Camden and Islington NHS
NHS Foundation Trust

Quality Accounts 2013/14

Camden and Islington
NHS Foundation Trust

Your partner in
care & improvement

Quality Accounts 2013/14

Camden and Islington NHS Foundation Trust

Contents

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Quality Accounts

1.1 2013/14 Statement of Directors' Responsibilities in respect of the Quality Report

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the commissioners dated 20 May 2014;
- Feedback from governors received on 28 February 2014 and on 14 March 2014;
- The 2013 national patient survey - published June 2013;
- The 2013 national staff survey - published in March 2014;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2014;
- CQC quality and risk profiles dated April 2014; and
- Board review of performance regarding numbers of complaints and timeliness of response to complaints on a quarterly basis in 2013/14.

The Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;

The performance information reported in the Quality Report is reliable and accurate;

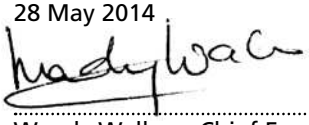
There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are effectively working in practice;

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

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

By order of the Board

Leisha Fullick, Chair
28 May 2014



Wendy Wallace, Chief Executive
28 May 2014

1.2 2013/14 limited assurance report on the content of the quality reports and mandated performance indicators

Independent auditor's report to the Council of Governors of Camden and Islington NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of Camden and Islington NHS Foundation Trust to perform an independent assurance engagement in respect of Camden and Islington NHS Foundation Trust's quality report for the year ended 31 March 2014 (the "quality report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Camden and Islington NHS Foundation Trust as a body, to assist the Council of Governors in reporting Camden and Islington NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their Governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Camden and Islington NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

1. Care Programme Approach 7 day follow up
2. Delayed transfers of care

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the quality report is not consistent in all material respects with the sources specified within the *Detailed Guidance for External Assurance on Quality Reports*; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the quality report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents specified within the *Detailed Guidance for External Assurance on Quality Reports*. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

"The Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered"

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the quality report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Camden and Islington NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the quality report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP

Deloitte LLP
Chartered Accountants
St Albans
28/05/2014

1.3 Statement on Quality from the Chief Executive

Welcome to Camden and Islington NHS Foundation Trust's (C&I) annual Quality Accounts for 2013/14.

The Quality Accounts are our annual report to the public from the Trust Board about the quality of services we deliver. The primary purpose of the Quality Account is to encourage the Trust Board to assess quality across all of the healthcare services we offer, allow clinicians and staff to demonstrate their commitment to continuous quality improvement and to explain to the public our progress towards improving quality in the services we provide. It is a legal requirement under the Health Act 2009. The Trust's quality goals are co-developed with a range of stakeholders and communicated within the annual Quality Accounts. The process for developing this year's quality accounts commenced on the 1st October 2013 and ran for 3 months, during which the indicators for inclusion within the quality accounts were discussed with key stakeholders. We held a further stakeholder event on 28 February 2014, where our priorities for the forthcoming year were refined. Our quality improvement priories are set out in this annual report, as is our analysis of our achievements against last year's priorities.

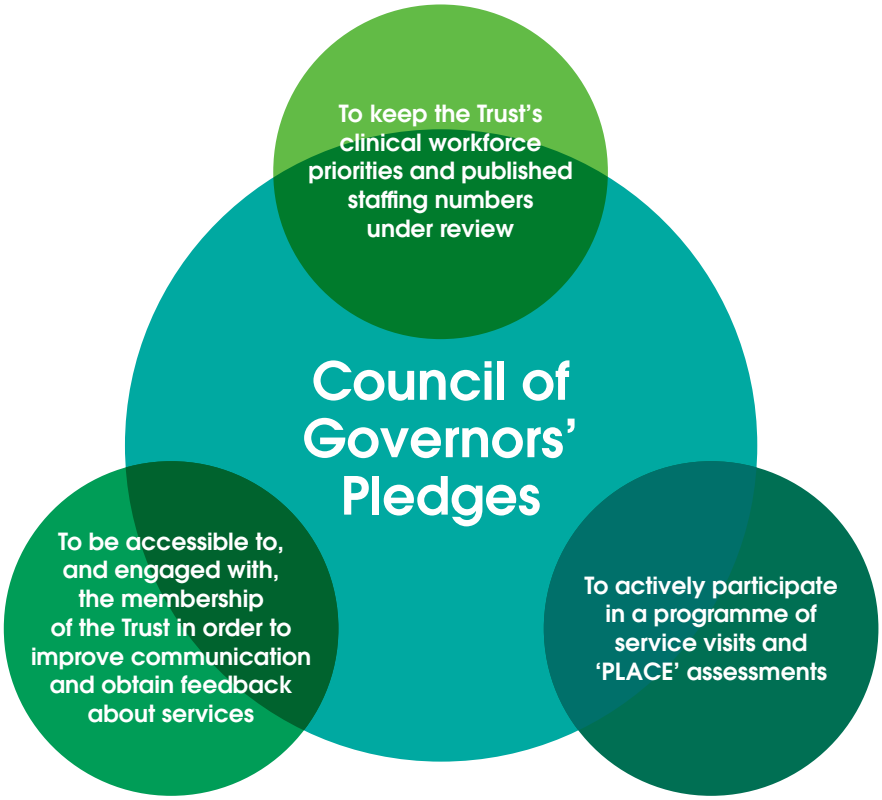
Throughout 2013/14 we have monitored the quality priority areas from the previous year. The last year has seen significant change in how healthcare is delivered in this country, not least through the changes brought about by the Health and Social Care Act 2012. The creation of Clinical Commissioning Groups (CCGS), Health and Wellbeing Boards and Healthwatch mean that the services we provide are commissioned through new local arrangements. NHS England has issued a 'Call to Action', setting out the challenges facing the NHS as our population changes, demands on services increase and expectations about the quality of care rise. The quality of care in both the NHS and social care has been the subject of much debate and discussion at a national and local level; with all NHS providers being tasked with responding to the recommendations of the Francis Inquiry, Keogh and Berwick Reports.

The lessons of the Francis Inquiry and the Berwick and Keogh reports continue to inform how we review and deliver care. Safe staffing levels, responsiveness to complaints and analysis and response to patient safety data have been high on the agenda across the Trust. As part of our response to the Francis Inquiry, the Trust governors have made three pledges in relation to our workforce and staffing, our participation in service visits and reviews and to improve communication and feedback with Trust membership. As we prepare for our forthcoming comprehensive inspection by the Care Quality Commission, in May 2014, quality of care and responsiveness to the needs of our service users have never been higher on our agenda.

The last year has seen significant change in how healthcare is delivered in this country, not least through the changes brought about by the Health and Social Care Act 2012

We continue to work towards our strategic goals of excellence, innovation and growth. These goals drive the decisions that are made about how our services are run. We continue to put our values into action in the ways we work with each other and with the people who use our services. The Trust undertook a major restructuring of services, creating more specialisation, improved access and alignment of services in care pathways during 2012/13, however this created significant change and anxiety for staff. This year has been a year of consolidation and improvement, following recent years of considerable change. I am pleased to report that our staff survey results this year have improved significantly on last year's results. Last autumn we began a major listening exercise which led to the creation of the new Trust Values and since then we have been working to both embed these and address issues raised by staff and service users. When the staff survey took place this year we had had 18 months of relative stability to focus the development of the new services and pathways. This year the Trust response rate to the 2013 Staff Survey of 56% is in the highest 20% of Mental Health/ Learning Disability Trusts in England and 3rd in London. Our scores improved significantly across all areas.

Council of Governors' Pledges.



Throughout 2013/14 we have listened to what staff members have told us about safe staffing and safe workloads, and we focused on reducing the vacancy rates and have invested in external analysis of how best to match our capacity with the demands on our services. We are embedding and refining performance and quality against new assurance frameworks.

As Chief Executive, I see the efforts made across our organisation to improve quality through research, service development and collaboration with our service users and carers. Major developments this year have been the opening of the Crisis House, the on-going work to redevelop the St Pancras site and exciting work which is underway to develop our liaison mental health services at the Royal Free and the Whittington. We continue to work, across all our services, to provide Camden and Islington residents, and our service users in Kingston and Westminster, with responsive, timely interventions across their pathway of care. We continue to put our vision of the best possible prospect of recovery for our service users into action through the development of our Recovery College and recovery oriented practice. The Recovery College will deliver comprehensive, peer-led education and training programs within mental health services. Courses will be co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals. This development is an important milestone in our work to redefine the power relationship between the mental health professional and individuals receiving services

As we move into 2014/15, we will be implementing a new real time patient experience and clinical audit system, which will further enhance our ability to gather, analyse patient experiences of safety and quality, enabling us to identify areas for improvement and respond more quickly. Creating more systematic and innovative ways of capturing service user reported experience is a priority for the Trust. The ability to bring patient experience closer to the Board, through the use of fast-paced technology is an essential expectation of Monitor's Quality Governance Framework. The rapid availability of qualitative data about the quality of care experienced by patients will highlight how we can adjust our delivery of care to continually improve and also assure stakeholders, senior managers and clinicians of our performance against a range of measures. The recommendations of the Francis Inquiry and Keogh and Berwick reports mean that we must be in touch with users' experiences and to respond to them continuously.

Our new system will be the basis for producing an internal Quality Assurance Framework, a critical component to ensuring the Trust is continually ensuring the overall quality of all of its services and prepared for CQC. As Quality Assurance must become intrinsic to every stage of the patient journey and every component of patient care and service delivery, absolute attention to its effectiveness is essential. We will focus on creating a system which allows quality assurance processes to be determined, maintained, measured, monitored, reported and continually improved. We will achieve this internal scrutiny, through developmental visits/inspections, a means of measuring quality and risk profiling and the introduction of a rapid improvement team.

The CQC's Quality Risk Profile (QRP) of the Trust has continued to show a very positive picture throughout 2013/14; with 94% of the 785 measures rated as similar or better than expected (as at April 2014) and no area rated as at risk of non-compliance. The QRP is the CQC's primary tool for summarising all the current information concerning the quality and safety in healthcare providers.

The Trust has maintained its performance against all the quality targets set out by our regulators and commissioners; this included focused annually agreed improvement targets agreed with our commissioners (CQUIN -Commissioning for Quality and Innovations). We received a favourable CQC review of our Camden care pathway this year, and we have made important steps towards addressing actions required following this CQC visit and our CQC visit to Stacey Street. In 2014/15 we will be undergoing one of the new style comprehensive inspections from the CQC; we are part of the phase two pilots for the process. We welcome the opportunity for this external review of the quality and performance of our services as a whole.

Our quality priorities for 2014/15 reflect progress and consolidation from previous years. We continue to work towards improving the physical health of our mental health service users, and continue to improve how we gather and respond to patient feedback. As in previous years, the Trust had agreed with its commissioners a very ambitious and challenging set of quality targets and initiatives through its 2013/14 Commissioning for Quality and Innovation programme. These targets covered issues relating to physical health, recovery oriented practice, collaborative care planning and smoking cessation. We have met the great majority of these targets and will work in 2014/15 to continue improvement in these areas and meet the new targets for the coming year.

We greatly appreciate the external input we have had in the production of these accounts. Our priorities over the coming year are a direct result of feedback from our stakeholders, commissioners and the Trust membership. This Account represents our commitment to ensuring that we continue to improve service user and carer experience and strengthening further our commitment towards recovery focused care and continuous quality improvement.

The Board is satisfied that the data contained in these Quality Accounts are accurate and representative.

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Wendy Wallace
Chief Executive
28 May 2014

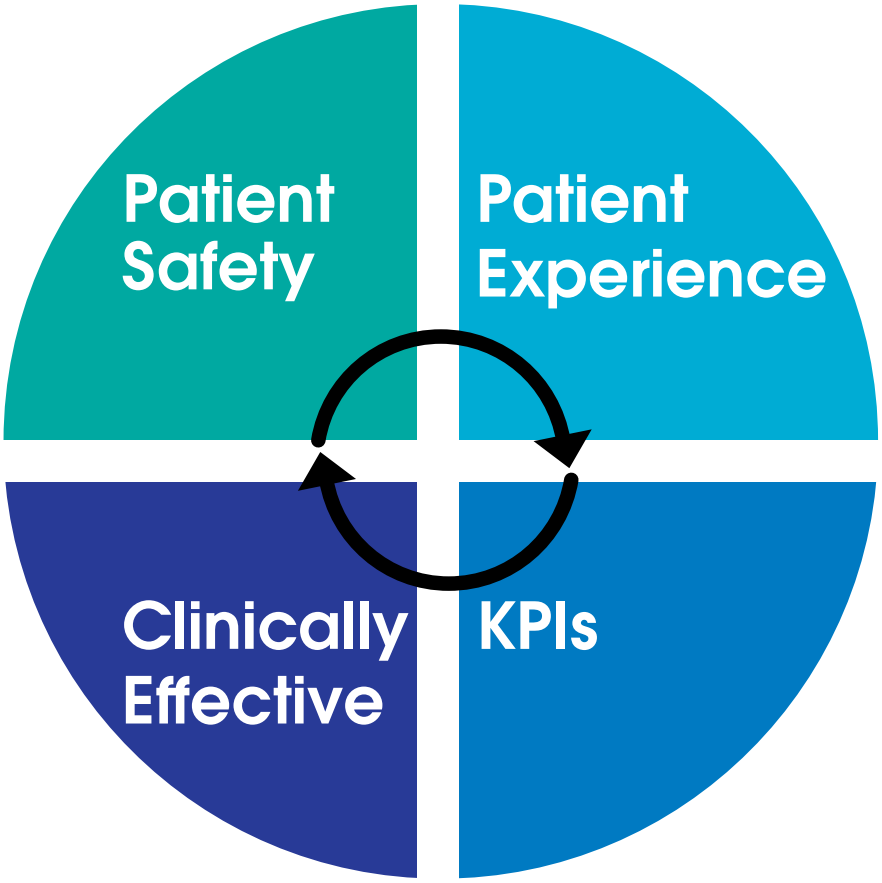
1.4 Priorities for improvement

We have developed our quality goals in collaboration with our stakeholders and our community. We held a stakeholder event on 28th February 2014 at which we agreed our priorities for the next twelve months. As we move into 2014/15 we will be seeking to further improve quality in the following areas:

- Physical health: Implementation of Modified Early Warning Scores (MEWS), ensuring that at least 80% of our ward based staff are trained in using this approach to monitoring physical health;
- Improved patient experience through improving how we gather and respond to service user and carer feedback;
- Recovery oriented practice, by working collaboratively with service users to improve their quality of life;
- Integrated care by working in association with GPs to develop collaborative care plans in line with the Advance Decision and Crisis Plan policy;
- To promote better health outcomes for patients through consistent assessment and management of substance misuse and mental health

The following section of our Quality Accounts describes in detail how these priorities will be addressed. We describe how the Trust will measure its performance against agreed standards for these areas, through CQUIN targets and other performance indicators.

Key performance indicators



Priority area 1 – Physical Health: Implementation of Modified Early Warning Scores (MEWS)

These measures build on the developments in improving physical health care for people with mental health problems from previous years.

Rationale

This continues to be a key priority nationally and for our local stakeholders. Research shows that people with serious mental health problems die ten to twenty five years younger than the rest of the population. The evidence of heightened risk of higher mortality from a range of physical health problems has made improving the physical health of our service user's one of the top priorities across all of the professional disciplines in mental health.

Key improvement initiatives

In accordance with the NICE guidelines around best practice for managing physical healthcare, over the past 12 months, we have introduced a 'track and trigger' system across all of our inpatient areas, to make it easy for staff to observe changes in physical observations over time, and to provide clear guidance as to when, and how to escalate concerns over a service users physical health. This allows staff to quickly calculate the state of a patient's physical health. MEWS draw together all aspects of a service user's physical health into a format which can be understood by all professional groups, and also includes a communication framework to ensure that physical health information is shared in a clear and consistent way between disciplines.

Over four months in 2013/14 the practice development nursing team provided training in the process for using this system to a minimum of 80% of staff on each inpatient ward across the organisation. The second phase of MEWS implementation is currently in development in our acute division. In order to ensure that service users who attend our integrated crisis services receive a comparable service with regards to attention to their physical health needs, MEWS will be launched across our crisis services in 2014/15.

