Camden and Islington NHS
NHS Foundation Trust

Camden & Islington NHS Foundation Trust
Quality Account 2016/17

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Part 1

1. Statement on quality from the Chief Executive

It is my pleasure to present the Quality Account for 2016/17. This has been a busy and important year for us at Camden and Islington NHS Foundation Trust, following the Care Quality Commission inspection report in June 2016, the ongoing development of our Clinical Strategy and the launch early this year of our new strategic priorities. To help us address our challenges our overarching strategic priorities put our future focus on what we think we are good at and how we will develop in the future: early and effective intervention; helping people to live well; and research and innovation.

For 2016/17 we set ourselves 12 quality priorities relating to the standard of care for our service users, spanning the three areas of patient safety, patient experience and clinical effectiveness. These reflected a combination of: required improvements in areas of concern highlighted in our Care Quality Commission inspection report; NICE-prescribed guidance; local health priorities or CQUINs (Commissioning for Quality and Innovation).

I am very pleased that with regard to patient experience, we made great progress
This included involving service users and carers in the implementation of our Clinical Strategy, continuing their strong input to something they had helped co-produce; and tightening up bed management and monitoring to reduce non-clinical ward transfers. Improving the information given to service users about their medication is an area we will continue to focus on.

With regard to patient safety we also made good progress in addressing the national issue of domestic violence. This was through relevant training and awareness-raising amongst staff. However, we were not quite as successful in ensuring violent and aggressive behaviour towards staff was reduced. This is a continuing concern which we need to work further on.

During the year, we have been tightening up our procedures for reviewing mortality and morbidity, and our monitoring of serious incidents involving service users. We appointed a Trust lead on mortality and set up a Mortality Review Group, and we also introduced more effective ways of sharing recommendations and learning from serious incidents. There will be further work in both these areas to review our processes, data and reporting.

We continue to make progress on a number of key priorities relating to clinical effectiveness.
I am very pleased that our approach to improving the physical health of our service users who have psychosis has been successfully developed and is bringing clear benefits. We also focused on increasing the numbers of service users who reduce or quit smoking and this will also be a key activity for the Trust. Ensuring the physical and mental wellbeing of all our service users continues to be a priority for the Trust.

In addition, we significantly improved our referral times to comply with the national guidelines for Early Intervention Services (EIS) and IAPT (Improving Access to Psychological Therapies). Activity to enhance staff training and awareness, included improving understanding across the Trust of the Mental Capacity Act (MCA). The inconsistent level of understanding amongst staff was highlighted in the CQC inspection and we will continue work in this area in the current year to ensure improvements are fully embedded.

These accounts represent our commitment to ensuring that we continue to improve service user and carer experience, and to strengthening recovery-focused care and continuous quality improvement. We have made good progress and believe the quality priorities we have selected for this year will help us achieve our ambition to provide outstanding care for every service user.

I declare that to the best of my knowledge the information in this document is accurate.

Angela McNab
Chief Executive
26 May 2017

Introduction

What is a Quality Report?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Report. Quality Reports aim to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

The safety and quality of the care we deliver at Camden and Islington NHS Foundation Trust is our utmost priority. Here we focus on three areas that help us to deliver high quality services:

- Patient safety
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience).

Scope and structure of the Quality Report

This report summarises how well we did against the quality priorities and goals we set ourselves for the last year and if we have not achieved what we set out to do, we have explained why and what we are going to do to make improvements. It also sets out the priorities we have agreed for the coming year and how we intend to achieve them and track progress throughout the year.

One of the most important parts of reviewing quality and setting quality priorities is to seek the views of our service users, staff and key stakeholders. This year we carried out a survey of all those involved with the Trust to discover what their concerns were. From this we drew up a long list of priorities which we put to a public vote. Our nine quality priorities for 2017-18 are the final result of this process.

The Quality Report also includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It also includes a description of audits we have undertaken, our research work, how our staff contribute to quality and comments from our external stakeholders.

In addition to complying with the Quality Accounts Regulations, NHS Foundation Trusts are required to follow the guidance set out by NHS Improvement, 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.

If you or someone you know needs help understanding this report, or would like the information in another format, such as large print, easy read, audio or Braille, or in another language, please contact our Communications Department.

If you have any feedback or suggestions on how we might improve our Quality Report, please do let us know either by emailing Communications@candi.nhs.uk

Language and terminology

It is very easy for people who work in the NHS to assume that everyone else understands the language that we use in the course of our day to day work. We use technical words to describe things and also use abbreviations, but we don't always consider that people who don't regularly use our services might need some help. In this section we have provided explanations for some of the common words or phrases we use in this report.

Benchmarking
Benchmarking is the process of comparing our processes and performance measures to the best performing hospitals, or best practices, from other hospitals. The things which are typically measured are quality, time and cost. In the process of best practice benchmarking, we identify the other Trusts both nationally and/ or locally and compare the results of those studied to our own results and processes. In this way, we learn how well we perform in comparison to other hospitals.

Care Quality Commission (CQC)
The CQC is the independent regulator of health, mental health and adult social care services across England. Its responsibilities include the registration, review and inspection of services and its primary aim is to ensure that quality and safety standards are met on behalf of patients.

Care Records Service (CRS)
The NHS has introduced the NHS Care Records Service (NHS CRS) throughout England and Wales. This is to improve the safety and quality of your care. The purpose of the NHS Care Record Service is to allow information about you to be safely and securely accessed more quickly. Gradually, this will phase out difficult to access paper and film records. There are two elements to your patient records:

- Summary Care Records (SCR) - held nationally
- Detailed Care Records (DCR) - held locally

CQUIN
A CQUIN (Commissioning for Quality and Innovation) is payment framework that enables commissioners to reward excellence, by linking a proportion of the hospital's income to the achievement of local quality improvement goals..

Datix
Datix is a patient safety body that produces web-based incident reporting and risk management software for healthcare and social care organisations.

CareNotes
CareNotes is an Electronic Patient Records system that is able to store more in-depth clinical information. All staff who are directly involved with a service user/patient's care will have some level of access to this system.

Foundation Trust
NHS Foundation Trusts in England have been created to devolve decision-making to local organisations and communities so that they are more responsive to the needs and wishes of local people.

Friends and Family Test
This is a survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

Improved Access to Psychological Therapies (IAPT)
IAPT is a national programme aimed at increasing the availability of talking therapies, such as cognitive behavioural therapy, on the NHS. It is primarily for people with mild to moderate mental health difficulties such depression, anxiety, phobias and post traumatic stress disorder.

Information Governance (IG) Toolkit
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.

Mental Capacity Act
The Mental Capacity Act 2005 is designed to protect and empower individuals who lack the mental capacity to make their own decisions about their care and treatment. Examples of conditions that might affect someone's mental capacity are dementia, severe learning disability, brain injury or a severe mental health condition. The law applies to people in England and Wales aged 16 or over.

Mortality
Mortality rate is a measure of the number of deaths in a given population.

The National Institute for Health and Care Excellence (NICE)
NICE provides national guidance and advice to improve health and social care. NICE's role is to improve outcomes for people using the NHS and other public health and social care services. Its main activities are:

- Producing evidence based guidance and advice for health, public health and social care practitioners.
- Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services.
- Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care.

Patient Safety Incident

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

Quality improvement (QI)
Quality improvement is a structured approach to improving performance by first analysing the current situation and then working in a systematic way to improve it. It is now an integral part of the quality agenda and aims to make health care safe, effective, patient-centred, timely, efficient and equitable.

Risk Adjusted Mortality Index
Hospital mortality rates refer to the percentage of patients who die while in the hospital. Mortality rates are calculated by dividing the number of deaths among hospital patients with a specific medical condition or procedure by the total number of patients admitted for that same medical condition or procedure. This risk adjustment method is used to account for the impact of individual risk factors such as age, severity of illness and other medical problems that can put some patients at greater risk of death than others. To calculate the risk-adjusted expected mortality rate (the mortality rate we would expect given the risk factors of the admitted patients), statisticians use data from a large pool of patients with similar diagnoses and risk factors to calculate what the expected mortality would be for that group of patients. These data are obtained from national patient records.

Risk management
Risk management involves the identification, assessment and prioritisation of risks that could affect or harm the organisation or staff and patients. The aim is to minimise the threat that such risks pose and to maximise potential benefits.

Serious incident investigation
Serious incidents in healthcare are adverse events where the consequences to patients, families, carers, staff or organisations are so significant that they require some form of investigation. These cases will be investigated thoroughly and lessons highlighted to ensure similar incidents do not happen again.

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

Serious mental illness (SMI)
An adult with a serious mental illness will have a diagnosable mental, behavioural or emotional disorder that lasts long enough to meet specific diagnostic criteria. SMI results in serious functional impairment which substantially interferes or limits one or more major life activities.

Part 2

2. Priorities for improvement in 2017-18

This part of the report describes the areas for improvement that the Trust has identified for the forthcoming year 2017-18. The quality priorities have been derived from a range of information sources, including wide-ranging consultations. 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, not least the increased focus on mortality review within mental health.

In order to make the final selection, the Trust carried out a survey to gather the views of patients, staff, volunteers, members, governors and other stakeholders on what they felt we needed to focus on to ensure ongoing improvements to the quality of care. From this we drew up a long list of potential quality priorities for 2017-18 based on local and national feedback and performance information.

This long list was then put to a public vote, open to everyone involved with the Trust, and as result the following priorities were selected:

Priorities for improvement in 2017-18

PATIENT SAFETY	
Priority 1	**Promote safe and therapeutic ward environments by preventing violence**
Priority 2	**Provide comprehensive risk assessment**
Priority 3	**Reduce poor health outcomes for people with serious mental illness**
PATIENT EXPERIENCE	
Priority 4	**Engage service users and staff in suicide prevention strategies**
Priority 5	**Better communication and involvement with families**
Priority 6	**Improve privacy and dignity for those with mental health needs who present to A&E**
CLINICAL EFFECTIVENESS	
Priority 7	**Ensure effective services by evaluating the outcomes from the Integrated Practice Unit for Psychosis**
Priority 8	**Better involvement of service users in developing and reviewing their care plans**
Priority 9	**Enable staff to protect service users through a good understanding of safeguarding and the Mental Capacity Act**

How these priorities will be delivered

We are confident we can deliver these priorities, as there will be a project plan in place to support their achievement. Each of the quality priorities above will be monitored at the Local governance meetings and Quality Committee. Members of the Board will sponsor relevant priorities and implementation leads will be assigned for each quality priority. This will ensure accountability in terms of oversight for each priority throughout the year with a final update to the Board in Quarter four of 2017-18.

Patient safety

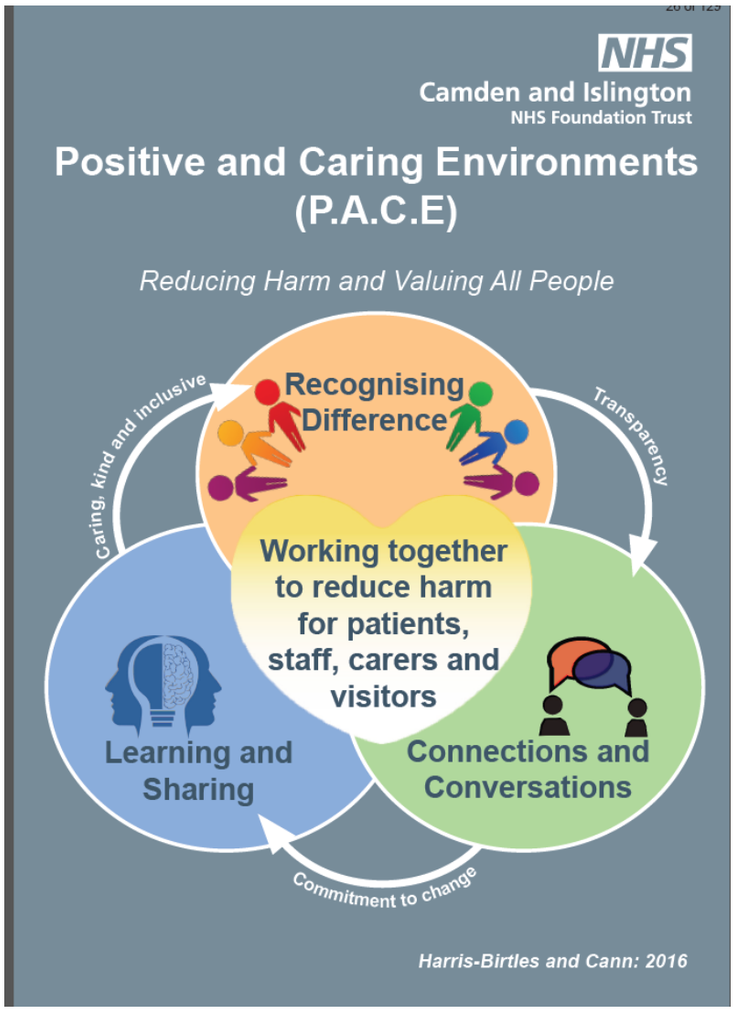
Priority 1: Promote safe and therapeutic ward environments by preventing violence

Description of the quality issue and rationale for prioritising
All staff, service users and visitors are entitled to feel safe on the wards at the Trust. Violent incidents are potentially harmful and impact on staff and patient wellbeing. We want to promote safe and therapeutic ward environments by preventing violence, reducing restraints and supporting staff and patients following assault incidents. This work builds on last year's quality priority.

The reduction of patient on staff assaults will largely be achieved as a secondary gain of reducing restrictive practice. NHS Protect (2013)

Current picture

- Number of Prone restraints (excluding seclusion) Prone restraints account for 28% of all restraints. Planned prone restraints Currently 1.5% of all restraints
- Proportion of restraints being offered physical health checks following restraint 80%
- 81% of prone restraints involve the use of Intra Muscular (IM) medication.
- Increase in violence and aggression incident reporting
- Positive and proactive training in place
- Introduction of Positive and Caring Environments Strategy (PACE)



Identified areas for improvements

- Reducing levels of violence in inpatient areas
- Reducing prone restraints
- Ensure physical observations are recorded when restraint has been used (After Action Review)
- Embedding PACE

How we will improve

- Continue to get more staff trained in IM injection alternative site training (the training has already been successful) This is a direct response to us identifying that nurses have predominantly only been trained to give IM injections in the Gluteal maximus. This necessitates the patient being prone in order to give IM medication.
- Roll out of positive and proactive care training to all member of the MDT including; rotations doctors, OT's, HCA's/Nurses and volunteers with the following topics covered:
  - ❖ Use of pharmaceutical care plans included in the Behavioural Support Plans
  - ❖ Use of debrief with staff and patients (using peer debriefs) in order to identify if there is anything that can be done differently
  - ❖ Minimise restrictive practice by using predictive tools of violence
- Direct support to all staff that have been assaulted with LSM and ward manager, immediate plan established to protect the victims of violent behaviour at work

How we will measure success

- Prone restraints (excluding seclusion) to account for less than 16% of all restraints
- Number of planned prone restraints (as defined by C&I) to be less than 1% of all restraints
- Proportion of restraints being offered physical health checks following restraint above 90%
- 75% of patients that have been restrained had Behaviour Support Plans in place prior to incident, if a historical risk of violence had already been identified or after incident if no historical risk was identified
- Formally collecting feedback from staff and patients involved in violent incidents
- Numbers of violent incidents (a reduction).

