5: QUALITY ACCOUNT

5.0 Quality Accounts

Part 1

Statement on quality from the Chief Executive

It is my pleasure to present the Quality Accounts for 2015/16. This has been a busy year for us at Camden and Islington NHS Foundation Trust with the launch of our new Clinical Strategy and a CQC comprehensive inspection in February 2016. Both required significant focus on safety and quality within the Trust and our stakeholders with the CQC inspection providing a valuable learning experience for all. At the time of writing this report, we are awaiting feedback from the comprehensive CQC inspection.

In 2014 we took part in a pilot to test out the CQC inspection methodology. Feedback from this pilot inspection provided an opportunity to fully embed the Quality Assurance Framework we have developed to help us monitor and ensure the quality of our service provision.

In 2014/15, we made internal quality assurance visits to our services as part of our standard practice. Lots of our staff have been involved in conducting the visits, as have our colleagues from the Clinical Commissioning Group. We have conducted an evaluation and a review of the Quality Assurance Framework

The improvements give us two tiers of improvement plans for services facing specific challenges; a standard improvement plan and an enhanced improvement plan for occasions where there are significant concerns about quality. The framework defines how decisions over improvement plans are made with reference to the Trust's risk management strategy and risk appetite. As a result of the feedback from this pilot, we undertook a major capital project to review the safety of our environments by removing ligature points. We are keen to reduce variability in the quality of our services and assessing quality through the quality assurance model enables us to standardise where possible and also to ensure that the quality of services does not fall below what we would expect in all our services.

An important focus for Camden & Islington Foundation Trust (C&I) in the last two years has been learning from serious incidents. Some of the changes made in 2015/16 included improving our communication with families and carers following serious incidents, and ensuring that we follow up everybody discharged from hospital within seven days, not only those cared for under the Care Programme Approach.

We have continued to build on this in 2015/16. To that end, we are working with other colleagues in healthcare to ensure that the way we implement the Duty of Candour is meaningful and sensitive to people's needs at a time when things have gone wrong.

We have also participated in an initial learning exchange forum, hosted by NHS England in April 2016, to share ideas about ensuring that service users and families are involved in the investigation process and that communication is person -centred and tailored to individual needs.

We have introduced a new electronic patient record system to further enhance the way that we use information to improve the quality of care. Our quality improvement priorities for 2016/17 reflect progress and consolidation from previous years.

We continue to work towards improving the physical health of our mental health service users, and establishing the integrated psychosis unit (IPU) will be a key part of how we make improvements in strengthening the way that we manage physical health going forward. In addition, we continue to improve how we gather and respond to patient feedback and have recently launched our Patient Experience Strategy to support this.

These accounts represent our commitment to ensuring that we continue to improve service user and carer experience, and to strengthening further our commitment towards recovery focused care and continuous quality improvement. I am excited for the coming year, and look forward to sharing the outcome of our plans and our progress next year.

To the best of my knowledge, I am satisfied that the data contained in these Quality Accounts are accurate and representative.

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Angela McNab
Chief Executive

XX May 2016

Introduction

The safety and quality of the care we deliver at Camden and Islington NHS Foundation Trust is our utmost priority. Therefore we value the opportunity to review the quality of our services each year and to outline the progress we have made in improving quality as well as acknowledging the challenges we have faced in delivering care to the standards that we aspire to.

Each NHS trust is required to produce an annual report on quality as outlined by the NHS Act 2009, in the terms set out in the NHS (Quality Accounts) Regulations 2010. The Quality Account is the vehicle by which we, as providers, inform the public about the quality of the services we provide.

The Quality Account enables us to explain our progress to the public and allows leaders, clinicians, governors and staff to demonstrate their commitment to continuous, evidence based quality improvement. Through increased patient choice and scrutiny of healthcare services, patients have rightfully come to expect a higher standard of care and accountability from providers of NHS services.

A key part of the scrutiny process is involvement of stakeholders. To that end, the Quality Accounts have been developed through consultation with staff and review of key themes from service user feedback and commissioners. Going forward, we intend to strengthen the involvement of stakeholders in developing and monitoring the Quality Accounts by holding quarterly stakeholder engagement workshops. These will provide an opportunity to review and monitor progress against the quality priorities throughout the year, and to improve learning by sharing best practice from across the wider health system.

In addition to complying with the Quality Accounts Regulations, NHS Foundation Trusts are required to follow the guidance set out by Monitor, which includes reporting on a number of national targets set each year by the Department of Health.

Through this Quality Account, we aim to show how we have performed against these national targets. We also report on a number of locally set targets and describe how we intend to improve the quality and safety of our services. Our quality priorities are described in terms of the three interlinked concepts of quality as defined by Lord Darzi in his review of quality and governance in health. These are shown above.

Quality highlights for 2015/16

5.2.1 Service user led audits

This year we have made great strides in relation to developing the way we engage with patients and we now have a suite of audits that are arranged and managed by our service users, such as the Acute division client satisfaction questionnaire.

5.2.2 Launch of the Clinical Strategy

Our new clinical strategy represents our current thinking on how we will deliver services in the future. As we move to implementing the strategy, the way that staff and commissioners have engaged with the strategy: this demonstrates collaboration across our health system of which we are truly proud.

5.2.3 Development of the Integrated Practice Unit (IPU)

We believe that the IPU is a great innovation which will transform mental health care provision for Camden and Islington patients. Through the IPU, we intend to streamline our patients' access to both physical and mental health care in order to achieve better outcomes overall for our patients.

5.2.4 Freedom to speak up

Following Sir Robert Francis' review, we have reviewed and amended our policy for raising concerns to align with the recommendation made in the review. In addition we have made provision for our staff to have access to an independent telephone line for raising concerns anonymously, 'Safecall'. This will further strengthen our process for raising concerns and we will be looking to formally appoint a 'Freedom to Speak Up' guardian in the coming year

Part 2

2.1 Priorities for improvement and statements of assurance from the Board

This part of the report describes the areas for improvement that the Trust has identified for the forthcoming year 2016/17. The quality priorities have been derived from a range of information sources consulting with service users and key staff, including our commissioners and council of governors. In addition, we have looked at the priority areas that we have set within our Clinical strategy, our Workforce strategy and Organisational strategy to align these work streams and so you will see that some of the priorities also reflect CQUINs; some reflect work related to CQC compliance etc. We have also been guided by our performance in the previous year and the areas of performance that did not meet the quality standard to which we aspire. Finally we have been mindful of quality priorities at national level as evidenced in the recent government publications not least the increased focus on mortality review within mental health. Through this process, we have identified the following priorities:

PATIENT SAFETY	
Priority 1 (New)	We will establish a mortality and morbidity review process. **(Local priority – 'Stolen Years' Keogh recommendation**)
Priority 2 (Carried over)	We will ensure lessons are learnt from serious incidents **(CQC Action Plan)**
Priority 3 (New)	We will promote safe and therapeutic ward environments by preventing violence, reducing restraints and supporting staff and patients following assault incidents. **Local priority – staff and patient wellbeing)**
Priority 4 (Carried over)	We will equip staff, through raising awareness and appropriate training to identify, prevent and reduce domestic violence and abuse. **(NICE Guidance and a local CQUIN)**

PATIENT EXPERIENCE	
Priority 5 (Carried over)	We will involve service users and carers in the implementation of the clinical strategy. **(Local priority)**
Priority 6 (Carried over)	We will improve information given to service users about their medication. **(Local priority)**
Priority 7 (Carried over)	We will reduce non-clinical ward transfers. **(CQC Action Plan)**

CLINICAL EFFECTIVENESS	
Priority 8 (New)	We will comply with the 18 weeks referral to treatment targets. **(National Guidance)**
Priority 9 (New)	We will finalise and implement evidence based outcomes for the Integrated Practice Unit for Psychosis. **(Local priority)**
Priority10 (Carried over)	We will increase the uptake of smoking cessation and promote a healthier lifestyle. **(CQUIN)**
Priority 11 (New)	We will improve the understanding of outcomes of the specialist care pathway. **(Local priority)**
Priority 12 (Carried over)	We will increase staff knowledge and understanding of the Mental Capacity Act to enable practical application. **(CQC Action Plan)**

Each of the quality priorities above will be monitored with progress tracked via existing governance structures and reported on at the proposed quality accounts workshop on a quarterly / bi- annual basis. Members of the Board will sponsor relevant priorities and an implementation lead(s) will be assigned for each quality priority. This will ensure accountability in terms of oversight for each priority

throughout the year. Board sponsors and trust leads will be required to update on progress of the priorities at Quality Account workshops.

Patient safety

Priority 1:

Establishing a mortality and morbidity review process

Description of the quality issue and rationale for prioritising

This priority has been chosen for inclusion in the quality accounts following a series of discussions both at local and national level on the need to strengthen the process for reviewing deaths in mental health. The mortality review agenda has gained further impetus through the Keogh review of mortality which commenced in 2013 and the subsequent follow on reviews and recommendations which also influenced the change in the CQC inspection methodology. From a local perspective, through collaboration with local partners, we recognise the need to develop a systematic way of reviewing deaths in mental health in order that we can bring down the number of premature years lost

Current picture

The trust does not have an established process for reviewing mortality as defined in the Keogh review, although has undertaken at least three thematic reviews of suicides cover the period 2010 - 2015.

Identified areas for improvements

Process for reviewing all deaths occurring in the Trust or within 6 months of discharge

How we will improve

- We will nominate a Trust Lead for Mortality
- We will establish a Trust Mortality Review Group which will be a sub – committee to the Quality Committee

What we will measure

- Quarterly mortality report to Quality Committee and Board
- Benchmarking data against other Trusts
- Completion of thematic review of unexpected deaths

- Mortality data to be included on divisional dashboards (link to IPU outcome data on mortality)

Board sponsor: Dr Vincent Kirchner, Medical Director

Trust Leads: Clinical Directors and Associate Director for Quality Assurance

Priority 2:

To ensure that lessons are learned from incidents

Description of the quality issue and rationale for prioritising

When we took part in the pilot CQC inspection, part of the feedback we received was that as an organisation, we did not appear to be able to demonstrate learning following incidents. In particular we were not good at sharing the learning across the trust which left some of our staff unclear about what learning had taken place. Our time taken to complete incident investigation was also protracted further impacting the ability to learn lessons in a timely way. We recognise the importance of getting this right, both for our service users and staff who are directly affected when incidents occur. Therefore we have carried over this quality priority from last year's quality accounts in order that we can continue to make improvements in this important area of care and service delivery.

Current picture

Recent CQC feedback suggests that we are not achieving the greatest impact when it comes to sharing learning from incidents across the organisation, and that some of our staff experience the current process as tick box and not adding real value.