Key performance indicators

- MEWS will be launched across our crisis services in 2014/15;
- 80% of our crisis service based staff will be trained in using this approach to monitoring physical health

Priority area 2 – CQUIN: Physical Health

Key improvement initiatives

The key initiatives in this area relate to improved information sharing between primary and secondary care. In 2010/11, 2011/12, 2012/13 and 2013/14 the physical health CQUIN indicators related to building better systems for ensuring that service user information stores in care settings are populated with key data fields for both mental and physical health diagnoses and ensuring that service users are helped to access primary physical health care for high mortality diagnoses. In addition, the CQUIN examined systems for ensuring safety regarding continuity of medication and strong communication across primary and secondary care. These are important patient experience, effectiveness and safety measures that form a basis for shared care to improve the physical health care of patients with mental health problems. Ensuring that we support our service users to stay healthy is an integral part of the work undertaken within Trust services. In 2014/15, this will be further developed with stretched performance targets to ensure improvement continues.

Key performance indicators

There are seven key indicator themes for this priority, set in conjunction with our clinical commissioning organisations:

- The Trust will demonstrate, through the National Audit of Schizophrenia, full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with schizophrenia.
- The Trust will demonstrate through internal audit that the Care Programme Approach (CPA) register has been shared with primary care;
- All relevant mental health and high mortality physical health diagnoses will be recorded on Trust patient administration systems;
- The Trust will demonstrate through internal audit that inpatients and service users on CPA have been supported to access relevant physical health checks and/or screening;
- The Trust will improve the medicines reconciliation of service users admitted to mental health inpatient units through taking a baseline audit of admissions associated with medication non adherence and meeting a target set in line with improvement on that baseline;
- The Trust will provide discharge letters to GPs on discharge from secondary mental health care;
- The Trust will provide copies of care plans to GPs within two weeks of CPA review meetings.

Priority area 3– Creating more systematic and innovative ways of capturing service user reported experience to improve the way we gather and respond to service user and carer feedback

Rationale

Creating more systematic and innovative ways of capturing service user reported experience is a priority for the Trust. The ability to bring a patient's experience closer to the Board, through the use of fast-paced technology is an essential expectation of Monitor's Quality Governance Framework. The Trust's action plans against both Francis and Berwick reports mean that we must be in touch with the users' experience and respond to it continuously. This integrated approach to gathering patient reported experience will be the basis for producing an internal Quality Assurance Framework, a critical component to ensuring the Trust is prepared for CQC inspections and continually ensuring the overall quality of all of its services.

Key improvement initiatives

Patient experience is complex and multifactorial and includes elements centred on services, individual healthcare professionals and also factors which are individual to each patient. Throughout 2014/15 we will be rolling out a new patient feedback tool. The procurement of this system will allow the Trust to capture effectively and report a wide range of patient experience in one platform which can be integrated within our current business intelligence system. This will in turn allow the Trust to meet the need for concise, accurate and timely reporting of patient experience across every service within the Trust. This development is part of our strengthened approach to Quality Assurance. We will focus on creating a system which allows quality assurance processes to be determined, maintained, measured, monitored, reported and continually improved. We must know when services are slipping against any dimension of expected quality at an early stage; we must understand when patient safety might be compromised due to challenges of candour or intolerable levels of risk. The culture of the Trust must be utterly focussed on the fundamentals of care and on allowing our values to thrive.

Key performance indicators

There is one key indicator theme for this priority:

- **The key indicator for this priority theme will be that the Trust successfully implements our new patient feedback tool throughout the Trust which is due to go live on 1st June.**

Priority area 4 – Recovery Oriented Practice

Rationale

We want to continue to increase the quality of life of our service users by working collaboratively with them to set and achieve goals that have meaning and value to them. Recovery oriented approaches seek to reduce relapse through collaborative and empowering engagement between service users and mental health workers. Our indicator here is in line with national policy which has increasingly recognised the importance of creating a mental health system that promotes independence.

The Trust through its recovery model is signed up to the promotion of sustainable recovery, and increasing self-esteem and self-management, and the indicators outlined in this domain aim to monitor how well this recovery approach has been implemented.

Key improvement initiatives

The key initiatives in this area relate to clinical services working collaboratively with service users in setting meaningful goals to promote recovery, increase the quality of life and reduce possible relapse. This collaboration should be evidenced through the care planning process and the key indicators seek to monitor and ensure that this is the case.

Key performance indicators

There is one key indicator theme for this priority:

While we have no CQUIN set for this year, we have developed a local target for 2014/15 that reflects our on-going commitment to recovery oriented working:

- **The Trust will complete a quality audit of recovery-orientated practice.**

Priority area 5 – CQUIN: Smoking cessation

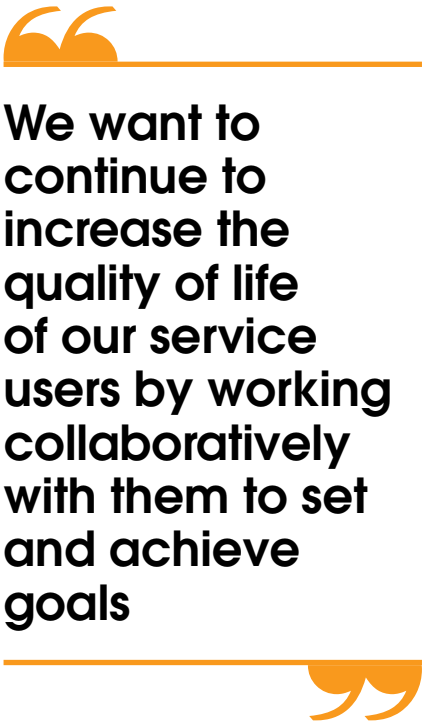
Rationale

Smoking is responsible for most of the excess mortality of people with severe mental health problems. Many mental health service users wish to stop smoking, and can do so with appropriate support. People with mental health problems need good access to services aimed at improving health (for example, stop smoking services).

Helping patients to stop smoking is among the most effective and cost-effective of all interventions the NHS can offer patients. Despite this, however, rates of intervention by healthcare professionals often remain low. Service users wishing to set a quit date should be provided with or referred for ongoing stop smoking support. This significantly increases the likelihood of a successful quit attempt. Where inpatient care is provided, for patients not wishing to set a quit date, provision of Nicotine Replacement Therapy (NRT) on admission can reduce cravings and may encourage patients to consider a quit attempt subsequently.

Key improvement initiatives

Simple advice from a physician or nurse, during routine service user contact, can have a small but significant effect on smoking cessation – more so than Nicotine Replacement Therapy (NRT) alone. Very brief stop smoking advice need only take as long as 30 seconds, and should be encouraged to systematically deliver very brief advice to all smokers at every opportunity, and in selected service user groups, a more proactive offer of assistance. Service users wishing to set a quit date should have anti-smoking treatment initiated and be referred for on-going stop smoking support. This significantly increases the likelihood of a successful quit attempt. For service users not wishing to set a quit date, provision of NRT on admission can reduce cravings.



The aim of this is to support improvement in the identification of smoking status and the stop smoking offer to service users in mental health specialties.

The incentive seeks to improve and ensure the recording of up to date smoking status and increase access to effective support and treatment to stop smoking.

Key performance indicators

There are three key indicator themes for this priority:

- **Smoking status will be recorded for all service users in the Trust;**
- **Trust staff will work with service users to produce mutually agreed care plans for smoking cessation. At least 35% of service users who are smokers will agree and adopt a care plan intervention for smoking cessation;**
- **The Trust will take a baseline audit of successful inpatient and community quits at 4 weeks following initiation of Nicotine Replacement Therapy and will meet a target set in line with improvement on that baseline.**

Priority area 6 – CQUIN: Assessment and management plan for substance misuse and mental health

Rationale

Alcohol-related problems represent a significant share of potentially preventable attendances. Screening for alcohol risk (hazardous and harmful drinking) can be provided effectively in routine patient contact, and has been shown to reduce subsequent attendances and alcohol consumption.

Key improvement initiatives

The vision for urgent care and its improvement here is to facilitate easier access to urgent care services, ensure the most efficient utilisation of resources, and reduce the duplication of urgent care provision and to ensure patients are seen by the most appropriate clinician to meet their needs. This CQUIN will ensure where patients who test positively at screening receive a brief intervention and their registered GP is aware of the result and intervention enabling clinical reinforcement, continuity and clarity of advice and prevention. This extends from an immediate and brief intervention enabling a long term approach as the long term effects of alcohol lead to and contribute to a range of long term conditions (Diabetes, CVD, Liver Disease, cancer, mental health problems) as well as a range of acute conditions.

Key performance indicators

There is one key indicator theme for this priority:

- **The Trust will provide all service users with an assessment and management plan for substance misuse.**

Priority area 7 – CQUIN: Integrated Care

Rationale

Our service users tell us that they want to be more involved in planning their care. Recovery oriented and collaborative care planning is central to contemporary mental health practice. The Trust continues to see integrated working across services as vital to recovery oriented care. We will continue to work to improve on our shared working with primary care services and seek to build on work in previous years to increase our fidelity to the Recovery model.

Key improvement initiatives

The Trust is required to demonstrate that 50% of all care plans for service users on CPA in adult and older adult services show evidence of collaborative care planning and contain 2 personal recovery goals and that input has been requested from the patients GP. The Trust will provide a breakdown of GP responses to the request.

Key performance indicators

There are three key indicator themes for this priority:

- All care plans show evidence of collaborative planning of care between service user and clinician, contain at least two personal recovery goals and show evidence that input has been requested from the patients GP. The Trust will provide a breakdown of GP responses to the request
- Service users seen by the Crisis Team will have crisis plans that show evidence of collaborative care planning, in line with the Advance Decision and Crisis Plan policy. The plans will include individual advanced decisions on early warning of a relapse, as well as preferred early interventions at times of crisis. The plans should set out the actions to be taken, based on previous experience, if the service user becomes very ill or their mental health is rapidly deteriorating.

The Trust has set a number of priority areas for 2014/15 all of which are underpinned by improving patient safety, enhancing the service user experience and further developing the clinical effectiveness of our services. The progress to achieve these priorities will be monitored, measured and reported through our on-going Monitoring Processes (see 4.1.4).

1.5 Quality of services provided

1.5.1 Statements of assurance from the Board

The Board is able to provide the following statements of assurance:

Review of services

During 2013/14, Camden and Islington NHS Foundation Trust provided and/or sub-contracted the following four NHS services:

- Adult Mental Health;
- Services for Ageing and Mental Health;
- Substance Misuse;
- Learning Disability.

Camden and Islington NHS Foundation Trust has reviewed all the data available to it on the quality of care in each of these NHS services.

The income generated by the NHS services reviewed in 2013/14 represents 100% of the total income generated from the provision of NHS services by Camden and Islington NHS Foundation Trust for 2013/14.

The Trust has been able to review data for each of these services in the areas of patient safety and clinical effectiveness. It has also been able to review data relating to patient experience for Adult Mental Health, Services for Ageing and Mental Health and Substance Misuse, through the use of the Trust's Patient Experience Tracking programme.

Participation in clinical audits and national confidential enquiries

Enquiries and audits are key regulatory requirements of NHS care providers. Standards in this area are a major component of CQC essential outcome 16 (assessing and monitoring the quality of service provision) and the Trust must also work to meet the national clinical audit requirements of the Healthcare Quality Improvement Partnership (HQIP) and the NHS Litigation Authority (NHSLA) among others.

During 2013/14, two national clinical audits and one national confidential enquiry covered relevant health services that Camden and Islington Foundation Trust provides.

During that period Camden and Islington Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Camden and Islington Foundation Trust was eligible to participate in during 2013/14 are as follows:

- Monitoring of patients prescribed lithium Prescribing Observatory for Mental Health (POMH)
- National Audit of Schizophrenia
- Confidential enquiry into suicide and homicide by people with mental illness (CISH)

In comparison, the national clinical audits and national confidential enquiries that Camden and Islington Foundation participated in during 2012/13 were as follows:

- Monitoring of patients prescribed lithium Prescribing Observatory for Mental Health (POMH)
- National Audit of Psychological Therapies
- National Audit of Schizophrenia
- Confidential enquiry into suicide and homicide by people with mental illness (CISH)

The national clinical audits and national confidential enquires that Camden and Islington Foundation Trust participated in, and for which data collection was completed during 2013/14, 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.

Table 1.1

	Cases Submitted	% of cases required
National confidential enquiry into suicide and homicide by people with mental illness (CISH)	11	100%*

*The Trust has 5 cases currently being reviewed for inclusion in this audit.

National audit of schizophrenia (Audit of practice 45/100, Service User Survey -18/200, Carers Survey – 7/200)

Monitoring of patients prescribed lithium Prescribing Observatory for Mental Health (POMH) - 44 patients were included in the 2013, second supplementary audit.

The reports of two national clinical audits Monitoring of patients prescribed lithium and National Audit of Learning Disabilities – Pilot Feasibility Study were reviewed by the provider in 2013/14.

Results from the national clinical audit programme administered by the Healthcare Quality Improvement Partnership (HQIP) are available at the HQIP website: www.hqip.org.uk/national-clinical-audit/

Monitoring of patients prescribed lithium

The Prescribing Observatory for Mental Health (POMH-UK) runs national audit based quality improvement programmes open to all specialists' mental health services in the UK. 57 Trusts participated in the second supplementary audit of lithium monitoring for 2013 with the first occurring in 2011. Each Trust was invited to include as many services as wished in the audit however patients could only be included if they were currently receiving lithium.

After receiving the results of the audit, an action plan has been agreed and re-audit will occur in specific divisions at regular intervals for the monitoring of progress. GPs also queried how they should communicate results with the Trust with current guidance stating the GP should inform in the case of an abnormal result. Actions to improve the quality of healthcare are as follows:

- Contact POMH to request communication with Trusts who have significantly improved performance since the previous audit
- Identify gaps in sharing information
- Work with CCG and divisional leads to improve communication and monitoring of results between the Trust and GPs
- Distribution of patient booklets for inpatient and community teams
- Updated lithium guidelines for better direction in regards to staff

The National Audit of Schizophrenia (NAS) audit

The National Audit of Schizophrenia (NAS) is managed by the Royal College of Psychiatrists' (Psych) College Centre for Quality Improvement (CCQI). It is funded by, and part of, the National Clinical Audit and Patient Outcomes Programme (NCAPOP), managed by the Healthcare Quality Improvement Partnership (HQIP). Common themes identified as the most important concerns faced by this group of service users included:

- Physical health monitoring – concerns that basic health checks were not being routinely carried out and a lack of clarity as to whose responsibility it was to complete them, e.g. community mental health teams or GPs. The service users wanted information and support so that they could take more responsibility to improve this.
- The need for information to be available in an accessible format that would enable service users to make informed choices about their care, which recognised the importance of physical and mental health and how both need to be considered when making treatment decisions, e.g. sharing information to consider a risk benefit assessment about medication in partnership with the service user.
- Being listened to and actively involved in their care, being respected and professionals being honest and non-patronising.
- Practical support for a 'normal life', e.g. socialising, employment opportunities.

Local audits

The Trust conducted 131 of local clinical audits the reports of which were reviewed by the provider in 2013/14. Camden and Islington NHS Foundation Trust uses the outcome of all audits to improve the quality of healthcare provided. Below are a few examples of changes made as a result of audits:

- The Trust will maintain and improve levels of client satisfaction
- The Trust will ensure good relations and communications with primary care
- The Trust will encourage clinicians to record reviews on RiO
- The Trust will implement local guidelines for the completion of care plans with regular reviews in addition to agreement and circulation of local policy
- The Trust will encourage smoking cessation and have more dedicated care plans towards quitting smoking.

The Trust has worked diligently in 2013/14 to continue to develop its programme of clinical audit to enhance and encourage clinician participation in this important work.

Camden and Islington NHS Foundation Trust has seen the introduction of the Quality Improvement Projects (QIP), which encourages all professions and disciplines to continuously look at areas for improvement in their place of work. Encouragingly, staff have taken an interest to participate in these projects. In 2014/15 the work from complete projects will be shared at a Quality Improvement forum, so that outcomes can be disseminated.