Priority 2: Provide comprehensive risk assessment

Description of the quality issue and rationale for prioritizing

Learning from serious incidents has shown us that good clinical risk assessment is a key part of providing the best care to service users and preventing incidents of self-harm and harm to others. Risk assessments need to be comprehensive and include all relevant information. It is essential staff have the right skills and tools to carry out effective risk assessments.

Current picture

To improve the quality of risk assessments the Trust reviewed the risk assessment training. The updated training was implemented throughout 2016. The training is run on a monthly basis in partnership with Middlesex University. The Clinical Risk Assessment and Management Policy is currently under review and is expected to be finalised in July 2017. The policy will be re-launched to staff. A series of lessons learned workshops are being planned throughout 2017 to support the re-launch of the updated clinical risk assessment policy.

Identified areas for improvements

- Staff skills in risk assessment
- Risk assessment tools

How we will improve

- Risk Assessment and Crisis Planning will be audited in supervision with clinicians (for Service Users on Care Programme Approach(CPA).
- Undertake a quarterly randomised audit using the same supervision audit to assess impact on the quality of crisis planning and risk care plans.
- Evaluate training provided to staff on risk assessment
- Share lessons learned from serious incidents to staff regarding risk assessment
- Developing effective risk assessment tools (review and implementation of the Clinical Risk Policy)

How we will measure success

- Carry out a baseline audit of risk assessments
- Re audit after implementation of policy
- Formally collecting feedback from staff after risk training

Priority 3: Reduce poor health outcomes for people with serious mental illness

Description of the quality issue and rationale for prioritizing
Reducing premature mortality for people with serious mental illness is a national priority. The importance of monitoring and managing physical health care has featured in service user feedback, incidents and complaints.

Current picture
There are two current CQUINS relevant to this priority:

- Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychosis. Demonstrated by a cardio metabolic assessment and treatment for patients with psychosis (in the following areas: inpatient wards, early intervention psychosis services, Community Mental Health Services patients on CPA.
- Improving physical healthcare to reduce premature mortality in people with SMI: Communication with GPs. Demonstrated by an updated CPA care plan or a comprehensive discharge summary being shared with the GP.

Identified areas for improvement

- How physical health is recorded and monitored to ensure consistency for service users with psychosis
- Communication with GPs

How we will improve

- Consistent recording of physical health status
- Regular review of physical health status
- GP name record in record
- Plan in place to support service users to register with a GP where necessary

How we will measure success
Measure the following

- Completion of physical health records
- GP details recorded
- Discharge summaries and updated care plans
- Plan in place to address patients not registered with a GP.

Patient experience

Priority 4: Engage service users and staff in suicide prevention strategies

Description of the quality issue and rationale for prioritising
The government has made a public commitment to reducing self-harm and suicide and is asking all agencies to work together to reduce suicide.

Current picture
Suicide numbers have been steadily reducing as part of a national trend . There is a local suicide prevention strategy in place that was developed with partners. Learning from Serious incident investigations has identified areas for improvement in preventing suicides. The recommendations from the National Confidential Inquiry into suicides will inform this work.

Identified areas for improvements

- The Trust will focus on implementing the local suicide prevention strategy and making staff aware of the best approaches to detecting risk and targeting help and support to prevent suicide
- Involving service users, carers, and families in suicide prevention strategy

How we will improve

- Provide focussed staff training and guidance on asking questions suicidal thoughts
- Talking to service users and carers after serious self-harm incidents to learn from their experiences
- Providing support for people bereaved by suicide
- Sharing learning from investigations into suicides
- Better detection of high risk service user

- Targeting of suicide prevention and help to service users

How we will measure success
- Audit the recording of suicidal thoughts in the records
- Number of avoidable deaths due to suicide for service users
- Service user, carers and families feedback

Priority 5: Better communication and involvement with families

Description of the quality issue and rationale for prioritising
The CQC Community Survey (2016) showed that we needed to improve communication and involvement with families. There is also a national drive to improve contact with service users, families and carers when there has been a serious incident

Current picture
Serious incident and complaints feedback as well as service user surveys tells us that we need to be consistent in making contact with families and carers, and involving them. Another aspect of this is ensuring that carers and families have positive contacts with teams when in contact with the Trust. This is particularly important when there has been a serious incident.

How we will improve
- More consistent recording of information on next of kin and service user preferences for contact with families.
- Update the serious incident policy to reflect the approach to communicating with service users, families and carers

How we will measure success
Measure the following
- Recording next of kin
- Recording arrangements and preferences for involving carers and families
- Feedback from service users and carers on communication

Priority 6: Improve privacy and dignity for those with mental health needs who present to A&E

Description of the quality issue and rationale for prioritising
Improving services for people with mental health needs who present to A&E is a national and local priority. The 2016 CQC inspection also identified this as a priority.

Current picture
In partnership with other Trusts there have been a number of improvements in Health Based Places of Safety to ensure patients are in a safe environment when they attend A&E, ligature points have been reduced. Our next step is to enhance the environment and make it comfortable for patients and carers.

Identified areas for improvements
- Privacy and dignity for service users using section 136 suites
- Keeping service users and their families comfortable and occupied during waits
- Keeping service users and their families informed about what will happen next

How we will improve
- Physical improvements to environment
- Regular reviews for patients in the suites
- introduction of Self-Occupying packs

How we will measure success
- Regular audits (including patient experience feedback)
- Quarterly checklists that comply with the Healthy London Partnership Health Based Place of Safety standards.

Clinical effectiveness

Priority 7: Ensure effective services by evaluating the outcomes from the Integrated Practice Unit for Psychosis

Description of the quality issue and rationale for prioritising
Implementation of the IPU has been a significant step in transforming the way in which we deliver person-centred care and will result in better outcomes for our service users. The IPU will have a strong focus on prevention and self-management. Through the IPU we aim to reduce the death rate in the psychosis population and improve health and social care outcomes.

Current picture
We have just completed the first year of the five-year programme. More information on this is in part 2 of the report. As of 31 Dec 2016 data showed 90% for COPD care plan in place and 63% for diabetes care plan in place

Identified areas for improvements
- Care plans in place for long term conditions
- Engagement with service users around self-management

How we will improve
Targeted improvement to complete care plans and interventions to engage service users in self managment

What we will measure
- Outcomes audit of care plans in place
- Feedback from service users and key stakeholders on the IPU

Priority 8: Better involvement of service users in developing and reviewing their care plans

Description of the quality issue and rationale for prioritizing
Feedback from CQC visits and patient surveys tells us that we need to improve how we involve patients in developing and reviewing their care plans

Current picture
There is a clear section on the care plan for the service users signature. There are care plan templates in place to ensure consistency. However, care plans should be tailored to each individual. The practice development team has been supporting best practice based approaches to care planning

Identified areas for improvements
- Service user involvement in care plans
- Quality of Care plans
- Regular review of care plans

How we will improve
- Share best practice with staff and use review and audit to share learning on care plans

What we will measure
- Care plan audits looking at rate of patients signing and review dates
- Peer review care plan audits to look at the quality of the care plans

Priority 9: Enable staff to protect service users through a good understanding of safeguarding and the Mental Capacity Act

Description of the quality issue and rationale for prioritising
The CQC inspection identified staff understanding of the Mental Capacity Act and safeguarding processes as an area for improvement. A number of improvements have already taken place to provide staff with training and ensure there is a clear process. This priority would focus on continuing these improvements by sustaining training rates for staff and auditing the process to measure improvement.

Current picture
The Trust has been delivering an action plan in response to the CQC's concerns. The plan includes further staff training and guidance, an updating of our safeguarding policy and a safeguarding 'dashboard' to provide improved oversight of referrals made by Trust staff.

Identified areas for improvements
- Training and guidance for staff

How we will improve
- Auditing the safeguarding and MCA processes
- Providing service based training

How we will measure success
- Audit results
- Training compliance at levels 1-2

Part 3

3. What we have achieved in 2016-17

Progress against the quality priorities that we set for 2016/17

This section describes the Trust's progress against the quality priorities that we set for 2016/17. The Trust had 12 quality priorities for the year, reflecting both CQUIN targets and progress towards the CQC action plan.

PATIENT SAFETY		
Priority 1	We will establish a mortality and morbidity review process. **(Local priority – 'Stolen Years' Keogh recommendation**)	Partly achieved
Priority 2	We will ensure lessons are learnt from serious incidents. **(CQC Action Plan)**	Partly achieved
Priority 3	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)**	Partly achieved
Priority 4	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)**	Achieved
PATIENT EXPERIENCE		

Priority 5	We will involve service users and carers in the implementation of the clinical strategy. **(Local priority)**	Achieved
Priority 6	We will improve information given to service users about their medication. **(Local priority)**	Partly Achieved
Priority 7	We will reduce non-clinical ward transfers. **(CQC Action Plan)**	Achieved
CLINICAL EFFECTIVENESS		
Priority 8	We will comply with the 18 weeks referral to treatment targets. **(National Guidance)**	Achieved
Priority 9	We will finalise and implement evidence based outcomes for the Integrated Practice Unit for Psychosis. **(Local priority)**	Achieved
Priority10	We will increase the uptake of smoking cessation and promote a healthier lifestyle. **(CQUIN)**	Partly achieved
Priority 11	We will improve the understanding of outcomes of the specialist care pathway. **(Local priority)**	Partly achieved
Priority 12	We will increase staff knowledge and understanding of the Mental Capacity Act to enable practical application. **(CQC Action Plan)**	Achieved

Priority 1: Establish a mortality and morbidity review

Partly Achieved

Why we adopted this as a priority

The Trust did not have a clear process for reviewing mortality as defined in the Keogh review on mortality. National reports from the CQC, National Quality Board and the Mazars report demand more open and transparent approaches to mortality investigation and reporting.

Identified areas for improvements

- 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
- 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)

What we have achieved
Over the last year we have:

- Appointed a Trust lead for mortality
- Established a Trust Mortality Review Group (MRG) which reports to the medical director. We also took account of the recommendations of the Care Quality Commission's report in December 2016, *A Review of the way NHS trusts review and investigate the deaths in England*.
- To take forward the learning from the Mazars report the Trust is holding weekly mortality review meetings to consider all patient deaths over the past week (Mazars categories are used). Preliminary reviews are also undertaken by the divisions to provide more information about care provided and any possible gaps that have been identified. In each case a decision is taken as to

whether an investigation into the care and service provision is required and, if so, what level of investigation is appropriate.

- The MRG also receives weekly updates on the progress of all on-going investigations that have been reported on StEIS (the national database for reporting serious incidents).
- One of the MRG's functions is to provide regular reports on deaths within C&I. Since September 2016 patient demographics and categorisation of death have been recorded on a tracker system.
- Thematic reviews of unexpected deaths undertaken.
- A mortality report sent to the Quality Committee including a plan for meeting the new national requirements on learning from death which will require quarterly reporting to the Board.

Future challenges
We partly achieved this priority because we did not establish data reports in a way that allowed for accurate data reporting. In March 2017 Learning from unexpected deaths guidance was published. The Trust has an action plan in place to meet the new requirements. Mortality data is being reviewed in light of new national guidance and will be reported to services in a new format. As part of this process benchmarking can be undertaken.

A leadership project is currently reviewing the processes, data and reporting used by the MRG. As part of this process it visited North East London NHS Foundation Trust's governance team which was rated outstanding in its CQC inspection. Several key ideas that emerged from this visit will be incorporated into the project's recommendations for the MRG.

Priority 2: Ensure lessons are learnt from serious incidents

Partly achieved

Why we adopted this as a priority
Our aim is to establish methods of communicating lessons about serious incidents across the organisation and to demonstrate how lessons learned in one part of the service may have applicability to others. Above all, we recognise that following a serious incident (SI) Investigation it is vital to disseminate recommendations widely and then act on them.

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.
- Standardise the delivery/agenda of the quality fora across the different divisions
- Establish 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.
- Extend the remit of the serious incident review group to have greater focus on disseminating learning across the organisation.
- 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 learnt are embedding within services

What we have achieved
Currently each division within C&I holds a monthly quality improvement forum where serious incident report findings are shared. As a result specific goals are devised to be incorporated in people's daily work, discussed at team meetings and used in supervision.

The governance team has also produced a new quarterly learning bulletin which aims to share learning from recent incidents and complaints across the organisation. The first bulletin was sent to all staff in January 2017. The aim is to identify those areas where teams can implement changes that will really make a difference to service users and carers.

Learning Lessons Workshops introduced
The focus in these workshops is on building a non-threatening atmosphere of learning and highlighting when change has occurred. It is an inclusive workshop where anyone from the division is encouraged to attend. Guest speakers are invited, including Lead and Expert investigators or other staff that may provide specialist knowledge.
The learning bulletin which contains three incidents or complaints is reviewed. This provides the opportunity for thinking about the quality and rationale for reporting through different mediums as well as taking an analytical stance on what could be done differently. Sufficient time is allowed for each incident

so that staff are able to consider thoughtfully and arrive at ideas for service implementation. These ideas are then drawn up on a flipchart to be used in the following months bulletin.

Future challenges
This priority is partly achieved because there is still work to do to embed the work that has been done to share lessons learned in services. Therefore, a key focus over the next few months will be setting up feedback mechanisms within each division so that evidence of how and when recommendations are being implemented can be understood. Currently a leadership project is focusing on how all staff members can implement learning from SIs. One idea is to use vignettes to give context to an action point and to use the intranet, one-to-one supervision and team meetings to disseminate these.

The governance team is also working with families to produce a leaflet that describes how an SI investigation works. In addition we are looking into providing families with a family liaison worker.

We are currently undertaking a review of the serious incident process to ensure further improvements are made and learning is shared.