Identified areas for improvements

- Systems and methods of communicating lessons across the organisation.
- Bringing relevance and demonstrating applicability of lessons learned in other service when sharing changes in practice trust wide.

How we will improve

- Standardise the delivery / agenda of the quality fora across the different divisions
- Establishing reflective practice on all inpatient wards
- Establish quarterly learning exchange sessions (quality half – day) where staff can share learning with other colleagues across the Trust.
- Extending the remit of the serious incident review group to have greater focus on disseminating learning across the organisation.

What we will measure

- Staff awareness of incidents occurring in their areas and trust wide
- Staff awareness of recommendations arising from serious incident investigations and relevant changes to practice
- The extent to which lessons learned are embedding within the services.

Board sponsor: Claire Johnston, Director of Nursing and People

Trust Leads: Clinical Directors, Matrons and Associate Director for Quality Assurance

Priority 3:

Promoting safe and therapeutic ward environments; preventing violence and reducing restraints and supporting staff and service users following incidents of violence

Description of the quality issue and rationale for prioritising

Information from our local incident management system shows that incidents of violence and aggression remain the top most reported incident in our trust. Therefore, we have selected this as one of our quality priorities in order to have a greater focus on this quality issue that affects both staff and service users.

Current picture

Incidents of violence and aggression are the top most reported incident in the trust. When assaults against staff occur, staff do not always feel confident to bring charges against the patient, further perpetuating the cycle of violence.

Identified areas for improvements

- Better management of incidents of violence

How we will improve

- Increase staff awareness of the value of pursuing a prosecution following assaults from patients when deemed appropriate
- Ensuring that we have an adequately skilled workforce to respond to the issue of violence.
- Working in partnership with the police to pursue sanction where appropriate and to support victims of violence
- Substantive appointment to LSMS post

What we will measure

- Number of violence incidents reported to see if improvements implemented result in reduction in these incidents
- Benchmarking data against other Trusts. Through this we can liaise with better performing trusts to see what we can learn from them
- Staff feedback on experiences of violence and how incidents of violence are managed.

Board sponsor: Claire Johnston, Director of Nursing and People

Trust Leads: Clinical Directors and Associate Director for Quality Assurance

Priority 4:

Equipping staff, through raising awareness and relevant training to identify, prevent and reduce domestic violence and abuse

Description of the quality issue and rationale for prioritising

This priority reflects the national concern around domestic violence which has resulted in a national CQUIN being put forward. We recognise the importance of timely detection of those vulnerable to domestic violence and taking action to mitigate tragic outcomes. The priority has been carried over from last year

Current picture

The trust has been working on this priority over the last year and we intend to continue to build on improvements made to date through working collaboratively with partner agencies to improve identification of domestic abuse and providing support.

Identified areas for improvements

- Consistency in responding to identified domestic abuse and ensuring appropriate escalation to relevant agencies such as MARAC

How we will improve

- Continue to provide relevant training to front line staff to support them in identifying and acting on domestic abuse
- Working with partner agencies to raise awareness of domestic abuse and the help and support available to victims
- Performance against the agreed CQUIN measures for this priority

What we will measure

- Staff receiving training in safeguarding at level 1 and 2
- The extent to which our service complies with the NICE quality standard on domestic abuse
- Implementation of NICE guidance

Board sponsor: Claire Johnston, Director of Nursing and People

Trust Leads: Deborah Wright, Head of Social Work and Social Care

Patient experience

Priority 5:

Involving service users and carers in the implementation of the clinical strategy

Description of the quality issue and rationale for prioritising

The new clinical strategy has been co –developed with servicer users and carers and so we are keen to maintain their involvement and engagement in the implementation of the strategy.

Current picture

We have just launched the new clinical strategy. There are monthly strategy steering meetings that are attended by both staff and service users to ensure that all relevant stakeholders remain involved in thinking through the implementation of the strategy and problem solving together.

Identified areas for improvements

- To maintain the engagement and involvement of service users and carers throughout the implementation phase of the clinical strategy

How we will improve

Maintaining engagement of service users and carers for the lifespan of the clinical strategy

What we will measure

- Implementation of the clinical strategy against the defined implementation milestones
- Method of engaging service users and carers

Board sponsor: Dr. Vincent Kirchner, Medical Director

Trust Lead: Deputy Chief Operating Officer

Priority 6:

Medication management: improving information given to service users

Description of the quality issue and rationale for prioritising

This priority has been chosen for inclusion in the quality accounts as we recognise the importance of ensuring that service users are given appropriate information about their medication, including side effects and how best to manage these. Later in the report, we describe some of the improvements that we intend to implement during the year aimed at educating staff.

Current picture

There is inconsistent practice in relation to the quality of information given to service users about their medication and their involvement in the review of their medication.

Identified areas for improvements

- Giving relevant information about prescribed medications, including dosages and side effects

How we will improve

- Development and implementation of IPU

What we will measure

- Quarterly audit of records for evidence of information given in relation to prescribed medication.
- Service user involvement in medication reviews

Board sponsor: Dr. Vincent Kirchner, Medical Director

Trust Leads: Lucy Reeves, Chief Pharmacist and ward managers

Priority 7:

Reducing non-clinical ward transfers

Description of the quality issue and rationale for prioritising

We know that ward transfers that are not based on clinical reasons can lead to disruption in the care pathway of a service user and poor experience. Consequently we have chosen to carry this priority over into this quality account in order that we can embed the ward transfer protocols that we have developed to ensure that when transfers occur, these are for clinical reasons

Current picture

There is variance in practice with increase in ward transfers for non –clinical reasons when there is an increase in activity

Identified areas for improvements

- Systematic monitoring of non –clinical ward moves in order to gain a better understanding of the reasons for these.

How we will improve

- Implement RCA process for each non – clinical ward move to better understand themes and reasons for these occurring
- Strengthening the process for moving patients between wards and having clearly set guidelines for managing this

What we will measure

- Number of ward moves each month and where they are occurring

Board sponsor: Paul Calaminus, Chief Operating Officer

Trust Leads: Service Managers and Divisional Business and Performance Managers

Clinical effectiveness

Priority 8:

Compliance with the 18 weeks referral to treatment targets for IAPT and EIS

Description of the quality issue and rationale for prioritising

This priority has been chosen for inclusion in the quality accounts to enable us to communicate tour quality accounts audience our performance in implementing these access standards. This is a national priority which aims to ensure that 50% of people experiencing first episode of psychosis are treated with a NICE approved care package and that 95% of people referred to IAPT receive treatment within 18 weeks.

Current picture

This is a new national target that the Trust is implementing

Identified areas for improvements

- This is a new national requirement and so the trust should ensure that it has systems in place to capture and report on this metric

How we will improve

- Achieving compliance with the target and then further improving on this each quarter.

What we will measure

- People referred to IAPT receiving treatment within the specified 18 weeks standard
- Number of people receiving a NICE approved care package

Board sponsor: Paul Calaminus, Chief Operating Officer

Trust Leads: Divisional Director and Business and Performance Manager

Priority 9:

To finalise and implement evidence based outcomes for the Integrated Practice Unit for Psychosis

Description of the quality issue and rationale for prioritising

We see the implementation of the IPU as being significant in transforming the way in which we deliver person – centred care. Success of the IPU will result in better outcomes for our service users

Current picture

The IPU is in development.

Identified areas for improvements

- Management of physical healthcare for psychosis patients, particularly management of diabetes, and COPD.

How we will improve

- Develop the IPU
- Develop the reporting framework for the agreed outcomes

What we will measure

- Performance on the agreed outcomes

Board sponsor: Dr. Vincent Kirchner, Medical Director

Trust Lead: Deputy Chief Operating Officer

Priority 10:

Smoking cessation and substance misuse

Description of the quality issue and rationale for prioritising

This priority is linked to the development of the IPU. We have chosen to include this in our quality accounts to enable us to continue the work that we have been doing as part of a CQUIN last year in promoting a smoke free lifestyle and improving the physical health of our service users

Current picture

This priority will build on work already undertaken in relation to smoking cessation.

Identified areas for improvements

- To increase the uptake of smoking cessation advice and promote a healthy lifestyle

How we will improve

- Continuing to offer nicotine replacement therapy to our service users
- Ensuring management plans are put in place to support service users with smoking cessation and substance misuse
- Offering brief advice to service users identified at risk of substance misuse

What we will measure

- Audit of records

Board sponsor: Dr. Vincent Kirchner, Medical Director

Trust Lead: Smoking Cessation Lead Nurse

Priority 11:

Understanding the outcomes of the specialist care pathways
(Kevin Please check formatting as cannot put bullets in this section)

Description of the quality issue and rationale for prioritising

It is important that the outcomes of our specialist pathway are understood and evaluated so that these pathways can continue to be improved in light of measured outcomes

Current picture

The outcomes of specialist pathways is not fully understood

Identified areas for improvements

To develop an understanding of the outcomes of the specialist pathways.

How we will improve

Through measuring outcomes and making improvements based on this

What we will measure

Outcomes of specialist pathways

Board sponsor: Dr. Vincent Kirchner, Medical Director

Trust Lead: Clinical Directors

Priority 12:

Increase staff knowledge and understanding of the Mental Capacity Act

Description of the quality issue and rationale for prioritising

Understanding of the Mental Capacity Act has previously been raised as a concern by the CQC following our last inspection. We continue to train staff and raise awareness but recognise that we have more to do in relation to this. By including this in the quality accounts, we will maintain focus on this important priority and track our progress throughout the year

Current picture

Understanding of the Mental Capacity Act is varied across the Trust.

Identified areas for improvements

- Staff training in the Mental Capacity Act
- Recording of mental capacity with records

How we will improve

- Increase the availability of training on the Mental Capacity Act and applicability in clinical situations
- Working with teams to ensure understanding of responsibilities and importance of documenting all MCA decisions

What we will measure

- Numbers of staff receiving Mental Capacity Act training
- Records audit to ensure that Mental Capacity Act decisions are appropriately

documented

Board sponsor: Claire Johnston, Director of Nursing and People

Trust Lead: Trust Mental Capacity Act lead

2.2 Statements of assurance from the Board

During 2015/16, Camden and Islington NHS Foundation Trust provided and/or sub-contracted the following four NHS services across approximately 40 sites in Camden, Islington, Westminster and Kingston:

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

Camden & 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 2015/16 represents 100% of the total income generated from the provision of NHS services by Camden and Islington NHS Foundation Trust for 2015/16.

The Trust has been able to review data for each of these services in the areas of patient safety, patient experience and clinical effectiveness, and the Board has received regular comprehensive updates and reports on quality throughout the year.

