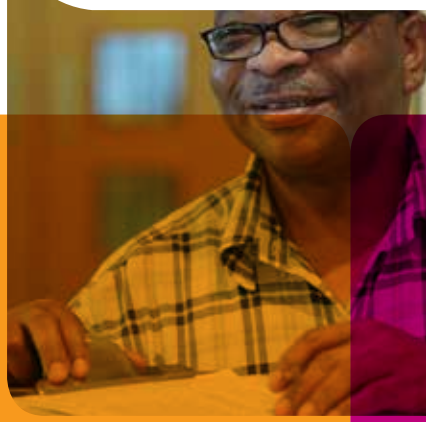
Camden and Islington NHS
NHS Foundation Trust

Quality Accounts 2014/15

Camden and Islington NHS Foundation Trust



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Quality Report

1.1 2014/15 Statement of Directors' Responsibilities in respect of the Quality Report

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

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

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

The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance;

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

- board minutes and papers for the period 1 April 2014 to 31 March 2015
- papers relating to Quality reported to the board over the period April 2014 to April 2015
- feedback from commissioners dated 14/05/2015
- feedback from Governors
- feedback from local Healthwatch organisations dated 14/05/2015
- feedback from Overview and Scrutiny Committee dated 14/05/2015
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national patient survey 2014
- the national staff survey 2014
- the Head of Internal Audit's annual opinion over the trust's control environment
- CQC Intelligent Monitoring Report dated 18/11/2014.

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

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

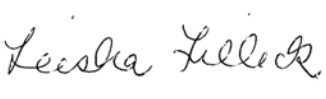
There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

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

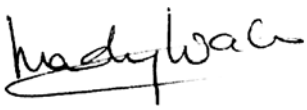
The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the Board



Leisha Fullick, Chair
27 May 2015



Wendy Wallace, Chief Executive
27 May 2015

1.2 2014/15 limited assurance report on the content of the quality reports and mandated performance indicators

Independent auditor's report to the council of governors of Camden and Islington NHS Foundation Trust on the quality report.

We have been engaged by the council of governors of Camden and Islington NHS Foundation Trust to perform an independent assurance engagement in respect of Camden and Islington NHS Foundation Trust's quality report for the year ended 31 March 2015 (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 2015, 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 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

1. Care Programme Approach 7 day follow up
2. 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 Monitor.

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

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

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

We read the other information contained in the quality report and consider whether it is materially inconsistent with Detailed Guidance for External Assurance on Quality Reports, and consider the implications for our report if we become aware of any material omissions.

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'.

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 2015:

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

Deloitte LLP

Deloitte LLP
Chartered Accountants
St Albans, United Kingdom
27 May 2015

In May 2014, the Trust received a comprehensive CQC inspection. We welcomed a team of over thirty inspectors to the Trust for several days, and shared with them all aspects of the work that we do.

1.3 Statement on Quality from the Chief Executive

Welcome to Camden and Islington NHS Foundation Trust's (C&I) annual Quality Accounts for 2014/15.

Quality Accounts provide the Trust Board with an opportunity to share with the public the Trust's work to continually improve quality across our services at Camden and Islington Foundation Trust (C&I). The Quality Accounts share our progress, our priorities for quality moving forward, and information about how we have progressed since last year. The quality goals presented here are co-developed with key stakeholders including staff, commissioners and feedback from service users. This document also meets our legal requirement for the Trust to produce Quality Accounts, under the Health Act 2009.

In the Chief Executive's statement in last year's Quality Accounts, I mentioned the significant changes we had seen, including the creation of Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards and Healthwatch which have significantly altered our commissioning arrangements. This year has been an opportunity for the Trust to build on the changes made and to continue developing and stretching ourselves in this new context. We have continued with our work to ensure that we have a culture of high quality service provision and quality improvement.

In May 2014, the Trust received a comprehensive CQC inspection. We welcomed a team of over thirty inspectors to the Trust for several days, and shared with them all aspects of the work that we do. This was a significant piece of work for the Trust and our stakeholders and has been a valuable learning experience for us. The feedback from the CQC highlighted some of the things we are rightfully proud of, including treating people with dignity and respect, and supporting service users to be engaged in their own care and involved in service development. It was apparent to the visitors that we genuinely put people using our services at the centre of our work. There are also some areas we must improve, which include improving our management of ligatures, ward transfers, falls management, learning lessons and ensuring we are using the Mental Capacity Act (1983) and Deprivation of Liberty Safeguards appropriately. Supported by our stakeholders, a large programme of work is underway to improve in these areas, and there is more to do in 2015-16. The areas in which we must improve feature in our key priorities for this year. We are already seeing the impact of changes from our CQC action plan. Our wards at St Pancras have undergone a major programme of ligature reduction work to make our environment safer, for example, and we have already improved our ward transfer process. Over this year, the CQC have been developing an intelligent monitoring system (www.cqc.org.uk/content/intelligent-monitoring-trusts-provide-mental-health-services-infographic)to gather together information on each provider registered with them. Under this system, each provider is assigned to a band of risk, with band 1 representing highest risk and band 4 lowest risk. Results for all Trusts were published in October 2014, which showed C&I in Band 4, among other trusts at lowest risk of non-compliance with regulations.

One of the things the CQC visit has supported us to do is to fully embed the Quality Assurance Framework we have developed to help us monitor and ensure the quality of our service provision. In 2014/15, we have made internal quality assurance visits to our services part of our standard practice. Lots of our staff have been involved in conducting the visits, as have our colleagues from the Clinical Commissioning Group. We have conducted an evaluation and a review of the Quality Assurance Framework so that it is revised for 2015/16. The improvements give us two tiers of improvement plans for services facing specific challenges; a standard improvement plan and an enhanced improvement plan for occasions where there are significant concerns about quality. The framework defines how decisions over improvement plans are made with reference to the Trust's risk management strategy and risk appetite. We have recently also added the review of Quality, Innovation, Productivity and Prevention (QIPP) projects and Cost Improvement Programmes (CIP) to the Quality Assurance Framework. These projects provide both opportunities and challenges to the Trust, and it is essential that the quality impact of this work is thoroughly assessed.