All professions and disciplines contribute to clinical audit across all services through the balanced scorecard programme and the active programme of local audit in all Divisions. Structures are in place locally within Divisions to encourage audit projects, monitor their progress and analyse and share their results. The findings and information accrued by these local groups are then shared at the Divisional Performance Meeting and the Trust's Quality Committee. The Governance and Quality Assurance Team are responsible for co-coordinating clinical audit centrally within the Trust.

Since 2006, the Governance and Quality Assurance Team has organised the bi-annual clinical audit event where clinicians can present the findings of their audits to their peers. In 2013/14 the prize-fund element was continued whereby the author of the best audit presentation, as agreed by a judging panel, was awarded a grant of £300 towards their personal professional development. One Clinical Audit event was hosted by the team in 2013/14.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Camden and Islington NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 448. Throughout the year, the Trust has been involved in 45 studies; 33 were funded (of which 1 were commercial trials), and 12 were unfunded.

Over the past year researchers associated with the Trust have published 103 articles in peer reviewed journals.

Quality and Innovation - The CQUIN framework

A proportion of the Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between Camden and Islington NHS Foundation Trust and any person or body it entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

For 2013/14, CQUINs were agreed with commissioners covering the following areas:

- Improving the physical health care of patients with mental health problems;
- Ensuring fidelity to the recovery model through collaborative care planning;
- Facilitating smoking cessation;
- Increasing successful completions for service users in drug treatment.

The quality areas included in the CQUIN framework for 2014/15 are:

- Implementing the staff Friends and Family Test
- Reporting on NHS Safety Thermometer outcomes for the incidence of a reported grade 2, 3 or pressure ulcer (old or new)
- Improving the physical health of patients with MH problems and good practice communication
- Encouraging more successful quits among patients who smoke by improving the stop smoking offer for patients seen by mental health services in North Central London.
- Improving the proportion of service users admitted within the period where no adherence with prescribed medication is recorded as a contributory factor.

The amount of income for both 2012/13 and 2013/14 conditional upon the achievement of quality improvement and innovation goals through the Associate Commissioner Agreements was £1,922,464 in 2012/13 and £2,049,726 for 2013/14.

1.5.2 Statements from the Care Quality Commission (CQC)

Camden and Islington NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditionally registered.

The Care Quality Commission has not taken enforcement action against Camden and Islington NHS Foundation Trust during 2013/14.

Camden and Islington NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust registers all of its services under two main locations

- St Pancras Hospital, and
- Highgate Mental Health Centre

All Trust services are then listed as subsidiaries of either of these two locations from which we are registered to provide a number of regulated activities.

As at the end of 2013/14, the Care Quality Commission had externally assessed eleven of the Trust's registered locations as part of the their formal Compliance Inspection programme; the CQC carried out an inspection of the Trust's services in Camden across a care pathway. The new model of inspection was used, which involves desk top scrutiny, front line visits and interviews with staff and service users. The team of nine inspectors between them visited the following services:

- North and South Camden Crisis Resolution Teams;
- Clozapine Clinic at the Hoo;
- Medication Clinic at the Peckwater Centre;
- North and South Camden Recovery Teams;
- Assessment Service;
- Wards at the Huntley Centre, St Pancras Hospital; and
- Community team of the Service for Ageing and Mental Health.

The Trust has implemented a robust action plan to ensure compliance with every element of each outcome that has led to the two moderate concerns associated with two standards (Outcome 2: Consent to Care and Outcome 4: Care and Welfare of People who use services). This is being monitored jointly with divisional managers at a weekly Quality Review Group which is chaired by Claire Johnston, Executive Director of Nursing & People.

In addition to a Camden Care Pathway inspection, which saw 9 discrete services inspected the commission also undertook two further compliance inspections of the Camden Specialist Alcohol Service and Stacey Street nursing home. The CQC provided extremely positive assessment reports and found us compliant with all quality standards at Camden Specialist Alcohol Service. There is one moderate concern in regards to a service provided at Stacey Street, but the CQC found positive improvement in 5 of the 6 essential standards including Outcome 4: Care and welfare of people who use services (People should get safe and appropriate care that meets their needs and supports their rights) which during the last CQC inspection in February 2013 had been judged to be non-compliant. This demonstrates that the action plan which was implemented to ensure and assure compliance by 20th May 2013 has been achieved.

Notwithstanding the positive improvements, the draft report indicates areas of non-compliance in regards to Outcome 9: Medicines Management. An action plan has been implemented to ensure and assure compliance by 31st May 2013. The specific actions being taken to assure and ensure compliance are detailed in an action plan which has been reviewed and signed off by Trust's Quality Review Group which includes senior staff and local commissioners.

Under Regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, on the 13th November 2013 the Trust submitted the report on actions to the CQC.

The Quality Committee has an important role in overseeing the response to CQC inspections and monitoring progress against associated action plans and to provide assurance to the Board.

1.5.3 Data Quality

In 2013/14 The Trust set the following actions with regard to data quality;

- To introduce a Trust Information Assurance Framework
- To agree a set of data quality indicators linked to CQUIN targets for monthly monitoring at the divisional performance meetings and quarterly monitoring with the lead commissioner;
- To continue to monitor the implementation of Data Quality Policy (2012) through regular audit;
- To further development of data quality and performance dashboards;
- To continue to develop our processes to ensure the effective and efficient implementation of pseudonymisation in line with Department of Health guidelines.

We are pleased to report that all of these actions have all been undertaken.

Going forward into 2014/15 Camden and Islington NHS Foundation Trust will be taking the following actions to improve data quality:

Table 1.2

Action	Rationale	Deadline
Continuation of MH Tariff clustering data completeness and cluster accuracy processes, in line with national standards	To provide more robust data for commissioning and care pathway analysis	Dec 2014
Alignment of MHMDS/ MHLDDS national reporting output with local performance frameworks	To provide consistent and transparent correlation between publicly available external metrics and local internal reporting	April 2015
Review and update the Trust Data Quality Policy in line with changing data and technology environments, monitoring its implementation through a series of audits	To provide clarity on roles and responsibilities for data quality for all staff during the transition from the national ICT system contract	April 2015

With the move towards MH Tariff and the focus on the Mental Health Minimum Dataset (MHMDS), the Trust completed the monthly submission cycle throughout 2013/14. Data quality was monitored for each submission, with NHS Number compliance above 99.7% for each submission. GP practice code and code of commissioner also exceeded 96.4% and 99.4% for each of the submissions. Missing data items were validated as people not registered with a GP Practice or overseas visitors.

Throughout 2013/14 the Data Quality Group has continued to meet on a monthly basis to co-ordinate the implementation of the data quality strategy and monitor performance against data quality standards. To assist this process and to provide real-time information for service managers and clinicians, the Trust has continued its development of electronic activity and data quality dashboards.

1.5.4 Information Governance Assessment Report attainment levels

The Trust's Information Governance Toolkit Assessment Report overall score for 2013/14 was 78% and was graded 'satisfactory'; this is one percentage point down from the previous year following a review of the IG Toolkit undertaken by Information Governance Manager (appointed in February 2014). This assessment provides an overall measure of the quality of data systems, standards and processes within an organisation. The Trust scored level two or above on all 45 requirements.

The Trust achieved 95% compliance in regards to the IG training and this resulted in the **'not satisfactory'** score for year 2012/13 to be lifted in this year's submission. An action plan will be implemented to ensure 95% of staff or above complete their Information Governance training and ensure a grade of satisfactory is maintained for next self-assessment. A full improvement from last year's submission will take place for all requirements to further build on the quality and standard of evidence presented.

1.5.5 Clinical coding error rate

Responsibility for the data assurance framework has moved, since 2012/13, from the Audit Commission to the Department of Health. C&I was one of the 25 mental health Trusts which volunteered to participate in the reviews. The review found that the Trust's quality of costing was adequate (possible outcomes are good, adequate or poor). Our cluster error rates were average, with 58% having no errors (against a national mean of 60%).

1.6 Review of Quality Performance

The Quality Accounts process requires that Trusts identify three key quality performance indicators for each of three quality domains: safety, effectiveness and patient experience. The Trust's performance on each of these indicators during the financial year (and in previous years where available) is set out below, along with a description of the construction of the indicator. This is usually done by working out a percentage of reviewed cases that meet an agreed standard. The percentage is worked out using relevant numerators and denominators for each indicator.

1.6.1 Safety

The Trust has selected the following three indicators to represent the safety domain:

- The proportion of Trust inpatient service users (Services for Ageing and Mental Health) who received assessment through the Malnutrition Universal Screening Tool (MUST) within 72 hours of admission;
- The proportion of service users receiving physical health assessments in line with Trust policy for inpatient, community and residential and rehabilitation based services;
- The proportion of staff reporting errors, near misses or incidents witnessed in the last month (from the annual CQC Staff Survey 2012).

i.Compliance with standards of MUST policy

The 'Malnutrition Universal Screening Tool' (MUST) is a validated, evidence based tool designed to identify individuals who are malnourished or at risk of malnutrition (under-nutrition and obesity). The use of MUST is included in NICE guidelines to tackle the issue of malnutrition and its use is particularly important for services such as those for older people.

Numerator

All service users admitted to inpatient services at the time of the (quarterly) audit receiving a MUST assessment within 72 hours of admission[1].

Denominator

All service users admitted to inpatient services at the time of the (quarterly) audit.

Reporting

This is audited and reported internally through the balanced scorecard process with results provided to commissioners as part of the Service Quality Improvement Plan which is presented to the Clinical Quality Review Group.

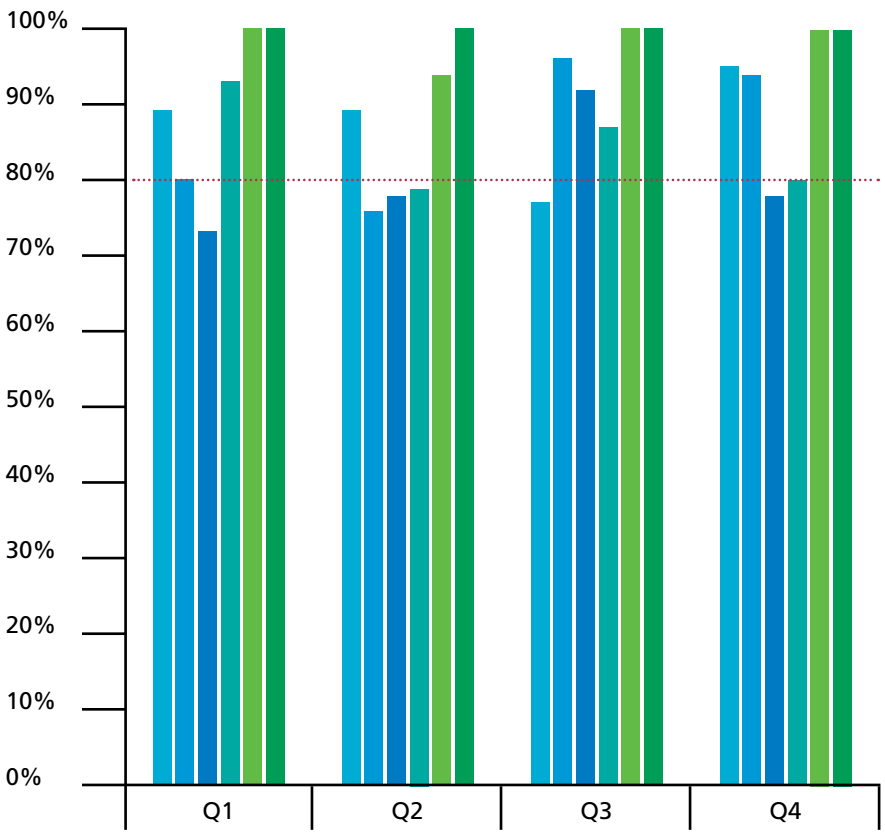
Table 1.3: Performance figures (proportion of audited cases complying with policy)

	Q1	Q2	Q3	Q4
2008/09[2]	89%	89%	77%	95%
2009/10	80%	76%	96%	94%
2010/11	73%	78%	92%	78%
2011/12	93%	79%	87%	80%
2012/13	100%	94%	100%	100%
2013/14	100%	100%	100%	100%

[2] This figure includes all service users receiving a MUST assessment within 72 hours and those for whom a transfer to/from general acute care necessitated a clinically acceptable deferment of assessment. As of 2011/12, admissions to acute wards are no longer categorised by the age of the service user within the new acute service lines. As such, the figures from 2011/12 onwards cover all acute wards.

Compliance with standards of MUST Policy

Target 2013/14: 80%



ii. Compliance with Physical Health Assessment Policy

The association between severe mental illness and physical health problems is well established with the life expectancy of people with severe mental illness being nine years less than that of the general population (Disability Rights Commission 2006). People with a mental illness are at a greater risk of premature mortality than the general population. The Trust has agreed policies and protocols for ensuring our service users receive effective physical health assessment and the implementation of these[3] policies is measured through the balanced scorecard process. Measures for monitoring liaison between primary and secondary care in relation to physical health care are also included in the CQUIN indicator set.

Numerator

All current service users in Residential & Rehabilitation and inpatient services and a percentage of community service users at the time of the (quarterly) audit with evidence of physical assessment being offered in the preceding 12 months.

Denominator

All service users in Residential & Rehabilitation and inpatient services and a sample of Community Mental Health Team service users at the time of the (quarterly) audit.

Reporting

This is reported internally through the quarterly balanced scorecard process with results provided to commissioners as part of the Service Quality Improvement Plan which is presented to the Clinical Quality Review Group and the Trusts Quality Committee.

[3] This figure includes all service users receiving a MUST assessment within 72 hours and those for whom a transfer to/from general acute care necessitated a clinically acceptable deferment of assessment. As of 2011/12, admissions to acute wards are no longer categorised by the age of the service user within the new acute service lines. As such, the figures from 2011/12 onwards cover all acute wards.

Action plan

The Trust has improved the overall quality of its services by prioritising physical health assessments across Trust services and maintaining the Physical Health CQUIN as a quality priority throughout 2013/14. This will support the continued improvement of performance compliance in this area. Our detailed analysis of data shows that we must increase our focus on physical health in Community Mental Health Teams. We have created Community Matron Posts with this remit and plan to launch our MEWS scheme across our community crisis services from Q1 2014/15.

