required improve, the effectiveness of the DESMOND training programme currently being delivered by HCH.

How are we going to achieve this?

- HCH will look to increase the number of referrals for attendance on the DESMOND training by educating GPs and practice nurses to ensure appropriate referrals are made
- The Diabetes Specialist Nurse Team will also re-design the service user information letter to promote the value of the training and encourage self management
- The team will also look at the training programme to ensure equity of access and consider providing training specifically targeted at carers.

How will this be monitored?

This data will be captured through service user questionnaires. Service users will be asked to complete questionnaires 4-6 weeks after completing the DESMOND training. The results of the questionnaires will be collated on a quarterly basis and monitored through HCH's Senior Management Team.

Community service Priority 4:

Offering and providing interpreting support to service users when they express a need for it

Why is this one of our priorities?

HCH serves a diverse population with several groups of ethnic minority and immigrant populations. Evidence gathered through Patient Advisory Liaison Service (PALS) indicated that our staff were not making appropriate use of interpreting services for service users whose first language was not English. Work has been undertaken to ensure all staff identify if interpreting support is required, and are aware of the process for booking an interpreter.

What is our measure and target for 2011/12?

- 90% of service users who expressed the need for interpreting support were provided with this service.

Why have we set these targets?

The 2009 Annual Patient Experience Survey reported that 86% of service users had been offered interpreting support when needed; in 2010 this had increased to 87%. The target we have set, in conjunction with Hillingdon LINKS Chair, is a stretch on the current HCH performance in this area and has been identified for additional improvement to ensure equitable access to health services for all service users.

How are we going to achieve this?

- HCH will raise awareness of the availability of the interpreting service:
    - the Heads of Services and Service Leads will continue to remind all staff of the need to advise service users of the availability of the interpreting service
    - posters produced by HCH's Communications team for all clinical areas will be used to advertise the service
    - by including information on the availability of the service in all standard appointment letters to service users
    - by ensuring newly recruited staff are advised at Corporate Induction of the available interpreting support
    - by ensuring that all clinic support staff are aware and are offering service users an interpreting service where necessary.
- HCH will work with all referring agencies / partners to ensure that any interpreting need is identified on the referral form
- HCH will continue to work on providing a mechanism for capturing real time service user views and experiences which will enable it to respond and modify service provision in an efficient and timely manner.

How will this be monitored?

Data will be captured through:

- Annual service user questionnaire
- Service line specific service user surveys
- Real time patient experience tracker devices (once implemented).

Part B - Camden Provider Services

As part of Central and North West London NHS Foundation Trust, Camden Provider Services (CPS) will continue to focus on achieving excellent performance on quality and safety in 2011/12. We will continue to improve our services by ensuring that our service models reflect best practice in international healthcare and we will robustly audit our performance against best practice standards. Our three quality improvement priorities for 2011/12 align with the key principles of quality in healthcare: safety, clinical effectiveness and user experience. The following table also shows how our quality priorities align with the domains of the NHS Outcomes Framework.

	Topic	**Relevant quality domains**	**Relevant domains from the NHS Outcomes Framework**
Priority 1	Improving telephone access	User Experience	4. Ensuring people have a positive experience of care
Priority 2	Introducing safer ambulatory syringe drivers	Safety	5. Treating and caring for people in a safe environment and protecting them from avoidable harm
Priority 3	Providing intensive stroke rehabilitation in accordance with NICE Quality Standards	Clinical Effectiveness	2. Enhancing quality of life for people with long term conditions. 3. Helping people to recover from episodes of ill health or following injury
Priority 4	Communication with GPs about the care of HIV patients	Safety & Clinical Effectiveness	2. Enhancing quality of life for people who have long term conditions. 5. Treating and caring for people in a safe environment and protecting them from avoidable harm

How have we decided on our priorities for 2011/12?

CPS quality improvement priorities have emerged from careful consideration of feedback received from its service users, from discussions with clinical leads and service managers and from analysis of information on incidents and complaints. CPS sought comments and advice from its local general practitioners, commissioners, LINks and patient representatives on whether these are the most important areas to make improvements in.

CPS has set its targets for quality improvement priorities by considering available data on incidents and complaints. CPS considered its performance over the past few years and, where data is available, has sought to benchmark its performance against similar organisations. CPS has taken into account advice from other organisations and evidence on the extent to which its desired improvements are achievable.

CPS is committed to achieving the targets it has set through regular monitoring of progress.

The following pages give a bit more detail on these priority areas and what CPS is planning to do.

Community service Priority 5:

Improving telephone access

Why is this one of our priorities?

Service users or their carers may need to contact with CPS by telephone. CPS would like to ensure that all calls are handled quickly and effectively and take into account any special needs of the caller. Some research was done by the Picker Institute in November 2009 – January 2010 and this assessed service users' experience of using CPS services. CPS surveyed service users that had tried to contact its service by phone. 641 of 1344 (48%) of service users reported that that they had had difficulties contacting one of CPS' services via this method. This performance clearly needs to be improved and hence CPS is making this a priority for 2011/12.

What are our measures and targets?

A. 80% of service users surveyed (or asked using the Patient Experience Tracker or equivalent real time feedback tool) report finding it 'easy' or 'very easy' to get through to services on the phone

B. 80% of calls to the key telephone contact points for services are picked up within 1 minute when assessed by mystery shopping survey

C. 100% of relevant members of staff receive practical training on handling phone calls from service users or their carers.

Note the staff training would include teaching staff skills to manage difficult calls and explaining to staff how a call is impacted by the behaviour and attitudes of the call taker.

Why have we these chosen these measures and targets?

Some of the stakeholders with whom we have discussed this improvement priority have been supportive of our intention to improve the experiences our service users have of our services by improving telephone access.

Achieving measure A will enable CPS to demonstrate that it has made considerable improvement in the ease with which service users are able to contact CPS services; the Picker Institute showed that improvement was required in this area. CPS does not currently have baseline data for measure B for all its services. CPS has set a target for this measure that it feels is a reasonable aspiration for its first year of measuring performance in this way. Measure C is something that CPS feels it must deliver in order to make a contribution to improving the experience service users have of its service,

How are we going to achieve them?

CPS will:

- Regularly check and keep up-to-date contact details for all services on the internet and in leaflets
- Continue investing into making better use of available technology. This includes messages to help callers identify which service they have been put through to and redirecting calls that are not answered within 20 seconds to an available member of staff at another location
- Continue to train our staff in dynamic ways e.g. using actors to create various realistic scenarios in order for them to practice handling calls
- In Podiatry when the Central Booking Office is relocated to the Peckwater centre, ensure that all the items that were identified for improvement in the review of incoming telephone calls are put into action
- In the Wheelchair and Seating Service, be implementing call centre technology.

How will performance be measured and monitored?

CPS will conduct service user experience surveys and perform quarterly mystery shopping exercises. CPS will also keep a record of staff who have attended customer call handling training.

Community service Priority 6:

Introducing safer ambulatory syringe drivers

Why is this one of our priorities?

Syringe drivers are medical devices which deliver subcutaneous medication over a calculated period of time, ensuring a continuous level of medication is administered to the patient. They are frequently used to control symptoms such as pain and nausea (sickness) in patients receiving End of Life Care. Some syringe drivers measure the amount of medication delivered in units of millilitres per hour and some measure the amount of medication delivered in millimetres per hour. This difference can cause confusion for those prescribing and administering the medication, and can result in harm to service users.

Following a Rapid Response Report issued by the National Patient Safety Agency (NPSA) on this issue, all providers are required to transition their syringe drivers to those that have rate settings in millilitres (ml) per hour and have additional safety features. Implementing the recommendations that accompany this alert will have significant practical and financial implications for CPS services. Focusing on this as a priority area will enable CPS to keep service users safe and ensure that national requirements regarding syringe drivers are being met.

What are our measures and targets for 2011/12?