An important focus for C&I in 2014/15 has been learning from serious incidents. Some of the changes made this year include improving our communication with families and carers following serious incidents, and ensuring that we follow up everybody discharged from hospital within seven days, not only those cared for under the Care Programme Approach. Patient safety is our paramount priority, and during this year we have been working on our analysis of incidents occurring across the Trust. In 2014, I commissioned a thematic review of 19 serious incidents, and asked an independent expert to chair the review panel. Their remit was to establish whether there were service-related themes, wider issues or links recurring across the incidents. The finding was that the spread of incidents, their relationship in time and place, and the lack of connections between individuals involved did not suggest the presence of a cluster. We have worked not only to ensure that we are learning lessons about improving service provision, but also to understand and address the impact these can have on staff. I would particularly like to thank Camden and Islington Clinical Commissioning Groups, and their Quality and Public Health Directorates for their input into this process.

C&I are committed to being an open, transparent and learning organisation. We welcome the new Duty of Candour requirements that require NHS Trusts to apologise and provide information when things have gone wrong. We also welcome the recent "Freedom to Speak Up" report from Sir Robert Francis QC setting out the principles and actions that create the right conditions for NHS staff to speak up when something is wrong. I give my commitment to ensuring C&I is somewhere where staff at all levels feel safe to do so and believe that appropriate action will be taken. This commitment is shared by the Executive Team and the Board, and in 2015/16 we will continue working to ensure this. Our staff are C&I's greatest asset, and we were delighted to make it into the Health Service journal's top 100 list of NHS employers in 2015, reflecting the flexible working, health screening and other benefits, including yoga and pilates classes that staff have access to.

In my role as Chief Executive, I am able to see the range of work that goes on to improve quality, including projects working alongside service users and carers, development of existing services, working with commissioners to develop new and exciting service models, and involvement in research to further local, national and international understanding about mental health. For example, the Trust is working alongside colleagues in CAMHS to develop the Minding the Gap Transitions Service for young people aged 16-24 years old. This project aims to facilitate the transition between child and adult services. Rather than provide an additional service to young people directly, this project brings together professionals from all relevant agencies to use their combined expertise to get the right result. The 'no bounce' and 'no delay' approach taken means that no longer will young people experience being referred to multiple services before finding the right one for them, and decisions about the appropriate adult service will be made more swiftly and effectively. We have also continued the development of the Recovery College, where courses co-designed and delivered by people with lived experience of mental illness with mental health professionals are making a real impact on people's lives. Over the coming year, C&I will be responding to the new access and waiting time standards for mental health. Alongside our commissioners, we will be working towards ensuring treatment within six weeks for 75% of people referred to IAPT, and within 18 weeks for 95% of people. We will also be expecting treatment within two weeks for over 50% of people experiencing a first episode of psychosis. We have also committed to continue working alongside partners across the public sector to deliver the crisis care concordat local action plan. This will help us work towards making mental health services more effective and accessible than ever.

I said in this statement last year that we would begin capturing real time patient experience data in 2014/15, so that we can continually improve our care on the basis of feedback. We have begun using this not only to collect standardised information across several services, but also to develop measures designed by our service users. These measures are already helping us to learn about what really matters to people using our services right now. In 2015/16, we will develop our new patient experience strategy, and patient experience plans for each clinical division alongside their existing clinical audit plans. This strategy will set the path for patient experience at C&I for the next three years.

During this year, myself and other colleagues have worked alongside other organisations to develop world-class mental health care in our own and other trusts and cities. I have met with other members of the Cavendish Group of ten London mental health trust CEOs, which was established to offer a collective voice to the mental health trusts and to the broader mental health community. These group meetings happened for a decade prior to formally becoming the Cavendish Group earlier this year, and have always proved to be a valuable space in which to consider the complex challenges facing the mental health community in London. I have also co-chaired the London Mental Health leadership group, which consists of leaders from London CCG's, local authority social care and NHS England. This group has led work on understanding demand for acute mental health services in London, Care Act readiness and the introduction of the new access targets for mental health. The Trust has worked closely with local NHS Trusts, CCG's and the local authorities to integrate care around the needs of service users. We have been part of projects to deliver improved co-ordination for frail elderly people, we are working with Whittington Health to provide a psychosis service which also provides support for many physical health conditions and have worked with three acute Trusts to provide an enhanced liaison service. The scale of the local work to integrate services led to the Trust being co-bidders to become one of the Vanguard sites to pilot new models of care.

For 2015/16, our quality priorities reflect progress and consolidation from previous years. We continue to work towards improving the physical health of our mental health service users, and continue to improve how we gather and respond to patient feedback. As in previous years, the Trust had agreed with its commissioners a very ambitious and challenging set of quality targets and initiatives through its 2014/15 Commissioning for Quality and Innovation (CQUIN) programme. These targets covered issues relating to physical health, recovery oriented practice, collaborative care planning and smoking cessation. We have met the great majority of these targets and will work in 2015/16 to continue improvement in these areas and meet the new targets for the coming year.

The purpose of these accounts is to share our priorities, progress and challenges with all of our stakeholders, and we greatly appreciate the external input we have had in the production of our Quality Accounts. Our priorities over the coming year are a direct result of feedback from our stakeholders, commissioners and the Trust membership. These accounts represent our commitment to ensuring that we continue to improve service user and carer experience, and to strengthening further our commitment towards recovery focused care and continuous quality improvement. I am excited for the coming year, and look forward to sharing the outcome of our plans and our progress next year.