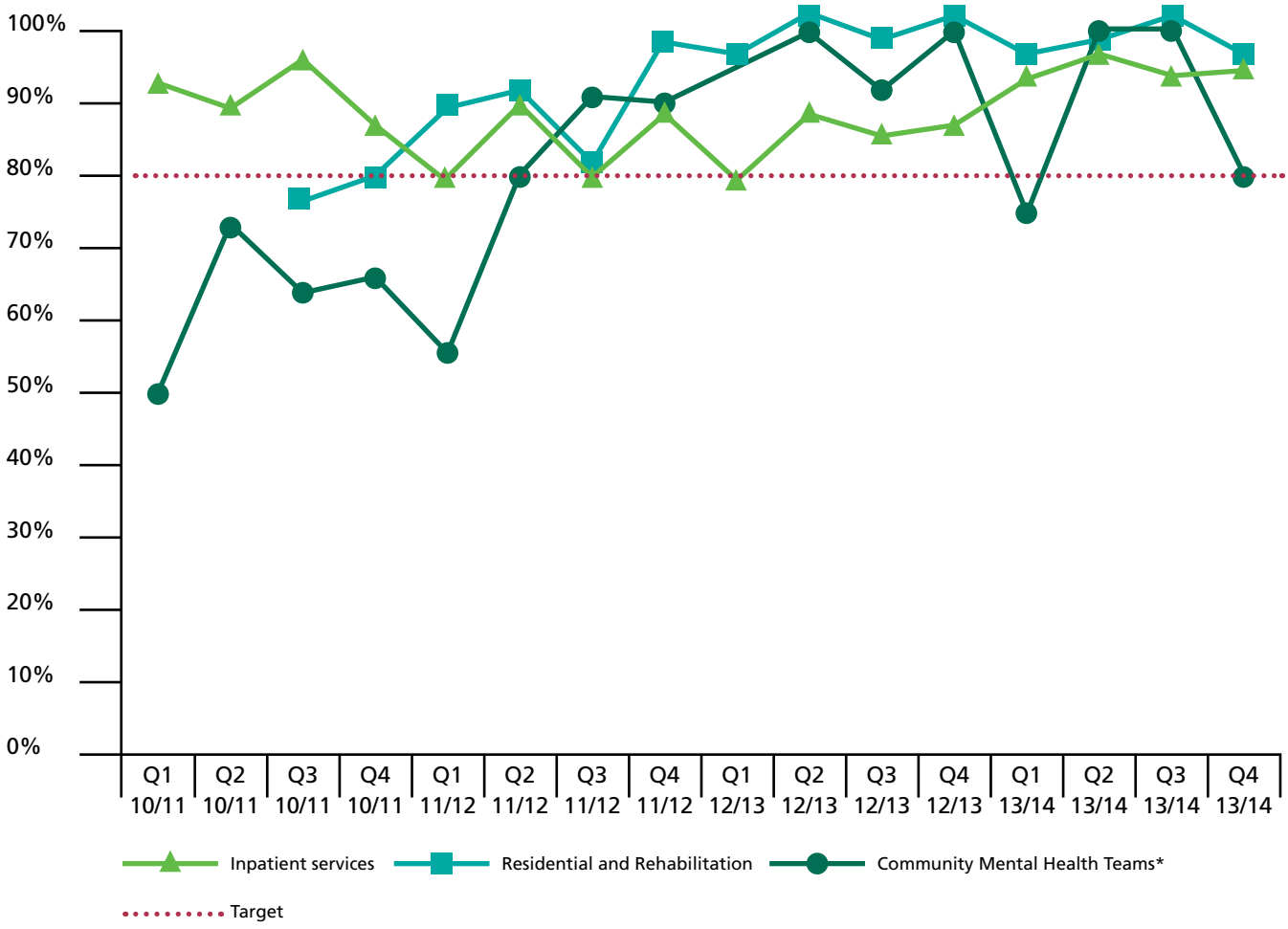
Table 1.4: Performance figures

Year	Division	Q1	Q2	Q3	Q4
2008/09	Inpatient services	88%	93%	80%	82%
	Residential & Rehabilitation services	78%	73%	74%	93%
2009/10	Inpatient services	67%	73%	72%	84%
	Residential & Rehabilitation services	86%	91%	94%	95%
2010/11	Inpatient services	93%	90%	96%	87%
	Residential & Rehabilitation services	N/A	N/A	77%	83%
	Community Mental Health Teams*	50%	73%	64%	66%
2011/12	Inpatient services	80%	90%	82%	99%
	Residential & Rehabilitation services	90%	95%	77%	83%
	Community Mental Health Teams	56%	80%	91%	90%
2012/13	Inpatient services	88%	89%	86%	87%
	Residential & Rehabilitation services	97%	99%	99%	100%
	Community Mental Health Teams	No data	100%	92%	100%
2013/14	Inpatient services	94%	97%	94%	95%
	Residential & Rehabilitation services	98%	99%	100%	97%
	Community Mental Health Teams	75%	100%	100%	80%

Target 2013/14: 85%

*A different measure was audited in Q1 and Q2: if the service user has identified physical health needs, do they have a current support plan addressing these needs.

Compliance with Physical Health Assessment Policy



*A different measure was audited in Q1 and Q2: if the service user has identified physical health needs, do they have a current support plan addressing these needs.

iii. Proportion of staff reporting errors, near misses and incidents witnessed in the month prior to the annual CQC survey

The CQC undertakes an annual survey of staff for all NHS Trusts and one area the questionnaire addresses is the reporting of errors, near misses and incidents. The Trust seeks incident reporting and learning from incidents and to create an environment whereby staff are encouraged and facilitated to report.

Numerator

The number of staff indicating in the annual CQC staff survey that they had witnessed an error, near miss or incident in the month prior to their completion of the survey questionnaire who had also indicated that they had reported this.

Denominator

The number of staff indicating in the annual CQC staff survey that they had witnessed an error, near miss or incident in the month prior to their completion of the survey questionnaire.

Table 1.5: Performance figures

Year	Trust Score	National Median
2008	92%	97%
2009	90%	97%
2010	98%	97%
2011	94%	97%
2012	96%	98%
2013	92%	92%

Trust scores here have gone down compared to last year, although we remain on a par with the National Average for this indicator.

1.6.2 Effectiveness

The Trust has selected the following three indicators to represent the effectiveness domain:

- The proportion of service users receiving a weekly review of their inpatient care plan;
- The proportion of inpatient service users whose stay was 100 days or more;
- Recovery rate in Improving Access to Psychological Therapies (IAPT).

i. Frequency of review of care plans in inpatient services

It is important for services to react swiftly to changes in our service users' mental and physical state and to their personal circumstances and we must be quick to review and amend care plans to reflect these changes. The Trust Care Programme Approach (CPA) Policy outlines the standards expected of our care teams in this area. A measure to monitor this is included in the balanced scorecard process for inpatient services.

Numerator

All service users currently admitted to inpatient services at the time of audit with evidence that their care plan has been reviewed in the seven days preceding the audit.

Denominator

All service users currently admitted to inpatient services at the time of audit.

Action plan

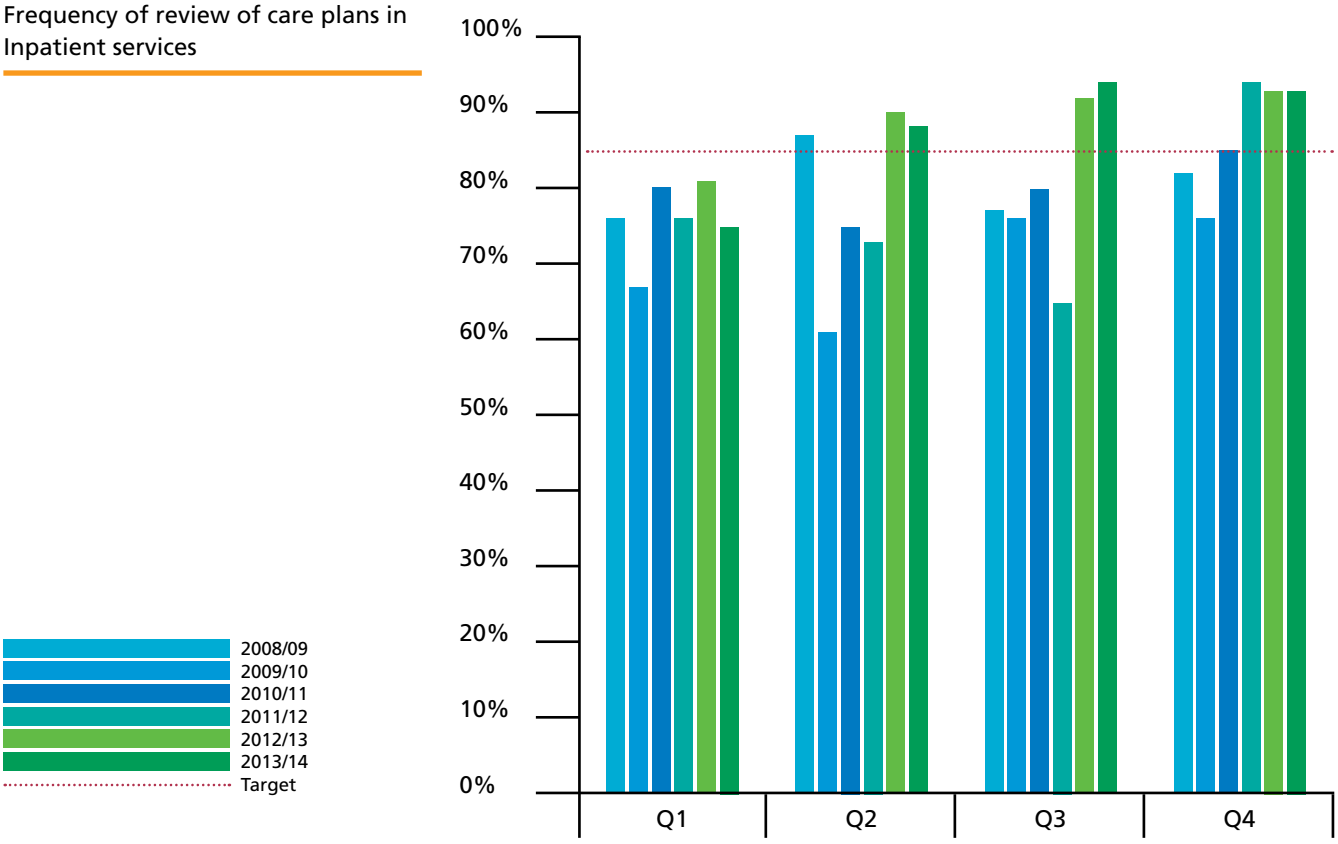
The Trust's historical performance differs across teams and divisions for this indicator. In 2011/12 while several teams are meeting the target consistently, others are performing less well. Performance against this indicator is monitored and reviewed at monthly divisional Performance Review Meetings. Actions taken to address low performance are taken at ward level, with outcomes against this indicator being published in clinical areas on a weekly basis. With the exception of a slight drop in performance in Q.1 2013/14 the action the Trust took to improve these percentages and so the quality of its services in 2012/13 has been maintained throughout 2013/14. This performance is reflected in the table.

Table 1.6: Performance figures

	Q1	Q2	Q3	Q4
2008/09	76%	87%	77%	82%
2009/10	67%	61%	76%	76%
2010/11	80%	75%	80%	85%
2011/12	76%	73%	65%	94%
2012/13	81%	90%	92%	93%
2013/14	75%	88%	94%	93%

Target 2013/14: 85%

Frequency of review of care plans in Inpatient services



ii. Average length of stay – Stays of three months or more

The Trust monitors its average length of stay for inpatient care spells to ensure that there is effective provision of care across inpatient and community-based services. As one aspect of average length of stay monitoring, in 2011/12 the Trust set, through a review of historical and benchmarked bed usage, an internal target of no more than 20% of inpatient stays being 100 days or longer. This is part of the process of ensuring that the realignment of services based on care pathways is better able to meet the needs of service users by ensuring that community services are proving able to maintain service users in the community, rather than in inpatient settings.

Numerator

Number of inpatient discharges per quarter whose length of stay is more than three months.

Denominator

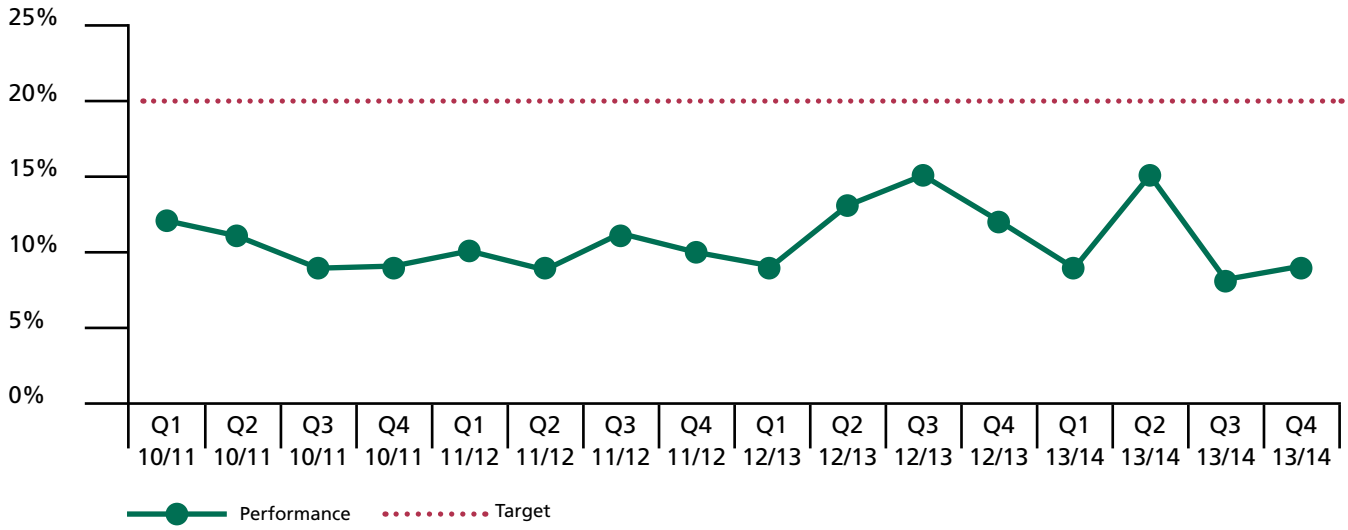
Number of inpatient discharges per quarter.

Table 1.7: Performance figures

	Q1	Q2	Q3	Q4
2010/11	12%	11%	9%	9%
2011/12	10%	9%	11%	10%
2012/13	9%	13%	15%	12%
2013/14	9%	15%	8%	9%

Target 2013/14: <20%

Compliance with Physical Health Assessment Policy



The target for percentage of admissions over 100 days was set within the Trust for the Balanced Scorecard programme at <20%. The Trust continues to experience bed pressures across its inpatient services. Despite this, ALOS and LOS over 100 days have continued to decrease.

iii. The number of people who are moving to recovery in IAPT services

The Improving Access to Psychological Therapies (IAPT) programme was launched in 2007. It aims to investigate ways to improve the availability of psychological therapies, especially relating to people with depression or anxiety disorders. It also aims to promote a more person-centred approach to therapy. This measure aims to assess the rate of successful treatment outcomes for the services.

Numerator

Number of service users completing treatment with IAPT services in the quarter who had recovered (i.e. who no longer met the criteria for depression or anxiety) at their final treatment session.

Denominator

Number of service users completing treatment with IAPT services in the quarter who at assessment had scores in the clinical range.

Table 1.8: Performance figures

	2010/11	2011/12	2012/13	2013/14
Camden	631 / 1706 (37%)	603 / 1622 (37%)	680 / 1684 (40%)	582 / 1512 38.5%
Islington	675 / 1740 (39%)	786 / 2053 (38%)	701 / 2009 (35%)	701 / 1909 36.7%
Kingston	102 / 259 (39.4%)	89 / 228 (39%)	87 / 229 (38%)	123 / 332 (37%)

Target 2013/14 – Camden: No target – aiming towards 50% for 2014/15, Islington: 38%, rising to 40% in Q.4.

The Trust continues to perform below target for this indicator. When the data for this year is broken down into quarters over the year there has been a steady increase in uptake of IAPT.

Islington

The Islington Recovery Rate has achieved above 40% for Q4 as required and for the year is at 37.6% against target of 38%. This is initial data and we expect this figure to go up slightly in the coming weeks. Part of the Recovery Action Plan which allowed this positive performance was increasing the number of sessions with those who are close to recovery to ensure that where possible they do recover, this has had an impact on the numbers entering treatment and explains the drop in numbers into treatment (though remaining above end of year target at 13.8% against target of 12.25%)

Camden

Camden Recovery Rate is up on previous quarter as the service continues to improve towards 2014/15 target. Numbers entering treatment remains above target for Q4 and 2013/14. The Camden numbers into treatment has gone up from Q2 and remains above target. Numbers are also above the identified aim of achieving 10% over target entering treatment this year. Recovery rate has dropped from 40% to 37.5% but remains within the usual range for the service. The service will continue to monitor this closely as part of implementing the Camden IAPT Action Plan initiatives.

The Trust also provides IAPT services in Kingston. The Kingston recovery rates have only slightly dropped from Q2 at 38.3% to 37.8% and the service continues to work towards the 41% Q4 target. There has been a significant improvement in numbers entering treatment increasing from 2.1% in Q2 to 3.5% in Q3. The service continues to closely monitor numbers in to treatment and has a detailed action plan in place.

The Trust has taken the following actions to improve the recovery rates, and so the quality of its services, by working in partnership with commissioners to aid recovery:

- The service is actively investigating why recovery rates are falling. A service recovery plan is being finalised detailing the service's strategy for improving recovery rates and will be presented at the next Integrated Primary Care Mental Health Group in May.
- The service plans to monitor average number of treatment sessions and to offer extra follow-up sessions for those discharged to ensure that recovery has continued.
- Current audits are looking at the "inclusive" criteria for entry into IAPT Services and its effect on recovery rates. It is possible that the inclusion of certain cluster groups in IAPT could be bringing down the overall recovery rate of the service.
- Currently undertaking research in conjunction with University College London (UCL) looking at C&I IAPT patients to investigate factors influencing recovery rates.
- Significant work undertaken to address waiting times for treatment – resulting in vast improvements in Q4.