A. To have completed all actions required in response to the patient safety alert before the first deadline of the 16 December 2011

B. To identify a preferred new model of ambulatory syringe driver to be used in CPS services (device selection to be undertaken in conjunction with the North Central London Palliative and Supportive Care Network) and an end date to complete the transition between existing ambulatory syringe drivers and ambulatory syringe drivers with additional safety features (CPS will be seeking to complete the transition to safer syringe drivers as soon as possible and within a time period shorter than the five year maximum specified by the NPSA)

C. To revise the syringe driver policy, training programme and competency assessments to support the safe operation of all designs of ambulatory syringe driver in use during the transitional period.

Why have we chosen these measures and targets?

CPS recognises that the measures and targets identified for this quality priority area may appear to be more qualitative than that we have selected for our other areas. However, CPS sees it as being essential that it implements the actions required by the NPSA alert, and that this is done sooner than is specified in the alert.

How are we going to achieve them?

CPS will:

- work with the Chair of the North Central London Palliative Care Network to ensure that this issue is given priority and to ensure that a Network wide solution is achieved quickly
- review and update the existing syringe driver policy (CPS currently operates a standardized protocol for syringe driver use throughout Camden; this has been in place and regularly updated since 1997). A pocket guide for relevant staff on using syringe drivers will be provided
- regularly support staff to deliver safe and competent practice through training staff in setting up and maintaining syringe drivers, and through competency assessment undertaken under OSCE (Observation of Skills of Clinical Examination) test conditions, in accordance with the skills for Health, National Occupational Standards for Syringe Drivers 2007.

In future years we will look to…

Fully implement the requirements of the NPSA alert on syringe drivers, by having switched over from existing equipment to those which have rate settings in ml per hour and have additional safety features (sooner than the five year maximum specified in the alert issued by the NPSA).

How will this be monitored and measured?

Quarterly reports from the project group to the GP and Hospital Support Business Unit Group.

Community service Priority 7:

Providing intensive stroke rehabilitation in accordance with NICE Quality Standards

Why is this one of our priorities?

NICE issued their quality standards for Stroke in June 2010. This set of quality statements (comprised of structure and process measures) provide clinicians, managers and service users with a description of what a high-quality stroke service should look like. This follows and reflects a wide range of other best practice guidance such as that developed by Healthcare for London.

There is growing evidence to show that the amount of therapy given to a person who has had a stroke is related to outcome. However, many therapy services will struggle to achieve the requirements of NICE Quality Statement 7 of being able to provide a minimum of 45 minutes of each therapy required at least five days a week. For example, a review of acute providers identified that 75% of clients received less than one hour of physical therapy input per day, limited to daytime hours and weekdays (Department of Health and Royal College of Physicians, Survey of Stroke Unit Staffing and Patient Dependency, 2007).

What are our measures and targets for 2011/12?

A. Patients with stroke are assessed and managed by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days (Adapted from NICE Quality Statement 5)

B. Patients with stroke are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of five days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it (NICE Quality Statement 7)

A. Patients with stroke who have continued loss of bladder control two weeks after diagnosis are reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers (NICE Quality Statement 8)

B. All patients after stroke are screened within 6 weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment (NICE Quality Statement 9)

C. All patients discharged from hospital who have residual stroke-related problems are followed up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management (NICE Quality Statement 10).

Why have we chosen these measures and targets?

The measures and targets we have chosen align with different NICE Quality Statements. By aligning our measures to NICE Quality Statements, we can be sure we are measuring and focusing on the key priorities relating to the provision of Stroke rehabilitation.

How will we achieve these?

CPS will:

- Continue implementing the action plan resulting from National Audit of Continence Care to improve assessment and management of continence problems
- Build on the excellent practice recognised in the Care Quality Commission's review of services for people who have had a stroke by participating in further benchmarking and improvement projects in collaboration with the NHS Improvement – Stroke and with the local Stroke Network. CPS has already agreed to participate in a local Stroke Network audit for 2011/12
- The Stroke REDS (Early Supported Discharge Service for Stroke) will continue to use a variety of validated assessments and screening tools for mood disturbance and cognitive impairment. These assessments are undertaken by neuropsychologists who are an essential part of our Stroke REDS team
- Attempt to review and evaluate its implementation of the NICE quality standards in the form of

clinical audits, and potentially conference presentations or submissions to peer reviewed journals, as part of our commitment to developing and sharing best practice.

How will this be monitored and measured?

We will seek to include regular reports of performance (adherence to the NICE quality standards) for stroke into our existing service line reporting arrangements. Performance against measures in service line reports is reviewed monthly by the GP and Hospital Support Business Unit Sub-Committee.

Community service Priority 8:

Communication with GPs about the Care of HIV patients

Why is this one of our priorities?

HIV patients are living longer and are at increasing risk of co-morbidities (one or more additional disorders). Whilst HIV services are best placed to care for the HIV needs of patients, shared care with GPs is important to ensure that the primary care needs of patients are appropriately met. Available data suggests that about 70% of people with HIV are registered with a general practice and have disclosed (or agreed to disclosure) their HIV status to their GP. However, data collected by commissioners of HIV services for London suggests that some services may not be routinely collecting data on the GP registration status of their patients, and therefore whether they would agree to letters being sent to their GP.

During September to November 2010, CPS undertook an evaluation of the medications being prescribed to patients with HIV by GPs and the CPS HIV service. The results from this evaluation indicated that, where GPs provided the prescribing information for patients with HIV, there were high rates of potential drug-to-drug interactions with those that were being prescribed by the HIV service (drug-to-drug interactions can occur when two or more of the medications being prescribed are not compatible, and on rare occasions drug-to-drug interactions can have serious adverse effects). As a result, all CPS correspondence to GPs now requests prescribing data to be faxed to CPS. Effective two-way communication is essential to minimise the risk of serious drug-to-drug interactions.

What are our measures and targets for 2011/12?

A. 70% of patients diagnosed with HIV since 2000 are registered with, and have their HIV status disclosed to, their GP
B. At least one communication each year with a patient's GP for 90% of HIV patients who are registered with a GP and who have consented to letters being sent to their GP.

Why have we chosen these measures and targets?

The inclusion of this area as one of our priorities has been welcomed by some of our stakeholders. Our commissioners have set the above measures and targets as one of our CQUIN indicators for 2011/12.

How are we going to achieve them?

CPS will:

- Continue to implement the action plan developed as a result of the evaluation carried out between GP prescribing data and that held by the CPS HIV service
- Ensure that the system which has been put in place to review and save GP prescribing information to the HIV patient's record is kept up-to-date with information where information is received
- Build on performance achieved (80%) against measure B last year by continuing to focus on ensuring that letters are sent to HIV patients' GPs at least once every year (where patients have disclosed their condition to their GP)
- Establish whether not it is possible to provide patients with access to their medical records on line.

How will this be monitored and measured?

Performance against measures in service line reports is reviewed monthly by the Sexual Health Business Unit Sub-Committee. As this is also a CQUIN measure we will be reporting our progress to the HIV Commissioners (LSCG) at the intervals specified by them in our agreed CQUIN scheme. CPS will also look to benchmark its performance in this area against other service providers that will also be measuring themselves against these targets.

Statements of assurance from our Board

Our regulators need to understand how we are working to improve quality so the following pages are specific messages they have asked us to provide.

Services

During [2010/11] CNWL provided and/ or sub-contracted [4] NHS services. These include Mental Health Services (Adult, Older Adults and CAMHS), Addictions, Learning Disability and Offender Care. The services were provided in the catchment areas illustrated in the table below. CNWL has reviewed all the data available to them on the quality of care in [4] of these NHS services. The income generated by the NHS services reviewed in [2010/11] represents [98%] per cent of the total income generated from the provision of NHS services by CNWL] for [2010/11].