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

Signed:

Wendy Wallace,
Chief Executive
27 May 2015

1.4 Priorities for Improvement and statements of assurance from the Board

We have developed our quality goals for 2015/16 in collaboration with our stakeholders and our community. This includes working with our commissioning colleagues to identify CQUIN targets, inviting suggestions and feedback from Trust staff, and learning from incidents, complaints, and service user feedback. The priorities also reflect the areas identified for improvement following the comprehensive CQC inspection in May 2014. As we move into 2015/16 we will be seeking to further improve quality in the following areas:

Patient safety

1. Domestic violence: including ensuring people experiencing or at risk of domestic violence are supported appropriately, including reporting, safety planning and information-giving;
2. Safety from ligatures: including completing our CQC action plan relating to ligatures, and implementation of ligature risk assessment training;
3. Falls Management: including National Patient Safety Thermometer measures, falls champions, and completion of the CQC action plan relating to falls;
4. Serious incidents: including robust evidence of delivery of recommendations and evidence of sharing learning across the Trust.

Clinical effectiveness

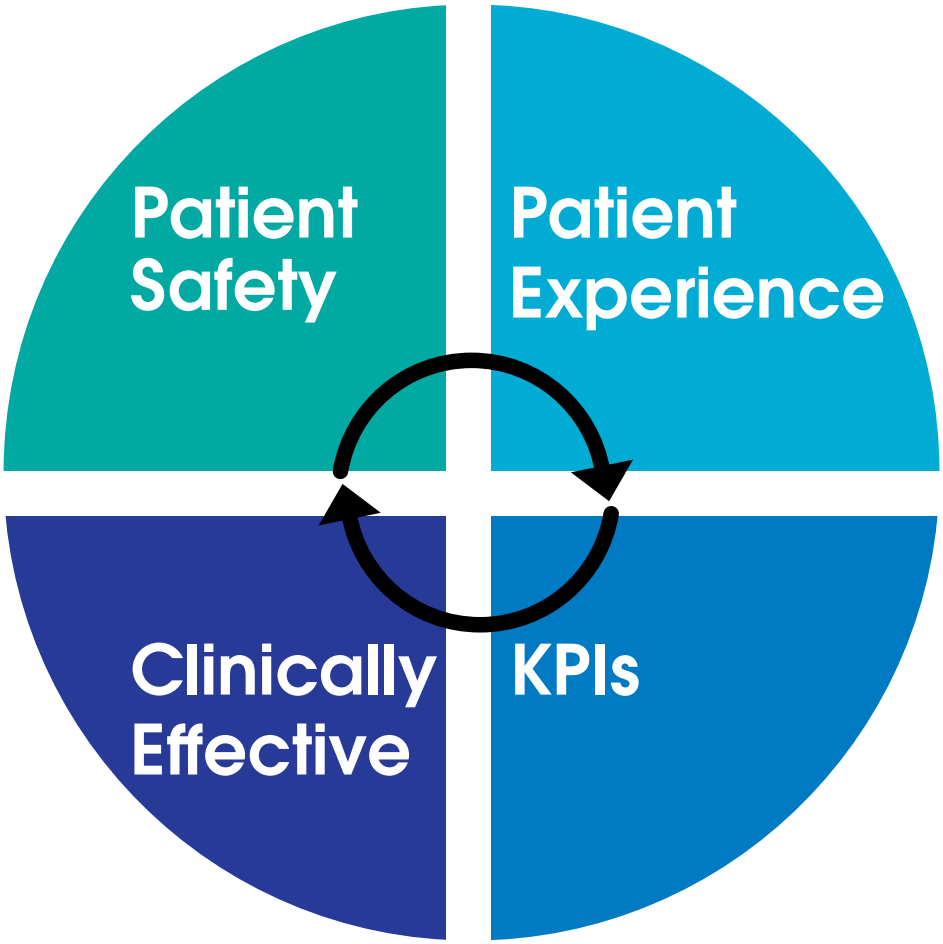
5. Physical health: using the National Patient Safety Thermometer and continuing to collect and monitor key cardio metabolic indicators for people with schizophrenia;
6. Working with other providers: improving communication with GPs, and working to reduce A&E re-admission rates by improvements in crisis planning;
7. Stopping smoking and substance misuse: ensuring service users have smoking cessation care plans, and have substance misuse assessments and appropriate management plans;
8. Mental Capacity Act: including ratification of policies by Quality Committee . following presentation to Mental Health Law Committee, and delivery of training plans.

Patient experience

9. Service user feedback: including participation in the Friends and Family Test;
10. Medication: including improving information given for new medication prescriptions;
11. Patient transfers: reducing moves between wards for non-clinical reasons.

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

Key performance indicators



1.1 Patient safety priorities

1.1.1 Priority area 1 - CQUIN Domestic Violence

This measure builds on last year's domestic violence CQUIN, moving beyond building awareness and focusing on quality of care for people at risk of domestic violence. Domestic violence is a complex issue, requiring sensitive and skilled handling by professionals. On average, a female victim of domestic violence will experience 35 assaults before going to the police (DoH Guidance, accessed 2015) www.gov.uk/government/uploads/system/uploads/attachment_data/file/211018/9576-TSO-Health_Visiting_Domestic_Violence_A3_Posters_WEB.pdf and therefore, mental health services may well be the first place that domestic violence is disclosed. Responding effectively to disclosures not only offers opportunities to improve the safety of victims and others, but also makes it more likely that somebody will continue to share their experiences, so that we can support them to maintain their safety.

Key improvement Initiatives

In 2014/15, the Trust rolled out updated domestic violence training, and incorporated domestic violence training into mandatory safeguarding training for all staff. This will continue in 2015/16. During the upcoming year, the Trust will be focusing on assessing, and then improving, our management of domestic violence disclosures to ensure that gold standard care is provided. The baseline period of assessing adherence to best practice in the first two quarters will provide an opportunity to assess areas of strength and challenge in current practice, and will inform action plans to facilitate improvements.