Priority 3: Promoting safe and therapeutic ward environments; preventing violence and reducing restraints and supporting staff and service users following incidents of violence

Partly achieved

Why we adopted this as a priority
Incidents of violence and aggression were the most reported type of event in the Trust last year. Moreover, when assaults against staff occurred, staff did not always feel confident to bring charges against the patient, further perpetuating the cycle of violence.

Identified areas for improvements

- 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 sanctions where appropriate and to support victims of violence
- Substantive appointment to Local Security Management Specialist post
- Number of violence incidents reported to see if improvements implemented result in a reduction of 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

What we have achieved
Over the past year we have appointed a Local Security Management Specialist (LSMS) and worked to increase staff awareness of the value of pursuing a prosecution following assaults from patients, when deemed appropriate.

In particular, we have:

- Developed a security management strategy aligned to NHS Protect's crime strategy
- Established effective relationships with local and regional anti-crime agencies to help protect staff
- Made security a key criterion in new build and refurbishment projects
- Implemented PACE
- An updated seclusion policy and all staff on PICU attending positive and proactive care training has led to significant decrease in seclusion use.

We have taken a number of actions to ensure staff are better supported. These include:

- All staff now know how to report a violent incident, theft, criminal damage or security breach
- All staff who have been victims of a violent incident have access to support services if required
- We use the Security Incident Reporting System (SIRS) to report details of all physical assaults on staff
- Induction leaflets explaining the need to report all incidents and contacts have been developed with Camden and Islington police stations.

- Training available for staff in managing violence and aggression

Future challenges
The reason we have only partly achieved this outcome is despite efforts the number of violent incidents reported in the Trust in the last year rose from 291 to 362. An analysis of this increase shows that there is no specific factor underlying the increase. This is an area requiring more improvement and is being carried over into 2017/18 Quality Priorities. More work is planned to understand the increase.
A full scoping of currently technology to support searching has been completed and the trust has developed a business case to run a pilot project on four wards with the device (cellsense).
Six service user volunteers will be fully trained in breakaway and positive and proactive care. These volunteers can debrief for patients who have been restrained.
A further reduction reducing restrictive practice can lead to reduce in overall incidents of staff assault.

Priority 4: Equipping staff, through raising awareness and relevant training, to identify, prevent and reduce domestic violence and abuse

Achieved

Why we adopted this as a priority
This priority reflected the national concern around domestic violence which resulted in a national CQUIN being put forward. We recognised the importance of timely detection of those vulnerable to domestic violence and taking action to mitigate tragic outcomes.

How we will improve
- Provide relevant training to frontline 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
- 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

What we have achieved
We have provided training to frontline staff to support them in identifying and acting on domestic abuse and worked with partner agencies to raise awareness of domestic abuse and the help and support available to victims.

Our Awareness and Response to Domestic and Sexual Abuse (AR-DSA) project, which ended in July 2016, was funded by the Department of Health and aimed to embed cultural change in the organisation. During the project's three-year life the Trust achieved all its objectives, including developing a domestic and sexual abuse policy, creating a staff training programme and producing a multi-agency risk assessment conference (MARAC) protocol for the Trust MARAC leads.

The Trust has now agreed to fund the Against Violence and Abuse (AVA) lead for a further 18 months. We have created an AR-DSA network which has representatives from a wide range of Trust services and links to service users on the Women's Strategy Group. We have also continued to run staff training courses and launched initiatives to engage with perpetrators of domestic and sexual abuse.

In addition:
- Evidence suggests that Trust staff are completing Datix when there is a disclosure which allows us to audit
- Trust intranet site has been refurbished so the safeguarding and domestic and sexual abuse resources are more easily available to staff
- Camden Safety Net will be piloting two domestic violence surgeries based at Greenland Road and Improving Access to Psychological Therapies (IAPTs)
- MARAC leads will continue to lead on research and feedback as well as encouraging attendance. Although the MARAC referral rate for both boroughs is not high, the level of joint working between Trust staff and domestic violence agencies is very evident from the Datix reports, Carenotes and safeguarding meetings.

Training
Domestic violence and abuse form part of the safeguarding adult and safeguarding children Trust induction and core training. Levels 1 & 2 of the NICE guidance are incorporated into the delivery of Trust safeguarding training. The CQUIN target for Q4 target for training was achieved at 80.2% in terms of meeting of the NICE Level 1 & 2 domestic violence training within the Trust. Safeguarding is a priority for this year and there will be a focus on training.

Priority 5: Involving service users and carers in the implementation of the clinical strategy

Achieved

Why we adopted this as a policy
The new clinical strategy was co-designed with service users and carers so we were keen to maintain their involvement and engagement throughout its implementation.
How we will improve

Identified areas for improvements

- To maintain the engagement and involvement of service users and carers throughout the implementation phase of the Clinical Strategy

What we have achieved
The Trust held monthly 'evolution' meetings and workshops with service users and carers throughout 2016. These focused on the themes in the clinical strategy and looked at ways of improving service user engagement when delivering the strategy. This has already led to changes in the design of care plans to ensure greater service user involvement and an improved interface with primary care.

We have also developed a service user involvement strategy which aims to bring greater consistency to our approach, creating more opportunities for service users to get involved in all parts of the Trust and to co-produce service improvements and new service design. So, for example, service users are now represented on all job interview panels and are paid for any Trust work they undertake.

In addition we have restructured the Service User Alliance, which is where service user groups meet and share information. And we have now appointed a full-time Band 4 service user involvement facilitator.

Every division in the Trust now has service user representatives and as a result is adopting a more consistent approach to its service users. We have also started holding regular service user conferences. The first two were in December 2016 and April 2017.

Plans for engagement with carers are at a less advanced stage. We have co-designed a series of leaflets for carers on such topics as community services, acute day units and drug and alcohol services. We are also working on implementing the "triangle of care" which seeks to ensure a consistent approach to the needs of service users, professionals and carers.

Priority 6: Medication management: Improving information given to service users

Partly achieved

Why we adopted this as a priority

The Trust recognises the importance of ensuring that service users are given appropriate information about their medication, including side-effects and how best to manage them. The objective has been to ensure they receive this information in a format they are able to understand and at an appropriate time.

Identified areas for improvements

- Giving relevant information about prescribed medications, including dosages and side-effects
- Development and implementation of IPU
- Quarterly audit of records for evidence of information given in relation to prescribed medication.
- Service user involvement in medication reviews

What we have achieved

Audits of patient records show that the information service users receive has improved (see Tables 1 and 2 below). However, were not able to meet the requirements around information on new prescriptions which are part of the national CQUIN.

Table 1.Percentage of patient records containing evidence that information has been provided to the patient about new medication prescribed.

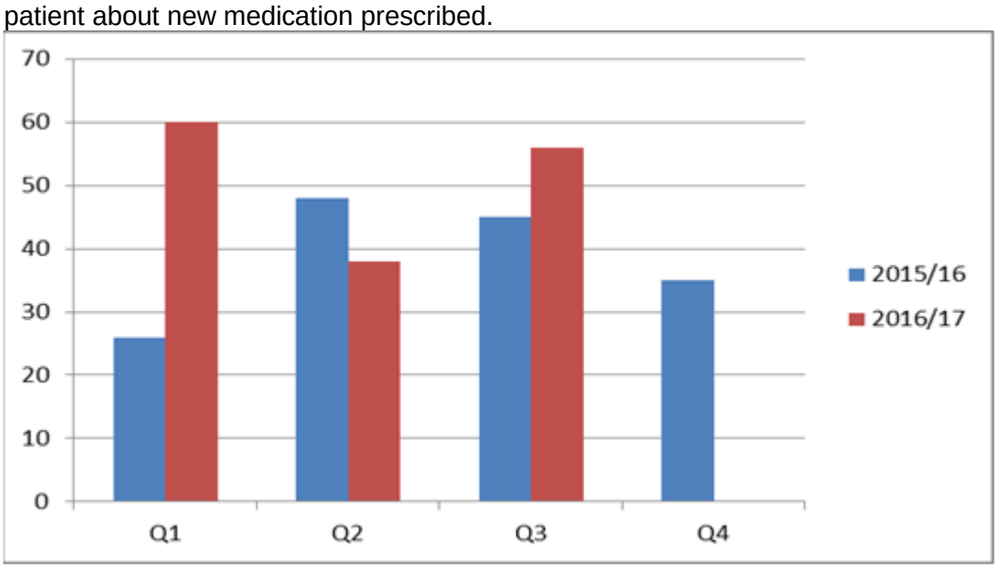
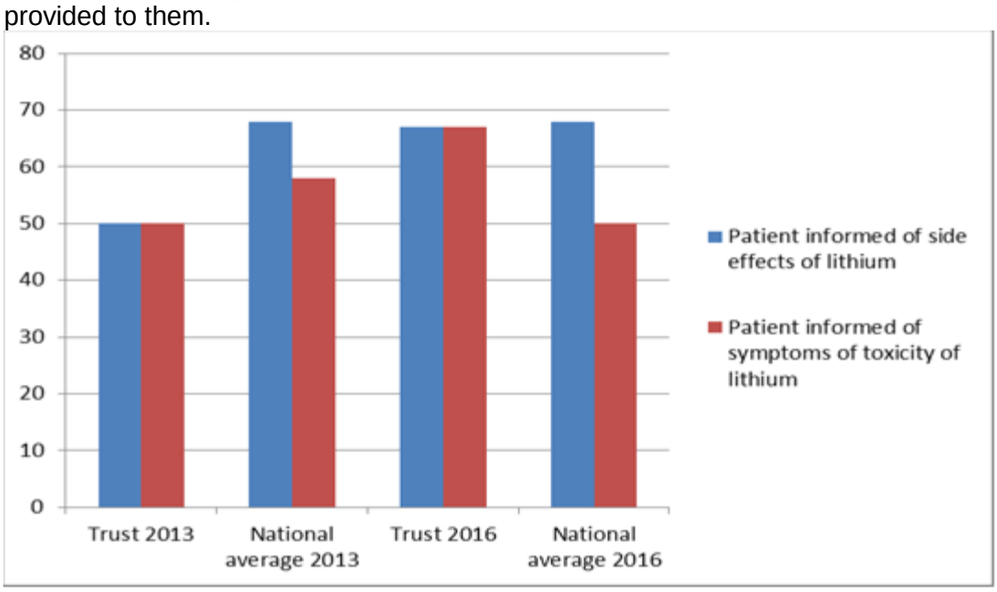


Table 2. Percentage of patients prescribed lithium with documented evidence of information being provided to them.



We recognise it is an ongoing task to ensure staff are trained and confident to provide information on medicines and document this in the patient records. A number of initiatives are under way to make sure we continue to improve and embed this in routine practice:

Staff training

We have developed a Medicines Management Train the Trainer course in house which is being implemented in 2016-17. The course includes modules on how to use the Choice & Medication (C&M) website effectively as well as counselling on medication, with specific reference to side-effects, follow-up monitoring and high risk medicines. Pharmacy staff are being trained to conduct individual medication reviews and counselling sessions as well as to facilitate group sessions for service users on medicine-related topics.

Information resources

The Trust currently subscribes to the C&M website which provides a comprehensive range of patient information leaflets on medication used in mental health. We have also subscribed to Medicines: A Patients Profile Summary (MaPPs) which produces an individualised summary of key information about a patient's medication (including physical health medicines).

Printed cards with details of the C&M website are supplied with all discharge medication.

An electronic version of the Glasgow Antipsychotic Side-effect Scale (GASS) has been developed in the electronic patient record (CareNotes). This informs service users of potential side-effects and enables a systematic review and assessment. The new physical health care assessment tool contains a link to the GASS tool. The clozapine-specific GASS tool has also been implemented in the clozapine clinics.

Provision of information
Service users should be provided with information on all new medicines prescribed. Hard copies of the most commonly used C&M information leaflets are now being pre-printed on the wards so that teams have ready access to them.

It is recognised that not all information can be provided or retained in a single discussion. For this reason we have been piloting different ways of providing information with a view to implementing across the Trust if successful. These include:

- Pharmacy and occupational therapy collaborative projects. Health and well-being sessions are delivered weekly to inpatients. Topics include weight and medication, insomnia, medicines and side-effects and smoking cessation. Pharmacy also delivers a session on medication and your lifestyle as part of the OT-run life skills programme.
- Pharmacy and service users are co-producing an 'Understanding your medication' course with St Pancras Hospital's Recovery College. The course aims to remove some of the barriers to understanding our relationship with medication and the professionals who recommend medication.
- Preparing for discharge. Prior to discharge pharmacy staff will counsel service users on their medicines as well as providing written information and reminder charts.

Future challenges
Improvements are still required to information on new prescriptions. Sustaining the improvements is also a challenge and the Trust will continue to monitor this area.

Priority 7: Reducing non-clinical ward transfers

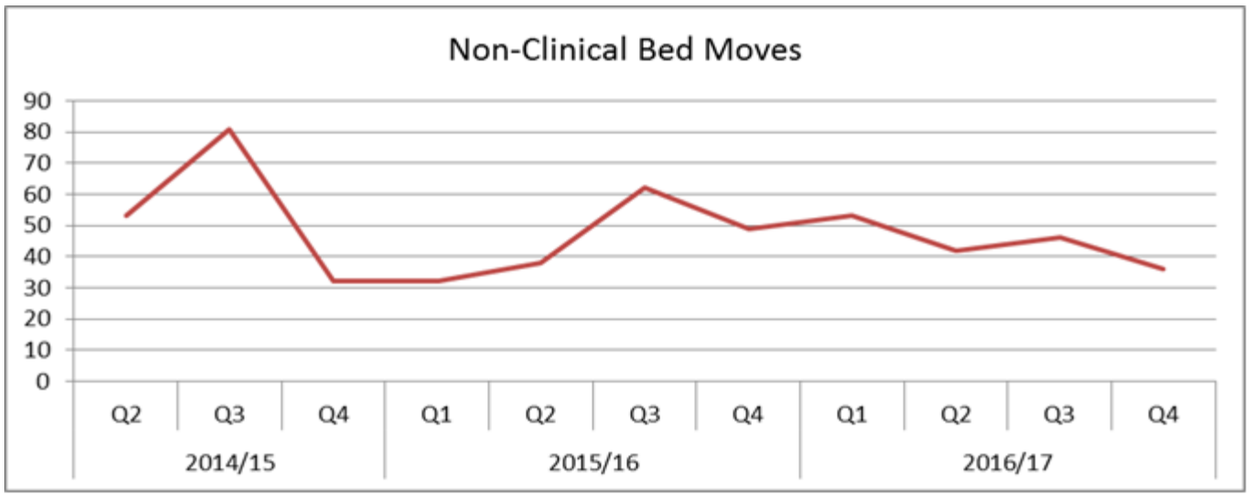
Achieved

Why we adopted this as a priority
The Trust's policy is absolutely clear that when somebody needs an inpatient admission, they will get one. At times when bed occupancy is high (>95%) this may mean some people are moved between beds for non-clinical reasons so that those in greatest need have the most appropriate bed. This priority was aimed at ensuring such moves were kept to the absolute minimum.