1.6.3 Patient experience

The Trust has selected the following three indicators to represent the patient experience domain:

- the number of carers receiving advice or services following a carer's assessment;
- the proportion of service users in inpatient services (and particularly Psychiatric Intensive Care Units or PICU) being offered at least 4 activities per week;
- PLACE (Patient-Led Assessments of the Clinical Environment) assessment scores.

i. Advice and services to carers

The needs of carers are of paramount importance. Ensuring the well-being of carers is a significant factor in also ensuring the wellbeing of the people for whom they care.

Numerator

The number of carers receiving a 'carer's break' or other specific carers' services, or advice or information, during the year following a carer's assessment or review.

Denominator

The number of adults receiving a community-based service during the year.

(Performance for previous years is provided in the table below)

Performance figures (historical):

Between 2008/09 and 2010/11 targets for advice and services to carers were set separately by commissioners in the boroughs of Camden and Islington and targets have been formatted differently as either absolute numbers of carers or as percentages of the overall number of carers. They have also in different years been set either separately for adults of working age and older people, or as a joint target. This has made trend comparisons complex. We now have comparable data.

Table 1.9: Performance figures (2013/14)

2011/12	Target	Performance
Camden	30%	28%
Islington	25%	26%
2012/13	Target	Performance
Camden	35%	25.91%
Islington	27%	26.5%
2013/14	Target	Performance
Camden	35%	19%*
Islington	28%	26%

*As at the end of February, March data has not yet been provided

ii. Provision of activities in inpatient teams (with particular reference to PICU)

The provision and encouragement of occupational therapy and leisure activities are a vital component of recovery within mental health inpatient services. This provision has been monitored by the Trust through its balanced scorecard process for several years and quarterly audits check to see whether individual service users have been offered or taken up at least four activities per week.

Numerator

The number of service users currently admitted to inpatient services at the time of the audit with evidence that they had been offered or taken up at least four occupational therapy, art therapies, or other leisure activities in the seven days preceding the audit.

Denominator

The number of service users currently admitted to inpatient services at the time of audit.

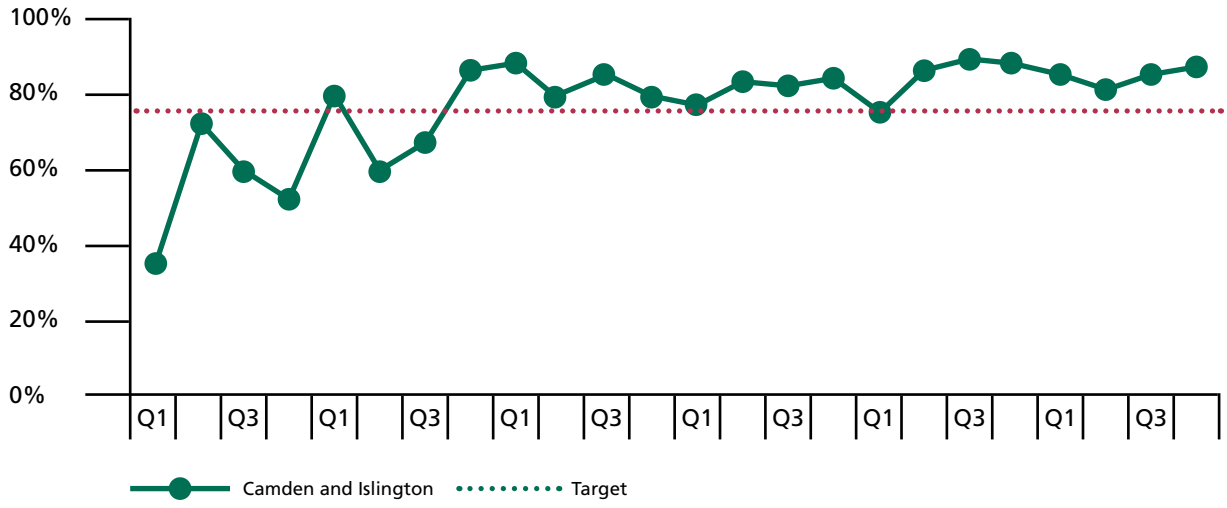
Action plan

The Trust is meeting the target set and showing steady improvement over the year. Data against this indicator is reviewed as part of the balanced scorecard audits. Although there was a slight decline in the Trust average in Q2, the Trust remains above the target of 75% for both quarters. Most wards have activity co-ordinators who ensure there are a variety of activities planned throughout the week.

Table 1.10: Performance figures

	Q1	Q2	Q3	Q4
2008/09	35%	72%	59%	52%
2009/10	80%	60%	67%	86%
2010/11	88%	79%	85%	79%
2011/12	77%	83%	82%	84%
2012/13	74%	86%	89%	88%
2013/14	85%	81%	85%	87%

Provision of activities performance chart



iii. PLACE (Patient-Led Assessments of the Clinical Environment assessment scores

PLACE (Patient-Led Assessments of the Clinical Environment) replaced PEAT in 2013/14, although the areas focused on remained essentially the same: environment, privacy and dignity, the food and food service and cleanliness. There was a requirement that at least 50% of the assessment team was comprised of service users, with an objective of putting service users in the driving seat for improvements.

All wards at St Pancras and the Highgate Mental health Centre (HMHC) were visited and assessed for cleanliness, privacy and dignity and against environmental standards. Two wards on each site were visited for the food assessment. PLACE auditors take a detailed look at all aspects of the environment. With regards to cleaning, every room has a list of items that need to be checked to see if they are satisfactory. Each item has to be marked as "pass" "fail" or "qualified pass" – this would be acceptable if a service user had just spilled coffee on their bedside table. A list of the comments made by the assessors for each unit visited were sent them to the site manager and Matrons/Service Managers, and also a report went to BBW (now Cofely) highlighting any areas for improvement. Action plans were produced by BBW and follow-up audits were carried out to ensure improvement. All six sites passed the PLACE assessments for 2013, Privacy, Dignity and Wellbeing.

Our PLACE (Patient-Led Assessments of the Care Environment) inspections in the summer of 2013 ranked C&I 40th out of 275 organisations that participated, putting C&I in the top 15%.

Table 1.11: Performance figures

Percentage of Trust sites rated as "Good" or "Excellent"	Environment	Food	Privacy and dignity
2009	100%	86%	100%
2010	78%	100%	100%
2011	100%	100%	100%
2012	100%	100%	100%
2013	Data not available until October 2014		

1.6.4 Review of Monitoring Processes

Progress to achieve our priority areas for improvement for 2014/15 (as set out at 2.1 will be monitored, measured reported through our on-going Monitoring Processes detailed here:

Balanced Scorecard process

The Trust completed its twelfth year of balanced scorecard service improvement work. The balanced scorecards for services are developed on an annual basis with performance indicators being amended to follow Trust and service need and targets being stretched. Balanced scorecards are produced for the vast majority of clinical teams with aggregated scorecards for service types and boroughs providing an overall summary of Trust performance. The measures chosen for inclusion reflect both national and local priorities and are categorised into four domains; service user outcomes, service user processes, resources and lifelong learning. Many of the quality indicators included in these Quality Accounts are monitored quarterly through the balanced scorecard process. The completed scorecards for each quarter are discussed at Trust-wide and local forums and action plans are produced at a team level to address any concerns raised in each report.

The balanced scorecard process is a key part of the Trust's commitment to encouraging and monitoring multi-disciplinary participation in audit, reflective practice and continuous quality improvement.

To enhance monitoring, the presentation of the balanced scorecards was revised for 2013/14 to include identification and analysis of consecutive red ratings of either results or action plans at a Divisional level. This overview has been included as part of the Trust's Performance Framework when reviewing Quality at monthly divisional performance meetings. Further lessons learned from clinical audit will be disseminated via the Governance and Quality Assurance Newsletter to share audit results within the Trust. It will be published twice a year. Key audit results are also communicated at Clinical Audit Events and via the weekly communications bulletin.

Performance Framework

To support the further development of the Service Line Management model within the Trust, there was a need to establish and embed a performance management framework that provides accountability and transparency in relation to the delivery of performance metrics and business plans.

The framework clearly sets out the Trust's performance management arrangements and how these will operate to support and drive divisional performance, and the delivery of local and national key performance indicators (KPIs) and targets.

The implementation of a revised performance framework in April 2013 following board sign off is expected to further embed the performance review strategy. It establishes consistent definitions for each risk rating and requirements for quarterly summaries to the Board as part of the integrated performance report.

Monthly Divisional Performance Meetings

In line with the overarching performance framework each division/operational department has monthly performance review meetings with the Chief Operating Officer. The meetings take place on the third Monday of each month. Performance review meetings are attended by members of the divisional/departmental team, and a representative from the corporate performance, HR, finance and information teams. On a quarterly basis, performance review meetings are attended by the Chief Executive, Director of Nursing and People, Deputy Chief Executive/Medical Director, Finance Director and Director of Integrated Care. Corporate departments have performance review meetings on a quarterly basis.

Quarterly Performance Reports

The Trust Board receives a quarterly performance monitoring report covering all national indicators and assessment processes, agreed quality indicator sets for commissioning bodies and locally derived quality measures.

In 2013/14 the Trust took a much more joined-up approach to using our Quality Accounts. The approach involved making a direct link between the Quality Accounts and a Trust's Quality Strategy, the former being seen as both the internal and external communication method for the latter. From Q.1 2013/14 the quarterly performance report to board included a quality report section to the board that mirrors the content of the Quality Account. Where the necessary data was made available by the Health and Social Care Information Centre, a comparison was provided within the integrated performance report to the board of the numbers, percentages, values, scores or rates for mandated national indicators with:

a) The national average for the same; and

b) Those NHS Trusts and NHS Foundation Trusts with the highest and lowest of the same.

This, in turn, improved the assurance that the board received at the end of this financial year when the Quality Account is signed off.

This information is shared publicly within performance reports published on the Trust website and information from the performance report shared at Council of Governors meetings.

Electronic Performance Dashboards

In 2013/14 the Trust continued to develop online quality and performance management dashboards available to staff to allow them to monitor performance in a new and more dynamic way. During 2014/15 the Trust will implement a real time patient experience and clinical audit system. This will provide an end-to-end solution for the capture, analysis and reporting of auditable patient activity, including the experience, safety and quality metrics. The information system will triangulate data streams from a range of data sources and give a realistic holistic evaluation of the Trust's performance. The system will flag areas of non-compliance and identify risks, which can then be addressed immediately, whilst risks are not causing major harm or quality concern. This just in time approach to action will keep teams on 'green' status and avoid the service having a planned or ad hoc inspection by the internal team.

Quality Reports to Commissioners

In addition to the activity reports provided to commissioners, 2013/14 saw the continuation of quarterly quality meetings and quality reports to the Trust's lead commissioners at the six weekly Clinical Quality Review Group (CQRG). Performance against CQUIN targets, contractual quality, and service development improvement plan indicators are monitored along with reviews of learning from incidents and complaints. Camden and Islington Clinical Commissioning Groups (CCGs) have significant input into deciding priorities for quality improvement and in setting quality indicator targets.

In 2013/14 the Trust continued to develop online quality and performance management dashboards available to staff to allow them to monitor performance in a new and more dynamic way

1.6.5 Key Quality Initiatives in 2013/14

This section of the report describes the initiatives that teams and services have undertaken in the past year to improve the safety and effectiveness of care and the quality of the service user experience.

Quality Assurance Framework

Quality Assurance must become intrinsic to every stage of the patient journey and every component of patient care and service delivery, absolute attention to its effectiveness is essential. The Trust board have signed off a plan to establish a Trust quality and patient safety risk based assurance programme. Adopting the CQC approach to the offer "continuous monitoring to identify risks from local and national information sources", we are introducing our own developmental Quality Assurance system. This has three elements.

First, we are creating an integrated quality assurance information system that can triangulate data streams from a range of data sources and give a realistic global evaluation of the Trust's performance. The system will flag areas of non-compliance and identify risks, which can then be addressed immediately, whilst risks are not causing major harm or quality concern.

The second element of our internal quality assurance programme is a bespoke resource of internal developmental inspections. Specially selected against the quality needs, this resource would have a set programme of scheduled and ad hoc quality assurance reviews to ensure that quality standards meet CQC fundamental standards in all registered services. These inspections follow a similar format to CQC inspections and flag up any potential areas of non-compliance within the service in addition to expected standards and high quality care, where every aspect is consistently good. Trust developmental inspectors will be applied to work on two work streams. The focus on Service users will also be involved through the use of an approach called Privacy and Dignity Walks (PDW). These PDWs will be agreed with the Matrons and the Service User Alliance, with scheduled visits to the wards to provide a quality inspection from the perspective of service users. This element will not only increase service user engagement but also provide experience by expert feedback; this will focus on inpatient wards in its first phase.

The third intervention this framework introduces is the Rapid Improvement Teams who will provide short term intervention to services identified as needing urgent improvement. This team will be a resource within the Trust which has experience of service improvement. They will be available to be parachuted into services swiftly to address non-compliance, safeguarding or serious quality concerns.

Recovery Colleges deliver comprehensive, peer-led education and training programs within mental health services

Recovery College

Recovery is a process through which people find ways of living meaningful lives with or without the symptoms of their condition. Recovery represents the next big transformational change for mental health services in this country - on a par with the closure of asylums and the move to care in the community.

Recovery colleges underpinned by a model of peer support essentially seek to redefine the power relationship between the mental health professional and individuals receiving services. They advocate the co-production agenda where individuals are encouraged to self-manage their condition and be viewed as equal partners.

Recovery Colleges deliver comprehensive, peer-led education and training programs within mental health services. They should be run like any other college, providing education as a route to recovery, not as a form of therapy. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals. Their services should be offered to service users, professionals and families alike, with people choosing the courses they would like to attend from a prospectus.

There are currently four Recovery Colleges in England, with several more due to open soon. As well as offering education alongside treatment for individuals they also change the relationship between services and those who use them; they identify new peer workers to join the workforce; and they can replace some existing services. Our commitment to developing a recovery college, and the significant investment in this regard from commissioners will have a real impact on the experience of our service users.

The college will run learning and development programmes for people who will be working as peer professionals alongside other mental health professionals and staff in multi-disciplinary teams. It will also provide psych-education on a range of topics traditionally provided by care co-ordinators particularly around self-management of long term conditions such as managing voices or managing CPA meetings.

A recent survey of people who participated in courses at the South West London Recovery College showed a significant reduction in use of community mental health services and a rise in the number who became mainstream students, gained employment or became a volunteer. Accompanying the briefing on recovery colleges is a second paper which looks at the progress NHS mental health services are making towards implementing recovery principles into their services.

Physical Health and Wellbeing work programme

The Trust has an evolving work programme to deliver health promotion, improve on the assessment and diagnosis of physical health conditions, and to support access to treatment across the care pathway through collaborative working with primary and secondary care services. In addition the Trust has been successful in obtaining funding from commissioners for new posts to support this evolving programme.

We have appointed two substantive community matrons for physical health, funded by Islington Commissioners. The overall aim of this new community matron role is to improve the quality of life for vulnerable patients with underlying physical health conditions by reducing the need for admissions to hospital, reducing lengths of stay, maintaining people within their owns homes and promoting self-care strategies to support their independence. Islington Commissioners have funded, and subsequently The Trust has appointed a matron for smoking cessation for a period of one year to lead the expansion of the smoke free agenda. This project can be seen as two phase in design, with an initial 3 month scoping exercise to develop the business case, followed by a 9 month implementation phase. The Trust has recruited a substantive nurse consultant in primary care post to commence in May 2014. Islington commissioners have funded this post to provide expert nursing practice, clinical leadership, individual training and consultancy, and on site group training in mental health for all GPs and their practice nurses across Islington.