Where we provide our four NHS services

	1			2	3	4
	Mental Health Adults	Mental Health Older Adults	Mental Health Child and Adolescent	Addictions	Learning Disability	Offender Care
Brent	✓	✓	✓	✓	✓	x
Harrow	✓	✓	✓	x	x	x
Hillingdon	✓	✓	✓	✓	x	x
Kensington and Chelsea	✓	✓	✓	✓	x	x
Westminster	✓	✓	✓	✓	x	x
Enfield	x	x	x	x	✓	x
Hounslow	x	x	x	✓	x	✓
Ealing	x	x	x	✓	x	
Hammersmith and Fulham	x	x	x	✓	x	✓
Islington	x	x	x	x	x	✓
City of London	x	x	x	x	x	✓

Participation in Clinical Audit

During [2010/11], [10] national clinical audits and [1] national confidential enquiries covered NHS services that [CNWL] provides. During that period [CNWL] participated in [50%] national clinical audits and [100%] national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that [CNWL] was eligible to participate in during [2010/11] are as follows (see table below). The national clinical audits and national confidential enquiries that [CNWL] participated in during [2010/11] are as follows:

National Confidential Enquiry / National Audit	Eligible to participate in 2010/11	Participated In 2010/11	Comment regarding why we did not participate
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	Yes	Yes	Not applicable
Confidential Enquiry into Maternal and Child Health (CMACH)	No	No	Not applicable
National Confidential Enquiry into Patient outcome and Death	No	No	Not applicable
National Audit of Psychological Therapies	Yes	No	There had been recent internal reviews of psychology services within the Trust at the time this national audit was recruiting participants.
National Falls and Bone Health Audit	Yes	Yes	Not applicable
National Audit of Schizophrenia	Yes	No	This was a pilot audit. The Trust has signed up to participate in 2011/12.
POMH-UK[4]: Monitoring of patients prescribed lithium	Yes	No	POMH have a number of topics on their annual programme, with some degree of overlap between them. The Trust therefore prioritised in favour of participation in new topics on the POMH audit programme for 2010.
POMH-UK: Screening for metabolic side effects of anti-psychotic drugs in patients treated by assertive outreach teams	Yes	No	
POMH-UK: Prescribing high dose and combined antipsychotics on adult acute and PICU wards	Yes	Yes	Not applicable
POMH-UK: Medicines reconciliation	Yes	Yes	Not applicable
POMH-UK: Use of anti-psychotic medicine in people with Learning Disabilities	Yes	Yes	Not applicable
POMH-UK: Use of antipsychotic medicine in CAMHS	Yes	Yes	Not applicable
POMH-UK: Prescribing antipsychotics for people with dementia	Yes	No	The Trust had already completed an internal audit of the prescribing on antipsychotics for people with dementia in 2010/11.

[4] Prescribing Observatory for Mental Health UK

The national clinical audits and national confidential enquiries that [CNWL] participated in, and for which data collection was completed during [2010/11], are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Confidential Enquiry / National Audit	Cases submitted
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	95.42% (for period January 2004 to January 2010)
National Falls and Bone Health Audit	Organisational data only – no individual cases
POMH-UK: Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards	No set number required - audit sample determined by Trust (338 cases submitted)
POMH-UK: Medicines Reconciliation	No set number required - audit sample determined by Trust (157 cases submitted)
POMH-UK: Use of anti-psychotic medicine in people with Learning Disabilities	No set number required - audit sample determined by Trust (18 cases submitted)
POMH-UK: Use of anti-psychotic medicine in CAMHS	No set number required - audit sample determined by Trust (51 cases submitted)

The reports of [3] national clinical audits were reviewed by the provider in [2010/11] and [CNWL] intends to take the following actions to improve the quality of healthcare provided.

- *Prescribing of high-dose and combination antipsychotics on adult acute and intensive care wards:* PRN Prescribing Policy is to be reviewed
- *Medicines reconciliation:* Revise Medicines Reconciliation Policy to specify the requirement that two sources of information are checked for all medicines reconciliations; Agree timing for pharmacist-led reconciliation
- *Use of anti-psychotic medicine in CAMHS:* CAMHS clinicians to review and agree a suitable target for health checks.

All the reports were discussed by the Trust's Medicines Management Group. In addition, the results have been disseminated to teams involved in the audit and through the local care quality management structures. Actions have been agreed through these structures to drive improvement in practice in identified areas.]

During 2010/11 the CQC completed three planned reviews of compliance at CNWL. These were at Collingham Child and Family Unit (1a Beatrice Place), 3 Beatrice Place, a continuing care unit and the Gordon Hospital. The review of compliance at Collingham and Gordon Hospital found that the units were compliant with all CQC Essential Standards of quality and safety. The review of compliance at 3 Beatrice Place raised the following concerns about compliance with the standards:

- Major concerns were raised with regard to outcome 2: consent to care and treatment.
- Moderate concerns were raised with regard to outcome 7: safeguarding.
- Minor concerns were raised with regard to outcome 13: staffing.

The Trust is committed to deliver high quality care and immediate action was taken to address these concerns. A robust action plan is in place and the Trust will report to the CQC by the 19 April on the actions it has taken to improve.

The reports of [approximately 70] local clinical audits were reviewed by the provider in [2010/11] and [CNWL] intends to take the following actions to improve the quality of healthcare provided. [Each directorate has a local care quality management group which is responsible for monitoring and taking action on the results of audits relevant to its services. Through these groups, the results of clinical audit reports are discussed, and any actions required to improve practice are identified. Some examples are given below.].

- *Audit of CNWL Community Depot Prescriptions:* further work and support to transfer prescribing and administration of depot medication to primary care as part of shared care arrangement between GP and CNWL.
- *Antipsychotic Medication Prescribing for People with Dementia:* an assessment and monitoring tool for antipsychotic prescribing in dementia patients has been developed and will be piloted across the Trust.
- *Audit of Physical Health Assessment on Admission to the Ward:* training through the Junior Doctor Induction programme
- *Mental Health Act Section 58 Audit*: section papers front sheet revised to include a prompt to record consent to treatment due date on medication chart; amend Section 62 form to include reasons why consultant uses Section 62 powers.
- *Mental Health Act Section 132 Audit:* Section 132 form to be amended as part of Section 132 policy review to include the trigger points for why the rights are explained.

Research

As an organisation Central and North West London NHS Foundation Trust (CNWL) recognises the importance research plays in the effective delivery of healthcare to its patients; the involvement of staff and patients in research demonstrates CNWL's commitment to improving the quality of care on offer to its patients. The Trust actively participates and supports research generated by its own clinicians as well as researchers from outside of the organisation.

The number of patients receiving NHS care provided by CNWL in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 1408 (externally funded studies).

CNWL was involved in conducting 64 clinical research studies approved by the ethics committee that related to mental healthcare provision during 2010/11; 42 funded and 22 unfunded.

The data for 2010-11 publications are still being collected however; in 2009-10 we had 51 peer reviewed publications with a further 11 in press from our involvement in NIHR research, which demonstrates our commitment to the dissemination of research findings as well as a desire to improve patient outcomes and experience across the NHS.

Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of CNWL's income in 2010/11 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 2010/11 and for the following 12 month period are available electronically at http://www.cnwl.nhs.uk/quality_account.html.

What others say about the provider

Statements from the Care Quality Commission

[CNWL] is required to register with the Care Quality Commission and its current registration status is [registered without conditions]. [CNWL] has the following conditions on registration [not applicable - none]. The Care Quality Commission (has not) taken enforcement action against [CNWL] during as of 31 March 2011. [CNWL] has not participated in any special reviews or investigations by the CQC during as of 31 March 2011.

Data quality

NHS Number and General Medical Practice Code Validity

[CNWL] submitted records during [2010/11 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:

- [**90%**] for admitted patient care;
- [**98%**] for out patient care; and
- [N/A] for accident and emergency care.

– which included the patient's valid General Medical Practice Code was:

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

Information Governance Toolkit Attainment Levels

[Central and North West London NHS Foundation Trust] Information Governance Assessment Report score overall score for [2010/11] was [provisionally 53%] and was graded [n/a].

Our score is a provisional one which needs to be approved by Connecting for Health. It is additionally subject to the satisfactory completion of Toolkit Requirement 112 by the end of June 2011.

Our result meets all the mandatory requirements necessary for foundation trusts (i.e. the 22 IGSoC Requirements) with other requirements addressed on a locally risk-assessed basis. As a foundation trust CNWL is not required to complete all 45 Toolkit requirements.