How we will improve
- Implement Review and systematic monitoring for each non–clinical ward move to better understand themes and reasons for these occurring
- Strengthen the process for moving patients between wards and having clearly set guidelines for managing this.
- Number of ward moves each month and where they are occurring

What we have achieved
We are pleased to note that following an increase in our number of beds in April 2016 we managed to achieve several months of managing demand within our own bed base - despite the increased bed pressure. This means we have not had to transfer patients into hospital beds provided by other organisations.

We know there is a direct relationship between high levels of bed occupancy and non-clinical ward transfers. Excess demands for either male or female beds can also create a peak in non-clinical transfers. However, our data, presented below, shows that despite an occupancy rate of between 98-99% in 2016-17 the number of non-clinical transfers has not increased significantly compared with last year.



	2014/15			2015/16				2016/17			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-clinical bed moves	53	81	32	32	38	62	49	53	42	46	36

We focused on ensuring that when these moves happened, they happened safely and effectively, with comprehensive handovers. We continue to 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. The inpatient management team applies strict rules for all non-clinical bed moves and manages these moves closely. This includes escalation processes and conference calls to ensure any such moves are planned appropriately.

We have also conducted a retrospective review of a sample of non-clinical moves to ensure the transfer protocol is being followed and to establish how the patterns of peaks and troughs relate to bed occupancy.

Priority 8 - Compliance with the 18 weeks referral to treatment targets for Improving Access to Psychological Therapies (IAPT) and Early Intervention Services (EIS)

Achieved

Why we adopted this as a priority

Meeting accessibility standards for IAPT and EIS services was made a national priority in 2015-16. The measures – which were also adopted as a priority by the Trust - are an indication of the quality of mental health care at service level, ensuring care is effective and safe. The aim is for 50% of people experiencing a first episode of psychosis to be treated with a NICE-approved care package and for 95% of people referred to IAPT to receive treatment within 18 weeks.

How we will improve

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

What we have achieved

We are on target to achieve the NHS Improvement targets during 2016-17. The data will need validating by the commissioning support unit to confirm the achievement.

Service Performance Target – Improving Access to Psychological Therapies (IAPT)	Target	Q4 Performance
People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral: Camden Islington Kingston	75%	 82.4% 81.8% 94.9%
People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral : Camden Islington Kingston	95%	 98.8% 99.1% 99.0%

Early Intervention Services	Target	Q4 Performance
People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%	87.5%

Priority 9: Integrated Practice Unit (IPU)

Achieved

Why we adopted this as a priority
The Trust began developing the Integrated Practice Unit for psychosis – or integrated pathway – last year as a means of transforming the way we deliver person-centred care and improving outcomes for our service users.

Identified areas for improvements

- Management of physical healthcare for psychosis patients, particularly the management of diabetes and COPD
- Develop the IPU
- Develop the reporting framework for the agreed outcomes

What we have achieved
In the first year of the programme we have trained a large number of the Trust's nurses to assess and treat physical health conditions such as diabetes and lung disease. We have also successfully run a number of smoking cessation classes (see Priority 10 for figures on training and cessation). And between September and December 2016 we collected 500 patient-reported outcome measures.

The programme's outcome measures have now been finalised and signed off by all the partners. It is intended that the partners will include these as quality indicators in their contracts.

We recognise this is the beginning of a fundamental change in the way we provide services for people with psychosis. It is estimated that half of all those with psychosis are in contact with C&I at any given time with the other half receiving care through primary care. We will work more closely with health and social care colleagues outside the Trust to ensure these patients can be supported in a co-ordinated way with care packages built around individual needs. The next stage will be to agree an information sharing agreement with primary care and to conclude a formal contract between all the partner organisations.

Future challenges
We are currently monitoring clinical outcomes through our balanced scorecard while we wait for wider system reports from the Commissioning Support Unit. This priority will be carried over into 2017-18 Quality priorities, where improvements will continue to be monitored

Priority 10: Smoking cessation and substance misuse

Partly achieved

Why we adopted this as a priority
Smoking cessation and access to substance misuse services were chosen as clinical priorities last year as part of the development of the IPU. It enabled us to continue the work that we were doing as part of a CQUIN to promote a smoke-free lifestyle, improve our service users' physical health and ensure they received an assessment in relation to substance misuse. The CQUIN focuses on training staff to enable them to undertake the assessment and provide appropriate support to service users.
How we will improve

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

Substance misuse
A CQUIN agreed in March 2016 set out targets to implement an agreed substance misuse screening tool to several frontline services via an online e-learning package. Our target was that 59% of agreed teams be trained by Q4 (Qtr 4 figures to be added). A brief, accessible screening tools training package has been completed on the Trust "training tracker" platform. This package includes referrals advice and screening tools for opiate overdose and substitution therapy, alcohol withdrawal and B6 replacement.

All appropriate staff have also completed a larger, more comprehensive e-learning based training package. This package is designed to inform and support staff from different healthcare branches. It contains both commonly known Mental Health Act information as well as updates on substance misuse.

We have identified a number of areas for further improvement and intend to:

- Keep monthly dialogue with the main points of referral to SMS and MH teams
- Collect monthly usage data via EPR/care notes team
- Discuss issues with service managers and directors. A training plan has been agreed in the new policy
- Maintain ongoing dialogue with current service user (SU) groups. Links with Islington Borough User Group (IBUG) and Camden Borough User Group (CBUG) frontline are already in place.

Smoking cessation
Smoking prevalence remains fairly constant, in the range of 50-80%, among those experiencing mental health problems. In the general population it has fallen to an average of 20% in recent decades. Smoking increases the risk of some mental health problems, including anxiety and depression, and can make pre-existing conditions worse. Smoking tobacco (as opposed to using nicotine replacement therapy) also disrupts the action of most psychoactive medicines, with smokers typically requiring higher doses. We are therefore committed to enabling service users to quit in pursuit of improved physical health and sustained recovery.

The Trust is addressing smoking and tobacco dependence through:

- Training staff from all disciplines to a level appropriate to their role, from basic awareness of smoking related harms and remedies to delivering smoking cessation interventions
- Appointed a Trust lead for smoking cessation
- Recruitment of two specialist nurses to promote smoking cessation
- Increased availability of nicotine replacement therapy (NRT) in all forms.

The total number of staff trained in smoking cessation since April 2015 is 193 (see below).

	Level 1	Level 2	Level 3	Total
No of staff trained in smoking cessation	151	34	8	**193**

In addition 208 service users (with severe mental illness were offered smoking cessation). Just under half (102) declined the offer, a significant number have reduced – or plan to reduce - their smoking and 27 have quit altogether.

We have identified a number of areas for further improvement and intend to:

- Train more staff to deliver smoking cessation interventions
- Ensure all newly referred service users are advised on where to access help to quit
- Make electronic cigarettes more available to service users
- Incorporate smoking cessation as a core component of all care plans, whether the therapeutic goal is to maintain current smoking status, reduce harm or to quit
- Engage service user groups in formulating revised smoking policies using a co-production approach.

Future challenges

Improvements are still required and the Trust is refreshing the strategy to ensure staff and service users are supported to quit smoking.

Priority 11: Understanding the outcomes of the specialist care pathways

Partly achieved

Why we adopted this as a priority

It is important that we understand and evaluate the outcomes of our specialist pathways so that they can be constantly improved. Pursuing this priority has also involved staff training on substance misuse assessment within mental health services.

How we will improve

Through defining and measuring outcomes and making improvements based on this

What we have achieved

This was an ambitious priority but we have made great progress in defining and establishing outcomes which will enable us to make improvements based on evidence from service performance. There is still work to be done in some areas to define key outcomes which is why the priority was partly achieved.

Community mental health division (CMH)

a. Traumatic Stress Clinic

Outcome measures which are routinely used include PCL- 5 (PTSD Checklist version 5) for post traumatic stress syndrome, PHQ-9 (Patient Health Questionnaire) and WSAS (Work and Social Adjustment Scale). These are administered at assessment, before the start of treatment and at the end of treatment as well as at various points during treatment to track progress. We also use a range of other outcome measures for our group interventions to track progress.

b. Complex Depression Anxiety and Trauma (CDAT) service

The individual psychological treatment measures used are BDI (Beck Depression Inventory), BAI (Beck Anxiety Inventory), and WSAS (Work and Social Adjustment Scale). In addition disorder specific measures are employed where appropriate. These are administered at assessment, before the start of treatment and at the end of treatment as well as at various points during treatment to track progress. Behavioural activation groups collect BDI, BAI and WSAS data. We also use a comprehensive range of pre- and post-intervention measures to assess the efficacy of transcranial magnetic stimulation. We also are about to introduce some individualised goal attainment scaling.

c. Psychotherapy service

The psychotherapy service uses a client self-report questionnaire designed to be administered before and after therapy for both individual and group treatment. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a five-point scale ranging from 'not at all' to 'most or all of the time'. The 34 items of the measure cover four dimensions:

- Subjective wellbeing
- Problems/symptoms
- Life functioning
- Risk/harm

The questionnaire is repeated after the last session of treatment with the comparison of pre-and post-therapy scores offering a measure of 'outcome'.

Serious mental illness

We also have specific targets for smoking (reducing incidence from 44% to 40% over the next five years), COPD screening (to rise from 70% to 75%), flu vaccinations for people with SMI and COPD (50% to 58%) and the number of patients with blood pressure of 140/80 or below (69% to 74%). A new screening programme to identify those with diabetes (currently believed to be three times higher than in the general population) is expected to see an increase because of better screening techniques before a slight fall in the final year of the programme.

The pathways will be measured though a combination of patient-reported outcome measures and other clinical, public health and mortality data. The first three measures relate to overall mortality, premature mortality and suicides. New national guidance will support the monitoring of this We are taking steps to introduce measurable improvements over the next five years in, among other things, patients' quality of life, symptomatic control, self-management, access to services, dignity, respect and absence of stigma, personalised care and side-effects from anti-psychotic medication.

Substance Misuse Service (SMS)

The pathways will be measured through NDTMS submitted data.The first measure is successful completions. Our target is for 8% opiate, 40% non-opiate, 40% alcohol and non-opiate and 45% alcohol only service users as a proportion of the caseload to exit treatment drug free or as an occasional user. In Camden at the end of Q3 75% of the opiate target, 71% of the non-opiate and 60% of the alcohol and non-opiate targets were met. In Islington, 38% of the opiate target was met, non-opiates exceeded its target by 50%, alcohol and non-opiate and alcohol only completions met 73% of their respective targets. Individuals achieving this outcome demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.

In addition, we have a 90% target for the completion of the Treatment Outcomes Profile (TOP) of which we are 100% compliant for starts, reviews and exits at Q3 (update). TOP measures the changes and progress in key areas of the lives of people being treated in drug and alcohol services and aids the achievement of key outcomes. There is a 96% target for effective engagement in treatment – that is, retaining service users in treatment for 12 weeks or discharging them successfully. By the end of Q3 86% of our users met this target.

Priority 12: Increase staff knowledge and understanding of the Mental Capacity Act (MCA)

Achieved

Why we adopted this as a priority
Understanding of the Mental Capacity Act (MCA) was varied across the Trust and had been raised as a concern in the CQC inspection. We recognised we needed to do more by tracking our progress against this important priority throughout the year.

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 the importance of documenting all MCA decisions
- Numbers of staff receiving Mental Capacity Act training
- Records audit to ensure that Mental Capacity Act decisions are appropriately documented

What we have achieved
MCA training is mandatory for all clinical staff in the Trust and covers not only legal requirements but also applying the MCA in clinical situations. All new clinical staff receive training in this area as part of the Trust induction programme. Existing staff are trained through an MCA workbook. Upon completion of the workbook the staff member takes a test to check understanding, which is then marked by the Mental Health Law Hub (MHLH). As a result of these initiatives, 83% of all the Trust's staff have now received training on the MCA.

- The MHLH has also developed MCA recording tools on the EPR system for all staff to use. Assessment forms to record capacity tests and best interests assessments are available on the EPR system. Other initiatives include:
- MCA and Deprivation of Liberty Safeguard (DoLS) flowcharts have been devised to help clinicians know when and how to apply the MCA and where to record tests for capacity and best interests.

- The MHLH has given presentations to all inpatient and community teams on how to record capacity and best interest assessments on the EPR system, stressing staff's responsibilities under the MCA and the importance of documenting all MCA decisions.
- The Trust organised an MHLH roadshow in November 2016 to increase staff knowledge and understanding of mental health law in general and mental capacity law in particular.
- Earlier this year the MHLH launched a new initiative enabling a group of clinicians to become mental health law champions. They received specific training on the MCA and are now responsible not only for advising their teams/colleagues on MCA issues but also for monitoring compliance with the legislation. We now have a mental health law champion in the Acute, R&R and SAMH divisions as well as in the Recovery College.
- The MCA lead has now completed an audit on EPR to ensure that MCA decisions are appropriately documented.

Future challenges
We have met the initial challenges we set for MCA in 2016. However, we believe there are still further improvements to be made to improve staff understanding of this area. The Trust is carrying over this priority into 2017-18 in conjunction with safeguarding as it is an important area of quality for services users that we can further improve and sustain

4. Statements of assurance from the Board

During 2016-17, 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 and Islington NHS Foundation Trust has reviewed all the data available to it on the quality of care in each of these NHS services.

The income generated by the NHS services reviewed in 2016-17 represents 100% of the total income generated from the provision of NHS services by Camden and Islington NHS Foundation Trust for 2016-17.

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.