Participation in clinical audits and national confidential enquiries

The Trust participates both in clinical audits and national confidential enquiries that are nationally mandated, and also those that are more locally agreed. During 2015/16, there were 3 national audits and 1 confidential inquiry that covered NHS services that Camden and Islington NHS Foundation Trust provides. During that period, the Trust participated in 100% national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries applicable to Camden & Islington Foundation Trust in 2015/16 were as follows:

a) Monitoring of antipsychotic prescribing in people (Prescribing Observatory for Mental Health – POMH-UK) - The Prescribing Observatory for Mental Health (POMH-UK) facilitates national audit-based quality improvement programmes open to all specialist mental health services in the UK. There is an annual planner for different audits which are conducted throughout the year. Results for different audits will be published intermittently throughout the year based on the POMH –UK schedule

b) National audit of intermediate care. The trust participated in this audit during the previous round and the audit report was published in 2015. Findings from the report

will be reviewed and shared across relevant services in line with the Trust audit programme.

c) Cardio metabolic assessment for people with schizophrenia (CQUIN

d) Confidential enquiry into suicide and homicide by people with mental illness (CISH). The trust participates in this audit and data collection for this audit is underway. In order to better understand suicide and homicides, the trust set up a thematic review group with a remit to review all unexpected deaths and has conducted three such reviews over the last year for deaths over the last 5 years. This work has proved valuable in helping develop an understanding of the themes emerging from these deaths and understanding service delivery issues relevant to this. We intend to share the findings from our thematic reviews with other London colleagues and will make improvements locally based on these themes.

As a consequence of the audits, Camden and Islington will be taking following action in order to improve quality.

In relation to the POMH –UK audits, the Trust will continue to participate in the next round of audits in line with the schedule. Results of completed audits will be reviewed once published and improvements to prescribing practices implemented in line with recommendations. Result if the POMH audits will also be disseminated locally to share learning.

Although the national audit of intermediate care is not included in this year's round of audits, the trust will develop an action plan based on the recently published 2015 audit.

The CQUIN work for cardio metabolic assessment for people with schizophrenia will be carried through for 2016/17 and the trust will look to incorporate this with the improvement work linked to the development of the IPU.

Finally the trust has reviewed the results of the national confidential enquiry and has undertaken at least two thematic reviews of unexpected deaths to assess if themes identified within these are similar to those highlighted in the confidential enquiry reports.

The table below summarises the national audits that the trust participated in, the data collection periods and the number of cases submitted for each one.

Audit Title	Data Collection Period	Number of Cases Submitted
POMH 13b - Prescribing for ADHD in children, adolescents and adults	May 2015	29
POMH 9c - Antipsychotic prescribing in people with a learning disability	February 2015	55
POMH 15a - Prescribing for bipolar disorder	September 2015	6

POMH 14b - Prescribing for substance misuse: alcohol detoxification	January 2016	14
EIP Audit (Early Intervention)	November 2015	75
National Audit of Intermediate Care	July 2015	N/A- Questions were asked around service provision
National Confidential Inquiry Suicide and Homicide for people with Mental Illness	TBC	TBC
CQUIN 1- Cardio Metabolic Assessment for patients with Schizophrenia	December 2015	100

Local audits

During 2015/16, the trust undertook a number of local audits and reported on these via the divisional dashboards. Some local audits were linked to local quality improvement initiatives such as the work to understand incidents of violence on inpatient wards, led by the positive and proactive group. Other local audits were linked to CQUIN activity such as audits of smoking care plans, and activities on offer to patients. Consequently, there have been action plans developed as a result and these are monitored at divisional quality forums.

Participation in clinical research

The Trust has a strong track record of participating in clinical research and is rated second best in the country for research activity. Over the coming years, C&I will be exploring the possibility of establishing a research institute to support all the research activity that it undertakes.

Quality and Innovation: The CQUIN framework

During 2015/16, 2.5% (£1.975m) of the Trust's income was conditional on achieving quality improvement and innovation goals agreed between Camden and Islington Foundation Trust and Camden and Islington CCG, in line with the Commissioning for Quality and Innovation (CQUIN) payment framework. This framework is revised annually, with national guidance offering an overview of quality priorities and scope for local development and adaptation to ensure measures are meaningful and provide an appropriate and achievable quality stretch to organisations. Further details of the agreed goals for the following 12 months are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/

The CQUINs agreed for 2015/16 between Camden & Islington Foundation Trust and our commissioners were in the following areas:

- Improving the physical health care of patients with mental health problems;
- Friends and Family Test;
- National Patient Safety Thermometer;
- A&E (Improving recording of diagnoses and reducing re-attendance rates of patients with MH needs);
- Communication with GPs;
- Prevention of Domestic Violence;
- Facilitating smoking cessation;
- Increasing successful completions for service users in drug treatment; and.
- Value based commissioning.

The Trust's performance against the CQUIN targets is shown in the table below:

	CQUIN Measures	Sample	Target	Q.1	Q.2	Q.3	Q.4
	Physical Health						
1.1	Cardio metabolic assessment for patients with schizophrenia	N	90%	N/A	N/A	N/A	19%
	Friends and Family Test						
2.1	Number of teams reporting FFT results	N	100% (25% increment target each quarter)	42%	57%	84%	100%
	Safety Thermometer						
3.1	National Safety Thermometer – Reduction in number of pressure ulcers (Lower numbers indicate fewer incidents)	Y	Zero pressure ulcers reported in NPST	2	0	0	0
3.2	National Safety Thermometer - Number of falls reported in falls census as part of NPST (Lower numbers indicate fewer incidents)	Y	Q1 baseline	2	3	1	4
3.3	National Safety Thermometer - Number of UTI reported as part of NPST (Lower numbers indicate fewer incidents)	Y	Q1 baseline	1	0	1	0
	A&E						

4.1	To improve recording of diagnosis in A&E	Y	Milestones agreed through the year	N/A	N/A	N/A	N/A
4.2	Improving Diagnoses and Re-attendance Rates of Patients with Mental Health Needs at A&E	Y	Manual audit Q4	N/A	N/A	N/A	Reported in Q1
	Communication with GPs						
5.1	Communication with GPs - quality	N	90%	N/A	30%	N/A	Reported in Q1
5.2	Communication with GPs - timeliness	Y	95%	91%	90%	88%	Reported in Q1
	Prevention - smoking						
6.1	Smoking cessation care plans	N	Q2: 50% Q4: 50%	N/A	26%	N/A	Reported in Q1
	Prevention - substance misuse						
7.1	Alcohol Screening - The number of service users provided with an assessment and management plan for substance misuse issues.	Y	90%	N/A	77%	N/A	Reported in Q1
	Integrated Care						
8.1	Medicines - Evidence in records of information given for new prescriptions about: purpose, dose, route, side effects, monitoring	Y	Milestones tbc at end of Q1	26%	48%	45%	Reported in Q1
	Prevention – Domestic Violence						
9.1	Measures to identify, assess and advice patients and encourage the provision of specialist advice, information and support services as well as mechanisms for further referral.		Quarterly monitoring and Q4 audit	N/A	N/A	N/A	Reported in Q1
	Value Based Commissioning Mental Health						
10.1	Ensure improved understanding of mental health service user pathways and sharing of digital information between organisations on the pathway. Acute providers will request a contact summary from the Trust for all service users using their services for the treatment of physical health high mortality.	N	End of Q1	The Trust continues to engage proactively with VBC			

CQUIN data listed as TBC is conducted via manual audit undertaken during Q4, and so are due to be reported in Q1.

CQUINs legend for RAG ratings,

- Green - Target met
- Amber - Target not met but projected to be met by year end
- Red - Target not met and remedial action required
- Blank - Target agreed at end of Q1

Care Quality Commission (CQC)

Camden & Islington Foundation Trust is registered with the Care Quality Commission (CQC). The Care Quality Commission has not taken enforcement action against Camden and Islington NHS Foundation Trust during 2015/16.

The Trust registers all of its services under three locations

1. St Pancras Hospital;
2. Highgate Mental Health Centre; and
3. Stacey Street Nursing Home.

All Trust services are then listed as subsidiaries of these locations, from which we are registered to provide a number of regulated activities. During the reporting period, Camden and Islington Foundation trust has not been subject to any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act (2008).

In 2014/15, the CQC undertook a comprehensive inspection, as part of the pilot of their new inspection methodology. Therefore, a formal rating was not been given. Subsequently, an inspection of Stacey Street Nursing Home was undertaken and a rating of Requires Improvement given to that service. The Trust has been working on an action plan to address the issues raised during the inspection. The Trust has had a comprehensive CQC inspection which took place in February 2016. At the time of writing the Quality Accounts, we await the outcome of that inspection.

Include ratings grid

Camden and Islington Foundation Trust did not submit records during 2015/16 to the secondary uses services for inclusion in the hospital episode statistics

Data Quality

In 2015/16, the Trust has continued its focus on improving data quality, and has built on progress achieved during the previous year. The Trust set itself the following actions with regard to data quality:

- To continue development of the Trust Information Assurance Framework;
- To agree a set of data quality indicators linked to CQUIN targets for monthly monitoring at the monthly data quality meetings, divisional performance meetings and quarterly monitoring with the lead commissioner;
- To continue to monitor the implementation of the Data Quality Policy through regular audit;
- To further develop the data quality and performance dashboards and align data quality measures to national standards; and
- To ratify the implementation of pseudonymisation in line with Department of Health guidelines.

With the focus on MH Tariff, Mental Health and Learning Disability Services (MHLDS), and Improving Access to Psychological Therapy Services (IAPT), the Trust completed the monthly submission cycles throughout 2015/16 adhering to all mandatory and voluntary deadlines. The performance is shown at trust level as well as by individual boroughs.