Statement on relevance of Data Quality and your actions to improve your Data Quality

[CNWL NHS Foundation Trust] will be taking the following actions to improve data quality:

- Complete the rollout of our information system and move to a paper light system to reduce duplication of recording and ensure quality items are located in the one place
- Review the Information Assurance framework on a quarterly basis. This has been developed to identify any gaps in data capture or processes across all service lines
- Continue with the distribution of monthly data quality reports with patient level data to identify any breach areas and ensure that systems are in place to capture and record information in a timely way
- Audits are developed in line with the standards set out in Data Quality Policy and all staff are made aware of the importance of data quality and the need to keep accurate records
- Review and monitoring of benchmarking data (both internal and external) to ensure that CNWL compares favourably with other leading Mental Health Organisations
- Monthly Red / Amber / Green (RAG) rating on the accuracy of all activity reports for every team down to staff member level
- Internal audits to measure compliance of KPI reporting against clinical notes.

Our compliance against a wide range of performance and quality metrics for the year 2010/11 is an indication of the high quality of care and support we provide to our patients and our ongoing commitment to ensure that our staff understand the importance of timely and accurate data recording.

Good data quality is recognised as a key tool to support service improvement and redesign projects within CNWL and is fundamental to identify priority areas of service delivery that are not achieving the quality standards we expect.

We rely on accurate data and reporting as one of the ways of identifying potential areas of poor care quality and it can be the first marker in determining a need for further in-depth audit or service improvement projects. It is also vital to ensure we can provide valuable benchmarking information for comparison against local population profiles and service needs to develop our services.

Clinical Coding Error Rate

CNWL was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

Part 3:

Review of performance against national priorities and other indicators

As well as our Trust-specific priority areas we are making sure that we don't lose sight of national priorities.

This year we have measured the indicators set out in last year's Quality Account, including national indicators and indicators required by Monitor (our regulator), along with others that are important to use in making sure we are providing quality services.

We report below on our performance against these indicators and our rationale for including them in our Quality Account. We have included historic performance and benchmarking data where available to help to put our performance into context. This helps to understand if we have improved over time and if our performance is better or worse than other similar providers.

This year we have included HCH performance against the indicators applicable to the services is provides separately at the end of this section. In future years we will provide a Trust-wide view of performance.

Service user safety

1. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
CPA 7-day follow-up – What percentage of our service users who are on Care Programme Approach did we contact within seven days of them leaving the hospital?	95% ★	98%	97%	**96% Dec '10**	96%[1]

★ Indicates that the target is a national one and is therefore governed by a standard national definition

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

This measure ensures that when service users are discharged from hospital, on a CPA, that they receive follow-up contact from us within 7 days. This is important as we want to ensure our service users remain safe when they are discharge into community care. Whilst our performance has slightly decreased over the year, it remains in-line with the regional average and above our target for the year.

2. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
Risk assessment and management – What percentage of service users have had a risk assessment completed and linked to their care plans? **This was a Quality Priority for 2009/10**	95%	87%	95%	**92%**	Not applicable

This measure assesses whether a risk assessment has been completed, and how risks identified will be incorporated into the care plan to be effectively managed. Our performance has fallen slightly since last year and is now below our target. We will continue to monitor this indicator in 2011/12 and focus efforts on ensuring that we achieve our target in future. Robust monitoring is in place in those areas not meeting the target.

3. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
Infection control • number of cases of MRSA (without bacteraemia) annually	Year-on-year reduction	12 MRSA cases	9 MRSA cases	**3 MRSA cases**	Not applicable
• number of cases of MRSA (with bacteraemia) annually	0 cases ★	0 cases	0 cases	**0 cases**	
• number of outbreaks of Clostridium Difficile annually.	0 C Diff ★	0 C Diff	0 C Diff	**0 C Diff**	

★ Indicates that the target is a national one and is therefore governed by a standard national definition

Reducing healthcare acquired infections is a priority for all Trusts. We have a duty to ensure our patients do not get any healthcare acquired infections whilst they in our care and / or in contact with any of our services. We are pleased to report that there have been no cases of MRSA (with bacteraemia) and Clostridium Difficile in 2010/11 and that we have seen a significant reduction in the number of MRSA cases (without bacteraemia).

Clinical effectiveness

1. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
Re-admission rates – What percentage of service users were re-admitted to hospital within 28 days of leaving?	<11%	4.3%	5.7%	**6.0% Dec '10**	Not available

Some users may get re-admitted to hospital shortly after leaving and this is important for us to measure and monitor as high re-admission rates may indicate that service users were discharged too soon or not given the appropriate support in the community. Given the slight rise year-on-year, Performance Management Committee will continue to monitor this closely and consider taking action if they feel it is becoming a significant problem.

2. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
Outcome measures – What percentage of our service users have had their condition formally assessed at a key point in their care pathway using HoNOS? **This was a Quality Priority for 2009/10 and was our CQUIN target for 2009/10**	Individual targets met by 31 March 2011	Not measured	All targets met	**By end Dec '10:** **Adults: 21 out of 25 targets met** **OA: 21 out of 25 met** **CAMHS: 9 out of 13 targets met**	Not applicable

This indicator helps us asses the degree to which the services we provide improve the health and social functioning of our service users. To date, we have been working to ensure that every service user has their condition assessed and scored on admission and discharge. In 2011/12 we will be working on 'pairing' these scores for our service users, as per our CQUIN target in this area. Pairing service user scores will enable us to understand whether our services are actually helping our service users.

3. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
Crisis Resolution Team gate keeping - The percentage of service users admitted to acute	90% ★	Trust declared	94.5%	**96.4% Dec '10**	95.1%[2]

adult inpatient beds who were assessed as to their eligibility for home treatment prior to admission?		compliance with Monitor standards			

★ Indicates that the target is a national one and is therefore governed by a standard national definition
[2] Source: CQC National Priorities Indicator Benchmarking 2009/10 (Regional average)

When service users experience a crisis, they may or may not need an admission. Crisis resolution teams can assess if home treatment is a suitable option for service users before the decision to admit is made. We feel it is important to ensure that we treat patients in the most appropriate settings hence this is an important indicator for us to monitor. We are proud of our performance in this area.

4. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
How many new crisis resolution home treatment episodes did we deliver?	2,724	Not measured	Not measured	**2,507 Dec '10**	**Not available**

Following on from indicator 3 above, our crisis resolution teams have delivered 2,507 home treatment episodes for our service users to date. Our agreed commitment with our commissioners was to deliver 2,724 crisis resolution home treatment episodes in 2010/11. We were just short of achieving this target at the end of December 2010 but we have continued to work hard in this area and expect our quarter 4 performance to deliver the target.

5. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
Early Intervention teams meeting commitment (set by commissioners) to serve new psychosis cases	204 cases by 31 March 2011 ★	Not measured	Not measured	**179 Dec '10**	**Not available**

★ Indicates that this is a national indicator and is therefore governed by a standard national definition

This indicator assesses the number of cases of First Episode Psychosis that have been taken on by our Early Intervention teams for treatment and support since 1 April 2010. Our agreed commitment with our commissioners was for our Early Intervention teams to serve 204 new psychosis cases in 2010/11. We had delivered 179 new psychosis cases by the end of December 2010. We have continued to deliver new cases and expect that we will have achieved our target when we have the finalised figures for the number of cases delivered during the final quarter of 2010/11.

Service user experience

1. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
Delayed transfers of care[3] – on average, what percentage of hospital beds are being used by service users who should have been discharged?	≤ 7.5% ★	Not available	4.4%	**3.2% YTD Dec '10**	**3.15%**[4]

★ Indicates that the target is a national one and is therefore governed by a standard national definition
[3] This indicator was labelled 'Delayed discharge' in the 2009/10 Quality Account. It has been renamed this year but the methodology for measuring performance remains the same
[4] Source: CQC National Priorities Indicator Benchmarking 2009/10 (Regional average)

This indicator assesses what percentage of hospital beds are being used by those who should have been discharged. This is an important measure to monitor because a) inpatient beds should be kept free for those who need them most and b) because service users should be treated in the most appropriate setting. We are pleased that we are continuing to improve our performance in this area.

2. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark

CPA 12 month review – what percentage of our service users who are on CPA received a full CPA review within the last 12 months where appropriate? **This was a Quality Priority for 2009/10**	95% ★	91% January 2009 (audit)	99% 1 January-March 2010 (audit)	**97% Dec'10**	**Not available**

★ Indicates that the target is a national one and is therefore governed by a standard national definition

This indicator assesses whether those who are managed on CPA have a documented review of their care plan every 12 months. Reviewing service users' care plans every 12 months enables us to update them inline with the service users' current needs. We are proud to report that we are exceeding our target in this area.

3. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
What percentage of our service users has been offered a copy of their care plan?	95%	Not measured	90%	**88%**	**Not available**

This indicator checks whether or not we are recording giving our service users a copy of their care plan. We also measure whether our service users report being offered a copy of their care plan. As our performance is good here, we do not feel our falling performance in this indicator is an issue but we need to document well all that we are doing. We will continue to have a focus on sharing care plans with users by making it a quality priority for 2011/12.

4. What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
Performance against the standards and milestones for improvement in CAMHS (as set out in the National Service Framework for Children, Young People and Maternity Services)	5/5	Not measured	Not measured	**5/5**	**Not applicable**

The trust is assessed against 6 questions and scored between 1 and 4 (where 4 is the maximum) on each according to the degree of implementation of protocols/mechanisms it has in place. We are pleased to report that each Borough scored 4 in all questions at Quarter 3.

Our staff

We recognise that the views of our staff are an important indicator of the happiness and well-being of our workforce, and therefore our ability to deliver high-quality services. We are pleased to report that our staff satisfaction was higher than the regional average in the CQC benchmarking analysis undertaken in 2009/10. Staff satisfaction is an area that we intend to explore in more detail in 2011/12 with the aim of including this as a quality priority area in future years.

We have begun this journey by including our performance against a small number of indicators in our Quality Account this year. We are already collecting data against these indicators internally. Our HR department collect data on, and report against, a range of indicators and we have included those that we believe provide a high-level indication of staff well-being.

What are we measuring?	Target	2008/09	2009/10	2010/11
Staff turnover The number of staff leaving as a percentage of total staff	Year-on-year improvement		11.7% Jan-Dec '09	**12.4% Jan-Dec '10**
Average sickness per employee The time lost to sickness per employee as a percentage of total time available	Year-on-year improvem		3.6% Jan-Dec '09	**3.7% Jan-Dec '10**

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Hillingdon Community Health performance against national indicators

What are we measuring?	Target	2008/09	2009/10	2010/11	Benchmark
Infection control					
• number of cases of MRSA (with bacteraemia) annually	0 cases ★	Not available	2 cases	**0 cases**	Not applicable
• number of outbreaks of Clostridium Difficile (CDiff) annually.	0 cases ★		0 cases	**2 cases**	
Referral to treatment waiting times – non-admitted – what percentage of service users' treated within 18 weeks of being referred?	95% ★	Not available	99.8%	**100%**	Not applicable

★ Indicates that the target is a national one and is therefore governed by a standard national definition

HCH report good performance against the MRSA and referral to treat indicators. However, there have been two cases of CDiff during 2010/11. HCH follow the DoH mandatory surveillance for CDiff cases, and report to the Health Protection Agency. HCH's inpatient facility works closely with its Infection Control Team to ensure they abide by local and national policy and guidance in this area, and any cases of CDiff are followed up with a Root Case Analysis, from which lessons learnt are derived and implemented.

Part B: Quality Overview - a review of Hillingdon Community Health performance in 2010/11

In 2010/11 Hillingdon Community Health (HCH) identified quality priorities under three areas. In this section we will report on what HCH has achieved in these areas and how this has been done. We have included historic performance where available to help to put this year's performance into context.

1) Service user safety

HCH has made significant headway in creating a patient safety culture through:

- the introduction of on online incident reporting
- membership of the patient safety first campaign
- the introduction of a series of patient safety forums and leadership WalkRounds.

HCH set the following measures and targets to record its performance:

A. Minimum of 10% decrease in the number of inpatient falls for 2010/11 at Northwood and Pinner Community Unit
B. Zero serious / red medication incidents or errors across HCH services
C. 100% compliance with online incident reporting (implemented 6 April 2010) for HCH staff by March 2011
D. 90% of respondents to annual Patient Experience Survey are happy with the healthcare professional's attention to hand hygiene.

We are reporting our performance against each of these targets.

Measure A

Following an analysis of reported incidents, it was noted that there was an increased number of falls for Q3 09/10 (21) and Q4 09/10 (10), this was reported in Quality Matters Q2/3 09/10. The target set was in-keeping with national guidance '*Nurse sensitive outcome indicators for NHS provided care*', where preventing falls has been identified as a high impact area.

An action plan for the management of falls by frontline staff was devised by the Ward Manager and Quality Governance Facilitator based on recommendations published in Patient Safety First '*How to guide on reducing harm from falls*'.

Several measures were introduced through the '*Productive Community Ward Programme and 'High Impact Actions*' to reduce falls. However the number of falls exceeded the set target. This issue was discussed at HCH Senior Management Committee meeting in March 2011, where it was identified that HCH would not meet the set target. It was however noted that the total number of falls for 2010/11 is consistent with that for 2009/10.

An analysis of falls has identified that:

- Bed occupancy for the Northwood and Pinner Community Unit increased by 5%
- An increase in the number of service users undergoing intensive rehabilitation, including inpatients that would be more prone to falls, e.g. inpatients with Parkinson's Disease.

Further discussion at SMT has agreed that all measures to reduce inpatient falls are being implemented.

Measure B

It was noted that there was an increase in the number of medication incidents or errors reported for 2009/10. HCH anticipated that, with the introduction of Datix (risk management software application), the total number of reported incidents would increase, and therefore worked to ensure that these incidents would result in no serious harm to service users. A review of the incidents that had occurred showed that none had resulted in either moderate or serious harm to service users. HCH used the outcomes of the review to create 'lessons learnt', which were circulated to staff to increase awareness and enhance patient safety.

At that time, the National Patient Safety Agency (NPSA) introduced a drive to reduce medication errors and published '*Safety in Doses – improving the use of medicines in the NHS*'. The Non-Medical Prescribing Lead for HCH worked in conjunction with NHS Hillingdon Medicines Management team to implement the recommendations in this report.

HCH services have since had one serious medication incident, which occurred in February 2011. The investigation of this

serious medication incident is nearing completion. HCH will look to use the resulting report to develop lessons learnt and share these amongst its staff to further increase awareness and prevent any further serious medication incidents from occurring.

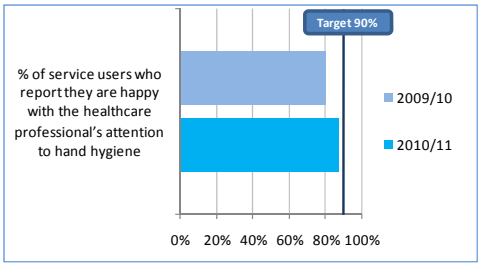
Measure C

HCH implemented online incident reporting in April 2010 to enable improvement in the quality of incident reporting and further enhance a culture of patient safety in the organisation. It was also envisioned that online reporting would support teams and service leaders to more effectively deal with incidents and improve communication between team members to embed patient safety and risk management.

Despite difficulties with the IT systems this target has been achieved with 100% of incidents being reported online since December 2010. HCH SMT feels that this has significantly contributed to embedding a patient safety culture in the organisation and helping clinicians to manage and learn from incidents.

Measure D

It has been well documented that good hand hygiene is an effective way to prevent transmission of infection. Over the past year the Infection Control Team have worked closely with all frontline staff to promote and improve infection prevention and control processes, and to ensure that supporting resources, e.g. anti bacterial gels, are available for staff. There has been significant improvement in this area but HCH performance (87%) has fallen just short of the 90% target.