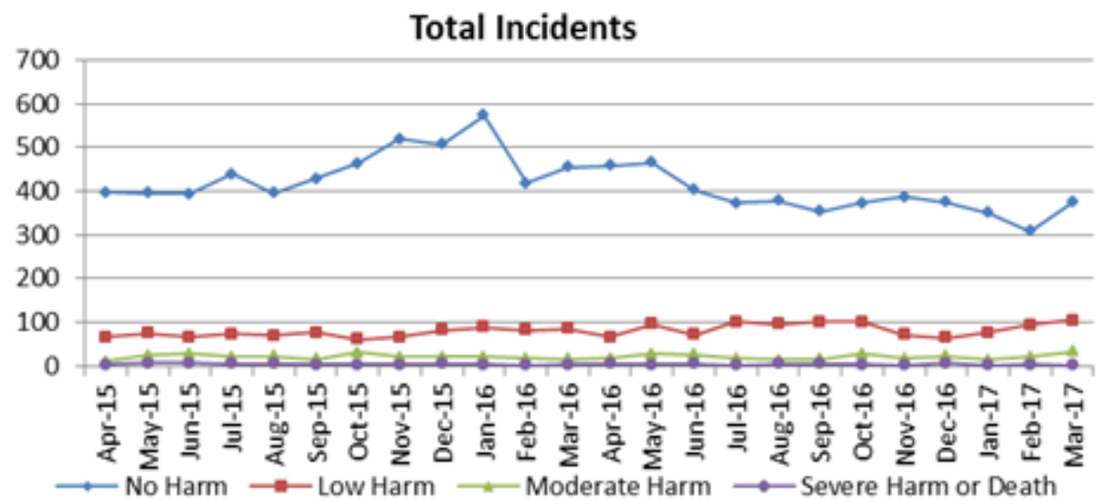
An overview of the quality of care offered by the NHS foundation trust:

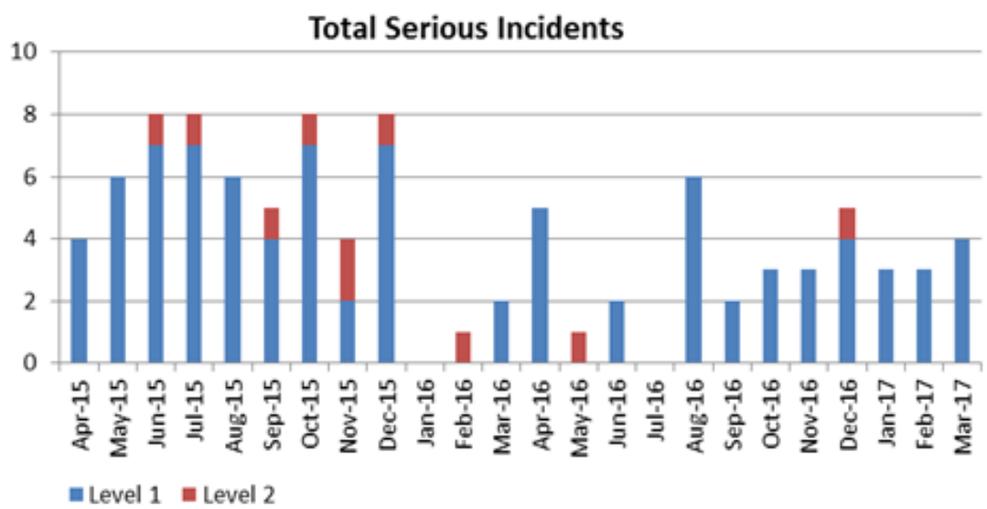
Key indicators of safety, effectiveness and patient experience

Patient safety

There was a decrease in incidents reported on the previous year. The Trust is further examining and will address if necessary as a good safety culture is indicated by a high reporting level.

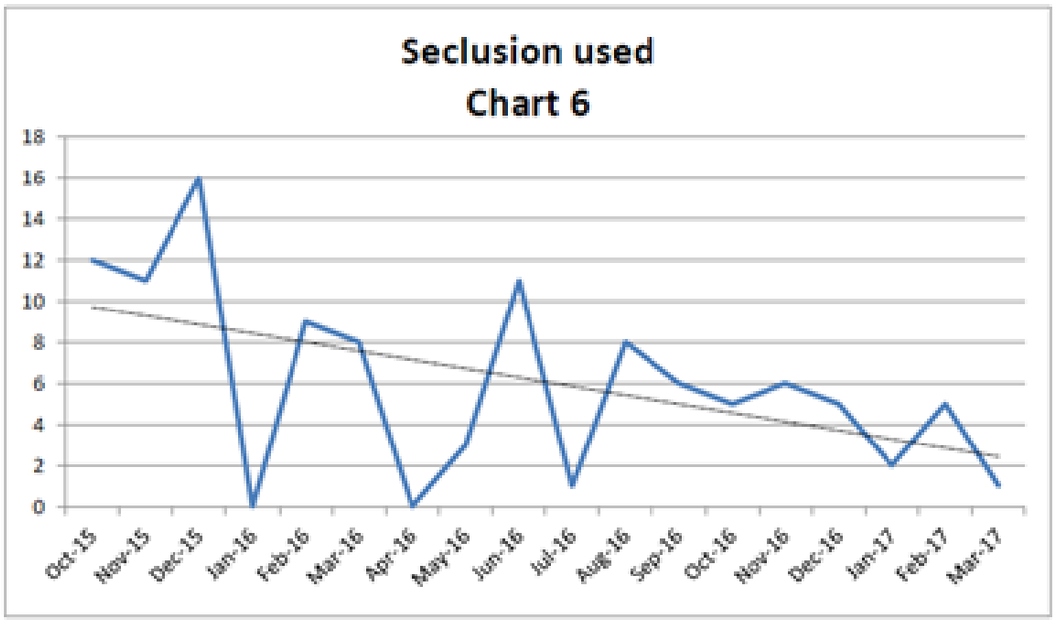
Incidents:





Seclusion:

A sustained reduction in the use of seclusion has occurred due to interventions based on training and guidance*.*



Patient experience indicators

Friends and Family Tests responses have improved and complaints have fallen. The Trust plans to reinvigorate the patient experience strategy.

FFT 2015/16 - 2016/17

Financial Year	2015/16				2016/17			
Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
FFT Responses	141	354	377	474	516	470	697	789
% Recommend	82%	79%	86%	89%	88%	92%	89%	89%

Community Mental Health Service User Survey

Survey Year	2015/16	2016/17
Overall Experience Score	68%	69%

Complaints

Survey Year	2015/16	2016/17
Number of complaints	190	170

Clinical effectiveness

The Trust is reviewing approaches to length of stay and avoiding emergency readmissions

Average Length of Stay	Target	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
Average length of Stay Assessment wards	<10 days	13.4	11.3	11	12.1	13.6	14.5	12.59	10.8

Re-admissions	Area	Target	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
Emergency Psychiatric Re-admission (28 days)	Camden	<6.2%	10.7%	7.7%	2.9%	4.2%	13.9%	9.2%	12.5%	10.5 %
	Islington		8.5%	6.2%	9.8%	9.3%	10.0%	8.7%	9.6%	6.2%

Re-admissions	Area	Target	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
Emergency Psychiatric Re-admission (90 days)	Camden	<10%	17.6%	16%	12.9%	18.3%	24.7%	23.0%	23.8%	23.7%
	Islington		19.4%	16.8%	16.6%	19.2%	18.8%	19.1%	16.7%	12.3%

Participation in clinical audits

National audits

The nationally mandated clinical audits that were applicable to Camden & Islington Foundation Trust in 2016-17 were:

a) 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. Results for different audits will be published intermittently throughout the year based on the POMH–UK schedule

b) Cardio metabolic assessment for people with schizophrenia (CQUIN)

c) The Early Intervention in Psychosis Audit (AEIP).

The Trust will continue to participate in the next round of POMH-UK 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. Audit results will also be disseminated locally to share learning.

In previous years, Camden and Islington has completed the Mental Health Indicator for Cardio Metabolic Assessment audit, as part of the Trust's CQUIN programme . In 2016-2017 , both inpatients and

community teams were included. The Trust is awaiting the publication of the final result which will be shared with participating teams across the Trust.

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	Actions
POMH 11c – Prescribing anti-psychotic medication for people with dementia	April 2016	121	Guidance and support are provided to ensure appropriate prescribing
POMH 7e – Monitoring of patients prescribed Lithium	June 2016	35	Guidance and support are provided to ensure appropriate prescribing
POMH 16a – Rapid Tranquilisation	September 2016	29	Guidance and support provided to ensure safe practice
POMH 1g and 3d - Prescribing high dose and combined anti-psychotics	February 2017	Currently completing data collection	The CQUIN work for cardio metabolic assessment for people with schizophrenia will be carried through for 2017/18 and the Trust will look to incorporate this with the improvement work linked to the IPU.
AEIP (Early Intervention in Psychosis) Audit	September 2016	104 (50 from Islington EIS and 54 from Camden)	IPU service in place to support psychosis care
Mental Health Indicator Cardio Metabolic Assessment	February 2017	150 – currently completing the data collection	

Participation in National Confidential Enquires

Audit Title	Data Collection Period	Survey requests
Homicide	16/17	4
Suicide	16/17	16

Findings from confidential enquiries inform the work on prevention of deaths

Actions taken in response to national audits
Camden and Islington were scheduled to participate in four POMH audits in 2016- 2017 (Prescribing Observatory for Mental Health). These audits form part of the Trust's Pharmacy Audit Programme. The provider reports are shared with the Trust's Drug and Therapeutics Committee, Pharmacy colleagues and the relevant teams and services. Where necessary an action plans are created to improve results

Local audits

During 2016/17 the Trust participated in a number of local audits both through the quarterly balanced scorecards and locally led divisional audits. Some local audits were linked to local quality improvement around the Mental Health Act and Mental Capacity Act, namely Section 132 and Section 17 Leave. Other audits were linked to the CQUINs around smoking care plans, the quality of crisis plans and patients who were offered the Malnutrition Universal Screening Tool (MUST) on admission.

The first clinical audit event of 2017 was held in January at Highgate Mental Health Centre. The entries this year were from across the Trust, incorporating a wide group of professions/specialties including

nurses, pharmacists, psychologists and junior doctors. The topics covered included antimicrobial prescribing, emergency equipment, The Friends and Family Test and outcome monitoring within Camden and Islington Psychodynamic Psychotherapy Service.

Actions taken in response to local audits

Local audit results are shared by the audit participants within their local teams and relevant service areas. The learning from these audits are also presented at local clinical governance forums within each division and the Clinical audit event also presents an opportunity for audits to be shared more widely across the organisation. The learning and action plans from the quarterly balanced scorecard audits, are also shared both locally at team and service level and is reported at monthly divisional performance meetings. The Trust will run another audit event this year to facilitate the learning and sharing of clinical audit within the organisation.

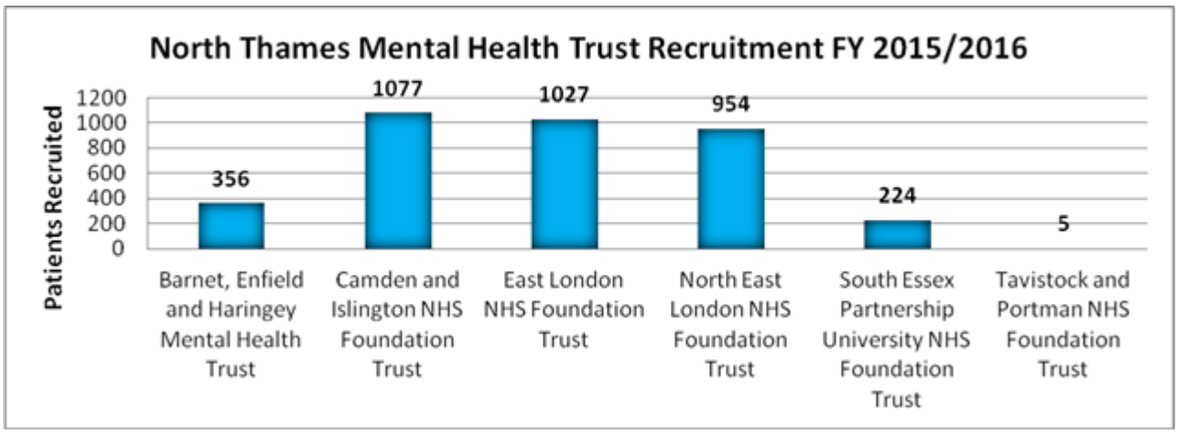
The Trusts Mental Health Law team also have an annual audit programme. The learning outcomes gained from the Mental Health Law Audits a disseminated through the trust through the Mental Health Law Monitoring group where the results are scrutinised and discussed. The audits also feed into the MHL Training Group and the MHL Policy and Procedure groups to inform the training we are providing trust wide and to update policy and procedure within the Trust. Through membership of the Mental Health law committee and Monitoring group, Divisional Service Directors and Clinical Directors receive the outcomes of these audits. They are also reported in the Mental Health Law Champion Group so that they can be promoted in clinical settings.

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.

It has continued to build on an already strong relationship with University College London (UCL), its main academic partner. We also work closely with Division 4 of the Clinical Research Network (CRN) North Thames, which focuses on dementia, mental health and neurology, and seeks to increase opportunities for service users and the public to participate in, and benefit from, research.

The Trust is a partner organisation of CRN, which covers North Central London, East London, Essex and Herts, and is one of six mental health trusts in the network. In 2015-16 we were the leading trust for patient recruitment in mental health across North Thames (see graph below).



Early indicators suggest we will remain the top recruiting mental health trust in 2016-17, with 89 studies currently active and 1,179 patients recruited to date, already an increase on last year's recruitment. Our academic partners have continued to attract a high level of grant funding to bring research into the Trust and we also host a growing team of researchers funded by the CRN.

Institute of Mental Health (IoMH)

The Trust continues to work with UCL to develop an IoMH presence and profile. The first academic symposium took place in September 2016, with more planned throughout 2017.

Biomedical Research Centre (BRC)

Mental health is now, for the first time, part of the remit of the Biomedical Research Centre (BRC), established between UCL and UCLH. Collaboration with the BRC will be central to delivering on

research and innovation. It will help disseminate scientific findings in mental health and dementia and deliver improved treatments.

Quality and Innovation: the CQUIN framework

A proportion of Camden and Islington Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Trust and local Clinical Commissioning Groups (CCGs). The income from the CQUIN Scheme for Adults and Older Adults Mental Health Services amounts to £2.031 million total for income In 2016/17 conditional on achieving all quality improvement and innovation goals

The monetary total for the associated payment in 2015/16 was:
CQUIN total value - £1,974,972
CQUIN achievement - £1,260374
(subject to confirmation by CCGs).

After negotiation with commissioners, C&I initiated a broad range of quality activities under the CQUIN scheme to improve the quality of care and the experience of both staff and service users. We implemented five national CQUIN schemes across the organisation and seven local schemes, based on local priorities.