Modified Early Warning Scores (MEWS)

Over the past 12 months inpatient services across the Trust have implemented a significant change to the process for recording and reporting physical health information by adopting a Modified Early Warning Scores (MEWS) system. MEWS is a type of 'track and trigger' system which allows nursing staff and allied health workers to quickly calculate an aggregate score for the level of abnormality present in a patient's physical health condition, and provides an associated algorhythm for appropriately escalating concerns according to the score generated. This ensures that the cumulative impact of mild to moderate abnormal readings is not missed, and that critical readings are responded to in an appropriate timeframe.
The MEWS also includes a communication framework to ensure that physical health information is shared in a clear and consistent way between professional groups, as multidisciplinary working on physical health was a key focus of the project.

Safewards

In January 2014, Rosewood became one of the first wards in the country to implement Safewards, a programme of 10 nursing interventions designed to reduce incidents of conflict in inpatient environments. The programme was developed by Professor Len Bowers from knowledge acquired over years of research at City University and the Institute of Psychiatry, and has been evidenced as effective by a high quality randomised control trial conducted in 2013. The interventions are a variety of strategies to promote effective communication and collaboration between staff and patients, and to ensure frameworks are in place to recognise and support patients' needs both before and after conflict situations. The Trust plans to roll out the Safewards programme Trust wide by 2016.

Clinical Leadership Programme

The Trust has responded to clinical leadership issues highlighted in the Francis Report and identified through internal training needs analysis. We are committed to developing strong leaders from our clinical community. Subsequent reports such as Berwick and work undertaken by the NHS Leadership Academy have shown this to be an area needing attention across the NHS. The restructuring in 2012 identified many managers as new to a leadership role but also indicated a need to further develop these skills. We provide (or support access to) a wide range of leadership development opportunities for staff across the professions and at all levels.
These offerings have been strengthened in the past years and continue to be built upon. The Clinical leadership programme is now open to non-medical as well as medical staff.

The First Line Manager (FLM) Programme has been running since September 2012. This is accredited by the Chartered Management Institute as a Level 3 Certificate in First Line Management. The programme is made up of three taught modules, self-directed learning, two CMI set assignments and a Trust project. Projects focus on management and/or service improvement issues. The programme was externally evaluated by Middlesex University in 2013 which gave positive feedback. In late 2013 and early 2014 the FLM programme was re-assessed by the Chartered Management Institute and the Trust re-accredited to run the programme. Every ward or team manager (corporate Band 7) has been through the FLM programme. The Band 6 Leadership Development programme also ran for two cohorts in summer of 2013. It was externally provided by QA Training Limited and ran over four single days (each approximately three weeks apart).

Quality Improvement Programmes involving trainee doctors

There are a number of initiatives in the Trust to engage trainee doctors and other members of the multidisciplinary team in quality improvement.

Clinical Leadership and Quality Improvement will be included in the Trust Induction for all new trainee doctors from February 2014. This will provide direction and encourage them to become involved in quality improvement in the Trust; trainees will be given access to internal and external resources to facilitate and guide this process.

A repository of Quality Improvement projects has been created, which will be available on the Intranet. This will list all live projects and the lead clinical supervisor for each. It will also include a list of senior clinical supervisors who can be contacted to request support and supervision of newly identified projects. Trainees will have to opportunity to present their completed projects as part of the Academic Programme.

Junior trainees are provided with a one day Clinical Leadership Programme to help prepare them for future leadership roles. The programme provides specific and well-established training on undertaking quality improvement.

In October 2013, the Quality Improvement Network in Camden & Islington (Quincy) was formed. This network of trainee doctors (now open to all members of the clinical staff) meets on a regular basis. The aim of the network is to promote a culture of engagement in quality improvement in the Trust and to provide support, guidance and education to trainees.

1.6.6 Patient Reported Experience Measures (PREMs)

To improve the quality of services that the NHS provides, it is important to understand how people who use these services, rate the level of care and treatment they receive. The Service User Survey undertaken by the CQC is a method of monitoring this, specifically with regard to those who use Community Health Services.

Positives (in relation to other Trusts)

- In the last 12 months, have you received support from anyone in mental health services in getting help with your care responsibilities?
- In the last 12 months, have you received support from anyone in mental health services in getting help with finding and/or keeping accommodation?
- In the last 12 months, have you received support from anyone in mental health services in getting help with financial advice or benefits?
- Before the review (Care review) meeting, were you given a chance to talk to your care co-ordinator about what could happen?
- Did you find the care review helpful?
- Have mental health services helped you start achieving these goals (from care plan)?
- Does your care plan cover what you should do if you have a crisis?
- Did you find the talking therapies you received in the last 12 months helpful?

Negatives (in relation to other Trusts)

- Did the worker who saw you most recently listen carefully to you?
- Did this person treat you with respect and dignity?
- Were you given enough time to discuss your condition and treatment?
- Can you contact your Care Co-ordinator (or lead professional) if you have a problem?
- Have you been given (or offered) a written or printed copy of your care plan?
- In the last 12 months, have you received support from anyone in mental health services in getting help with finding or keeping work?
- Have NHS mental health services involved a member of your family or someone else close to you, as much as you would like?

Action Plan

Creating more innovative ways of capturing service user reported experience was the quality priority requested by the Council of Governors and other key stakeholders in developing the 2012/13 Quality Accounts.

'Hard' data that can be measured via the Trusts operational electronic performance dashboards must be supported by 'soft' performance measurement that involves more personal and subjective interaction and measurement throughout the organisation. There is a range of soft information-gathering approaches that the Trust currently uses, for example:

- Wards and sites visits - The annual schedule for ward and site visits includes visits from all executive directors and governors, as well as non-executive directors. Through these visits Trust services have clarity as to who is taking an interest in their performance and the opportunity this presents to have a route to the board.
- Patient stories - Board meetings now include attendance by a service user and discussion of patient journeys. Focus on stories that relate to a particular quality issue, for example, delayed transfers of care or staff shortages in a particular area or department. Stories, both positive and negative, can provide valuable lessons on quality.

Assessing patient experience is complex and multi-factorial and includes elements centered on services, individual healthcare professionals and also factors which are individual to each patient. Therefore no single survey, CQC compliance review, Monitor declaration, complaints, incident or performance report, metric or audit will cover all elements, so the development of an internal quality risk profile which is presented as a strategic integrated quality assurance dashboard that would allow comparison and triangulation across quality, performance, workforce, productivity is essential.

In order to meet this challenge the Trust has undertaken the following actions to improve this indicator, and so the quality of its services:

- Implementing a new patient experience tool which will provide the Trust with the ability to capture service user reported experience in a more systematic and innovative way. Through the expansion of the work programme using PETs (hand-held touch-screen devices) that ask a brief set of questions for both service users and or carers with free-text areas allowing comment on anything the respondent wishes to share. Service users and their carers will have more opportunity than ever before to tell the Trust how to improve their experience of care, support and treatment.
- Working to the national models for advice and complaints services, ensuring that all service users and carers have access to a professional and responsive service. Integrated complaints, claims and incidents analysis reports have been further developed to provide greater identification and analysis of themes which have been shared with commissioners and stakeholders in 2012/13.

1.6.7 NHS Litigation Authority (NHSLA) – Risk Management Standards assessment

The Trust successfully achieved a Level 2 assessment of the NHSLA Risk Management Standards in September 2011. Following a change in approach, the NHSLA will not be updating these standards and will be carrying out no further assessments after March 2014. In their place the NHSLA are developing a 'Safety and Learning Service', with the aim of supporting Trusts to build a safety and learning culture through their work in learning from claims.

The NHSLA risk management standards however, reflect good risk management practice, and the Trust will continue to use them as a basis to address relevant areas of risk for as long as they apply to the Trust and reflect current processes and practice.

Advice and Complaints Service

Table 1.12: Response to complaints – timeliness

Complaints category - required response times	Q1	Q2	Q3	Q4
10 days	90%	69%	72%	47%
10 days	86%	31%	70%	60%
10 days	100%	-	0%	-
Total	88% (51/58)	49% (27/55)	69% (35/51)	53% (16/30)

Local target: 80%

Our internal Trust targets for responding to formal complaints are either 10, 25 or 45 days, depending on the complexity of the complaint. The Trust has struggled to meet the target level set in terms of timeliness of response to complaints in Q2, Q3 and Q4 2013/14. This is in the context of the number of complaints received increasing. The number of informal complaints and contacts received was 216 compared to 193 in 2012/13. In addition to this, we received 216 formal complaints compared with 151 in the previous year.

Of the 216 formal complaints received, at the time of writing in April 2014, 189 have completed responses. Of these 189 complaints, 69% were responded to within the relevant timescale.

The Trust has undertaken the following actions to improve this indicator, and so the quality of its services, by ensuring:

- Monitoring and tracking of complaints handling is now part of our divisional Performance Meeting monitoring agenda.
- The Quality Committee now has oversight of divisional response rates.
- Training for reception and administration staff on is underway that incorporates informal complaints management.

1.6.8 Performance against key national indicators

Care Quality Commission (CQC)

As of 2010/11, the CQC's primary tools for monitoring healthcare providers are the individual location assessments and the monthly updates to the Quality Risk Profiles (QRP).

The Quality Risk Profile is a collation of all data available to the CQC from other national regulatory bodies, local stakeholders and the NHS Information Centre. A risk rating is calculated for each of the 16 CQC Quality Outcomes. This document is updated using over 700 individual quality indicators and is categorised into five key areas with a performance rating assigned to each, green being performing better than expected, amber performing as expected and red performing worse than expected. The Trust's monthly Quality Risk Profile updates have similarly been extremely positive since their introduction in September 2010. As of April 2014, the Trust is performing as follows in the five QRP sections:

Reducing risk of non-compliance Increasing risk of non-compliance

Outcomes					
Involvement and information	Respect and involvement	Consent to care and treatment			
Personalised care	Care and welfare	Meeting nutritional needs	Co-operating with other providers		
Safeguarding and safety	Safeguarding	Cleanliness and infection control	Management of medicines	Safety and suitability of premises	Safety, suitability and availability of equipment
Suitability of staffing	Requirements relating to workers	Staffing	Supporting staff	Lower risk of non-compliance	
Quality and management	Assessing and monitoring quality	Complaints	Records	Higher risk of non-compliance	

These ratings suggest that overall the Trust is performing as expected or better for each of the outcomes where the CQC have collated enough data to calculate a risk. **94% of the 785 measures show the Trust performing as expected or better than expected and no area rated as at risk of non-compliance.**

Monitor

The Trust is assessed on a quarterly basis by Monitor through seven distinct performance indicators. The measures are intended to indicate the quality of mental health care at a service level, with quality being: care that is effective, safe and provides as positive an experience as possible. Trust performance against these is provided in the table over[4]:

[4] Percentages here have been rounded up or down to whole numbers. Where comparator data is given with decimals (as in 3.1.9) we have presented our data in the same format.

Table 1.13

	Target	Method	Q1	Q2	Q3	Q4
CPA – having formal review in the last 12 months	95%	**Numerator:** Number of adults in the denominator who have had at least one formal review in last 12 months. **Denominator:** Total Number of adults who have received secondary mental health services who had spent at least 12 months on CPA at the end of the reporting period or at the time of discharge from CPA.	96%	96%	95%	96%
CPA – follow up within 7 days of inpatient discharge	95%	**Numerator:** Number of people under CPA who were followed up either by face-to-face contact or phone discussion within 7 days of discharge from Psychiatric Inpatient Care. **Denominator:** Total Number of people under CPA discharged from Psychiatric Inpatient Care	96%	98%	97%	98%
Admissions to inpatient care having access to Crisis Resolution Home Treatment Teams	95%	This indicator applies only to admissions to the foundation Trust's mental health psychiatric inpatient care. The following cases can be excluded: (i) planned admissions for psychiatric care from specialist units; (ii) internal transfers of service users between wards in a Trust and transfers from other Trusts; (iii) patients recalled on Community Treatment Orders; or (iv) patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. This includes CAMHS clients only where they have been admitted to adult wards. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission.	98%	99%	98%	98%
Minimising delayed transfers of care	<7.5%	**Numerator:** Number of inpatients (aged 18 and over upon admission) whose transfer of care was delayed during the quarter, per day. (For example, one patient delayed for 5 days would be 5) **Denominator:** Total Number of Occupied Bed Days during the Quarter.	1.6%	2.16%	1.34%	0.91%
Meeting commitment to serve new psychosis cases by Early Intervention Teams	95%	Quarterly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.	100%	100%	100%	100%
Mental Health Minimum Data Set	97%	**Numerator:** Count of valid entries from the following; NHS Number, DOB, Postcode, Gender, GP Registration, Commissioner Code. **Denominator:** Total number of entries.	99%	99%	99%	98%
Mental Health Minimum Data Set: Data Completeness Outcomes*	50%	**Employment Numerator:** The number of adults in the denominator whose Employment Status is known at the time of their most recent review. **Employment Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported quarter **Accommodation Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. **Accommodation Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported quarter. HoNOS[5] Numerator: The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. HoNOS Denominator: The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.	80%	87%	88%	88%

* The Trust will not receive scores for Quarter 4 from the NHS Information Centre until June 2014 at the earliest. The scores indicated here are internal estimates from Trust data.

[5] Health of the Nation Outcome Scale (HoNOS)

1.6.9 Department of Health Indicators 2012/13

The Department of Health has drawn up a list of indicators for mandatory inclusion in Quality Accounts from 2012/13 onwards due to their pertinence and potential to provide an assessment of quality across the 5 domains of the NHS Outcomes Framework from the list of mandated indictors; six are relevant to the Trust.

Prescribed Indicator	Quality Domain of NHS outcomes framework
1.Percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric in-patient care	1. Preventing People from dying prematurely 2. Enhancing quality of life for people with long-term conditions
2.Percentage of admissions to Acute wards for which the CRT home treatment team acted as a gatekeeper	2. Enhancing quality of life for people with long-term conditions
3.Percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust	3. Helping people to recover from episodes of ill health or following injury
4.Percentage of staff who would recommend the provider to friends or family needing care	4. Ensuring that people have a positive experience of care
5.Patient experience of Community Mental Health Services score with regards to a patients experience of contact with a health or social care worker	2. Enhancing quality of life for people with long-term conditions 4. Ensuring that people have a positive experience of care
6.Rate of patient safety incidents and percentage resulting in severe harm or death	5. Treating and caring for people in a safe environment and protecting them from avoidable harm

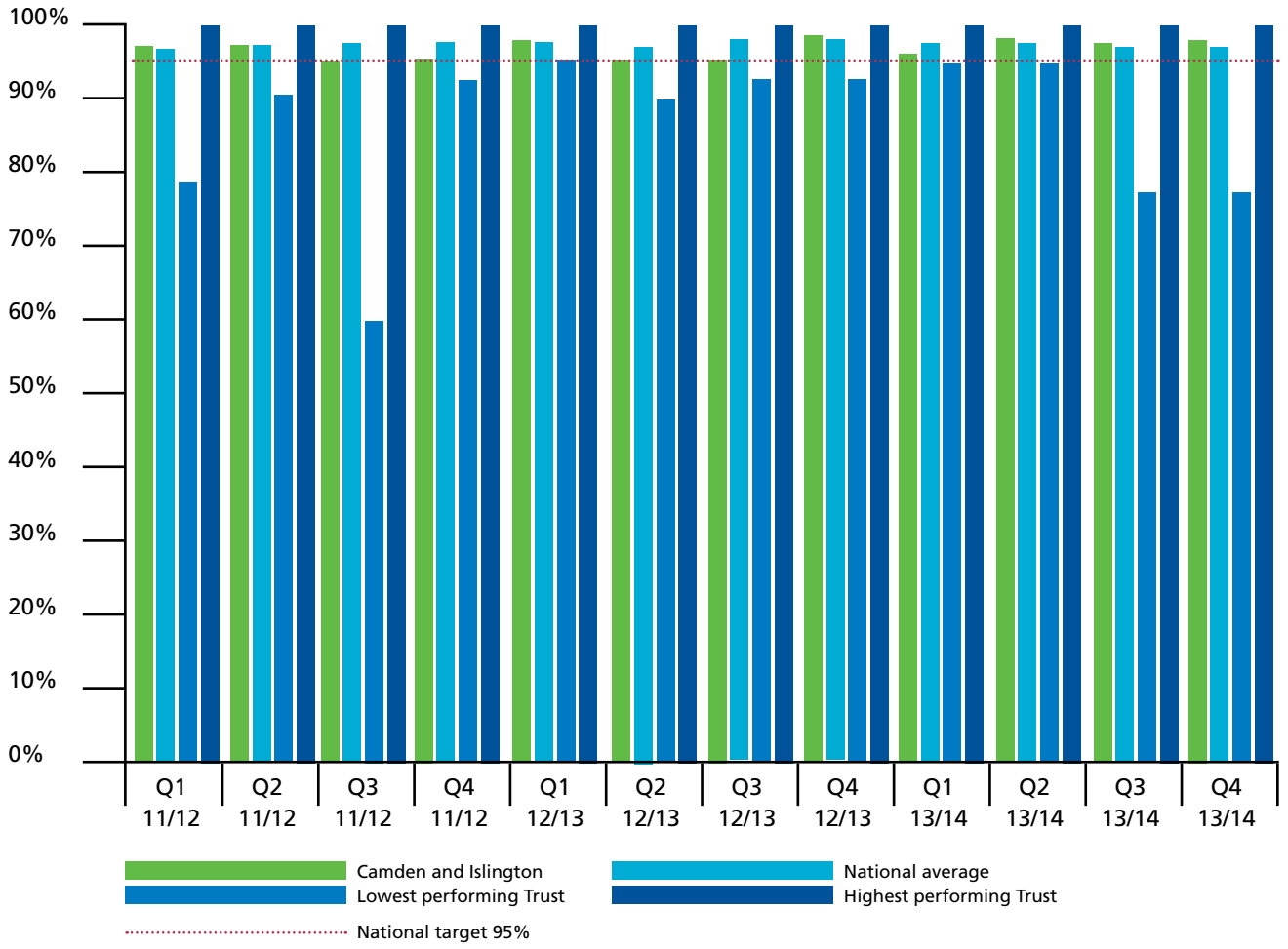
Data for all of these measures for the reporting periods 2012/13 and 2013/14 are provided below.