Additional measures have been introduced to further improve performance in this area:

- Maintain high levels of attendance at mandatory Infection Control and Prevention training
- HCH Infection Control and Prevention team to undertake an annual hand hygiene audit and continue participation in the 'clean your hands' campaign
- Programme of spot check audits to be undertaken by the HCH Infection Control and Prevention team across all HCH services.

2) Clinical Effectiveness

HCH's clinical services have made significant progress in recent years in regard to the delivery of quality patient care and are performing well against performance and quality indicators. All clinical teams have participated in clinical audits and have made changes to the delivery of services to further enhance clinical effectiveness.

We set the following measures and targets to record our performance:

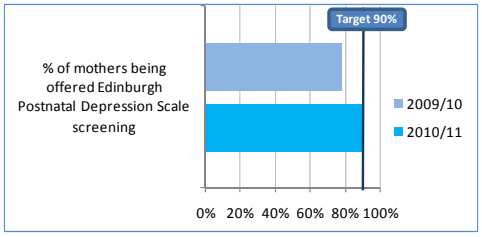
A. 90% of mothers being offered EPDS (Edinburgh Postnatal Depression Scale) screening (CQUIN target)
B. 55% of women sustaining breastfeeding 6-8 weeks after delivery
C. Maintain the decrease in waiting times for wheelchair assessment for Hillingdon service users
D. Ensure the effectiveness, productivity and efficient use of the recently launched Ambulatory Wound Management service, ensuring that service users get better quality of care closer to their homes.

We are reporting our performance against each of these targets.

Measure A

It is recognised that postnatal depression is under diagnosed and can have a significant impact on women and their families. This target was set to improve the quality of life for women and their families.

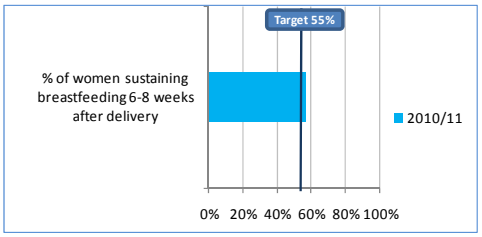
HCH was previously achieving 78% and recognised that this area required further improvement to align performance with the CQUIN target.



As a result of increased training to health visitors and recruitment to the Specialist Health Visitor post, the 90% target has been successfully achieved in 2010/11.

Measure B

As well as being an NHS London target, sustained breastfeeding for 6 weeks and longer has been proven to have long term health benefits for both mother and baby. HCH anticipated that this target would be challenging due to the requirement of a large number of organisations such as local GPs and hospital maternity units working with HCH in a coordinated manner to promote mothers to breast feed.



HCH is pleased to report that 55% target has been achieved for the first three quarters of 2010/11 and HCH expects quarter 4 performance to also exceed the target set. This performance has been delivered through the work of HCH Breastfeeding coordinator and additional training provided to health visitors, children's centre staff and other stakeholders.

Measure C

A significant amount of work had already been done to improve waiting times in this area, reducing waiting times from 23 weeks to 13 weeks. The performance of this service had to be sustained to enable the service to meet its contractual obligations as well as providing a more effective service to a group of particularly vulnerable service users. This indicator was developed in conjunction with the Chair of Hillingdon LINks.

This target has been achieved with waiting times now down to an average of 11 weeks.

Measure D

The development of this innovative service was sanctioned by Practice Based Commissioners; it was envisaged that the service would offer enhanced care for patients requiring wound care and would relieve the pressure from practice nurses who maybe inexperienced in providing wound care.

This was a newly developed initiative and as such a specific target was not set. However, we have monitored the performance over the past year, which has shown that over 2,000 service users have accessed the service. The service has received good overall evaluations from all stakeholders.

3) Service user experience

HCH's annual Patient Experience Survey has for the past 2 years shown a high percentage of overall satisfaction; this is consistent with the findings of service specific surveys. The targets identified below are the areas where HCH services fared less well in the 2009 annual Patient Experience Survey

We set the following measures and targets to record our performance:

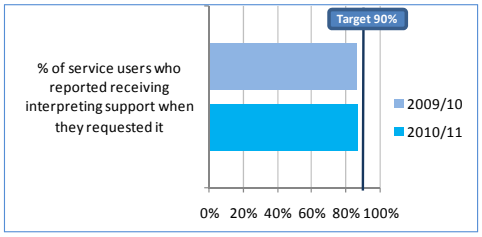
A. 90% of service users report receiving interpreting support when they request it
B. 60% of service users report knowing how to compliment or complain about a service
C. Improved access to domiciliary phlebotomy service[5].

We are reporting our performance against each of these targets.

Measure A

With such a diverse population it is crucial that service users, their families and/or carers are able to communicate with their healthcare professional to fully understand their treatment and their role in maintaining a health lifestyle.

The 2010 annual Patient Experience Survey results indicate that HCH performance in this area has slightly increased to 87% in 2010/11, but remains behind the target of 90%.

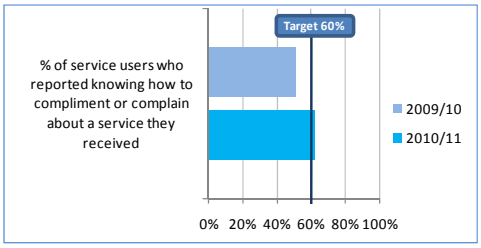


[5] This service is the taking of blood samples from service users at home. HCH have a team of staff who do this

HCH understands the importance of this target and in conjunction with Hillingdon LINks has decided to carry forward this area as a quality priority in 2011/12.

Measure B

As an open and transparent organisation HCH encourages services users to compliment or complain about the service they receive as this informs future service delivery and development.



There has been a sustained increase in the percentage of service users who reported that they knew how to make a compliment or complaint about their service and the quality of their care; HCH performance exceeded the target set (60%) and achieved 62% in 2010/11.

Measure C

Following feedback from service users, the Chair of Hillingdon LINks advised that service users greatly valued a domiciliary phlebotomy service. A thousand patients have used the domiciliary phlebotomy service between October 2009 and March 2010. Early indications show that both service experience and GP satisfaction has been enhanced with this Practice Based Commissioned service.

This was a newly developed initiative and as such a specific target was not set. However HCH have monitored the performance over the past year, which has shown that nearly 3,000 service users have accessed the service. The service has received good overall evaluations from all stakeholders.

Statements of Assurance from Hillingdon Community Health's Board

Services

During 2010/11 Hillingdon Community Health provided and / or sub contracted [32] NHS services.

Hillingdon Community Health has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100 per cent of the total income generated from the provision of NHS services by Hillingdon Community Health in 2010/11.

Participation in Clinical Audit

During 2010/11 [4] national clinical audits and [1] national confidential enquiries covered NHS services that [Hillingdon Community Health] provides.

During that period [Hillingdon Community Health] participated in [50%] national clinical audits and [0%] national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Hillingdon Community Health developed a 'shadow' Quality Account for 2010/11 in readiness for the requirement for 2011/12, and as such participated in only one out of the possible three National Clinical Audits which were deemed relevant for the organisation.

Hillingdon Community Health will continue to participate, when invited, in national audits and will also endeavour to participate in other national clinical audits where they are deemed relevant for Community Provider Services and fall within the remit of Hillingdon Community Health. We will also continue to undertake robust local audits as identified in the organisation's local audit programme.

The national clinical audits and national confidential enquiries that [Hillingdon Community Health] was eligible to participate in during [2010/11] are as follows:

- [National clinical audit of falls and bone health
- National Cardiac Arrest Audit].

The national clinical audits and national confidential enquiries that [Hillingdon Community Health] participated in, and for which data collection was completed during [2010/11], 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 clinical audit of falls and bone health - 75%
- National Cardiac Arrest Audit - 0%. HCH participated in the audit but there were no cardiac arrests on the unit for the duration of the audit. Therefore no data was submitted.