The CQUINs agreed for 2016/17 between Camden & Islington Foundation Trust and our commissioners were in the following areas:

1 NHS staff health and well-being
2 Mental health
3 Substance misuse
4 Physical health
5 Prevention of domestic violence
6 Quality of crisis planning

The table below summarises how the Trust has fared in delivering its CQUIN targets:

Indicator	Q1	Q2	Q3	Q4 *
1. NHS staff health and well-being				
1.1b Introduction of staff health and well-being initiatives Introducing health and well-being initiatives covering physical activity, mental health and improving access to physiotherapy for people with musculoskeletal issues.	Met	N/A	N/A	Met
1.2 Development of an implementation plan and implementation of a healthy food and drink offer Submitting data on the food suppliers operating on NHS premises and taking action in four areas including: banning price promotions, advertisements and sale at checkouts of food and drink high in fat, salt, sugar and saturates as well as ensuring healthy options are available for staff at night.	Met	N/A	N/A	Met
1.3 Improving the uptake of flu vaccinations for frontline clinical staff Achieving an uptake of flu vaccinations by frontline healthcare workers.	N/A	N/A	N/A	Partially Met
2. Mental health				
2.1 Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychosis Demonstrating cardio metabolic assessment and treatment for patients with psychosis in the following areas: inpatient wards, early intervention psychosis services, Community Mental Health Services patients on care plan approach (CPA).	N/A	N/A	N/A	Results will be available in June 17

2.2 Improving physical healthcare to reduce premature mortality in people with SMI: Communication with GPs An updated CPA care plan or a comprehensive discharge summary to be shared with the GP.	N/A	N/A	Met	N/A
3. Substance misuse				
Effective identification and management of substance use / misuse (year one of two-year substance use focused CQUIN) Evidence to be provided on the delivery and effectiveness of mental health staff training on identifying and managing substance use / misuse in individuals referred for mental health assessment and / or treatment.	Met	Met	Met	Met
4. Physical health				
4.1 Medicines New prescriptions should contain information about: reason for prescribing, dose/duration, method of delivery, side-effects, monitoring/review arrangements and self-management.	Not Met	Not Met	Not Met	Not met
4.2 Obesity prevention and management in hospital settings This focuses on identification of obesity, assessment and management of overweight and obese children, young people and adults in hospital and the plan of care after discharge.	N/A	Met	Not Met	Not met
4.3 Smoking cessation care plans The incentive seeks to improve the recording of smoking status in community and secondary care, increase access to effective support and offer treatment to stop smoking.	N/A	Met	N/A	Met
5. Prevention of domestic violence				
5.1 Staff training Number of eligible staff that have accessed level 1 and level 2 training.	Met	Met	Met	Met
5.2 Patients Number of people disclosing/experiencing domestic violence that are referred to a specialist service.	N/A	Met	N/A	Met
6. Quality of crisis planning				
Audits into the quality of crisis plans to ensure they are robust, personalised and timely.	Met	Met	Met	Not met

* Q4 results are provisional pending confirmation from CCGs
**N/A means that there was no specify measure to meet in that period

Care Quality Commission (CQC)

Registration:

CQC register Camden and Islington NHS Foundation Trust services to carry out the following legally regulated activities.

Accommodation for persons who require nursing or personal care
Stacey Street Nursing Home

Treatment of disease, disorder or injury
St Pancras Hospital
Stacey Street Nursing Home
Highgate Mental Health Centre

Assessment or medical treatment for persons detained under the 1983 Act
Registered services
St Pancras Hospital
Highgate Mental Health Centre

Diagnostic and screening procedures
Stacey Street Nursing Home
Highgate Mental Health Centre

Participation in reviews and investigations

CQC inspections

The Trust has participated in a full inspection by Care Quality Commission relating in February 2016 and produced its report and ratings in June 2016. Overall it rated the Trust as requiring improvement

Overall rating for services at this Provider	Requires improvement
Are Mental Health Services safe?	Requires improvement
Are Mental Health Services effective?	Requires improvement
Are Mental Health Services caring?	Good
Are Mental Health Services responsive?	Requires improvement
Are Mental Health Services well-led?	Requires improvement

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community-based mental health services for older people	Good	Good	Outstanding ☆	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Substance misuse services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good

Mental health crisis services and health-based places of safety were rate as Inadequate. Wards for older people with mental health problems, community-based mental health services for older people, and community mental health services for people with a learning disability or autism were rated as Good overall

The inspection highlighted a number of areas of good practice, with a rating of 'good' across the board for older people's community services and inpatient wards and an 'outstanding' for caring. It also rated our staff, trust-wide, 'good' for caring, with the inspectors describing them as "responsive and respectful" and willing to go "the extra mile". However, the inspectors also concluded that a number of areas required improvement. To address the requirements we have a full priority action plan in place. We have made progress in a number of areas. The summary below shows the Must do areas we are required to improve by CQC and the key actions we have taken.

The CQC required action be taken in the following areas

Must do Action required	Summary of key actions we are taking
Ensure the environment is safe, remove identified ligature risks, ligature risk assessments contain plans for staff to manage risks, including mitigation for obstructed lines of sight. Address safety concerns in the health-based places of safety	The safer environment group has developed and introduced a clear system for assessing and managing ligature risks, with support and guidance for staff in place. There have been extensive works to reduce potential ligature points and provide clear lines of sight . A Section 136 working group has reviewed the current provision and governance arrangements against the draft London standards. Improvement works have been completed at two hospitals and the work at the third hospital awaits sign off.
Ensure repairs to the patient care areas are completed in a timely manner.	There is now protocol in place for registering, tracking and signing off (by team managers) of repairs. Regular monitoring of performance in place. A Reference Guide and Checklist for managing environments is completed

Ensure robust and effective governance systems to monitor the quality, performance and risk management of services. Completion of: • Clinical records • Risk assessment • Care plans • Medication reviews • Clinic and medication storage fridge temperatures • Individual practitioner caseloads records	CareNotes will be improved to ensure that information recorded will be more streamlined, intuitive, and user-friendly. Records completion is assessed and report on the local service performance report. The Clinical Risk Policy is being updated to reflect best practice and guidance on completion. The Trust will develop standard operational guidance and checklists on how key records are to be maintained around care planning. Audits of patient involvement will be undertaken. The Trust has protocols in place for the physical health monitoring for patients on lithium, clozapine, and antipsychotics (including high dose antipsychotics). These are monitored through audit (including POMH). The numbers of Medication reviews completed are monitored and reported to services. The physical health-screening tool is now live on Carenotes. Temperature monitoring compliance is now included in the infection control environmental audit. Training is available for staff to share best practice. Individual practitioner caseloads is audited through the Monthly Managers Performance meeting.
Equipment on site for staff use in emergencies Equipment is serviced regularly and decommissioned when no longer fit for purpose	There is guidance for staff in place and emergency equipment available to teams. This is being audited to ensure compliance. A new contractor has now taken over the servicing and removal of all equipment
Ensure all staff are meeting the requirements of the Mental Health Act and Mental Capacity Act	The Trust has developed a flow chart to support staff with decision making and a SOP for Section 132 rights. Assessment forms have been added to Carenotes and a signposting message has been added to the login page regarding rights and capacity. The seclusion policy was reviewed. Over 80% of staff have completed the training. We plan more work around leave and after care.
Safeguarding information is recorded appropriately and staff understand the process	Screensavers were used to raise awareness of safeguarding processes with staff. Online training is now on the training tracker. All teams display the safeguarding flowchart. The guidance has been updated and will be ratified in June 2017.
Staff receive an annual appraisal and staff training records includes specialised training	Developing our People and Appraisal Processes and Policies has been launched as has a new recording system. An audit of supervision records will be carried out. We have simplified the training matrix for staff and added more e training modules to make it easier for staff to take part in training. A training tracker has been introduced for Core Skills Training for specific levels across teams.
The Trust must ensure there are sufficient experienced staff on duty at all times to provide care to meet patients' needs	As safer staffing process is in place and the establishment has been increased in the acute areas.
The Trust must monitor people on the waiting list and identify any patients with increased risk to take appropriate action.	The Trust will undertake a review of how teams monitor those on waiting lists for increased risk and will implement an enhanced approach.
Mixed sex breach/beds/leave	Female only bed areas in 154 Camden Road and Highview will be opened up.

The Trust will continue to working closely with commissioners and the CQC to further progress our improvements in the next 6 months.

Mental Health Act monitoring visits

As a Mental Health Trust the CQC carries out a regular cycle of MHA monitoring visits and we participated
In nine MHA monitoring visits in 2016-17 to our wards. When recommendations are made the service completes an action plan that is monitored by the Trust mental health law committee.

Data quality

Information Management in the NHS is increasingly under scrutiny and the ability of care providers to produce accurate and reliable information is often used as a measure of governance, accountability and efficiency of modern NHS services. A high level of data quality is an essential facet of any NHS provider's ability to maintain service user safety. To that end, the Trust Data Quality Policy outlines the expectations for staff on how high data quality can be promoted and maintained within the Trust.

- Camden and Islington Foundation Trust will be taking the following actions to improve data quality:
- Ensure all our staff are trained to record effectively on CareNotes (our electronic patient record system)
- Further enhancement of our Clinical Dashboard to check completeness of recording information on CareNotes

- Quality assurance process of the Mental Health Services Data Set and other external submissions
- Explore business intelligence options that can support an array of solutions and systems to support clinicians with data quality improvements

As a Mental Health provider we do not submit records to the Secondary Uses Service. We are required to submit data to NHS Digital

- The most recent information from NHS Digital on Data Quality Maturity Index (DQMI) on percentage of patient records with NHS Number and General Medical Practice code is shown below,
- NHS number - 99%
- General Medical Practice code - 100%

Clinical coding

Camden and Islington Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Information Governance Toolkit

Information Governance (IG) is about how NHS and social care organisations and individuals handle information.

The Information Governance Toolkit is a performance tool produced by NHS Digital. It draws together the regulations and central guidance related to information governance and presents them as one set of information governance requirements. For the 2016/17 submission, C&I's overall score was 96%, rated as a pass (green).

The Trust continually reviews its information governance framework to ensure all personal and medical information is managed, handled and disclosed in accordance with the law and best practice. In addition we attach great importance to training, data quality and clinical records management. As a result, we have seen improvements across the Trust.

Reporting against core indicators

The Trust is required to report our performance against a core set of indicators, which is published by NHS Digital. There are five indicators, which are relevant to the services we provide and below is our performance against this set of measures.

Indicator	2016/17	National Target	Top performer	Worst Performer	2015/16	2014/15
Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay	96.3%(Q4)	95%	100%(Q3)	73.3%(Q3)	95.2% (Q4)	98% (Q4)

Camden and Islington Foundation Trust considers this data is as described for the following reasons - performance is monitored locally via the Trust's Business Intelligence systems which reports all discharges so that local performance teams can track patients who have or have not been followed up. Clinicians are alerted to those patients requiring follow up, ensuring focused and informed actions are taken.

Camden and Islington intends to improve this indicator, and so the quality of its services by upholding the CPA policy operational delivery of follow up contacts, publishing and sharing this information each month at Divisional Performance meetings and discussing this indicator at local management and team meetings.

Indicator	2016/17	National Target	Top performer	Worst Performer	2015/16	2014/15
Admissions to Acute wards where the crisis resolution home treatment team were gate keepers	100%(Q4)	95%	100%(Q3)	88.3%(Q3)	99%(Q4)	100% (Q4)

Camden and Islington Foundation Trust considers this data to be as described for the following reasons - performance is monitored locally via the Trust's Business Intelligence systems which identifies all patients who were readmitted. The Trust supports staff with ongoing information on business rules ensuring activity is recorded and captured accurately.

Camden and Islington intends to take the following actions to improve the percentage score, and so the quality of its services, by developing robust systems to closely monitor this activity and alerts teams to any deterioration in performance.

Indicator	2016/17	Local Target	Top performer	Worst Performer	2015/16	2014/15
Patient readmitted to a hospital within 28 days of being discharged	10.5% (Camden) 6.2% (Islington)	6.2%	N/A	N/A	4.2% (Camden) 9.3% (Islington)	8.2% (Q4)

Camden and Islington considers the data to be as described due to the following reasons - we have developed our electronic patient record to ensure robust reporting systems are in place and have validation processes that assures data quality improvements. No comparable national benchmarking data has been available.

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 enhancing the quality of discharge planning documentation, identify causes for readmission and share the lessons learned at operational management meetings. We aim to continue to monitor and report on this indicator routinely to all relevant areas across the Trust.

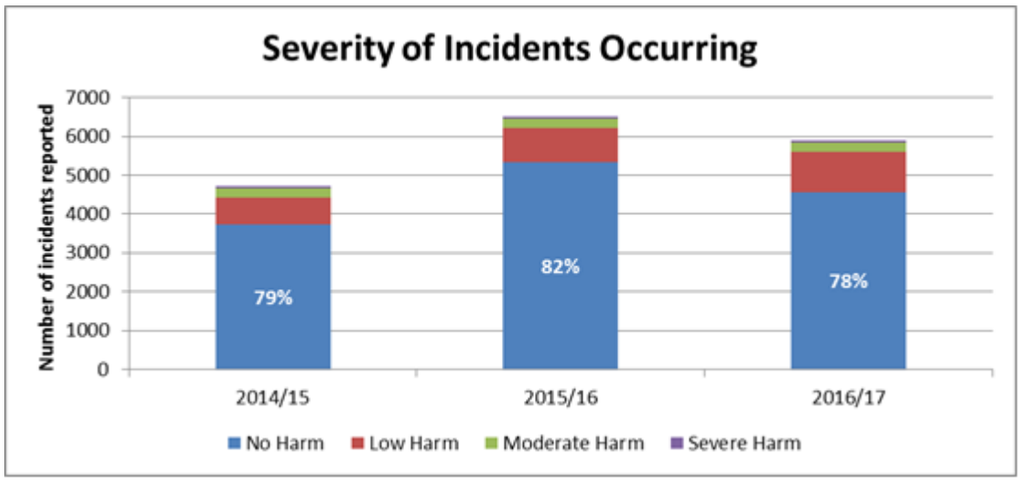
`	2016/17	Top performer	Worst Performer	2015/16	2014/15
The Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	7.3	8.1	6.9	7.5	8.2

Camden and Islington considers the data to be as described due to the following reasons - the national Community Mental Health survey is compulsory for all Trusts. The data for this indicator is provided by the CQC and Department of Health.