Measure	Regulator	Camden	Islington	Trust	Target
CPA – having formal review in the last 12 months					
Adults who have had at least one formal review in the last 12 months who have spent at least 12 months on CPA at the end of the reporting period or at the time of discharge from CPA.	Monitor	**96.8%**	**96.6%**	**96.5%**	95%
CPA – follow up within 7 days of inpatient discharge					
The percentage 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	Monitor/ VSMR	**97.5%**	**92.4%**	**95.2%**	95%
Gatekeeping					
Admissions gatekept by Crisis Resolution Teams	Monitor	**99.0%**	**98.0%**	**99.0%**	95%
Minimised delayed transfers of care					
Number of inpatients whose transfer of care was delayed during the quarter, per day.	Monitor	**0.17%**	**0.68%**	**0.61%**	<7.5%
Number of new cases of psychosis served by EIS					
All new cases taken on the caseload of an EI team for the quarter.	Monitor	**100%**	**100%**	**100%**	95%
Mental Health Minimum Data Set—Identifiers					
Count of valid entries from the following; NHS Number, DOB, Postcode, Gender, GP Registration, Commissioner Code	Monitor	-	-	**99.2%**	95%
Mental Health Minimum Data Set—Outcomes					
Employment - The number of adults whose Employment Status is known at the time of their most recent review.	Monitor	-	-	**87.7%**	50%

Accommodation - The number of adults 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 **HoNOS** - The number of adults who have had at least one HoNOS assessment in the past 12 months.					
No. of Home Treatment Episodes carried out by CR/HT teams -					
The total number of treatment episodes and not the number of patients who received an episode of care during the year.	VSMR	**237**	**267**	**504**	750 (year) per team
No. of assessments made by CR teams					
The total number of assessments made by the CR/HT teams with a breakdown of assessments by the setting (home or otherwise) in which the assessment was made.	VSMR	**467**	**449**	**916**	N/A
No. of patients receiving home treatment episodes by CR/HT teams					
Number of patients who have received a home treatment Instead of counting separate episodes, each patient should only be counted once in each year.*	VSMR	**227**	**253**	**480**	N/A
New EI cases of psychosis served by EI teams					
All new cases taken on the caseload of an EI team for the quarter.	VSMR	**21**	**22**	**43**	24
No. of People Receiving Early Intervention Services					
The total number of people who are accepted cases and are on the caseload of an early intervention team at the point in time requested.	VSMR	**227**	**236**	**463**	Camden - 150 Islington - 138
No. of patients receiving assertive outreach services					
The number of people who are on the caseload of an assertive outreach team at the point in time requested.	VSMR	**88**	**111**	**199**	Camden – No target Islington – 110**

In Quarter 2, the Trust introduced a new electronic patient record, 'Carenotes'. Since the migration to Carenotes the Trust has experienced some data quality issues and is working with the provider of Carenotes to resolve these.

Clinical Coding

Along with the increase in the number of patients clinically coded we have also seen a year on year improvement in the quality of clinical coding. Data quality of clinical coding is monitored weekly in seven key areas. Definitions of each area are given below:

- Rare Transitions (There has been an unlikely clinical movement between cluster);
- Diagnosis Mismatch (There is a mismatch between diagnosis and cluster);

- Team Mismatch Inapplicable (There is a likely mismatch between the service and the cluster, and so the cluster requires an update);

- Team Mismatch Review (There is a possible mismatch between the service and the cluster. Cluster requires review);

- Initial Assessments (Cluster is based on the initial assessment);

- Red Rule (Cluster does not match the cluster assigned from HoNOS, based on Mental Health Clustering Tool (MHCT) algorithm); and

- Cluster Missing from Cluster Record (Cluster assessment has been completed but no cluster has been selected).

Information Governance Toolkit

Information Governance (IG) is about how the NHS and social care organisations and individuals handle information. This can be personal/patient, sensitive and corporate information.

The Information Governance Toolkit is a performance tool produced by the Health and Social Care Information Centre (HSCIC). It draws together the legal rules and central guidance related to Information Governance and presents them as one set of information governance requirements. The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments. There are 45 requirements in the IG Toolkit relevant to the Trust. For the 2015/16 submission The Trust achieved an overall score of 91%, 'satisfactory' for Version 13 of the IG Toolkit, which is a green rating.

The Trust continually reviews its Information Governance Framework. This is to ensure that all personal and medical information held is managed, handled, used and disclosed in accordance with the law and best practice. In addition to the mandated information governance requirements training, data quality and clinical records management remains an area of focus. As a result, improvement has been seen across the Trust.

2.3 Reporting against core indicators

In the following section, we report on matters relating to the quality of NHS services provided as stipulated in the regulations. The content is common to all providers so that Quality Accounts can be comparable between organisations.

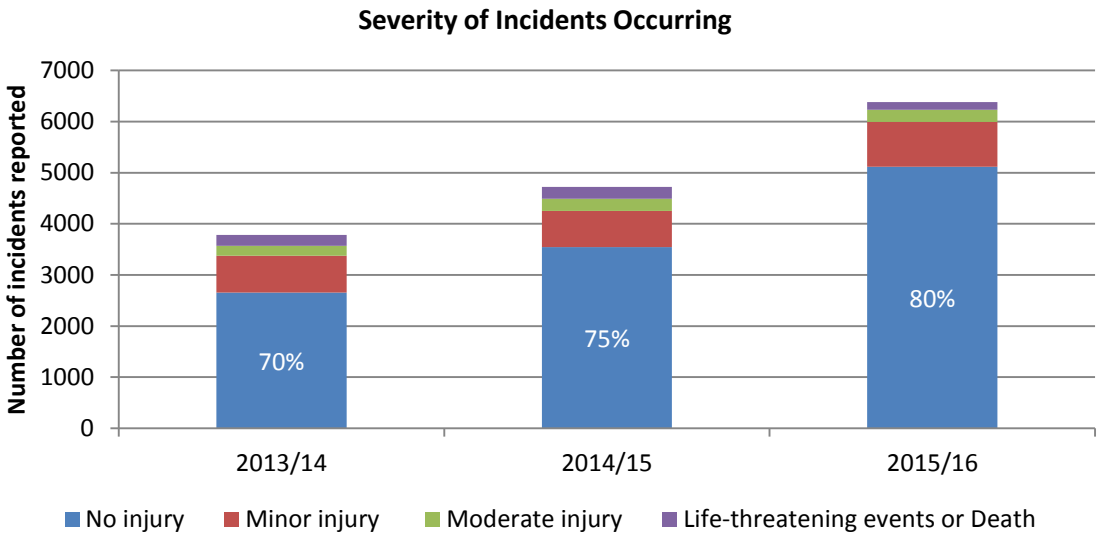
The Department of Health has drawn up a list of indicators for mandatory inclusion in Quality Accounts from 2012/13 onwards due to their pertinence and potential to provide

an assessment of quality across the five domains of the NHS Outcomes Framework. From the list of mandated indictors; six are relevant to the Trust.

NHS Outcome Framework Domain	Indicator	2015/16	National Target	Top performer (where applicable)	Worst Performer (where applicable)	2014/15	2013/14
Doman 1 – Preventing People from Dying Prematurely	Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay	95.2% (Q4)	95%	100%	-	98% (Q4)	98% (Q4)
Camden and Islington Foundation trust considers this data is as described for the following reasons: The trust has recently migrated to a new electronic patient record system and has experienced some data quality issues which may have contributed to the decline in performance albeit still within the national target. Camden and Islington intends to improve this indicator, and so the quality of its services by embedding of the new system and addressing the data quality issues through regular audit and reminder prompts to staff teams of the importance of establishing contact with patients within the first 7 days of discharge.							
Domain 2 – Enhancing Quality of Life for People with long term conditions	Admissions to Acute wards where the crisis resolution home treatment team were gate keepers	99%(Q4)	95%	100%	-	100% (Q4)	98% (Q4)
Camden and Islington Foundation Trust considers this data to be as described for the following reasons: The data is monitored regularly and discussed at team level meaning that all trust staff working within the home treatment teams have a god understanding of their responsibilities in relation to gatekeeping and ensure that appropriate documentation is maintained. Camden and Islington intends to take the following actions to improve the percentage score, and so the quality of its services, by ensuring good documentation by the crisis resolution home treatment teams and having this recorded in a readily accessible place within the care records.							
Domain 3 – Helping People to recover from episodes of ill or following injury	Patient readmitted to a hospital within 28 days of being discharged	4.2% (Camden) 9.3% (Islington)	6.2%	N/A	N/A	8.2% (Q4)	7.10% (Q4)
Camden and Islington considers the data to be as described due to the following reasons. There are various reasons contributing to readmission and this may sometimes be due to inadequate support being provided at the point of discharge or a breakdown in the handover process between inpatient teams and teams working within the community. It is also possible that this may be owing to the complexity of the needs of some patients. Over the last year, the Trust has been working on the Crisis Care Concordat as reported in our previous accounts and this work will help support developing more robust arrangements for supporting people in crisis which may reduce the potential for readmission Camden and Islington Trust has not always achieved this target and intends to take the following action to improve this indicator, and so improve the quality of its services by strengthening discharge planning, improving handovers as well as the support offered to service users upon discharge.							

Domain 4- Ensuring people have a positive experience of care	Staff who would recommend the trust to their family or friends	3.72				3.57	3.56
	Patients who would recommend the trust to their family or friends	100%				-	-
Camden and Islington Foundation Trust considers the data to be as described due to the following reasons: The trust has worked to improve patient FFT which was implemented for this first time this year and we will be caring this work over into the coming year. We recognise the low performance with regards to staff recommending the trust to friends and family and continue to work with staff to improve the staff FFT. Following the staff survey results, we will be developing joint action plans to ensure that staff experience informs the improvement targets Camden and Islington trust intends to take the following action to improve the percentage recommend for staff, and so the quality of its services by implementation of the workforce strategy elements relating to staff engagement							
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	Patient safety incidents and the percentage that resulted in severe harm or death	****					
Camden and Islington Foundation Trust considers the data to be as described due to the following reasons: The Trust has made a significant improvement in increasing its reporting rate and raising staff awareness with regards to the importance of incident reporting. The profile of the % of safety incidents resulting in severe harm or death is in line with expectations. Camden and Islington trust intends to take the following action to reduce the percentage of incidents resulting in severe harm or death by strengthening risk management processes and ensure that staff have received appropriate health and safety training to manage risks within their areas.							

***** Performance against this indicator is shown in the graph below.



Part 3

Other Information

2015/16 Quality Priorities – Progress report

This section describes the Trust's progress against the quality priorities that we set for 2015/16. The Trust had eleven quality priorities for 2015-16, reflecting both CQUIN targets and progress towards the CQC action plan.

Priority 1: CQUIN Domestic Violence

The Trust has worked on improving awareness and offering information for service users experiencing domestic violence. Performance against the CQUIN has not been finalised due to the reporting schedule however this CQUIN will be carried over into the new year with emphasis on staff receiving training in level 1 and 2 safeguarding as an addition to the specification. Other work that the Trust has undertaken in relation to this includes the AR-DSA – Awareness and response to domestic and sexual abuse, a DOH funded 2 year project in collaboration with AVA is coming to an end. The main aim was to embed a cultural change in the whole organisation by a range of activities including training and policy.

a) Over the 2 years over 300 staff have attended a 3 hour stand- alone training session designed by AVA and the Trust or have attended at least level 2 training where the issues are embedded.

b) We now have six more trainers, including the lead (SMCN) and the three hour training session is core business for the Trust and a session is provided every other month going into 2017 and will be a continued training requirement of the Trust. It is not mandatory but very well attended.

c) All nurses in the current preceptorship training will attend a one day course.

d) The course covers all aspects of domestic abuse including honour based violence, stalking and FGM, but these particular subjects are not covered in-depth.

e) In November 2015 and again in 2016 we held a White Ribbon conference. In 2016 this brought together partner agencies from the boroughs and the theme was Harmful Practises. Over 100 people attended and speakers were Vanessa Lodge, NHS England lead for FGM, Afruca, IKWRO and Hopscotch, as well as Shabana Kausar from AVA and Shirley Mcnicholas, Women's Lead and lead practitioner on domestic abuse.

f) Camden Marac – Adult mental health and substance misuse senior staff attended the Camden Marac and are the Marac coordinators for the Trust, doing the research and liaising with staff and recommending actions.

g) 'Evidence of success- DOH funded research project will produce results regarding impact of AR-DSA. Trust is responding to CQUIN targets in relation to DV training and current CQUIN to introduce and/or develop existing measures that will help to identify, assess and advise patients where there is evidence of domestic violence. To encourage the provision of specialist advice, information and support services as well as mechanisms for further referral where domestic violence has been identified.

h) Care notes – new patient record, flexible to make it responsive to needs so improving safeguarding records, we have improved the FGM assessment form.