The reports of [TBC] national clinical audits were reviewed by the provider in [2010/11] and [Hillingdon Community Health] intends to take the following actions to improve the quality of healthcare provided [TBC].

The reports of [24] local clinical audits were reviewed by the provider in [2010/11] and [Hillingdon Community Health] intends to take the following actions to improve the quality of healthcare provided. A short list of the key local clinical audits is included in the table below; the complete list can be found in Annex 4.

Local clinical audits 2010/11 – reports reviewed	Findings/Action Points to improve patient care 2010/11

Re-audit of Acupuncture Safety	1. Further work is to be done on tailoring advice to patients as there was an under achievement against the set standards of 100% 2. A future audit is planned comparing the nurse led weight loss service to that of the dietician as regards hard outcomes of weight loss, and improvements in metabolic parameters.
Patient Identification wrist band audit	In order to achieve and maintain 100% compliance with the standard, each member of staff will be asked to complete a 'wrist band' in the required format identifying training needs. The audit will be undertaken bi-monthly to monitor continual compliance.
Antibiotic prescribing	Audit results demonstrated good compliance with Antibiotic prescribing guidelines within the Community Dental Service.
The Transfer of Patient Identifiable Information	Transportation of Patient Identifiable Data guidelines to be developed to enable the delivery of care outside the clinic setting and to minimise the risk of information security incidents. Guidelines approved January 2011 and disseminated to all staff.

Local clinical audits are conducted by individual healthcare professionals or teams evaluating aspects of care that they themselves have selected as being important to them and/or their team.

Research

The number of patients receiving NHS services provided or sub-contracted by [Hillingdon Community Health] in [2010/11] that were recruited during that period to participate in research approved by a research ethics committee was [0].

Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of Hillingdon Community Health income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between Hillingdon Community Health, NHS Hillingdon 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 2010/11 and for the following 12 month period are available electronically at http://www.institute.nhs.uk/images/documents/wcc/PCT%20portal/CQUIN%20schemes/London%202010.11%20-%20Community%20Hillingdon%20Community%20Health.pdf.

What others say about the provider

Statements from the Care Quality Commission

Hillingdon Community Health is required to register with the Care Quality Commission and its current registration status is unconditional registration. Hillingdon Community Health has the following conditions on registration [none].

The Care Quality Commission has not taken enforcement action against Hillingdon Community Health during 2010/11.

Hillingdon Community Health has not participated in any special reviews or investigations by the CQC during the reporting period.

Data quality

Statement on relevance of Data Quality and your actions to improve your Data Quality

The Hillingdon Community Health Business Manager chairs the integrated Data Quality Group which is attended by NHS Hillingdon Commissioners and Public Health and Primary Care representatives. At the monthly meetings the group discuss and address any issues relating to the quality of patient data.

Hillingdon Community Health has a dedicated data quality administrator in post within the RiO team, whose role is to review the integrity of all data and ensure compliance with Data Quality Standards. Hillingdon Community Health will continue to undertake regular data quality audits and address any identified areas of non compliance.

NHS Number and General Medical Practice Code Validity

Hillingdon Community Health did not submit records during [2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Information Governance Toolkit Attainment Levels

[Hillingdon Community Health] Information Governance Assessment Report score overall score for [2010/11] was [64%] and was graded Amber on 25 March 2011].

Clinical Coding Error Rate

Hillingdon Community Health was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

Annex 1:

Statements from primary care trusts, Local Involvement Networks, Overview and Scrutiny Committees and our Commissioners

Annex 2: Glossary of Terms

Abbreviations

CAMHS	Child and Adolescent Mental Health Service
CDAT	Community Drug & Alcohol Team
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPS	Camden Provider Services
CQMG	Care Quality Management Group
CRHT	Crisis Resolution Home Treatment
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DESMOND	Diabetes Education and Self Management for Ongoing and Newly Diagnosed
DoH	Department of Health
EPDS	Edinburgh Postnatal Depression Scale
GP	General Practitioner
HCH	Hillingdon Community Health
HoNOS	Health of the Nation Outcome Scales
IGSoC	Information Governance Statement of Compliance
LINks	Local Involvement Networks
MHA	Mental Health Act
NHS	National Health Service
NHSLA	NHS Litigation Authority
NIHR	National Institute for Health Research
NPSA	National Patient Safety Agency
OSC	Overview and Scrutiny Committee
OSCE	Observation of Skills of Clinical Examination
PALS	Patient Advice and Liaison Service
PCT	Primary Care Trust
POMH	Prescribing Observatory for Mental Health
SMT	Senior Management Team

Care Programme Approach (CPA)

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

CPA Assessment

All those being seen by the mental health service will receive a holistic assessment of their health and social care needs.

CPA Care Co-ordinator

A CPA care co-ordinator is the person responsible for overseeing the care plan of someone on CPA. See also Lead Professional.

CPA Care Plan

A written statement of the care, treatment and/or support that will be provided. In mental health services, people on CPA have a formal CPA care plan and people on LPC have a less formal LPC care plan in the form of a standard letter

Clinical/Specialist Care Plans

Clinical/specialist care plans give the detailed procedure for each service identified as being appropriate to support the service user within their overall CPA care plan.

Crisis Plan

A crisis plan is included within the CPA care plan. It sets out the action to be taken if the service user becomes ill or their mental health deteriorates.

Contingency Plan

A contingency plan is included within the CPA care plan to outline the arrangements to be used to prevent a crisis from developing. Contingency planning is the process of considering what might go wrong and pre-planning to minimise adverse or harmful outcomes.

CPA Review

Care plans are reviewed at least once a year, in partnership with service users and carers wherever possible.

Carer

A carer is someone who provides regular and substantial assistance/support to a service user. Carers are not paid to provide this support and are entitled to have an assessment of their own caring needs.

Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a screening tool that was developed for assessing new mothers for postnatal depression in outpatient, home visiting settings, or at the 6-8 week postpartum examination.

Lead Professional

The professional, in mental health services, who provides care or treatment for someone who needs support from secondary mental health services, but has more straightforward needs than someone on CPA and usually only needs support from one professional.

Local Involvement Networks (LINks)

Local Involvement Networks (LINks) are made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services and provide a community ‘voice’ in determining local health and social care priorities.

Patient Advice and Liaison Service (PALS)
PALS offers help, support, advice and information to service users, carers, family or friends.

Practice based commissioning

Practice based commissioning enables GPs and other front line clinicians to redesign services that better meet the needs of their patients.

RiO (electronic Records in Operation)

RiO is the clinical information database used by Community Service providers.

Service User

The term “service user” refers to those people receiving treatment and care.

Annex 3 – HCH local clinical audit reports reviewed and actions emerging

No.	Local clinical audits 2010/11 – reports reviewed	Findings/Action Points to improve patient care 2010/11
1	Peer Review (podiatry)	1. Improve time keeping 2. Advised staff without uniform of uniform policy and how to go about ordering new 3. The importance of clinical set up and chair pre and post operative wiping 4. Recommendation on removal of gloves when opening unit drawers and cupboards and also before post operative cleaning of patient chair 5. Separating the dirty instruments from the clean on the sterile sheet and not to place in foot tray amongst skin debris 6. Check patient personal details, record triage and upload changes to medical history and medication. Extra 10 minutes on each appointment to update and upload details
2	Peer Review (podiatry) re-audit	1. Clinicians need to introduce themselves and other staff present to the patient on entry to surgery 2. Medical history taking should include checking whether or not pt has had local analgesic in last 24 hours 3. Improve LA depositon technique by holding apex of toe and re-sheathing needle to workstation 4. Let chlorhexidine dry before injecting LA to prevent spirit trickling into injection site 5. Good vascular return needs to be vocalised at procedure and recorded in progress notes
3	Safeguarding Adults Audit of Telephone queries & referrals	Adult abuse can be a hidden problem. There should be a new government of Dept of Health doc including a London Policy released later this year. By continuing to work closely with LBH SGA Team and other local partners and continuing to teach awareness when we re-audit, should see a rise in the amount of referrals going to SGA LBH To re-audit in April 11 for 3mths
4	Learning Disabilities	LD steering group will be identified and from this a basic programme of LD awareness will be recommended, materials should be put in place to ensure that people with LD are more likely to receive an equal service. Patients should be treated as individuals with individual needs, therefore reasonable adjustments may need to be identified and applied i.e. possible double appt. times and home visits instead of clinic appointments LD steering group - already forming.
5	Medication Audit	1. Identify patients who are not currently optimised where reasons are unknown