Camden and Islington intends to take the following actions to improve the percentage score, and so the quality of its services, by developing robust systems to closely monitor this activity and alerts teams to any deterioration in performance.

Patient safety incidents and the percentage that resulted in severe harm or death

Camden and Islington considers the data to be as described due to the following reasons - the data for this indicator is derived from Datix our internal patient safety software. Only a small fraction of our incidents results in sever harm. The Trust is committed to implementing a process to learn from serious incidents.



Our achievements in quality improvement

We are in the process of introducing a five-year quality improvement programme in the trust with the aim of creating a culture of continuous improvement.

QI is an established method for testing and implementing changes. It gives staff the authority, responsibility and tools to make changes in how services are delivered with the aim of improving quality.

The impact of the programme will be measured in three ways:

- Reducing levels of avoidable harm
- Improving staff morale, demonstrated by C&I being in the top 20% of providers, according to the national staff survey
- Improving the patient experience, demonstrated by C&I being in the top 20% mental health providers, as measured by the Friends and Family Test.

A central QI hub is being created which will be responsible for engaging with staff and users to ensure everyone knows about QI and feels empowered to get involved in improving care. The hub will also build capacity and capability through education and training and support teams to deliver QI projects. There are also plans to develop a cohort of QI champions across the organisation.

The board will receive six-monthly progress reports on the programme. Implementation leads will also be assigned to each Trust-level quality priority.

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 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.

A recent internal audit concluded that the Trust has a well-designed process for identifying strategic risk and escalating concerns for review. It also highlighted opportunities to consolidate the level of risk reporting to the Audit and Risk Committee to help it identify significant risks and take appropriate action. In line with the recommendations from this audit a new format for reporting to the committee is under consideration. This will be further developed in 2017-18.

Sign up to Safety

Sign up to Safety is a 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 five 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.

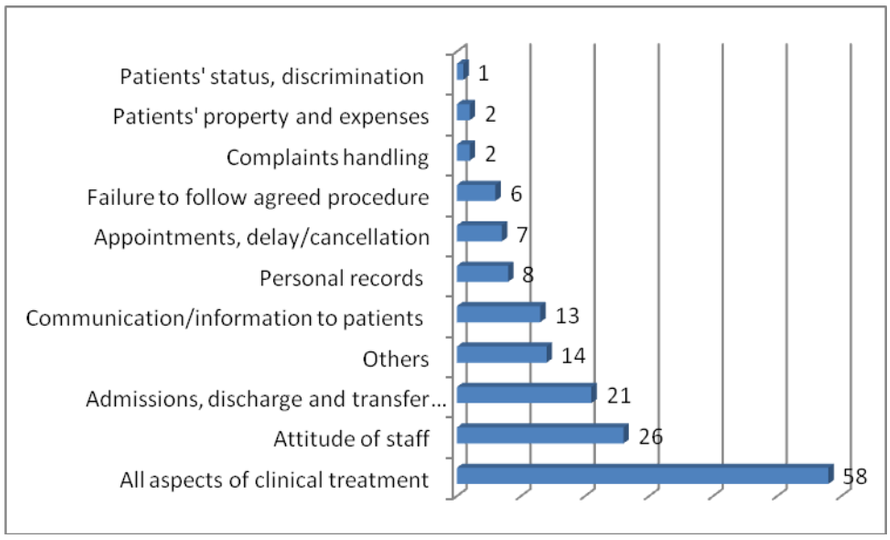
We have action plans to address the following areas:

- Learning lessons from serious incidents
- Reducing falls
- Reducing non-clinical bed moves.

Complaints

The Trust received slightly fewer formal complaints this year than last year: There were 171 complaints compared to 190 in 2015/16. In addition, 210 concerns received via the Advice and Complaints Service were resolved informally. Of course, this only represents a proportion of the issues that staff resolve directly with service users on a daily basis (figures correct as at 20/02/17, will need to be amended at year end).

The chart below shows the different categories of complaint (to be updated at year end). Complaints about clinical treatment were by some way the largest category, followed by staff attitudes and admissions, discharge and transfer issues (which generally relate to access to service).



The Trust is committed to using the feedback we receive through complaints to improve our services. All staff have a regular slot at their team meetings where any complaints can be discussed. Complaints which are either partially or fully upheld will have an action plan to ensure that recommendations are implemented. Action plans are discussed and reviewed at divisional quality forums.

The Advice and Complaints Service produces a newsletter which includes changes made in response to complaints, ensuring this information is shared across the organisation. These newsletters are now produced jointly with the Serious Incident team so that learning from both processes can be co-ordinated. This reflects the new-style Aggregated Complaints and Incidents report which is now being produced bi-monthly with an emphasis on identifying common themes in investigations. The Trust website also identifies lessons learned from complaints with examples of actions taken, so service users and carers can be assured their feedback really does make a difference.

The Trust continues to review and upgrade its complaints reporting systems to ensure we meet national reporting requirements. This also provides us with better quality information to help us respond in a timely manner to any themes or trends arising from complaints.

Below are some examples of improvements made in the last year as the result of feedback from complaints:

- We know that demand for some services outstrips currently available resources, leading to delays in service users being seen. We are working with our commissioners to try to address this. But in the meantime some of the affected teams have reviewed their referral pathways to ensure they are clear to both GPs and service users, so people know what they can expect from our services. Standard letters and leaflets have been updated to support this.
- The medicines management policy has been reviewed and amended to cover the situation where a person requiring admission to inpatient or crisis services is taking an unlicensed medication, or taking it for an unlicensed purpose.
- The home treatment teams have piloted a named worker scheme which they hope to roll out permanently over the coming months. This change aims to provide a more personalised service and offer a contact for service users.
- Communication issues are often part of the complaints that people raise with us. Sometimes this is about how we communicate with them directly - for example, telephones not being answered or delays in responding to messages. It can also be about communication between staff - for example, quality of handovers. All teams have been asked to consider these issues and to review how they can improve the quality of service we provide.
- A new trolley service run by our volunteer team for the inpatient wards on the St Pancras site will begin in the near future. It will offer a wider range of items for service users, particularly those who cannot leave the ward.

Depending on the complexity of the complaint, our internal Trust targets for responding to formal complaints are either 10, 25 or 45 days. We aim to respond to at least 80% of complaints within these

timescales. However, despite this being a key focus for both the Advice and Complaints Service and the divisions, we have struggled to meet these targets.

From Quarter 3 we have been piloting a new approach aimed at improving the timeliness of responses. Under the new arrangements all complaints have a 25-day timeframe unless they are identified as being complex, in which case the timeframe will be negotiated individually with the complainant. Extensions for the 25-day timeframe can also be agreed with complainants where necessary and appropriate. Divisional leads have been reminded of the need to allocate investigators promptly and increased quality checks by the complaints manager have enabled the chief executive to sign them off more quickly. In addition we have continued to encourage prompt informal resolution of concerns at team level wherever possible.

The evidence so far indicates that these proposals have had the desired effect with significant improvements in Quarters 3 and 4. They are therefore likely to be incorporated into policy.

The Trust previously arranged for the Patients Association to run a survey to monitor satisfaction with the way we handle complaints. Unfortunately levels of returns were too low to provide reliable data. We have therefore worked with Trust colleagues responsible for the Friends and Family Test to put together our own bespoke survey covering all formal complainants. We hope this will provide useful information to help us improve people's experience when they complain.

A key priority for next year is to roll out training for investigators. In the meantime the complaints team continues to provide one-to-one support to staff as required.

Compliance with NICE guidance

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 while preventing ill health.

Each month, new guidance released by NICE is circulated to the clinical directors for each division and other members of staff as considered appropriate. Any relevant guidelines (whether partial or completely relevant) are identified and a baseline assessment is completed to include an action plan to move the Trust towards compliance.

There are 59 guidelines that focus on mental health and are applicable to the Trust, but increasingly we also take into consideration physical health conditions including sepsis, diabetes and oral health.

The Trust is now fully compliant with 32 of the guidelines and is making good progress on the other 27 that have still to be completed. Currently only one guideline requires a lead and one baseline assessment is outstanding.

The table below illustrates the Trust's current compliance status on NICE guidelines from 2011 through to February 2017.

Division	Guidelines Applicable from 2011 – 2017	Outstanding Baseline assessments	Partially Implemented	Completed
Acute	2	0	0	2
R&R	3	0	3	0
CMH	7	0	1	6
SAMH	10	1	2	7
SMS	4	0	0	4
Trust	33	0	20	13
Total	59	1	26	32

Key quality initiatives in 2016/17

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.

New psychiatric research database

The Trust can now research thousands of anonymised clinical records using a super database which has the potential to identify which treatments work best, where things don't and what can improve care.

The wide scope of the Clinical Record Interactive Search (CRIS) data, which includes data from other mental health trusts, makes the information far more meaningful and evidence-based when it comes to clinicians and policy makers making decisions about the most effective mental health services in the future.

C&I clinicians are currently working in collaboration with other trusts on several research projects, including:

- Identifying the key factors that increase the likelihood of patients relapsing and being admitted to acute mental health services, including A&E
- Examining the influence of environment on suicide and suicidal thoughts.

Identifying and supporting ex-servicemen in prison

The Trust has been collaborating through the London Veterans' Service (LVS) to help identify and improve the care of ex-servicemen who are in custody with mental health problems. The scheme has now been extended from Wandsworth prison to Brixton and Thameside prisons as well as Isis young offenders' institution.

In collaboration with veteran custody support officers our clinical nurse specialists are able to draw on a network of support to help these individuals both in prison and in the community when they have been released.

The project, run by the LVS, aims to reduce re-offending by ex-servicemen who get hooked into a pattern of criminal behaviour, often involving violence. It is estimated that between 3.5% and 17% of male prisoners are ex-servicemen.

Online therapy service for our Korean community

C&I psychological therapists and wellbeing specialists have developed an online therapy service which offers support to the area's large Korean population to try to break down the strong stigma many have about mental health.

A trainee psychological wellbeing practitioner will work with the service for a year to strengthen links with the community. The package will help educate local people of Korean background about what help is available and will encourage easier access.

One of the key themes in C&I's clinical strategy is making services available to all communities.

Drug resistant depression treatment

C&I is now offering an innovative new treatment to help individuals with drug-resistant depression.

The Transcranial Magnetic Stimulation device has been shown to increase recovery rates in patients who either cannot tolerate drug treatment or who have seen no improvement in their condition with the use of medication. In addition there are no systemic side-effects, unlike most drug treatments.

TMS uses a pulsating magnetic field to target specific sites in the brain, stimulating nerve cells in those areas, which helps to ease symptoms of depression. Treatment-resistant depression affects one-third of service users with depression and can blight people's lives.

For the initial stage of the service, the treatment is being limited to patients under the care of the Complex Depression Anxiety and Trauma Service.

Community talks reducing stigma around mental health

We recently set up a programme of community talks for adults in Islington to reduce stigma around mental health and help people access mental health services.

The project was organised by psychologists from the Trust and ran in 15 Islington primary schools as a series of coffee morning talks for parents on different topics, including helping people to think about the signs and symptoms of stress, low mood and worry.

The vast majority of parents said that after attending a talk they would seek help from C&I's Islington service, as well as recommend it to others – a view supported by the increase in referral numbers after the project began.

The project, run by the Trust's Islington iCope Psychological Therapies & Wellbeing Service, won a £10,000 prize in regional Health Education England Quality Awards to promote healthy living through education and training.

Crisis resolution teams win accreditation

The Trust's crisis resolution teams in Islington and North Camden have been endorsed by the Royal College of Psychiatry under its home treatment accreditation scheme.

The scheme supports services to improve and demonstrate the quality of care they provide. Information gathered through the accreditation process can be used in the Trust's quality accounts, as recommended by the National Quality Board.

Our crisis resolution and home treatment teams can provide an alternative to acute inpatient care. They also:

- Provide a service that responds rapidly and is intensive and time-limited
- Gate keep acute inpatient beds to prevent people being admitted who could be treated in the community
- Support early discharge of people who are admitted to acute inpatient services.

New simulation suite

The suite, which consists of a large simulation room with cameras, together with an adjoining observation studio, is available to trainee psychiatrists and other clinical staff. Staff are able, through simulation exercises, to develop their patient consultation and wider communication techniques as well as helping in preparing for clinical assessment exams.

The Trust has also recruited a Psychiatry Simulation Fellow to drive the project and is already running simulation training events with clinical staff.

Recovery College

The Trust continues to offer a range of free courses and workshops at its Recovery College in the grounds of St Pancras Hospital. The sessions are open to any adult from Camden and Islington – whether staff, user or member of the public.

All the courses are based on our recovery principles and topics include understanding mental and physical health conditions, well being, building self-confidence and returning to work or study.

All our sessions – which have been running since 2014 - are created and delivered by two tutors, working together as equal partners, with one offering an expertise based on personal experience and the other based on professional expertise.

5. Additional Information as stipulated by NHS England

Implementation of duty of candour

Duty of candour is a key focus when investigations take place into incidents that have caused harm (severe and moderate harm). Lead investigators are trained to help patients receive accurate, truthful information from the Trust and to be open when errors have occurred. The computer software programme Datix has a function that records duty of candour for every incident that has occurred. It also makes clear to the user what duty of candour is.

In line with the quality priorities we have selected we will be focusing on improving communication with families and services users**.** The recent National Quality Board's new guidance to trusts on learning from deaths in particular asks that the needs of bereaved families be taken into account. We aim to ensure that bereaved families and carers:

- Should be treated as equal partners following a bereavement;
- Must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
- Should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs. They should also be offered appropriate support, including providing, offering or directing people to specialist suicide bereavement support;
- Should be informed of their right to raise concerns about the quality of care provided to their loved one;
- Should help to inform decisions about whether a review or investigation is needed;
- Should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;
- Should be partners in an investigation to the extent that they wish to be involved since they offer a unique and equally valid source of information and evidence that can better inform investigations.
- In addition all bereaved families and carers who have experienced the investigation process should be supported, if they are willing, to work with Trusts to deliver training for staff on some of these issues.

Equality and Diversity, Staff Engagement and Organisational Development

Staff survey results

We set up and implemented divisional action plans to address some of the issues raised in the 2015 annual staff survey. The plans, which were supported by the Equality and Diversity, Staff Engagement, Organisational Development and Staff Side representatives, with additional help from the Network for Change (BME) coordinators, included a series of team away days to discuss issues around conflict and poor communication.

The Human Resources and Organisational Development Team continued to support the plans ahead of publication of the 2016 staff survey results.