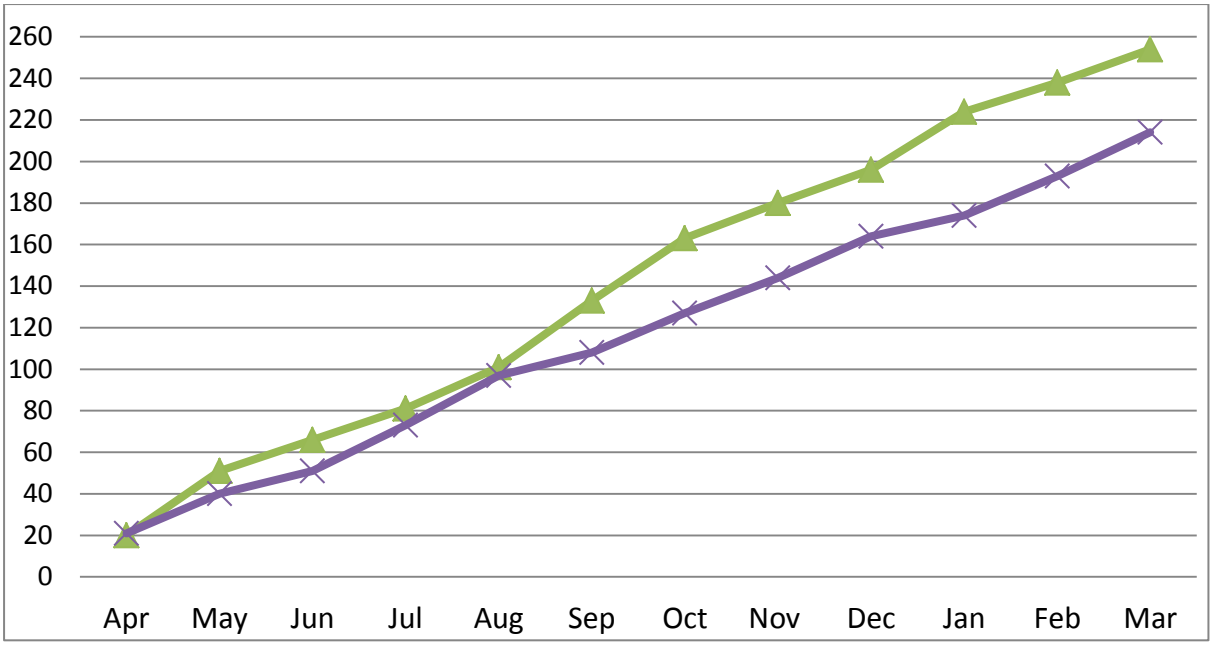
i) Within the last year FGM meetings, specialist input from Trauma team who are leading in routine inquiry of FGM and Drayton Park is beginning this from 1st June. FGM posters for staff and service users are available on intranet and are given out in DV training.

Priority 2: CQC Action Plan: Ligatures

The Trust continues to implement the major estates programme to reduce ligature risks across the Trust and to closely monitor completion of ligature risk assessments. The Trust-wide ligature quality planning group continues to monitor this work, chaired by the Associate Director for Governance and Quality Assurance. Completion of ligature risk assessments is monitored monthly at divisional performance meetings.

Priority 3: CQC Action Plan: Falls Management

The following chart shows the reduction in falls over a 2 year period. The green shows performance in 2014/15 and the purple represents performance in 2015/16.



The Trust aims to minimise the risk of falling for all service users who receive care from the Trust. To achieve this the Trust is committed to: enhancing the knowledge of staff; ensuring that staff identify those at risk of falling; taking preventative action to reduce the risk of falls; and, ensuring patients who have fallen are offered appropriate interventions with the aim of reducing injury and the incidence of further falls. The Trust also works with patients, carers and family members to mitigate the risk and consequences of any falls. In Q3, the Trust's falls risk management quality improvement programme: FallStop brought about improved procedures and a newly developed Falls policy. Throughout Q4 teams have been embedding this policy into their everyday practice. The Falls Champions have continued to lead on implementing falls risk reduction strategies in their local teams, and the Matron for Falls Prevention and Training has continued to roll out the extensive staff training programme.

The Falls Census, which measures compliance against falls risk management documentation and strategies, has been reviewed and developed. A new audit tool has been created on Meridian which provides improved data on quality care relating to falls management. The new tool gives the teams more meaningful data allowing the identification of areas of good practice as well as highlighting certain areas which the team can work on improving. The new tool will be rolled out in Q1 2016/17.

The falls quality improvement project has demonstrated a 15% reduction in falls in the 24 hour bedded settings in 2015/16 compared to the previous year. This reduction was achieved due to the support of the programme from staff from all levels, all Divisions and all Departments within the Trust, and importantly from a team of enthusiastic Falls Champions.

There is improved awareness and knowledge in teams in the Community Services of the role that they can play in reducing the risk of service users falling in the community, ultimately improving the quality of life of our service users.

Priority 4: CQC Action Plan: Learning Lessons from Serious Incidents

C&I are committed to being a learning organisation, and this is never more important than when things go wrong. In Q4 a "Learning Lessons Handbook" was issued to all sites, reminding staff of key learning points over recent months, and giving hard copies of all patient safety alerts issued to address immediate concerns. During our recent comprehensive inspection, inspectors commented that the SAMH division have been doing well at learning from incidents, and so a priority moving into 2016/17 is to share good practice across all divisions.

Priority 5: CQUIN: Physical Health

The 2015-16 physical health CQUIN assesses performance on cardio-metabolic screening for people with schizophrenia. The Trust performance on this was below what would be expected as shown in the earlier table on CQUIN performance, and therefore this work will continue into the coming year 2016/17. This is an important measure for our patient group and so it is important that we continue to focus on this until we make substantial improvements in our performance.

Priority 6: CQUIN: Working With Other Providers

Teams across the Trust work collaboratively to provide high quality care with a range of other providers, including local authorities, third sector agencies, and other NHS Trusts. Among the most frequent colleagues our staff are required to work alongside are those in Accident and Emergency (A&E) departments and general practitioners. Effective communication and collaboration is key to ensure a smooth transition between different parts of the care pathway and effective multi-agency care.

During 2015-16, audits are being undertaken of two key measures, each based on a sample of 100 patients:

- **Timeliness of communication with GPs:** Percentage of discharge notifications sent to GPs within five working days by electronic communication. Quarterly audits are being conducted to assess performance against this measure. The Trust scored 90% for this in Q2, just below the target of 95%. This measure is monitored internally via monthly divisional performance meetings, and ongoing action planning is underway not only to drive towards improved performance in Q3 and Q4. To support seamless communication with primary care, the Trust continues to roll out Docman, with thirty seven teams and services are now using the system to share patient information.

- **Quality of communication with GPs:** Percentage of a sample of letters to GPs that include:

    - Diagnostic coding;

    - Up to date care plan information;

- Information about medication; and
- Monitoring and treatment requirements.

The trust narrowly missed the target for this CQUIN, achieving 90.3% against a target of 95%. This is an important quality measure for the trust and we will continue to build on work undertaken in 2015/16 to strengthen how we communicate with our local GPs.

Priority 7: CQUIN: Assessment and management plan for substance misuse and mental health

During 2015/16, the Trust had an improvement goal relating to managing and assessing for substance misuse within mental health. Although the trust did not achieve the target set at 90%, we were able to demonstrate continued improvement between the quarters and finished the year at 80%. Whilst disappointing not to have met the target, lots of work has been done and this quality goal will be taken forward to 2016/17 which will ensure that the trust continues to build and strengthen the systems and process established in the previous year to support this.

Priority 8: CQC Action Plan: Mental Capacity Act

One of the identified areas for improvement by the CQC was in relation to staffs' understanding of the Mental Capacity Act. During 2015/16 the trust has worked to increase training provision in relation to MCA and has also established a Mental Health Hub following the appointment of a mental health act trust lead and mental capacity lead. There is a training compliance trajectory that the trust has been working toward. However at the end on 2015/16, that trajectory had not been achieved and so this priority will be taken forward into the coming year.

Priority 9: CQUIN: Service user feedback

We are pleased to have achieved 100% of teams taking part in the Friends and Family Test during 2015/16. In the community teams, 89% of respondents said they were likely or extremely likely to recommend the service to a friend or family needing similar care. In the inpatient services, this was 68%. Our focus now is moving to increasing numbers of responses and learning from feedback. Many of our teams now have "You said, we did…" displays in their services, with these rolled out across the Trust over the coming months.

NHS England regularly publishes national data. The helpful infographic available here (https://www.england.nhs.uk/wp-content/uploads/2016/03/fft-summary-infographic-jan-16.pdf) shows the responses for different types of services across England. By the end of January 2016, there had been over one million FFT responses across the country. Based on the January 2016 NHS England analysis, at 89% C&I has performed above the London mean score of 84% recommending services to friends and family, and above the overall mental health trust England mean of 87%. However, there is more to do. Our aim for 2016-17 is to increase participation, and to demonstrate the tangible changes made as a result. We have begun this process by displaying "you said, we did" signs in

all of our inpatient services. Our internal analyses show that community services are consistently given higher ratings than inpatient services (provisionally 89% vs. 68% recommend at year end). Whilst this is a national trend, we aim to bring the scores to be more closely aligned during the coming year.

Table 1. London mental health trusts FFT results for January 2016 (Source: NHS England)

Trust Name	Total Responses	Percentage Recommended
Barnet, Enfield & Haringey NHS Trust	534	81%
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	**212**	**89%**
Central North West London NHS Foundation Trust	135	90%
East London NHS Foundation Trust	337	82%
North East London NHS Foundation Trust	330	90%
Oxleas NHS Foundation Trust	266	85%
South London & Maudsley NHS Foundation Trust	492	81%
Southwest London & St Georges NHS Trust	167	89%
West London NHS Trust	102	71%

Priority 10: CQUIN: Supporting medication

Supporting medication was set as a CQUIN target in recognition of the importance of ensuring people prescribed medication are fully informed and involved in decisions. This in turn makes it more likely that people will take their medication, manage side effects well and benefit from the intervention.