Key performance indicators

Quarterly audits of a case sample will be undertaken. Where domestic violence has been disclosed, clinical records will be reviewed, assessing the care provided against best practice guidance. Specifically, this will review whether disclosures have been followed by:

- Reporting: including appropriate consideration of safeguarding alerts and/or reporting to the police. This will be based on appropriate consideration, as the appropriate decision will vary on a case by case basis;
- Safety planning: including the development of plans to keep the service user and others around them safe. Safety plans include identification of safe places to go, actions to be taken at times of heightened risk and consideration of others (including children); and
- Information giving: provision of accurate and comprehensive information about options and support available.

Performance on this measure will be reported and shared in quarterly performance reports.

1.1.2 Priority area 2 - CQUIN Action Plan: Ligatures

Sadly, over the past two years the Trust has experienced two deaths involving ligatures in inpatient services. Hanging is the most common method of suicide in mental health services, and whilst we cannot eliminate the risk entirely, there is more to be done to improve patient safety in this area. This is something that was recognised by the CQC as a 'must do' in the May 2014 comprehensive inspection, and much of this work is already underway.

Key improvement Initiatives

In 2014/15, the Trust began a major programme of estates work to reduce ligature risks in our inpatient and residential environments. This programme will continue in 2015/16 and is scheduled for completion in February 2016. These estate works been accompanied by risk and patient safety workshops delivered to inpatient staff from December 2014 - February 2015. From May 2015, ligature risk assessment will be incorporated into a 'Keeping Patients Safe' monthly themed training day, providing brief training sessions to build staff confidence and skills in managing ligature risks in their environment.

Key performance indicators:

Key milestones for monitoring progress in this area are:

- Completion and close down of CQC action plan relating to ligatures;
- Delivery of estates programme for ligature reduction; and
- Establishment of regular ligature risk assessment training sessions.

1.1.3 Priority area 3 – CQC Action Plan: Falls Management

Falls can affect people of all ages, but are particularly relevant to older people who are most likely to experience serious injury (NPSA, 2007). Dementia, depression and side effects of medication can make people in mental health services particularly vulnerable to falls. The challenge for our services is to support people at risk of falling to stay safe, whilst also supporting them to maintain independence and dignity. Our CQC inspection report showed the need for us to do more to manage the risk of falls. In June 2014, a falls summit was held and a plan of work was developed to establish a baseline position to confirm current practice and shortfalls in falls management. A falls management group has been established and work on improving this has been underway since. This remains a key priority for 2015/16.

Key improvement Initiatives

In 2014/15, the Trust has made improvements to the management of falls, particularly via the roll out of the FRASE assessment tool for those at risk of falling. In 2015/16, falls management improvements will be facilitated by the continuing work on the CQC action plan. This will include ensuring that a bespoke training package is delivered to staff members, providing staff with up to date knowledge and skills not only in managing falls, but also in falls prevention. Throughout 2015/16, falls will continue to be closely monitored through the monitoring processes described in section 1.1.3. This will include monthly monitoring at divisional performance meetings and the development and implementation of action plans to address quality concerns at an early stage. Quarterly audits will also be undertaken and reported to the Audit and Risk Committee.

Key performance Indicators

Key milestones for monitoring progress in this area are:

- Falls champions in place in all relevant services;
- Completion and close down of CQC Action Plan for falls management; and
- Quarterly reporting of Falls Census data & National Patient Safety Thermometer.

1.1.4 Priority area 4 – CQC Action Plan: Learning Lessons from Serious Incidents

C&I are committed to being a learning organisation, and this is never more important than when things go wrong. In 2014/15, the Trust has introduced Learning the Lessons workshops for clinicians as a core part of all Grade 2 serious incident investigations. These workshops provide an opportunity for staff members involved in incidents to find out about the investigation process and findings, and to contribute to the development of meaningful recommendations. The Serious Incident Management Policy has been reviewed to strengthen the processes and accountabilities for learning from incidents, introducing the requirement for team managers to confirm that serious incident investigation reports have been shared with the team members. In the upcoming year, our priority will focus on further embedding these learning processes into our Trust culture. The Trust will also continue to use preliminary reviews, completed by clinical teams within 72 hours of an incident, to identify any immediate learning or actions required following a potentially serious incident.

Key improvement Initiatives

2015/16 will see the implementation of a serious incident review group, supported by the Clinical Directors of each division. This group will ensure clinical leadership in the management of and learning from serious incidents. Although changes to the national serious incidents framework mean that incidents will no longer be classified as Grade 1 and Grade 2, we will continue to hold learning the lessons workshops following serious incidents to promote systems-level learning. There will also be a continued focus on sharing incident reports, recommendations and actions with frontline staff.

Key performance indicators

Key milestones for monitoring progress in this area are:

- Evidence of delivery on all recommendations and action plans from serious incident investigations; and
- Learning being shared across the Trust, evidenced by improvements in awareness of frontline staff.

1.2 Clinical effectiveness priorities

1.2.1 Priority area 5 – CQUIN: Physical health

In recent years, physical health issues and specifically metabolic and cardiovascular comorbidity in different severe mental illnesses have become a major focus in both clinical care and research. Both older and more recent studies have confirmed the high rate of premature mortality in people with schizophrenia due to cardiovascular disease. In 2014/15, the Trust has continually worked to address the mortality gap between the general population and mental health service users.

Key improvement Initiatives

The Trust will continue to participate in the National Audit for Schizophrenia (NAS). The NAS provides the Trust with a template for auditing a sample of patients, which is then completed and uploaded to a national database. Participation in this large-scale audit allows the Trust to compare our performance with national standards and to benchmark against other Trusts. Whilst the audit covers a range of measures, including quality of prescribing, patients' experience of treatment and outcomes, in 2015/16 C&I will continue to prioritise cardio metabolic assessment for service users with schizophrenia, to ensure that key cardio metabolic parameters are assessed consistently for service users, with a record of associated interventions. More information about this national audit is available here. www.rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit.aspx

Key performance indicators

The KPI for this priority will be performance on cardio metabolic screening as per the results of the NAS. This will assess for a sample of patients prescribed antipsychotics whether appropriate screening of specific risk factors has been undertaken including:

- Smoking status;
- Lifestyle (including exercise and diet);
- BMI;
- Blood pressure;
- Glucose regulation; and
- Blood lipids.