No.	Local clinical audits 2010/11 – reports reviewed	Findings/Action Points to improve patient care 2010/11
		2. Investigate why these pts. Are not on the optimal recommended dose 3. Document any reasons for pt. being on sub-optimal doses; or titrate doses if indicated.
6	Prevention of Admission	All community matrons should use the listed criteria to identify prevented admissions either after each visit or as part of reflective practice at the end of each day. In this way the Team can ensure that they are capturing the correct data; it also provides a standardised approach for the team. A laminated A4 copy of the criteria will be circulated to all members of the Community Matron team by 01.10.10
7	Case Management Documentation review	1. Revise Case Management Assessment Documentation 2. Devise re assessment tool & Guidelines 3. For all community Matrons to complete the ongoing monitoring note at each visit.
8	Catheterisation	All staff should be made aware of the correct answers and these will be sent out to the Band'7's to ensure each member of staff read them
9	Clinical Outcomes (Complex wound care)	Continue to provide high quality of service. Ensure all stakeholders are given results of audit to ensure community based services are commissioned closer to peoples homes for all patients in Hillingdon with complex wounds. Ensure that staffing levels meet demand to ensure no waiting list for 1st assessments.
10	Pressure Ulcer Prevalence	1. Feedback to each DN team on their specific results from this audit. 2. Targeted training to each DN team: assessment & documentation of pressure ulcer grades to include Walsall score guidance. 3. Raise awareness of the National Institute of Clinical Excellence (NICE) (2004) Prevention & Management of pressure ulcers.
11	Outcomes of Physiotherapist treatment of patients with Osteoarthritis of the knee	1. Knee Class review 2.Mini audit on why physiotherapists do/don't refer to class 3. Presentation to physiotherapy teams re: audit and recommendations.

No.	Local clinical audits 2010/11 – reports reviewed	Findings/Action Points to improve patient care 2010/11
12	Nail Surgery Peer Review	Clinicians to introduce themselves & other staff present to pt. on entry to surgery. Medical history should include checking if pt has had local analgesic in last 24hrs. Improve LA deposition technique by holding apex of toe and reshreathing needle at station. Let chlorhexidine dry before injecting LA to prevent spirit trickling into injection site. Emergency procedure should be in place in clear visibility, and changed so that epipen should be available. Tourniquets should be applied with tag attached. Excessive phenol should be dried with sterile gauze and used with sterile glycerol. Good vascular return needs to vocalised at procedure and recorded in progress notes. Better ventilation in podiatry room at Hesa. All Nov 10
13	Re-audit of Acupuncture Safety	Recommendations: 1. Further work is to be done on tailoring advice to patients as there was an under achievement against the set standards of 100%. 2. A future audit is planned comparing the nurse led weight loss service to that of the dietician as regards hard outcomes of weight loss, and improvements in metabolic parameters
14	Patient Identification wrist band audit	In order to achieve and maintain 100% compliance with the standard, each member of staff will be asked to complete a 'wrist band' in the required format identifying who needs training. The audit will be undertaken bi-monthly to monitor continual compliance.
15	Security & Storage of Records	All managers must ensure their staff read and implement Guidance for the protection of Patient identifiable Data (PID) whilst working in the community in regard to diary entries. All managers must ensure compliance with NHS Hillingdon Records Management Policy in regard to the lifecycle of clinical records. Clinic Supervisors and managers must ensure compliance with NHS Hillingdon Records Management Policy in regard to tracking clinical records.
16	Outcome Measures	1. To develop consistent outcome measures across the 3 teams. 2. Develop individual outcome measures format in pre school special needs team. 3. Review attendance at Bluebells group. 4. Informal training on setting SMART targets for schools team. 5. Develop outcome measures for group therapy within the clinic and early year's team. 6. Re-format the outcome measure forms for groups using EKOS measurements.
17	Safeguarding children Action Plan Audit	1. All therapists to ensure that children are transferred on the RiO caseload. 2. Ensure that the CAF spreadsheet is updated as appropriate. 3. That they liaise appropriately for Children on the RED list and record this liaison on the RiO progress notes. 4. Request information on siblings as appropriate for all children on the RED list and record this on Rio progress notes. 5. Medical Alerts: to ensure that the medical alert has been activated

No.	Local clinical audits 2010/11 – reports reviewed	Findings/Action Points to improve patient care 2010/11
		in all cases where this is appropriate. 6. Carry out and record verbal handover for children on the RED caseload. 7. Tracer card system is being implemented and used. 8. Team leaders and Clinical service lead. to amend the audit tool to reflect the collection of more accurate and meaningful data 9. Contact QG team around appropriate method of analysis for this type of audit following the difficulties experienced as detailed above.
18	Safeguarding Children Action Plan Re- Audit	1. A shared confidential Q drive needs to be set up.... 2. A sign in sheet for the CAF 3.Child protection supervision to address issues Risk Assess following Merlin receipt and documenting concerns in siblings records 4. All children with medical conditions to have alerts placed on RiO records and condition documented in comment box. 5. RiO templates formulated and presented to PAG for ratification and then submitted to Clinical Gov 6. Child protection supervision attendance sheet, minutes and agenda to be completed for each session. 7. Launch revised HV standards re: roles, responsibilities handover of red families etc.
19	Domestic Violence Baseline Audit	1. Package of teaching to be given to all HV teams in Hillingdon - highlighting resources already available. 2. Traffic light system to be introduced to provide guidelines for HV teams 3. Encouraging use of children's centres as alternative venue. 4. Liaise with children's centre manager 5. Designing of RiO template to standardise guidelines for HV teams. 6. Raise awareness of HIDVAP & other local services within HV teams. 7. Raising awareness of internet resources (Greater London DV Project DV Project)
20	Reviewing the processes of info sharing	1. Meeting with Administration Mgr A&E clinical coding team/Liaison HV team to strengthen systems around quality of data/information sharing 2. Acquisition of scanner and approval to use 3. Work with RiO team once scanner obtained to ensure referrals from liaison service can be activated directly onto RiO for teams 4. Ongoing training for staff-targeting nursing team leaders so information can be cascaded to all staff 5. Succession training of staff to cover liaison HV during any periods of absence 6. A&E Paediatric Nursing lead in post

No.	Local clinical audits 2010/11 – reports reviewed	Findings/Action Points to improve patient care 2010/11
		7. Scanning of casualty cards direct to clinic bases 8. Use of Paediatric specific casualty card with referral to Liaison Service incorporated
21	Antibiotic prescribing	Audit shows antibiotic prescribing falls within the guidelines, no recommendations are needed at this stage
22	Wheelchairs Note Writing audit	1. Ethnic monitoring, next of kin and religion require more consistent documentation by all staff. This is an ongoing recommendation and has been carried over from last audit as further improvement still needs to be made 2. Consent to treatment is now gained prior to assessment via the referral form. This information needs to be documented onto BEST 3. All therapists to remain aware of importance of completing notes in a timely manner and ensure clients have been discharges from RiO/completed on BEST as soon as episode of care is complete 4. Staff to refer to Trust Clinical Record Keeping Policy and wheelchair service written procedure on note writing to ensure consistent best practice.
23	Hand Hygiene	Continue to heighten awareness on good hand hygiene for staff through mandatory training, ad hoc training and workshops Engage with the public at twice yearly road shows
24	The Transfer of Patient Identifiable Information	Development of diary guidelines to enable the delivery of care outside the clinic setting and to minimise the risk of information security incidents. Guidelines approved January 2011 and disseminated to all staff.

Annex 4 - Borough performance against priorities in 2010/11

Attached separately. This information will appear in the space below in the final published Quality Account.