New initiatives:

- Introduction of medicine education groups on wards delivered by pharmacists. Provide information to service users on medication and forum for service users to ask questions.

- Promoting more 121 counselling opportunities for service users with pharmacist during inpatient stay

- Introducing discharge counselling on medication (pharmacy staff & nursing staff)

- Choice and medication cards (details of website) issued with all TTA medicines – provides information on medication and side effects.

Community / outpatients – medication is initiated and reviewed by prescriber until optimum maintenance dose is achieved. Pharmacists now visiting and supporting community team clinicians and able to advise on medication, review prescribing and provide individual medication reviews and discuss & counsel patients on medication. They make recommendations to prescribers and service users on medicines optimisation and ensure appropriate monitoring.

All patients are reviewed at least annually. This may be more frequent depending on individual case.

Clozapine clinic HMHC has pharmacist (non- medical) prescriber. They review service users medication and side effects during clinic times and adjust dose and/or prescribe medication to manage side effects where appropriate.

Primary care mental health team (Islington) includes a pharmacist who reviews medication with service users and recommends appropriate changes and or advice on reducing side effects and ensure appropriate monitoring.

New initiatives:

- Choice and medication cards (details of website - provides information on medication and side effects). To be available from community teams to promote better use of website and information.

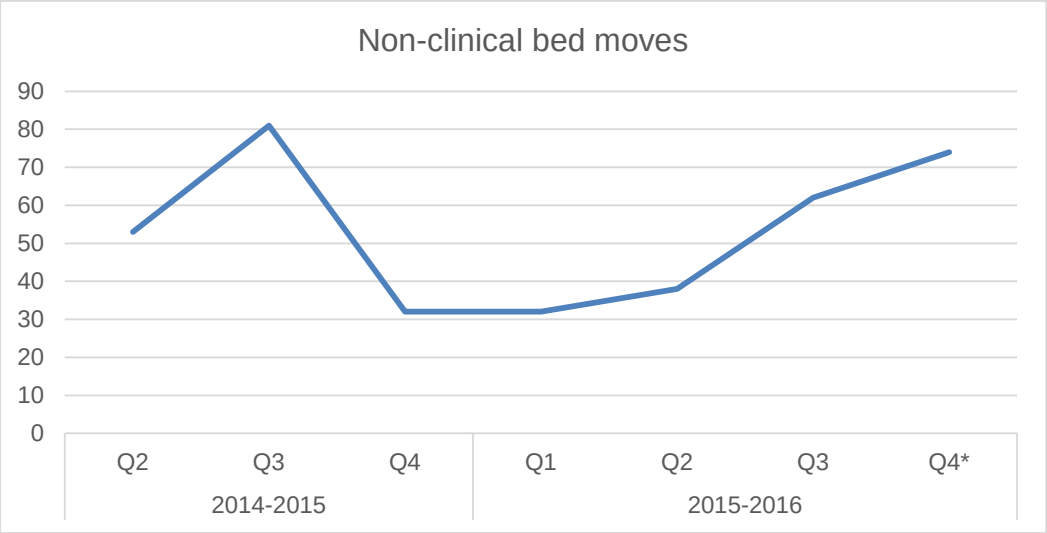
- Training for nursing and other healthcare professionals to support more effective side effect monitoring and referral for medication review.

- Developing and promoting more effective / efficient use of side effect monitoring templates. To facilitate identifying patients who are experiencing adverse effects and ensuring their medicine is reviewed promptly and appropriately.

- Medication education/information forums to be provided for outpatients as ongoing improvement initiative.

Priority 11: CQC Action Plan: Patient transfers

Alongside other Trusts both in London and other parts of the country, C&I continues to experience significant pressures on the available bed base. The Trust's policy is absolutely clear that when somebody needs an inpatient admission, they will get one. This sometimes means that people need to be moved between beds for non-clinical reasons. Data across 2015/16 is presented below and shows that despite a peak in demand in late 2015 and early 2016. Some challenges with data quality have been identified with this measure and additional audits are currently underway. Therefore, this data should be considered provisional at present.

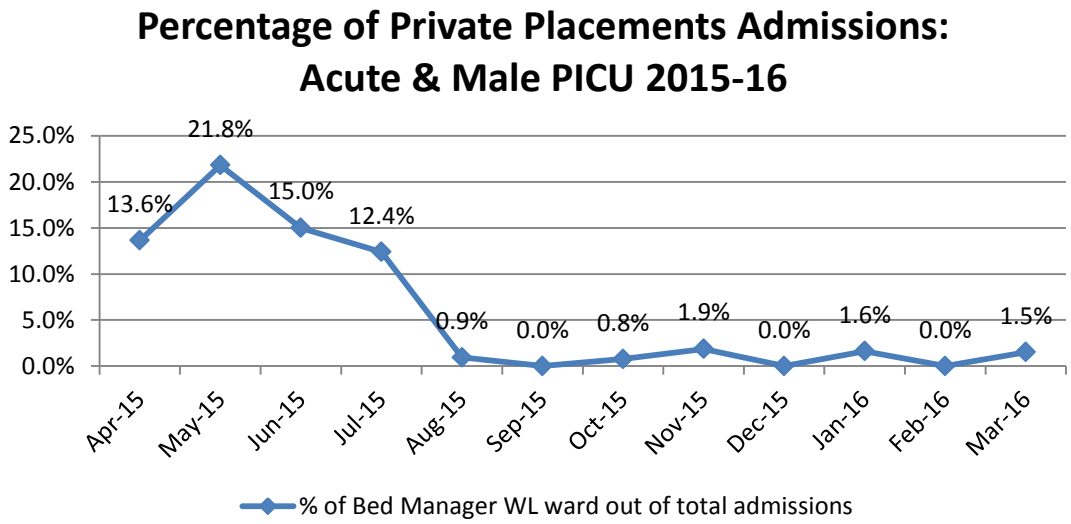


	2014-2015			2015-2016			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4* (Jan-Feb only)
Non-clinical bed moves	53	81	32	32	38	62	74

Our focus in 2015-16 has been on ensuring that when these moves happen, they happen safely and effectively, with comprehensive handovers. We have also undertaken work to ensure these do not happen during the evening or night-time, that patients are not moved more than twice, and that moves for non-clinical reasons only occur when absolutely necessary. In 2015/16, new rules have also been introduced which mean that if somebody does not return from planned leave at the agreed time, their bed is held for 24 hours to minimise the disruption to their care if they return in this period. During recent months, despite the increased bed pressure reflected in these figures, we are pleased that following an increase in our bed base since the previous year, we have achieved several months of managing demand within our own bed base, which means that we have not had to transfer patients into hospital beds provided by other organisations.

Use of private beds over the last year – Governor selected indicator

This year our governors chose to examine the use of private inpatient admissions as the indicator for inclusion in the quality accounts. This indicator seeks to measure how many patients Camden and Islington trust has not been able to provide a bed for during the course of the year and therefore had to make use of a private bed. The table below show private bed usage during 2015/16. This shows that over the year there has been a gradual decrease in the usage of private beds by Camden and Islington. This is a positive marker of quality and ability to manage our bed base. The trust made significant efforts to reduce the use of private beds and was able to work with partners across the health system to gradually bring back all patients within private placements.



Our Approach to Quality Improvement

C&I's Clinical Strategy outlines our ambition and vision for transforming our services with a strong focus on quality underpinning the principles set out in the strategy. As well as setting out the strategic direction over the next 5 years, we will also focus on the immediate local quality issues and will define our quality improvement methodology which will be informed by

the work of the Institute for Healthcare Improvement, due to their track record in improvement science as well as the more recent insights from the Kings Fund which seeks to use a values based approach to quality improvement.

Risk Management

The Trust has an established process for managing risk, and detecting and responding to quality concerns. Each Division has a risk register that is monitored regularly to ensure that any risks that cannot be managed within the Division are escalated to the corporate risk register. The risk management strategy is reviewed annually, with the Audit and Risk committee having oversight of this process. Quality within clinical areas is monitored via the service quality assurance reviews which consist of site visits, document review and staff interviews. External stakeholders are invited to take part in the service quality assurance reviews and help provide additional independent scrutiny in this process. Service improvement plans are put in place to address any areas identified in these reviews.

Approach to Quality Impact Assessment

The importance of assessing the quality impact of any transformation initiatives and cost improvement programmes is well understood within the organisation and the Trust has with commissioners, an agreed process for assessing the impact of CIP programmes which involves use of a template that provides assurance on a number of key considerations for commissioners.

Complaints

The Trust received slightly more formal complaints this year than last: 190 in 2015/16 compared to 180 in 2014/15. In addition to this, 229 concerns which were received via the Advice and Complaints Service were resolved informally. Of course this only represents some of the issues that staff resolve directly with service users on a daily basis.

The Trust is committed to using the feedback we receive through complaints to improve the services we provide. This year we have strengthened our processes for ensuring that this happens, by introducing a new action plan template and ensuring that all complaints where recommendations for change are made have an action plan against them. The Advice and Complaints Service have begun sending out regular newsletters which include changes made in response to complaints, so that this information is shared across the organisation. We have also set up a new page on the Trust website about learning lessons from complaints with examples of actions taken, so that service users and carers can be assured that their feedback really does make a difference. This is updated regularly.

The Trust is currently reviewing and upgrading its reporting systems for complaints to ensure that we are able to meet national reporting requirements. In addition this will provide us with better quality information to help us to identify and act upon any themes or trends arising from complaints in a timely manner.

Below are some examples of improvements made in the last year:

- A complaint was received about lack of organisation or a queuing system in one of our clinics, which made attending a stressful experience. As a result a ticket dispenser system was purchased and has resulted in a more orderly and fairer system for service users.

- Some of our service users have let us know that the conduct of a small minority of other users has made attending certain clinics a less welcoming experience than we would like it to be. As a result expectations will be made clear at the outset to all who attend and this will be reinforced through signage and staff engagement in waiting areas.

- We received a number of complaints following the implementation of the no smoking ban across the Trust, in line with national NHS policy. As a result it is acknowledged that we can do more to let service users know about the nicotine management policy and how it will affect them if they are admitted to a ward, by increasing the work that our community teams do with service users around this issue. We will also provide more information to visitors about the reasons for the policy and the support and nicotine replacement products that we can provide.

- As a result of a complaint about breach of Information Governance procedures, staff will receive further training to ensure that patients' information is handled correctly.

- Service user feedback has led to redrafting of team assessment protocols to ensure timeliness and quality of assessments.