Reporting on this measure will be via the NAS results publication, close to the end of 2015/16.

1.2.2 Priority area 6 – CQUIN: Working together with other providers

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

Key improvement Initiatives

During 2015/16, the Trust will continue to prioritise providing general practitioners (GPs) with timely discharge information when people leave inpatient care. Additionally, the Trust will continue looking to maximise the quality of this communication to ensure its effectiveness. Supported by the CQUIN framework, the Trust will improve this communication by ensuring GPs have copies of up to date care plans, diagnostic information, and information about medication, monitoring and treatment requirements for patients on CPA.

C&I have agreed with commissioners this year to work towards a new national CQUIN aiming to reduce A&E readmissions. An important factor in reducing A&E readmission is ensuring crisis planning is effective. With a view to moving towards a more comprehensive review of process and care provision, we have agreed with our commissioners to produce a qualitative report in Quarter 4 of 2015/16 reviewing quality and implementation of crisis plans. This review work will be undertaken under the Trust's Quality Assurance Framework, and will be closely aligned with the standards of the Crisis Care Concordat.

Key performance indicators

Quarterly audits will be undertaken of two key measures, each based on a sample of 100 patients:

- Timeliness of communication with GPs: Percentage of discharge notifications sent to GPs within five working days by electronic communication
- Quality of communication with GPs: Percentage of a sample of letters to GPs that include:
  - Diagnostic coding;
  - Up to date care plan information;
  - Information about medication; and
  - Monitoring and treatment requirements.

A further key performance indicator for 2015-16 will be:

- Delivery of a Quarter 4 quality report on crisis planning. This report will include:
  - A review of crisis plans against national best practice standards;
  - Findings from interviews with staff members and service user feedback;
  - Formal qualitative and quantitative analysis to ensure findings are robust and reliable; and
  - As appropriate, development and implementation of action plans based on findings.

Findings from audits and the Q4 quality report will be shared with key stakeholders as part of quarterly performance reporting.

1.2.3 Priority area 7 – CQUIN: Smoking cessation & substance misuse

Recently, the Trust has gone smoke free. This means that there are no longer facilitated smoking breaks, or any smoking permitted on Trust sites. To support this significant policy change, the Trust is redoubling efforts to provide support to stop smoking. This includes both direct support, such as provision of nicotine replacement therapy, and indirect support, such as provision of alternative activities in the 26 hours of nursing time saved each day by the removal of smoking breaks. This exciting but challenging step forward will also support improvements in physical health and wellbeing for service users. More information on the smoke free work is given in section 1.2. The Trust will also continue to prioritise supporting service users to manage substance use, and the provision of appropriate substance use assessment and management plans for service users.

Key performance indicators

Twice throughout the year (Quarter 2 and Quarter 4), C&I will include the results of two audits in quarterly performance reporting. These audits will be based on a sample of patients, and will be completed by reviewing a sample of clinical records. The audits will cover the:

- Proportion of service users with smoking cessation care plans; and
- Proportion of service users with substance misuse assessments and appropriate management plans in place.

1.2.4 Priority area 8 – CQC Action Plan: Mental Capacity Act

One of the six CQC 'must dos' related to capacity and consent. The CQC noted that C&I needed to improve arrangements for obtaining and acting in accordance with service users' consent, or where that does not apply, for establishing and acting in accordance with people's best interests. To support this work and to develop best practice, the Trust has recently appointed a Mental Health Law Manager and a Mental Capacity Act Lead.

Key improvement Initiatives

In 2015/16, these leads will support the ongoing implementation of the CQC action plan for Mental Capacity Act. Their work will involve ensuring MCA policy and associated procedures are reviewed and reflect best practice, and that these provide clear guidance for staff members across the Trust. They will also lead a programme of training to develop knowledge and skills in C&I staff.

Service user feedback is essential for ensuring that the Trust is responsive, has a learning culture, and meets the needs of the local population

Key performance indicators

Key milestones for monitoring progress in this area are:

- Ratification of policies by Quality Committee following presentation to Mental Health Law Committee; and
- Delivery of training plans for capacity and consent across the Trust.

1.3 Patient experience priorities

1.3.1 Priority area 9 – CQUIN: Service user feedback

Service user feedback is essential for ensuring that the Trust is responsive, has a learning culture, and meets the needs of the local population. In 2014/15, the Trust achieved the Friends and Family Test CQUIN by making the Friends and Family Test (FFT) available to service users on the Trust website. (www.candi.nhs.uk/service-users-and-carers/friends-and-family-survey). This year, the Trust will move on to encouraging all teams to remind service users to complete this, and using our iPads to allow service users to take part quickly and easily in services. We have been developing innovative ways to make this accessible to people who are most unwell in our services, including a project inviting former service users to visit acute division wards to support people in giving their feedback. More information about this exciting piece of work is given in section 5.7_2.4, page 86.

Key performance indicators

Performance on this priority in 2015/16 will be measured by two key indicators:

- Number of teams collecting FFT data. This CQUIN will be reported each quarter as part of the business as usual performance report.
- Examples and evidence of changes made from patient feedback. It is essential that we not only receive feedback, but make changes based on the things people tell us. Therefore, we commit to sharing on our website throughout the year, and in next year's Quality Accounts, examples of the changes we have made as a result.