Percentage of Patients on CPA who were followed up within 7 Days after discharge from psychiatric in-patient care

Table1.14: Performance figures

Trust	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
Camden and Islington	97.0%	96.6%	94.7%	95.5%	97.8%	94.9%	95.3%	98.5%	96.0%	98%	97.4%	98%
National Average	96.7%	97.3%	97.4%	97.6%	97.5%	97.2%	97.6%	97.6%	97.4%	97.5%	96.7%	96.7%
Lowest Performing Trust	78.4%	90.3%	60.0%	92.4%	94.9%	89.8%	92.5%	92.5%	94.1%	90.7%	77.2%	77.2%
Highest Performing Trust	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
National Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Percentage of patients on CPA followed up within 7 days



Assurance statement

Camden and Islington Foundation Trust considers that this data is as described for the following reason: that the data is subject to monthly monitoring and is regularly audited internally to assure its accuracy. The Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

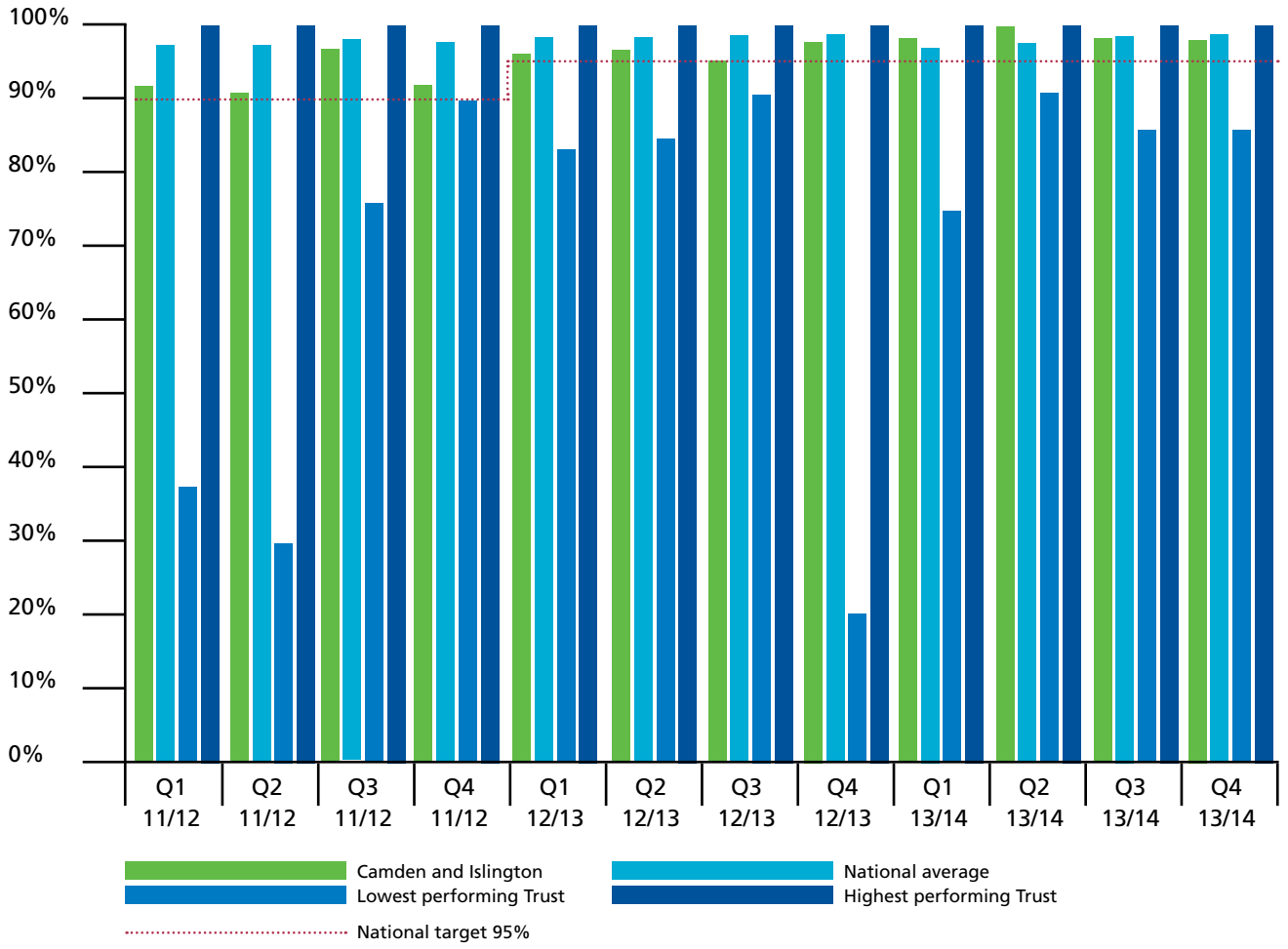
- Benchmarking Trust performance and commissioner level targets set for other Mental Health providers to understand the definitions and methodology used to calculate and report their position.

Percentage of admissions to Acute wards for which the Crisis Resolution Home Treatment Teams acted as a gatekeeper

Table 1.15 Performance figures

Trust	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
Camden and Islington	91.5%	90.6%	96.6%	91.7%	96.0%	96.5%	95.1%	97.8%	98%	99.6%	98%	98%
National average	97.0%	97.3%	97.7%	97.7%	98.0%	98.1%	98.4%	98.7%	97.7%	97.5%	98.6%	98.6%
Lowest Performing Trust	37.2%	29.8%	75.7%	89.6%	83.0%	84.4%	90.7%	20%	74.5%	90.7%	85.5%	85.5%
Highest Performing Trust	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
National Target	90%	90%	90%	90%	95%	95%	95%	95%	95%	95%	95%	95%

Percentage of admissions to Acute wards for which the Crisis Resolution Home Treatment Teams acted as a gatekeeper



Assurance statement

Camden and Islington Foundation Trust considers that this data is as described for the following reason: that the data is subject to monthly monitoring and is regularly audited internally to assure its accuracy. The Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

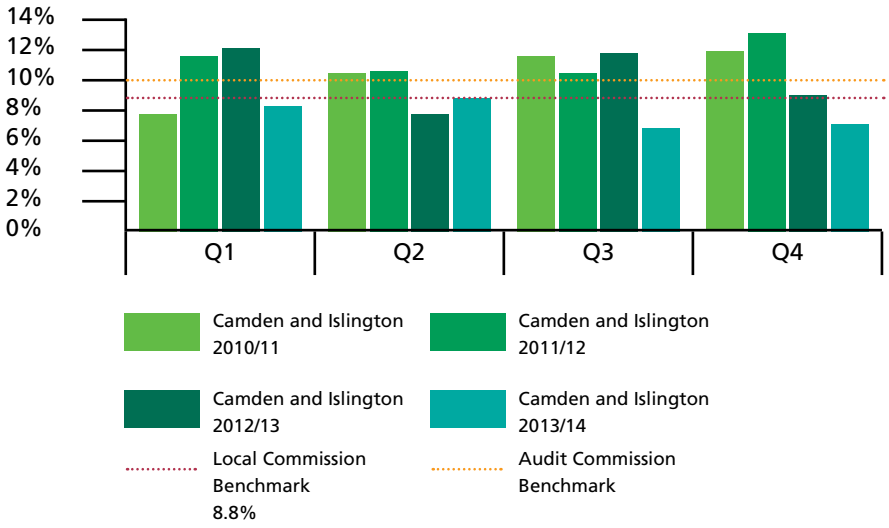
- Examining comparative figures and learning lessons from the experience of hospitals with low readmission rates.
- Benchmarking Trust performance and commissioner level targets set for other Mental Health providers to understand the definitions and methodology used to calculate and report their position.
- Completion of an audit which examines the emergency readmission rates and explores whether factors such as ethnicity, age, gender, diagnosis or contacts with community services can predict whether service users will be readmitted.

Percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital[6]

Table 1.16: Performance figures

	Q1	Q2	Q3	Q4
2010/11	7.80%	10.50%	11.60%	11.90%
2011/12	11.60%	10.60%	10.50%	13.10%
2012/13	12.10%	7.80%	11.80%	9%
2013/14	8.70%	10.30%	7.30%	7.1%

Readmissions within 28 days of discharge



Although readmissions occur for a variety of reasons, which can include service users being readmitted to hospital shortly after leaving as part of a care pathway, one potential inference drawn from higher rates is that the readmission results from ineffective treatment in hospital, in addition to poor or badly organised readmission or support services following discharge, consequently it is important for the Trust to measure and monitor readmission rates. As of Quarter 3 the Trust was below the local commissioner target of 8.8% achieving a readmission rate of 6.83%. This was also below the audit commission benchmark.

Assurance statement

Camden and Islington Foundation Trust considers that this data is as described for the following reason: that the data is subject to monthly monitoring and is regularly audited internally to assure its accuracy. The Trust has taken the following actions to improve this indicator, and so the quality of its services, by

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- Completion of an audit which examines the emergency readmission rates and explores whether factors such as ethnicity, age, gender, diagnosis or contacts with community services can predict whether service users will be readmitted.

[6] The information Centre provides benchmarking data up until 2010/11 however there is no data within for comparative mental health Trusts as such the Audit Commissions Q2 2011/12 benchmarking data has been used for reference.

Percentage of staff who would recommend the provider to friends or family needing care

The Trust score from the annual CQC Staff Survey in 2013 was 3.56 out of 5 which is a slight increase on the score for 2012 (3.23).

Table 1.17: Performance figures

Service	Score
Camden and Islington Foundation Trust 2013	3.54
Camden and Islington Foundation Trust 2012	3.23
Camden and Islington Foundation Trust 2011	3.25
National Average 2013 (MH/LD Trusts)	3.55
Best 2012 score (MH/LD Trusts)	4.07
Lowest 2012 score (MH/LD Trusts)	3.01

The staff survey is extremely useful in helping the Trust to measure staff satisfaction levels, as staff wellbeing and views of Trust services have a direct impact on the quality of care the Trust provides. This year the Trust response rate was in the highest 20% of mental health / Learning Disability Trusts in England which means we can have confidence in the validity of the results. Overall the results showed significant improvement from last year and are similar to those before the significant organisational changes which were made during 2011-13. The results have improved across the whole range of areas covered by the survey, in some cases by a large percentage. This reflects the efforts taken to engage staff throughout the year.

Assurance statement

Camden and Islington Foundation Trust considers that this data is as described for the following reason: that the data is subject to monthly monitoring and is regularly audited internally to assure its accuracy. The Trust has taken the following actions to improve this indicator, and so the quality of its services, by

- Continuing to use the national staff survey to measure staff satisfaction in the workplace;
- Improving staff confidence in the quality of Trust services by providing access to real-time information regarding the quality of services and performance data.
- Instigating a programme of staff listening events;
- Refocusing the work of the staff survey action group onto addressing priority issues raised by staff;
- Working with the staff wellbeing group to addressing staff set wellbeing priorities, such as support to exercise and to quit smoking;
- Continuing to align the organisation to our co-created values and behaviours in order to sustain continued improvement in staff and service user experience;
- Addressing comments from staff surveys about bullying and harassment and violence and aggression towards staff.
- Introducing the Staff Friends and Family Test. Staff positive responses to the Friends and Family Test is a CQUIN indicator for the Trust in 2014/15.

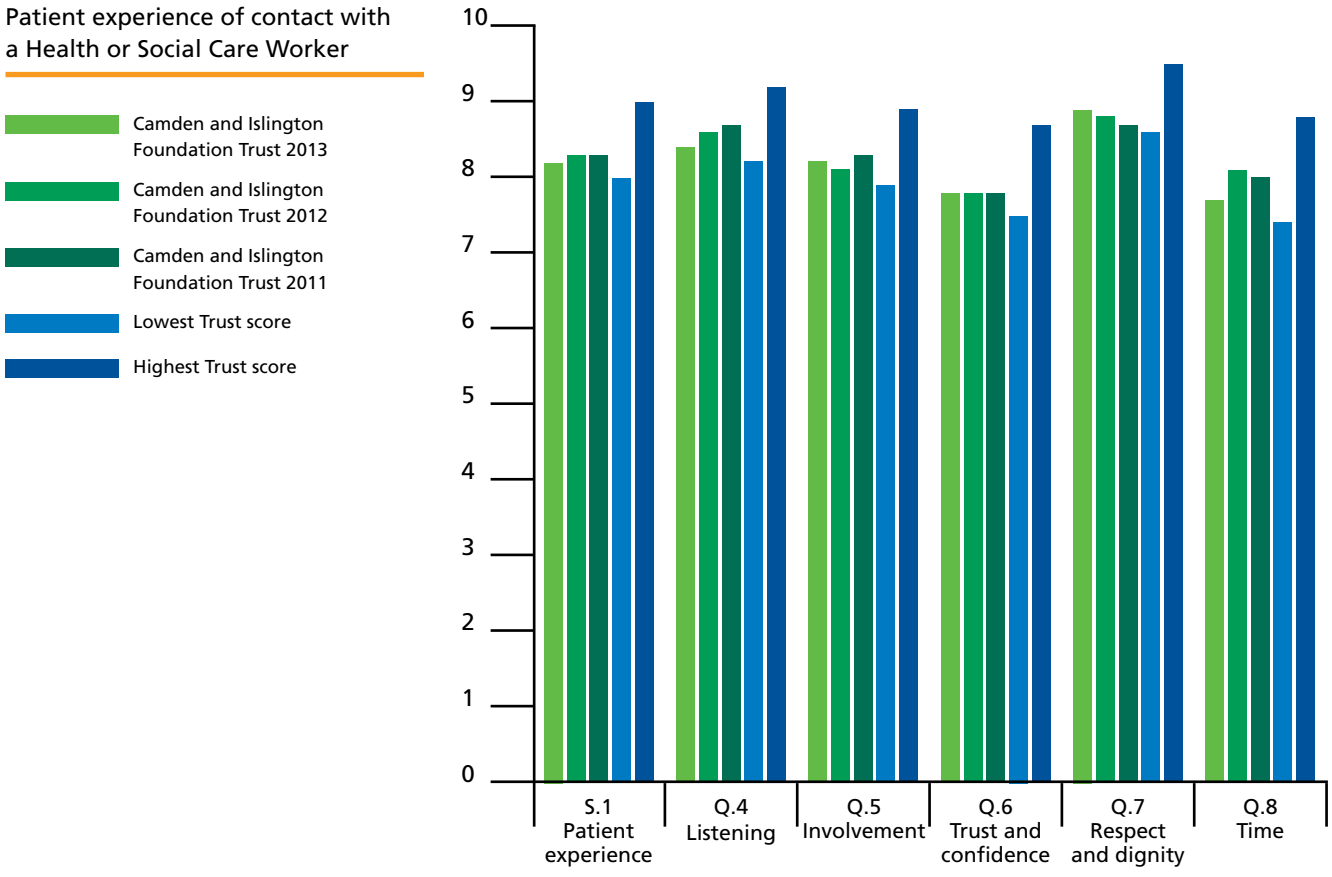
Patient experience of Community Mental Health Services score with regards to a patients experience of contact with a health or social care worker

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. To monitor this, Quality Health, on behalf of the Care Quality Commission, conducted the Survey of People who used Trust Community Mental Health Services 2012. The table below summarises "Patient experience of community mental health services" and provides indicator scores with regard to patient experience of contact with a health or social care worker during the reporting period.