KF26 - % of staff experiencing harassment and bullying from other staff

The Trust performance against this indicator is shown in the table below. Our 2016 scores are in line with the national average for mental health trusts.

2016	21%
2015	22%
2014	21%

We have a dedicated 'Freedom to Speak Up' guardian who is fully supported in their role to encourage staff to raise concerns and also be a listening ear. This is a formal part of the Raising Concerns and Whistleblowing Policies.

In addition, the Trust is training staff to become mediators to help to resolve and improve working relationships before they develop into formal grievances or allegations of bullying and harassment. Our aim is for the mediators to be trained by May 2017 and we will monitor the impact over the coming year.

KF21 - % believing that they have equal opportunity for career progression and promotion

The table below shows the Trust's performance which is significantly below the national average of 87% for mental health trusts and has declined from 2014.

2016	76%
2015	77%
2014	82%

The year on year results are similar. To address this ongoing issue, we have already implemented a number of interventions as part of the Our Staff First action plan.

The Network for Change was launched by staff from black and minority ethnic backgrounds in 2016 and is gaining momentum. Members from the network have been trained to sit on recruitment panels for Band 8a roles and above. This is already in operation for all senior roles and will be monitored.

The network will be a confidential space for staff to raise concerns around bullying and harassment and receive support and advice from fellow members.

We will also implement the following initiatives over the coming year:

- Unconscious bias training for all recruiting managers
- Advertising roles on diversityjob.co.uk to attract and recruit more BME applicants into senior positions
- Career clinics
- Leadership Development Programmes to develop staff from Bands 6a
- A new NHS Diversity Training e-learning package for all staff
- E-learning advice on completing applications and interview skills training, backed up by face-to-face coaching.

In addition, all staff in Band 7 posts and above will be offered coaching to apply for senior posts within the Trust.

NHS Improvement Targets

In 16/17 the Trust continued to be assessed on a quarterly basis to meet selected national standards for access and outcomes. From April 2016 NHS improvement became the operational name that brings together Monitor and the NHS Trust Development Authority (TDA) Accountability Framework. In October 2016 the Single Oversight Framework replaced Monitor's Risk and Assessment Framework, one of the main goals was to reduce information burden and ensure performance data is collected centrally scaling down data "industry". The framework assists NHSI across five themes and under the operational performance theme the indicators relate to one or more facets of quality (i.e. safe, effective and caring and/or responsive). Trust performance against these indicators is provided below.

Risk Assessment Framework

Service Performance Target	Target	Q1 Performance	Q2 Performance
Care Programme Approach (CPA) service users receiving follow-up contact within seven days of discharge from hospital	95%	**95.8%**	**95.1%**
CPA service users receiving formal review in the last 12 months	95%	**96.6%**	**96.0%**
Admissions to inpatient services had access to crisis resolution home treatment teams	95%	**99.6%**	**100%**
Minimised delayed transfers of care	<7.5%	**1.4%**	**3.6%**
Number of new cases of psychosis served by EIS	95%	**100%**	**100%**
People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%	**77.3%**	**79.1%**

Improving access to psychological services (IAPT) **a)** People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral **b)** People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	75% 95%	**81.7%** **98.9%**	**82.1%** **99.2%**
Mental Health Data Completeness: —Identifiers	97%	**97%**	**97.5%**
Mental Health Data Completeness: —Outcomes for patients on CPA	50%	**88%**	**87.5%**
Learning disability access criteria	Compliance with the 6 learning disability criteria	**Assurance provided via LD Annual reports to Board.**	**Assurance provided via LD Annual reports to Board.**

Single Oversight Framework

Service Performance Target	Target	Q3 Performance	Q4 Performance
Care Programme Approach (CPA) service users receiving follow-up contact within seven days of discharge from hospital	95%	**96.0%**	**96.3%**
CPA service users receiving formal review in the last 12 months	95%	**95.9%**	**96.1%**
Admissions to inpatient services had access to crisis resolution home treatment teams	95%	**99.2%**	**100%**
People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%	**96.1%**	**87.5%**
MHSDS: Identifier metrics	95%	**97.4%**	**97.0%**
MHSDS: Priority metrics	85%	**88.9%**	**89.7%**

Service Performance Target – Improving Access to Psychological Therapies (IAPT)	Target	Q3 Performance	Q4 Performance
Proportion of people completing treatment who move to recovery: Camden Islington Kingston	50%	**49.0%** **49.8%** **52.8%**	**50.9%** **49.3%** **53.3%**
People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral: Camden Islington Kingston	75%	**82.4%** **81.8%** **94.9%**	**84.5%** **87.2%** **94.8%**
People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral : Camden Islington Kingston	95%	**98.8%** **99.1%** **99.0%**	**98.0%** **98.8%** **99.5%**

6. 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.

In order to finalise the selected Quality Priorities for 2017/18, the Trust carried out a survey to gather the views of patients, staff, Volunteers, Members, Governors and other stakeholders on what they feel the Trust needs to focus on to ensure ongoing improvements to the quality of care. The information from this survey is used to inform the development of the Quality Account.

A "long list" of potential priorities was developed using a range of sources including: Quality and Safety scorecards, reports and groups (areas of underachievement and areas of focus for coming year) including:

- Governance and management leads and groups
- Feedback received through user forums during the year
- Commissioner feedback
- Stakeholder event

7. Stakeholder Statements

Statement for Camden and Islington Foundation Trust 16/17 Quality Accounts

Commissioners' Statement for Camden and Islington Foundation Trust 16/17 Quality Accounts

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

We confirm that we have reviewed the information contained within the Account. We have checked the information against data sources available to us, as part of existing contract/performance monitoring discussions, and that the information presented is accurate in relation to the services provided. We feel that the account provides a comprehensive summary of the work carried out by the Trust in 2016/17 to improve the safety, patient experience and outcomes of its service.

The priorities taken forward in 2016/17 focused on:

- *Improvement of mortality and morbidity review process.*
- *Learning from serious incidents*
- *Promotion of safe and therapeutic ward environments by preventing violence, reducing restraints and supporting staff and patients following assault incidents.*
- *Reduction of domestic violence and abuse.*
- *Increase service users and carers involvement in the implementation of the clinical strategy.*
- *Improvement of information given to service users about their medication.*
- *Reduction of non-clinical ward transfers.*
- *Improvement of compliance with the 18 weeks referral to treatment targets.*
- *Evidence based outcomes for the Integrated Practice Unit for Psychosis.*
- *Increase in the uptake of smoking cessation and promotion of a healthier lifestyle.*
- *Improve outcomes of the specialist care pathway.*
- *Increase staff knowledge and understanding of the Mental Capacity Act.*

We confirm that the Account complies with the prescribed information, form and content as set out by the Department of Health and represents a fair and balanced overview of the quality of care at CIFT. We also note the work that the Trust has undertaken to address the recommendations made in the latest CQC inspection report whilst continuing its focus on the quality priorities set for 2016/17.

The CCG looks forward to working with the Trust as it implements the ambitious quality priorities set for 2017/18 and is keen to work with the Trust to ensure sustained improvements in safety, patient experience and clinical effectiveness and better involvement and communication with families of people with mental illness.

Alison Blair
Accountable Officer
NHS Islington Clinical Commissioning Group

Received by the Trust 12 May 2017
The Trust would like to thank commissioners for their response and comments and helpful feedback on the report. We look forward look forward to working with them on quality and safety in the forthcoming year.

Comments from Healthwatch Camden, incorporating comments from Camden Health and Adult Social Care Scrutiny Committee
As a provider that was rated as Requires Improvement by CQC in 2016, the Trust clearly had a lot to do to improve quality. We welcome the open way they have approached this challenge. We note that during 2016 the Trust held an extensive consultation with the service users, their carers and relatives and other stakeholders, to form a long list of priorities from which a public vote produced nine quality indicators, which form the basis of the Trusts Quality Assurance Programme. We welcome the public involvement in setting priorities. We recognise that as this is the first year they are work in progress; they are ambitious and require a great deal of management effort as well as staff training.
We have a number of observations about specific priorities:

Patient Safety
It is welcome that improvement has been made in the number of prone restraints and there are good plans to reduce this further.
Risk assessment
We note that updated training for staff for clinical risk assessment is currently under review and will be finalised this year. We think there is much work to be done in this area as well as learning the lessons from serious incidents.
Health outcomes for people with serious mental illness
We would like to see real progress in the consistent recording and measurement of physical health in the patient records, working with the GP and helping those who do not have a GP to register, and regular audits to measure care plans and progress.
Suicide prevention strategies
We welcome the trust's Suicide Prevention Strategy, and their ambition to support those bereaved by suicide more.
Involving families
The issue of communication and involvement with families has been flagged as a problem area both by the CQC report and in Healthwatch Camden open meetings. So we welcome the plan to be more consistent with recording the details of next of kin as well as the service user's wishes of who to contact and communicate.
Emergency care
Effective action on improving the environment in the Accident and Emergency department will require a productive partnership with acute trusts; we look forward to learning of progress on this important area of care.
Care plans
The trust has an established system for involving people in their own care plans, and we welcome the initiative by the Practice Development Team to produce more tailored care plans around the individual.
Safeguarding
We were concerned that CQC found gaps in staff understanding of the Mental Capacity Act and how the safeguarding processes work. This issue was also raised in the previous CQC inspection and it is disappointing that it remains a serious training issue for the staff, which will require audit.
There is a great deal of work to be done in creating therapeutic ward environments and it is disappointing to see that the number of violent episodes has increased.
We are concerned that when staff were assaulted they were reluctant to want action taken; staff are entitled to feel safe, violent incidents can escalate. A new security post has been created which is obviously welcome but action should be taken and staff supported to do this.
There has been good progress on raising awareness and training to identify and prevent domestic abuse, those vulnerable to abuse need quick help and support if a tragedy is too be avoided so it was encouraging to note that the Trust has agreed to fund this project for a further 18months.
There is still much to do to keep patients safe but it is hoped that the five year quality plan will provide continuous improvement,
Improving outcomes
Local people had raised many concerns over bed availability. The increase in the number of their beds during April 2016 did enable the Trust to achieve their priority of reducing non-clinical ward transfers and transfers to hospital beds provided by other organisations. Moving away from staff they know was very unpopular for the patients so it is very good to see the progress made in achieving this priority.
Improving physical health by assessing physical health providing care packages for COPD and Diabetes as well as help with smoking cessation and substance abuse is a great step forward.
Learning Disability
Information given in the report states that all data available has been reviewed for this service as well as receiving regular quality updates. There is no sense that the Trust is engaging with the Transforming Care agenda, or that it has absorbed the lessons from the Mazars report, or that it makes particular efforts to engage people with a learning disability. This is a pity, as the rating of 'good' for these services suggests they are doing a lot of things well – it would be helpful to see this reflected in the Quality Account.
Working across the community

We would have liked to have seen more focus on collaborating with and reaching out to local residents and organisations, listening to, learning from and also spreading the Trust's good practice. We were disappointed that there was not a greater sense in the report that this was a priority for the Trust.

Note on content and style:
National audits: 6 of those were applicable to the Trust, figures were given for the Trust but no parameters for comparison given.

Received by the Trust 12 May 2017
The Trust would like to thank Healthwatch Camden and Camden Health and Adult Social Care Scrutiny Committee for their response and comments. We look forward look forward to working with them on quality and safety in the forthcoming year.

LEAD GOVERNOR'S COMMENT ON THE QUALITY REPORT

I can confirm that as part of the processes involved in the production of this report I met with the Head of Governance and Quality Assurance, who confirmed to me that the priorities selected this year, a smaller and more manageable set than last year, did take into account issues raised by Commissioners, the CQC and Service Users. Moreover Governors were directly involved by way of the Service User and Staff experience sub group of the Governors. (There are a number of sub groups of the Council of Governors. They focus on different topics with different terms of reference: all Governors are required to serve on at least one group. Groups are chaired by a Governor and attended by the relevant NED. Groups are rather smaller than a full meeting of the Council, consist of Governors who have selected themselves for the group due to a particular interest or expertise, and are able to give topics detailed scrutiny in a way a plenary meeting of the Council of Governors would normally not attempt. The Service User and Staff Experience Group is seen as the appropriate one to deal with the Quality accounts.) In addition an open stakeholder event was held in February 2017 which all Governors were free to attend. In any case I am satisfied that the opportunities available to Governors to participate in the process were sufficient to fulfill relevant statutory obligations.

David Barry
Lead Governor
17 May 2017

Received by the Trust 17 May 2017
The Trust would like to thank the lead governor for the response and comments and look forward to working with governors on quality and safety in the forthcoming year.

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.

8. Annex 1: 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.
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

 the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance

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

- Board minutes and papers for the period April 2016 to May 2017
- papers relating to quality reported to the Board over the period April 2016 to May 2017
- feedback from commissioners dated 12 May 2017
- feedback from governors dated 17 May 2017
- feedback from local Healthwatch organisations dated 12 May 2017
- feedback from Overview and Scrutiny Committee dated 12 May 2017
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 18 May 2017
- the national patient survey October 2016
- the national staff survey 2016
- the Head of Internal Audit's annual opinion of the trust's control environment dated 26 May 2017
- CQC inspection report dated June 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 NHS Improvement's annual reporting manual and supporting 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

26 May 2017 .....Chairman

26 May 2017 .....Chief Executive

9. Annex 2: Independent auditor's report to the Council of Governors of Camden and Islington NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of Camden and Islington NHS Foundation Trust to perform an independent assurance engagement in respect of Camden and Islington NHS Foundation Trust's quality report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Camden and Islington NHS Foundation Trust as a body, to assist the Council of Governors in reporting Camden and Islington NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Camden and Islington NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement (NHSI):

- Care Programme Approach 7 day follow up
- Access to Crisis Resolution Home Treatment Team (gatekeeping)

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual, and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2016 to March 2017;
- papers relating to quality reported to the board over the period April 2016 to 31 March 2017;
- feedback from the Commissioners dated 12 May 2017;
- feedback from the governors dated 12 May 2017;
- feedback from local Healthwatch organisations dated 12 May 2017;
- feedback from Overview and Scrutiny Committee, dated 12 May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 18 May 2017;
- the latest national patient survey dated October 2016;
- the latest national staff survey dated 2016;
- Care Quality Commission inspection dated June 2016;

- the Head of Internal Audit's annual opinion over the Trust's control environment dated 15 May 2017; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

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

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

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

Limitations

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

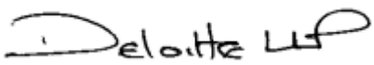
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary.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

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.



Deloitte LLP
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26 May 2017

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