1.3.2 Priority area 10 – CQUIN: Supporting medication

A number of people using our services are prescribed medication as part of their care plan, to support their journey to recovery. It is well-documented that people often find it difficult to take their medication as prescribed, which can have substantial impact on its clinical effectiveness. In 2015/16, C&I will be focusing on providing people with appropriate information and support when they are prescribed medication. In turn, this may mean people are more likely to be able to take their medication as prescribed, including managing side effects that may occur. Further, this then reduces the risk of someone's mental health deteriorating, and thus prevents crisis and avoidable hospital admissions. With this in mind, we have agreed with commissioners a CQUIN based on documentation of conversations about medications with each new prescription.

Key performance indicators

Quarterly audits will be undertaken of:

- Proportion of new prescriptions where evidence is documented of appropriate information giving at the time of prescription, including side effects. This audit will be based on a review of a sample of electronic patient records. Results will be shared in quarterly performance reports.

1.3.3 Priority area 11 – CQC Action Plan: Patient transfers

Alongside other Trusts both in London and other parts of the country, C&I have experienced significant pressures on the available bed base throughout 2014/15. The Trust's policy is absolutely clear that when somebody needs an inpatient admission, they will get one. At times, this means that beds need to be found with other providers. During the CQC visit, it was noted that sometimes people had been moved between wards for non-clinical reasons, because a bed was needed. This is something the Trust must improve and has made significant steps towards doing so. In addition to reducing non-clinical bed moves, the CQC action plan is also supporting work to develop transfer protocols so that when someone does move between beds for a clinical reason (e.g. moving from an assessment ward to a treatment ward) the handover is thorough and detailed, ensuring continuity of care.

Key performance indicators

Performance on this priority will be measured by:

- Number of non-clinical bed moves (rigorously monitored and discussed at weekly bed management meetings); and
- Completion and close down of the CQC action plan for ward transfers.

Clinical Professional of the Year:
Winner: David Mason, South Camden Drugs Service

Taking initiative: David helped set up a Club Drug clinic

1.5 Other information

This section includes information about the services provided by C&I, and about the audits and research the Trust has been involved in. It also reports information about data quality, information governance, and the most recent CQC review of our services.

1.1 Review of services

1.1.1 Statements of assurance from the Board

During 2014/15, Camden and Islington NHS Foundation Trust provided and/or sub-contracted the following four NHS services:

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

Camden & Islington 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 2014/15 represents 100% of the total income generated from the provision of NHS services by Camden and Islington NHS Foundation Trust for 2014/15.

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.

1.2 Participation in clinical audits and national confidential enquiries

The Trust participates both in clinical audits and national confidential enquiries that are nationally mandated, and also those that are more locally agreed.

The national clinical audits and national confidential enquiries applicable to Camden & Islington Foundation Trust in 2014-15 were as follows:

1. Monitoring of antipsychotic prescribing in people with a learning disability (Prescribing Observatory for Mental Health – POMH-UK)
2. National audit of intermediate care
3. Cardio metabolic assessment for people with schizophrenia (CQUIN)
4. Confidential enquiry into suicide and homicide by people with mental illness (CISH).

1.3 Monitoring of antipsychotic prescribing in people with a learning disability

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. Data upload for this audit is currently underway. Results will be published in July 2015.

1.4 National audit of intermediate care

This audit is managed by the National Benchmarking Network, and results were published (www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/NAICSummaryReport2014.pdf) in November 2014. The Trust submitted organisational data on the reablement service to this audit, which aimed to take a whole system view of intermediate care effectiveness, to support the development of quality standards, patient outcome measures and of local performance monitoring against agreed national standards.

1.5 Cardio metabolic assessment for service users with schizophrenia

In January 2015, the Trust submitted 100 records for this audit, which formed part of the 2014/15 CQUIN suite. This audit, led by the Royal College of Psychiatrists, considers the implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors for people with schizophrenia. Results of the analysis will be published in April 2015.

1.6 National Confidential Enquiry into Suicides and Homicides

In 2014/15, the Trust has completed 22 suicide questionnaires as part of this audit and one sudden unexplained death questionnaire. This national audit reviews incidents of suicide and homicide in mental health patients and provides insight into patterns and risk factors, such as increased risk of suicide post-discharge from hospital. The findings of these reports influence local and national quality priorities.

Results from the national clinical audit programme administered by the Healthcare Quality Improvement Partnership (HQIP) are available at the HQIP website (www.hqip.org.uk/national-clinical-audit/). Findings from the June 2014 report highlight the importance of follow up of people discharged from hospital, and the importance of managing ligature risks. Information about the Trust's work in these areas is given in section 1.4_1.1.2, page 14.

1.7 Local audits

The Trust conducted 270 local clinical audits in 2014/15, the results of each of which have been reviewed by key leaders within the relevant teams, divisions or Trust-wide, dependent on the scope and requirements of the audit. Local audits have supported teams within the Trust's divisions to monitor and improve their own practice, with support of the Clinical Audit Team. This has included quarterly audits of key indicators as part of the balanced scorecard programme. Balanced scorecards are developed for individual teams, with a focus on key quality metrics relevant to each service, as well as Trust-wide priorities. These audits are reviewed at divisional performance meetings, and action plans are developed to support improvements where needed.

1.8 Participation in clinical research

During 2014/15, 2,450 service users receiving services provided or sub-contracted by Camden & Islington Foundation Trust were recruited to participate in research approved by a research ethics committee. The Trust has been involved in 43 research studies, including 35 funded studies (one of which was a commercial trial) and eight unfunded. Researchers associated with the Trust have published 231 articles in peer reviewed journals.

1.9 Quality and Innovation: The CQUIN framework

During 2014/15, 2.5% of the Trust's income was conditional on achieving CQUIN targets agreed at the beginning of the year, in line with the Commissioning for Quality and Innovation (CQUIN) payment framework. This framework is revised annually, with national guidance offering an overview of quality priorities and scope for local development and adaptation to ensure measures are meaningful and provide an appropriate and achievable quality stretch to organisations.

The CQUINs agreed for 2014/15 between Camden & Islington Foundation Trust and our commissioners were in the following areas:

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

The income for 2013/14 conditional upon the achievement of quality improvement and innovation goals through the Associate Commissioner Agreements was £2,049,726. In 2014/15, this was £1,839,752.