Table 1.18: Performance figures

	S.1 Patient experience	Q.4 Listening	Q.5 Involvement	Q.6 Trust and confidence	Q.7 Respect and dignity	Q.8 Time
Camden and Islington Foundation Trust 2013	8.2	8.4	8.2	7.8	8.9	7.7
Camden and Islington Foundation Trust 2012	8.3	8.6	8.1	7.8	8.8	8.1
Camden and Islington Foundation Trust 2011	8.3	8.7	8.3	7.8	8.7	8
Lowest Trust score	8	8.2	7.9	7.5	8.6	7.4
Highest Trust score	9	9.2	8.9	8.7	9.5	8.8

Patient experience of contact with a Health or Social Care Worker



The results reflect that the Trust's performance is on par with the national average.

Assurance statement

Camden and Islington Foundation Trust considers that this data is as described for the following reason: that the data is subject to monthly monitoring and is regularly audited internally to assure its accuracy. The Trust will take the following actions to improve this indicator, and so the quality of its services, by:

- Addressing improvement in service user experience through real-time tracking and response to patient feedback.
- Meeting our CQUIN targets for 2014/15 on Collaborative Approaches to Care and Recovery Oriented Practice.

Rate of patient safety incidents and percentage resulting in severe harm or death

This item has been chosen by the council of governors as one of the Trust's quality and safety measures. In 2013/14, staff reported a total of 1,396 patient safety incidents. From this total, 52 were related to severe harm or death. There were 100,807 occupied bed days[7] in the Trust in the same period.

- Rate of patient safety incidents = 13 incidents per 1,000 occupied bed days (although a significant proportion of these incidents occurred in community settings).
- Percentage of incidents involving severe harm or death = 3.7%

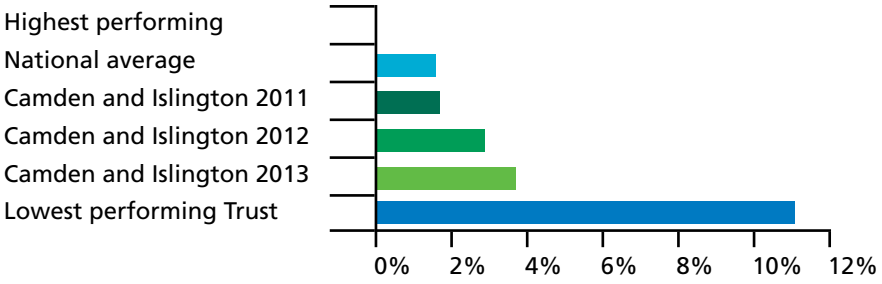
  We are reviewing why there is an increase in patient safety incidents, as part of a review of our risk and serious incident management policies.

Table 1.19: Performance figures

Trust	Numbers of incidents involving severe harm or death	Percentage of patient safety incidents relating to severe harm or death
Camden and Islington 2011/12	43	1.70%
Camden and Islington 2012/13	35	2.90%
Camden and Islington 2013/14	52	3.7%

The updated requirements from Monitor coupled with the amendments to Quality Accounts regulations required the Trust to benchmark performance against those key quality indicators mandated for 2013/14. In the absence of a full year's data on Health and Social Care Information Centre, the data for the period of April 2013 to - September 2013 has been used as a reference, to benchmark Trust performance.

Percentage of patient safety incidents resulting in severe harm or death



[7] This number includes patients on leave.

A total of 3,813 incidents have been reported via the Trust's online incident form (Datix Web) in the last year, an average of 317 incidents per month. This is a huge increase from the year 2012/13 when 2,734 incidents were reported. This represents a 39% increase in incident reporting in 2013/14. The increase in incident reporting was achieved by engaging staff at team level through the circulation of educational material and attendance at team meetings in order to promote a better reporting culture as well as the recent issuing of an internal patient safety alert linked to the importance of incident reporting. Analysis has been undertaken to look at reporting levels for individual divisions and teams and incident reporting rates are also monitored at the monthly Divisional Performance Meetings, with a clear focus on increasing reporting rates. In addition, a large amount of work was completed in 2013/14 on the Datix system to streamline the reporting process.

Assurance statement

Camden and Islington Foundation Trust considers that this data is as described for the following reason: that the data is subject to monthly monitoring and is regularly audited internally to assure its accuracy. The Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- A full review and update of the Trust Serious Incident policy;
- Making refresher Risk Assessment training available to clinical staff;
- Conducting audit and full risk assessment of all ligature risk points (using more rigorous criteria than nationally agreed);
- Health and Safety Risk assessments;
- Suicide Prevention Strategy;
- 72 hour follow up of all patients discharged from inpatient care;
- Incident Reporting Policy and Procedure ;
- Quarterly Aggregated incidents, complaints, claims report which provides the Trust with trend analysis.

Further in October 2013 the Trust carried out a cluster review of 10 incidents occurring within a three week period. The Review looked at any factors potentially linking these incidents. This work was led internally by the Associate Medical Director and consisted of a panel of independent reviewers which included colleagues from Camden and Islington Clinical Commissioning Groups and NEL CSU. The group was chaired by the Assistant Director of Public Health from the London Borough of Islington. The findings of the review were that although there were some themes that carried across more than one incident, alcohol being the most prevalent factor, there weren't any factors identified that could be considered to link these incidents in any significant way. There were no additional recommendations for the Trust arising out of the review. Following this model, in April 2014 the Trust initiated a cluster review into the Camden Crisis Pathway following identification of 5 unexpected deaths.

1.6.10 2012/13 Quality Priorities – Progress

This section describes the Trust's progress against the quality priorities that we set the previous year.

The Trust 2012/13 Quality Accounts set out five quality priorities for 2013/14:

Physical Health (CQUIN)

Ensuring that we support our service users to stay physically as well as mentally healthy is an integral part of the work undertaken within Trust services. These are important patient experience, effectiveness and safety measures that form a basis for shared care to improve the physical health care of patients with mental health problems in hospital and community based settings. Association between physical co-morbidity and mental ill health has long been established. People with severe mental illness (SMI) experience worse physical health and reduced life expectancy compared to the general population. On the other hand, poor physical health can have a negative effect on mental health.

The table below provides information on the specific indicators used to monitor this patient safety measure which form CQUIN and results achieved throughout 2013/14:

CQUIN Measures					
Physical Health	Target	Q1	Q2	Q3	Q4
Sharing of CPA register with primary care.	N/A	N/A		N/A	
Complete physical and mental health diagnostic coding (ICD 10) - Recording mental health and key physical health (diabetes, COPD, CHD, Hypertension, Hep C) diagnoses	95%	89%	96%	98%	96%
Completion of annual physical health check - Patients on CPA (who are registered with a GP) identified as having Diabetes, CHD, COPD, hypertension and/or obesity with either a completed health check or recorded evidence of an attempt to facilitate it.	Q1 - 95% Q2 - 96% Q3 - 97% Q4 - 98%	95%	97%	99%	98%
Reduction of medication errors through medicines reconciliation on admission to hospital - Audit of care plans using POMH UK definition and audit tool completing at least two of the reconciliation approaches	95%	N/A	N/A	95%	95%
Adequate and timely communication between primary and secondary care. Inpatients - Discharge Notification/GP Letter to be sent to primary care within 5 working days of discharge	Q1 - 85% Q2 - 90% Q3 - 92% Q4 - 95%	94%	93%	95%	95%
Discharge summaries - Number of fully completed discharge summaries (all fields complete; no missing information or illegible)	Q1 - 90% Q3 - 95%	Audit in Progress	65%	Audit in Progress	70%
Adequate and timely communication between primary and secondary care. Sending CPA Letter Review / Care Plan to GPs within 10 working days of CPA reviews	Q1 - 50% Q2 - 65% Q3 - 75% Q4 - 85%	44%	69%	71%	62%

- *Discharge Notification / GP Letter to be sent to primary care within one week of discharge.* Whilst our performance against this target continues to fall below expectations, the Trust is continuing to increase its compliance, with a steady increase over the year and since previous years. This achievement reflects quality improvements within practice in regards to improving communication between primary care and Trust services.
- *Sending CPA Letter Review / Care Plan to GPs within 2 Weeks of CPA reviews.* Although we continue to have difficulty meeting this challenging target we have steadily improved over the year and we continue to review operational practice in our efforts to address this deficit.

- The Trust continues to work to maintain the improvement being made to ensure that Trust services share information with GPs in a timely fashion; providing a useful framework in which to improve the Physical health care of our service users and develop closer working relationships with GPs over the coming year. As highlighted in 2.1 above, we have once again decided to include physical healthcare as one of our quality priorities for the next year.

Fidelity to the recovery model

This CQUIN relates to patient experience and effectiveness and was identified by commissioners across London in 2012/13 and 2013/14. The Trust through its Recovery Model approach to care delivery, subscribes to the promotion of sustainable recovery and increased self-esteem. This London-wide CQUIN sought to measure the application of this approach. We have achieved our targets here. Information on the indicator used for this measurement and the results for 2013/14/13 is provided below:

CQUIN Measures					
Fidelity to the recovery model	Target	Q1	Q2	Q3	Q4
Audit of recovery orientated practice within the organisation	N/A	N/A	N/A	Audit complete	Audit Presented
Collaborative care planning and personal recovery goals - demonstration of 50% of all care plans for service users on CPA in adult and older adult services show evidence of collaborative care planning and contain 2 personal recovery goals.	50%	N/A	N/A	N/A	81%

Over 2014/15 the Trust will work to maintain our high performance in this area, and will continue to monitor this. In 2013/14 the Trust plans to further measure the promotion of recovery and the improved health and wellbeing from a service user's point of view.

Collaborative planning of care between service user and clinician

This priority area for 2013/14 builds on recovery orientated practice CQUINs for 2013/14. Our key performance indicator here was the completion of a quality audit (via service user feedback) to provide assurance from a service users lived experience that they have been supported to identify their own goals within the care planning process and work towards achieving these.

As a means of addressing this priority, service users were asked to participate in the Patient Experience Forum on the 25th February 2014 after being chosen through a sample conducted by the Clinical Audit and Service Improvement Facilitators. Themes that arose from the discussion were the importance of continuity, good communication, better humanity and understanding, mistrust in government restructures and having confidence in the people they work with. Service users told us that care plans were not always geared towards their needs and that they were not always sure of the importance or usefulness of their care plans. We will be working in 2014/15 to address this. Our work this year on improving patient experience through patient feedback will be informed by the findings of this review. Our 2014/15 CQUIN target on collaborative care planning and recovery goals within care plans will go towards addressing this vital patient experience feedback.

Smoking cessation (CQUIN)

This London-wide CQUIN sought to enhance the access that people with mental health problems have to appropriate support with the aim of improving the physical health of users of mental health service by providing smoking cessation support. Smoking Cessation remains a priority area for us in 2014/15, with revised CQUIN targets. We have put in place several measures in order to address our performance against these targets, including the appointment in Islington of a matron for smoking to lead the expansion of the smoke free agenda.

CQUIN Measures					
Smoking Cessation	Target	Q1	Q2	Q3	Q4
Smoking Cessation Training - implement a comprehensive programme of training in smoking cessation for staff so that at least a third of professional staff have been trained in a recognised brief intervention protocol.	45%	N/A	N/A	N/A	Achieved
Pilot of level 2 to work out best way to offer interventions, to be attached to starting of level 2 to inform CQUIN 2014/15	-				
Recording of smoking status	75%	78%	79%	82%	-%*
Care planning for smoking cessation	30% by Q.3 35% by Q.4	N/A	N/A	21%	30%
Audit report of pilot of NRT for inpatients with production of recommendations for improvement.		N/A	N/A	N/A	Data pending

*Q4 data not yet available

1.7 Stakeholder Involvement in Quality Accounts

The Trust's quality goals are co-developed with stakeholders and communicated within the Trust and the community it serves. We held a stakeholder event on 28th February 2014 where service users, carers, governors and other internal and external stakeholders worked together to define our quality goals and priorities for the coming year.

Trust staff

Trust staff were invited to contribute suggestions for areas of inclusion within the priorities for 2014/15 and the review of 2013/14. Input was received from across clinical disciplines in the Trust and from staff in central support services.

Healthwatch

An invitation to contribute to the process of the Quality Accounts was provided to both Camden Healthwatch and Islington Healthwatch.

Trust Governors

The Trust Governors have similarly provided input to the Quality Accounts development and their suggestions have been included in these Quality Accounts.

Stakeholder statements

i. Lead commissioners

Provided below are the comments provided by the Trust's lead commissioners:

NHS Islington Clinical Commissioning Group is responsible for the commissioning of health services from Camden and Islington (C&I) NHS Foundation Trust on behalf of the population of Islington and surrounding boroughs. NHS Islington Clinical Commissioning Group welcomes the opportunity to provide this statement on C&I's Trust's Quality Accounts.

We confirm that we have reviewed the information contained within the Account and checked this against data sources where these are available to us as part of existing contract/performance monitoring discussions and is accurate in relation to the services provided. The account provides a comprehensive summary of the work done by the Trust in 2013/14 to improve safety for service users, the effectiveness of care offered to service users, and the engagement of service users in shaping the services. Significant improvements have been made over the last 12 months and we have also had the opportunity to develop good relationships with the Trust since the CCGs became authorised in 2013. This has led to increased transparency.

We have taken particular account of the identified priorities for improvement for C&I and how this work will enable real focus on improving the quality and safety of health services for the population they serve.

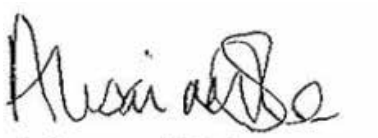
We have reviewed the content of the Account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. We believe that the Account represents a fair, representative and balanced overview of the quality of care at C&I. We have discussed the development of this Quality Account with C&I over the year and have been able to contribute our views on consultation and content.

This Account has been reviewed within NHS Islington, NHS Camden, and by colleagues in NHS North and East London Commissioning Support Unit. Commissioners have been involved in stakeholder engagement events this year which were well attended and allowed for helpful dialogue.

We are pleased to see the five priority areas for improvement in 2014/15 and that they support the Health and Well Being Strategies in local boroughs. The five priority areas are: Physical Health – implementation of Modified Early Warning Score (MEWS), improved patient experience, recovery orientated practice, integrated care and promotion of better health outcomes. These are detailed through seven initiatives, four of which are CQUIN targets for 2014/15. The quality goals were developed with staff, service users, stakeholders and the local community.

Overall we welcome the vision described within the Quality Account, agree on the priority areas and will continue to work with C&I to continually improve the quality of services provided to patients. It links to the Trust's vision and on-going review of their quality strategy.

NHS Islington Clinical Commissioning Group



Alison Blair
Chief Officer
Islington Clinical Commissioning Group

ii. Camden Healthwatch (LINks)

An invitation to comment on the draft Quality Accounts was provided to Camden Healthwatch on 29th April 2014.

iii. Islington Healthwatch (LINks)

An invitation to comment on the draft Quality Accounts was provided to Islington Healthwatch on 29th April 2014.

iv. Overview and Scrutiny Committee

An invitation to comment on the draft Quality Accounts was provided to the Joint Overview and Scrutiny Committee (OSC) on 29th April 2014.