Depending on the complexity of the complaint, our internal Trust targets for responding to formal complaints are either 10, 25 or 45 days. The Trust has struggled to meet the target timescales this business year and improving the timeliness of responses has been a key focus both for the Advice and Complaints Service and the divisions. Of the 190 formal complaints received, at the time of report (1 April 2016), 165 have been responded to. Of these 165 complaints, 50% were responded to within the relevant timescale. However, it is encouraging to note that there have been significant improvements in Quarters 3 and 4 and we will continue to build on this going in to the new business year, with the aim of achieving our target of at least 80% of responses being completed within the timeframe.

The following measures have been put in place to help us achieve this:

- New response templates have been introduced to help investigators structure their investigation and draft their response. Feedback suggests that investigators have found these helpful and that they have improved the quality and clarity of responses;

- The Advice and Complaints Team send out a weekly open complaints status update to the divisions. 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;
- Where investigators are having difficulty completing investigations due to circumstances outside their control, for example because key staff are absent from work, they are asked to work closely with the Advice and Complaints Team to keep complainants updated and to negotiate extensions where appropriate.
- A programme of training sessions is to be run by the Complaints and Incidents Manager for managers who are allocated to investigate complaints;
- Raising the profile of complaints within the Trust – via newsletters, training etc.
- Wherever possible we aim to resolve concerns informally and promptly at a local level, whilst being aware that our service users and carers have the right to complain formally if they wish to do so.

The Trust is also signed up to a survey run by the Patients Association to monitor satisfaction with the way that we handle complaints. We hope that this will provide us with useful information to help us improve people's experience of complaining to us. We hope that this will provide us with useful information to help us improve the quality of our complaint responses.

Compliance to NICE Guidance

There are currently 47 NICE Guidelines that are applicable to the Trust from 2011 – May 2016. A 100% of all applicable guidelines now have leads. This was an issue mainly for guidance applicable to the Trust but this has now been resolved. This should also help to decrease the number of baseline assessments outstanding over the next few months.

There are 15 partially implemented NICE Guidelines across the Trust.

The National Institute of Clinical Excellence (NICE) produces guidance from the people who are affected by our work. This includes health and social care professionals, patients and the public in addition to guidance from the Department of Health. It is based on best evidence and designed to promote good health whilst preventing ill health.

This summary provides support in regards to The Trust's compliance with CQC Essential Standards of Quality and Safety and the NHSLA's Risk Management Standards.

Positively, progress is being made towards compliance for each of the guidelines applicable to the Trust. Action plans against each of the applicable guidelines are monitored and reviewed monthly at the local clinical governance meetings within each of the divisions. It is at these meetings that the Divisional Clinical Leads are asked to provide a progress summary on compliance.

The table below illustrates the Trust's current compliance status on NICE guidelines that are applicable to each division from 2011 to May 2016.

Division	Guidelines Applicable from 2011 – 2015/16	Outstanding Baseline assessments	Partially Implemented	Completed
Acute	2	0	0	2
R&R	3	0	3	0
CMH	7	1	2	4
SAMH	7	0	1	6
SMS	4	0	0	4
Trust	24	6	9	9
Total	47	7	15	25

Key Quality Initiatives in 2015/16

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.

Sign up to Safety Campaign

Sign up to Safety is a new national patient safety campaign that was launched in June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

This campaign wants to establish and deliver a single vision for the whole NHS to become the safest healthcare system in the world. The campaign aims to take all the activities and programmes that each of the NHS organisations currently own and align them with this single common purpose.

C&I signed up to this campaign in 2015 and has published its 'Safety Improvement Plan' on the Trust website and can be viewed here. By signing up, we have made 5 commitments, which are:

- **Put safety first**: Commit to reducing avoidable harm in the NHS by half and make public the goals and plans developed locally.
- **Continually learn:** Be more resilient to risks as an organisation, by acting on the feedback from patients and by constantly measuring and monitoring how safe services are.
- **Be Honest:** Be transparent with people about progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

- **Collaborate:** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

- **Be Supportive:** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

We have a detailed action plan which is refreshed every quarter with up to date progress. The first identified priorities are:

- Learning lessons from serious incidents

- Reducing falls

- Reducing non-clinical bed moves.

Additional Information as stipulated by NHS England in letter to all Trusts dated February 2016

Implementation of Duty of Candour

In October 2014, The Duty of Candour was introduced and became one of the CQC compliance regulations. The Trust already has in place a process for involving service users and carers in the serious incident investigation process which includes routinely sharing final reports with families. During 2015/16, the Trust has maintained this process but has sought feedback on how the service user experience can be enhanced. To that end the Trust has collaborated with colleagues across the mental health sector to improve current practice and will be hosting a one day workshop facilitated by external members on 25 June 2016, ***'Making Families Count'***. This will also serve as a launch day for the revised approach to implementing duty of candour.

Also during 2016/17 the clinical governance team will be providing training for staff on duty of candour so that staff have a clear understanding on their responsibilities. This will include some best practice guidance on having good quality 'duty of candour conversations'.

Staff Survey Results – Performance against KF19 and KF27

The approach to the 2015 Staff Survey results will be very different this year as the results year on year remain the same and previous approaches haven't addressed the issues raised by the survey. This year the plan is that each division will look at their results through a 'heat map' to identify hot spots by staff group, ward, team or ethnicity. Associate Directors will be supported to develop divisional action plan and Staff Side representatives are keen to support this work especially where focus groups will take place.

Human Resources and Organisational Development will work with stakeholders in terms of working through the bottom five scores and will work up a Trust-wide action plan. In terms of the following specific two questions:

KF19 - % of staff experiencing harassment and bullying from other staff

The trust performance against this indicator is shown in the table below:

2014	C&I 38%	National 29%	0% improvement
2013	C&I 38%	National -	

Locally the divisions will be able to address exact areas to focus on, the overarching Trust plan will include continued work to embed the Trust values and reinforce the expected behaviours of our staff and managers. We have in place a Trust Whistleblowing Policy and will soon have a dedicated Whistleblowing Guardian in the Trust as well as having a raising concerns at work helpline.

KF27 - % believing that that they have equal opportunity for career progression and promotion

The table below shows the trust performance

2014	C&I 22%	National 12%	1% decrease
2013	C&I 23%	National -	

With an Equality and Diversity Manager in post (although relatively new) we now have dedicated resource to address this agenda and we know we have much to do when considering our current workforce.

In our workforce, 41.4% are Black and Minority Ethnic (BME) staff as compared to 55.9% White staff (2.7% not stated). In our workforce, 16.5% of our staff in bands 8 and above are BME staff (including medical staff and Non Executives) as compared to 77.1% White (6.4% not stated).

The majority of staff in Band 1-5 are BME staff (58.2%) while the majority of staff in Bands 6-9 are White staff 70.6%. In terms of having a representative workforce, 32.8% of the local population is from a BME background while 67.2% are white.

It follows that the Trust overall has a higher representation of BME staff as compared to the local population but a lower representation of BME staff in higher bands, Executive and Board level.

We are taking forward a comprehensive Workforce Race Equality Standard implementation plan to address these imbalances.

Care Quality Commission

The CQC have developed an 'Intelligent Monitoring' system to gather together information on each provider registered with them. Full data from C&I's most recent intelligent monitoring report is available via the CQC website (http://www.cqc.org.uk/content/monitoring-trusts-provide-mental-health-services).

Monitor Targets

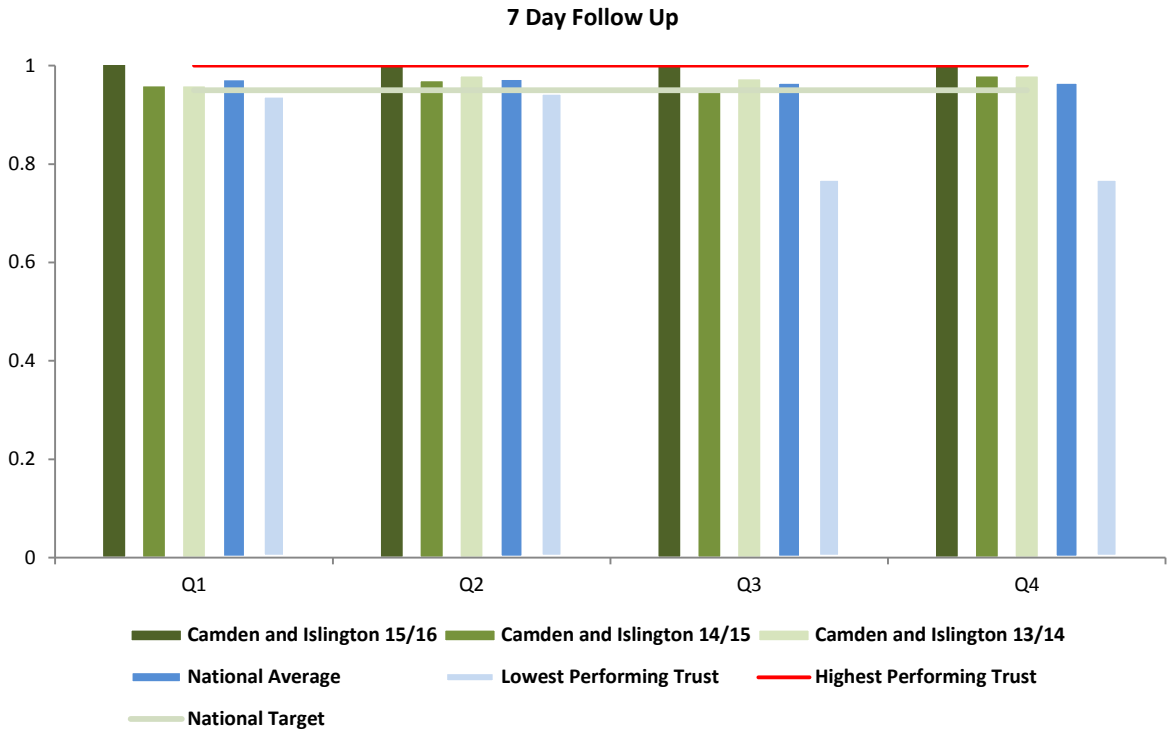
The Trust is assessed on a quarterly basis by Monitor through seven distinct performance indicators. The measures are intended to indicate the quality of mental health care at a service level, with quality being: care that is effective, safe and provides as positive an experience as possible. Trust performance against these is provided below. Percentages here have been rounded up or down to whole numbers. Where comparator data is given with decimals, we have presented our data in the same format.