1.10 Statements from the Care Quality Commission (CQC)

Camden & Islington Foundation Trust is registered with the Care Quality Commission (CQC).

The Care Quality Commission has not taken enforcement action against Camden and Islington NHS Foundation Trust during 2014/15.

The Trust registers all of its services under three locations

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

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

In 2014/15, the CQC undertook a comprehensive inspection, as part of the pilot of their new inspection methodology. Therefore, a formal rating has not been given. The CQC report and subsequent quality summit identified a number of areas of good practice including strong leadership and praise for our caring staff.

The CQC identified six areas in which the Trust must improve:

1. Staff working in the acute wards must be clear about the steps they need to take to reduce the risk of ligature points to patients, while work to reduce these is taking place. The acute wards had many ligature points. Although these had been assessed by a specialist surveyor and a programme of building work was scheduled to start just after our inspection, and individual clinical risk assessments were in place, ward staff were not clear about how this risk should be managed.
2. There were a number of falls in the inpatient services for older people. The policy for managing the risk of falls needs to be updated to consider recent NICE guidance and staff must follow this guidance.
3. Learning from serious untoward incidents must be shared across wards and teams quickly. Staff need to be supported to understand and use these lessons to improve their service.
4. The development of procedures, training and management to ensure the effective use of the Mental Capacity Act and Deprivation of Liberty Safeguards has started. However, this needs further development so that staff, especially in inpatient wards and the crisis resolution and home treatment teams, can use the legislation with confidence to protect people's human rights.
5. The movement of patients between acute inpatient wards for non-clinical reasons must be kept to the minimum. Where it is unavoidable, arrangements must be in place to ensure that a thorough handover takes place to promote continuity of care.
6. The trust must ensure that the action plan for the PICU, which is part of the 'rapid improvement plan', is kept up to date. This is to ensure the actions are completed quickly so that people using the service receive the appropriate care and treatment.

Following the visit, a Quality Summit was held together with our stakeholders to consider the issues raised. This positive event was an opportunity for everyone involved to consider the findings and the next steps. Following the CQC visit, the Trust developed a comprehensive action plan to address not only the 'must do' actions, but also the 'should do' actions. As the themes of the action plan cut across the Trust's five divisions, the action plan is divided into ten cross-cutting themes. Each theme has a lead, who has project management support to ensure a robust approach to delivery. Themed leads report to the CQC Programme Management Group, which in turn reports to the Quality Governance Committee. The cross-cutting themes of the CQC action plan are:

1. Recruitment
2. Falls Management
3. Risk Management
4. Capacity and Consent
5. Acute Care Pathways
6. Patient Experience
7. Access and Choice
8. Learning Disabilities
9. Medicines Management
10. Therapeutic Activities.

Throughout 2015/16, the themed leads and the CQC Programme Management Group will be reporting regularly to the Quality Governance Committee on progress and completion of action plans. The CQC will revisit the Trust in May 2015 to assess progress on the action plans. The CQC's full assessment report is available on their website (www.cqc.org.uk/sites/default/files/new_reports/AAAA1933.pdf).

1.11 Data Quality

In 2014/15, the Trust has continued its focus on improving data quality, and has built on progress achieved during the previous year. The Trust set itself the following actions with regard to data quality:

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

With the focus on MH Tariff, Mental Health and Learning Disability (MHLDDS), and Improving Access to Psychological Therapy Services (IAPT) the Trust completed the monthly submission cycles throughout 2014/15 adhering to all mandatory and voluntary deadlines.

Data quality was further monitored for each submission throughout the year, with NHS Number compliance showing continual improvement with 99.9% for each submission, a 0.2 increase on the previous year. GP practice code and code of commissioner exceeded 99.6% for each of submission, showing increases from the previous year of 3.6% and 0.2% respectively. Missing data items were validated as people not registered with a GP Practice and of no fixed abode because of the transient nature of the Trust's population.

Throughout 2014/15 the Data Quality Group has continued to meet on a monthly basis to co-ordinate the implementation of the data quality strategy and monitor performance against data quality standards. To assist this process and to provide real-time information for service managers and clinicians, the Trust has continued its development of electronic activity and data quality dashboards. A significant effort has been made to implement MH Tariff with the percentage of services users being clustered increasing from 80% to 94% and alignment of datasets to the national defined MH Tariff methods. This means that the number of eligible patients in trust MH Tariff services has increased by over 1,110 as of 20th March 2015.

1.12 Clinical Coding

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

- Rare Transitions (There has been an unlikely clinical movement between cluster)
- Diagnosis Mismatch (There is a mismatch between diagnosis and cluster)
- Team Mismatch Inapplicable (There is a likely mismatch between the service and the cluster, and so the cluster requires an update)
- Team Mismatch Review (There is a possible mismatch between the service and the cluster. Cluster requires review)
- Initial Assessments (Cluster is based on the initial assessment)
- Red Rule (Cluster does not match the cluster assigned from HoNOS, based on Mental Health Clustering Tool (MHCT) algorithm)
- Cluster Missing From Cluster Record (Cluster assessment has been completed but no cluster has been selected).

Each of these key areas has demonstrated a measurable improvement by up to 6% in some cases and this has demonstrated a reduction in clinical data quality issues of 2.07% whilst seeing the count of patient rise by over 1,110 as of 20th March 2014.

1.13 Information Governance Toolkit

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

The Information Governance Toolkit is a performance tool produced by the Health and Social Care Information Centre (HSCIC). It draws together the legal rules and central guidance related to Information Governance and presents them as one set of information governance requirements. Camden and Islington NHS Foundation Trust score for the Information Governance Toolkit was 78% and rated as a pass (green).

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

The Trust is currently developing an information governance improvement plan to improve scores rated Level 2 this year, to Level 3.