Service Performance Target	Threshold	Monitoring Period Relevant to Declaration	Q1 Performance	Q2 Performance	Q3 Performance	Q4 Performance
Care Programme Approach (CPA) service users receiving follow-up contact within seven days of discharge from hospital	95%	Quarterly	**96%**	**96%**	**96%**	**95.2%**
CPA service users receiving formal review in the last 12 months	95%	Quarterly	**95.32%**	**97.5%**	**95.6%**	**96.5%**
Admissions to inpatient services had access to crisis resolution home treatment teams	95%	Quarterly	**99%**	**96%**	**99%**	**99%**
Minimised delayed transfers of care	<7.5%	Quarterly	**0.81%**	**1.2%**	**1.23%**	**0.61%**
Number of new cases of psychosis served by EIS	95%	Quarterly	**100%**	**100%**	**100%**	**100%**
People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%	Quarterly	**Required from Q4 2015/16**	**Required from Q4 2015/16**	**Required from Q4 2015/16**	**62.3%**
Improving access to psychological services (IAPT) **a)** People with common	75%	Quarterly	**Required from Q3 2015/16**	**Required from Q3 2015/16**	**90.4%**	**76.2%**

mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral **(new)** **b)** People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral **(new)**	95%	Quarterly			**99.3%**	**98.6%**
Mental Health Data Completeness: — Identifiers	97%	Quarterly	**99.85%**	**99.9%**	**99.70**	**99.2%**
Mental Health Data Completeness: — Outcomes for patients on CPA	50%	Quarterly	**91.24%**	**92.6%**	**90.46**	**87.2%**

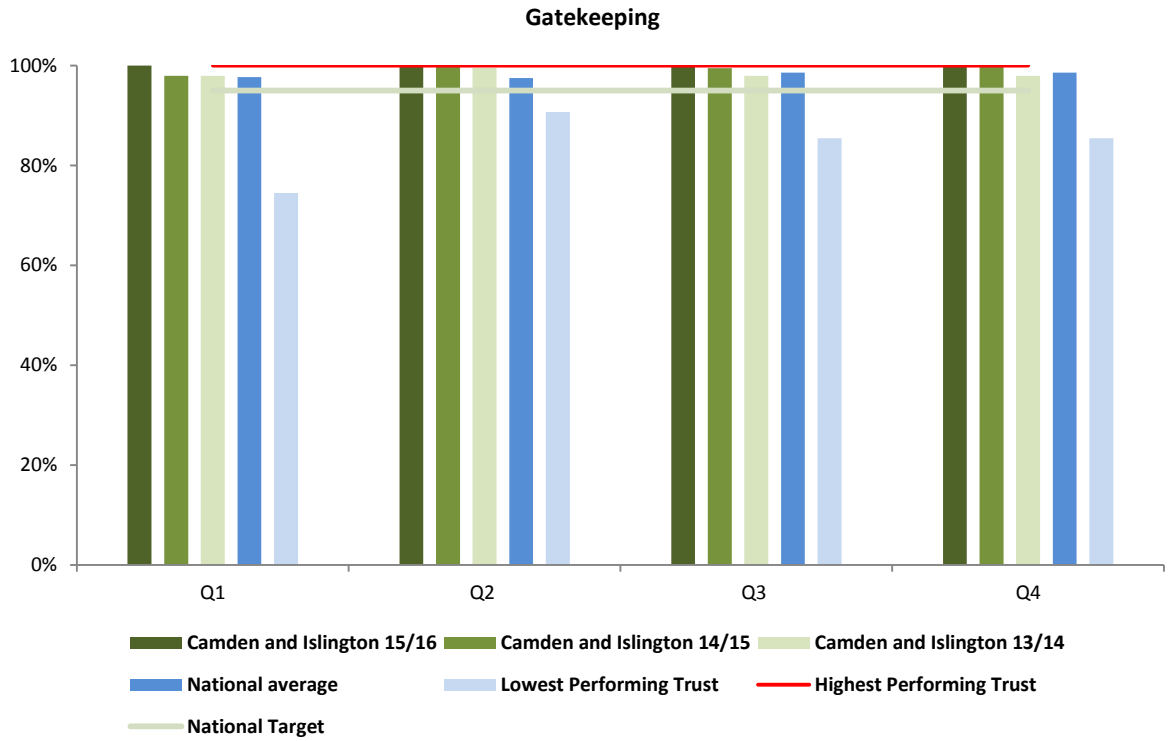
DOH Indicator 1. Percentage of patients on CPA followed up within 7 days after discharge from psychiatric in-patient care

The Trust is required to follow up all service users on CPA within 7 days of discharge from an inpatient unit. This is an important aspect of care and suicide prevention, as the first 1-2 weeks post-discharge are a time of high risk. The Trust again exceeded the target of 95% of service users on CPA being followed-up within seven days in Q4. Divisional performance meetings also review monthly follow up rates for people not on CPA, an action taken from learning from serious incident recommendations.



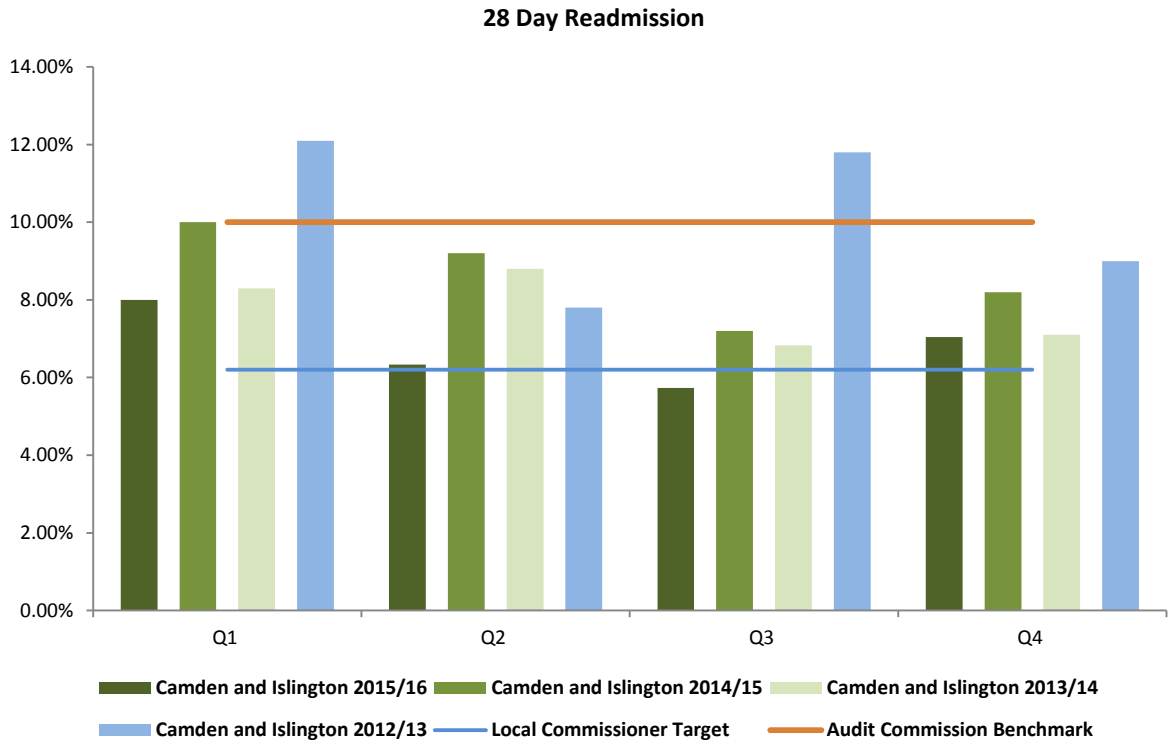
DOH Indicator 2. Percentage of admissions to Acute wards for which the Crisis Resolution Home Treatment Teams acted as a gatekeeper

As with all NHS trusts, we are required by Monitor to ensure that these assessments are completed for service users receiving care, support and treatment from services. "Access to crisis teams" is a key performance indicator for the Trust, with a 95% target. This is monitored on a regular basis and reported at monthly and quarterly intervals. The Trust Q4 2015-16 performance of 99% is above target. The reporting of this indicator has been fully automated which means that teams are able to monitor their performance via the dashboards on a close to real-time basis. Following the change to a new EPR system, work is ongoing between the Business and Performance Managers and Information Team to reinstate full automation. This measure is being supported by manual audit in the meantime.



DOH Indicator 3. Percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged

Although readmissions occur for a variety of reasons, one potential inference drawn from higher rates is that the readmission results from ineffective treatment in hospital, or from poor or badly organised readmission or support services following discharge. Therefore, it is important for the Trust to measure and monitor readmission rates. In Q4, the Trust had 7.04% readmission rate within 28 days, slightly above the target. There are some data quality issues with reporting this measure currently, and so data will be refreshed in the Q1 report.


28 Day Readmission
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Q1
Q2
Q3
Q4
Camden and Islington 2015/16
Camden and Islington 2014/15
Camden and Islington 2013/14
Camden and Islington 2012/13
Local Commissioner Target
Audit Commission Benchmark

2015/16 Limited assurance report on the content of the quality reports and mandated performance indicators

To be inserted when received

Statement of the Directors' responsibility for the Quality Report

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information, including:
    - board minutes and papers for the period 1 April 2015 to 31 March 2016;
    - papers relating to Quality reported to the board over the period April 2015 to March 2016;
    - feedback from commissioners dated **to be added when received**
    - feedback from Governors dated – **dated to be added once received**
    - feedback from local Healthwatch organisations dated - **to be added**
    - feedback from Overview and Scrutiny Committee dated - **to be added**
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
    - the national patient survey 2015;
    - the national staff survey 2015;
    - the Head of Internal Audit's annual opinion over the trust's control environment dated
    - CQC Intelligent Monitoring Report dated February 2016.

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

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

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

The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

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

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

By order of the Board

NB: sign and date in any colour ink except black

XX May 2016 .....Chair

XX May 2016 .....Chief Executive

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.

Trust staff

Trust staff were invited to contribute suggestions for areas of inclusion within the priorities for 2015/16. The staff consultation period commenced in October 2015 and finished at the beginning of December 2015.

Camden Healthwatch & Camden Health and Adult Social Care Scrutiny Committee (HOSC)

An invitation to contribute to the process of the Quality Accounts was provided to Camden Healthwatch and the Camden HOSC. Date to be included once received

Islington Healthwatch

An invitation to contribute to the process of the Quality Accounts was provided to Islington Healthwatch. - Date to be included once received

Trust Governors

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

Stakeholder Statements

Lead commissioners

Islington Healthwatch (LINks)

Islington Healthwatch were invited to make a statement for inclusion in the Quality Accounts.

Joint statement by Camden Healthwatch and the Camden Health and Adult Social Care Scrutiny Committee

Feedback

If you would like to give any feedback on the Quality Accounts 2015/16, suggest measures for 2016/17, or to ask questions, please contact the Governance and Quality Assurance Team. The team can be contacted by email at governanceandquality.assurance@candi.nhs.uk. If you would like to give feedback on services at Camden & Islington Foundation Trust, please contact feedback@candi.nhs.uk or call 020 3317 3117.