1.6 Review of Quality Performance

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

1.1 Safety

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

- The proportion of inpatient service users (Services for Ageing and Mental Health) who received assessment through the Malnutrition Universal Screening Tool (MUST) within 72 hours of admission;
- Completion of annual physical heath checks; and
- Proportion of staff reporting errors, near misses and incidents witnessed in the month prior to the annual CQC survey.

1.1.1 Compliance with standards of MUST policy

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

Numerator

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

Denominator

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

Reporting

This is audited and reported internally through the balanced scorecard process with results provided to commissioners as part of the Service Quality Improvement Plan which is presented to the Clinical Quality Review Group. The results of the quarterly audits of a sample of cases are presented in Table 1.

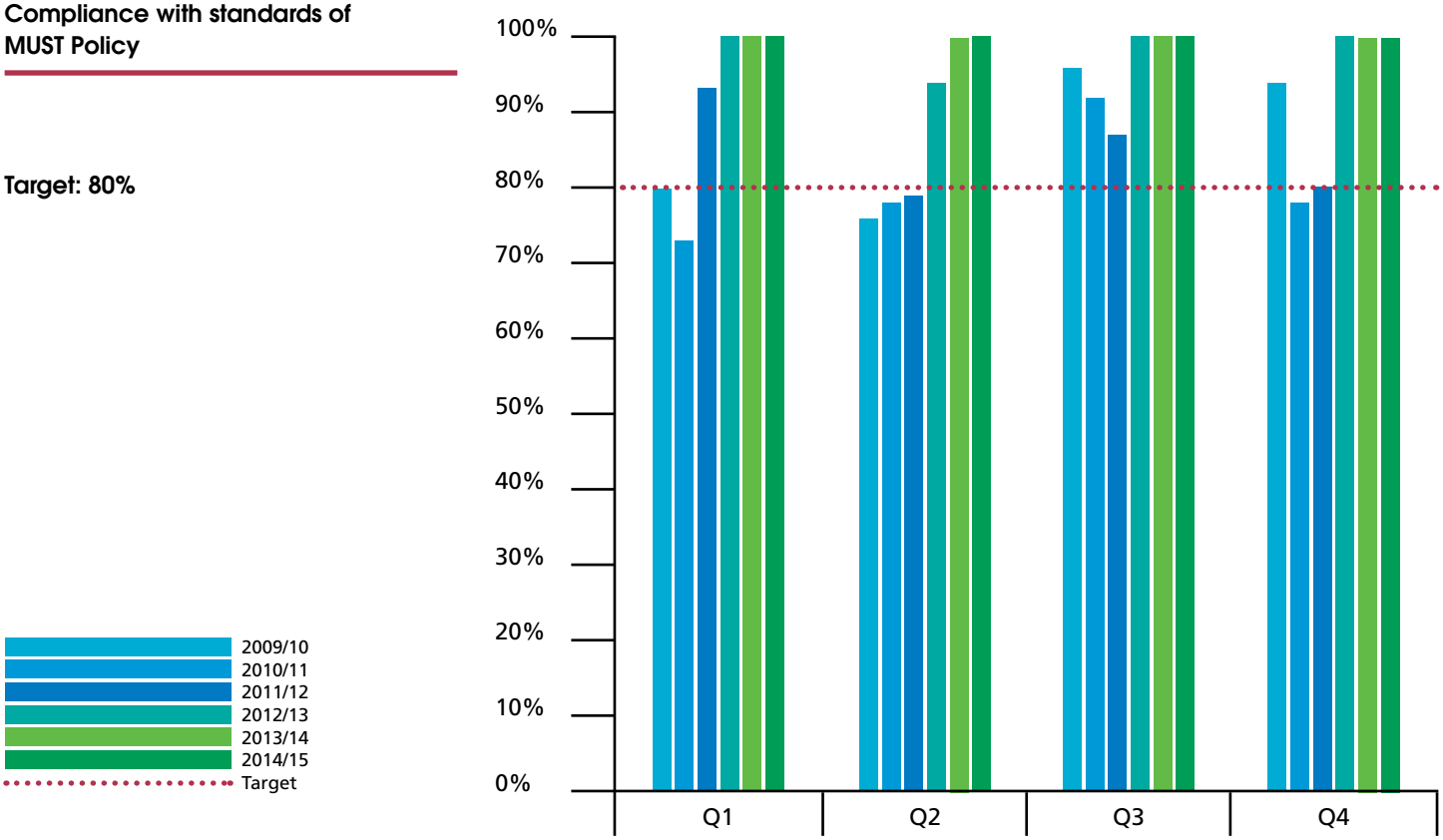
Table 1: Performance figures

Year	Q1	Q2	Q3	Q4
2009/10	80%	76%	96%	94%
2010/11	73%	78%	92%	78%
2011/12	93%	79%	87%	80%
2012/13	100%	94%	100%	100%
2013/14	100%	100%	100%	100%
2014/15	**100%**	**100%**	**100%**	**100%**

The target for this measure was 80%. The Trust has continually maintained 100% performance on this measure. Over the past four years, the Trust has undertaken a significant amount of work to improve nutrition screening, and these positive results show that this work is fully embedded in our practice.

Compliance with standards of MUST Policy

Target: 80%



1.1.2 Annual physical health checks

This measure replaces the previous Quality Accounts measure regarding compliance with the Trust physical health policy. This change has been implemented to match the CQUINs C&I agreed with commissioners and to match quality priorities. This measure focuses on completion of physical health checks for patients on CPA with high risk physical health conditions; diabetes, CHD, COPH; hypertension and/or obesity. To evidence the work teams undertake to engage clients with physical healthcare, it is the expectation that at least two (and often more) outreach attempts to facilitate physical health checks are made for those who have not completed it.

Numerator

No. of patients on CPA (who are registered with a GP) identified as having Diabetes, CHD, COPD, hypertension and/or obesity with either a completed health check or recorded evidence of at least two outreach attempts to facilitate it.

Denominator

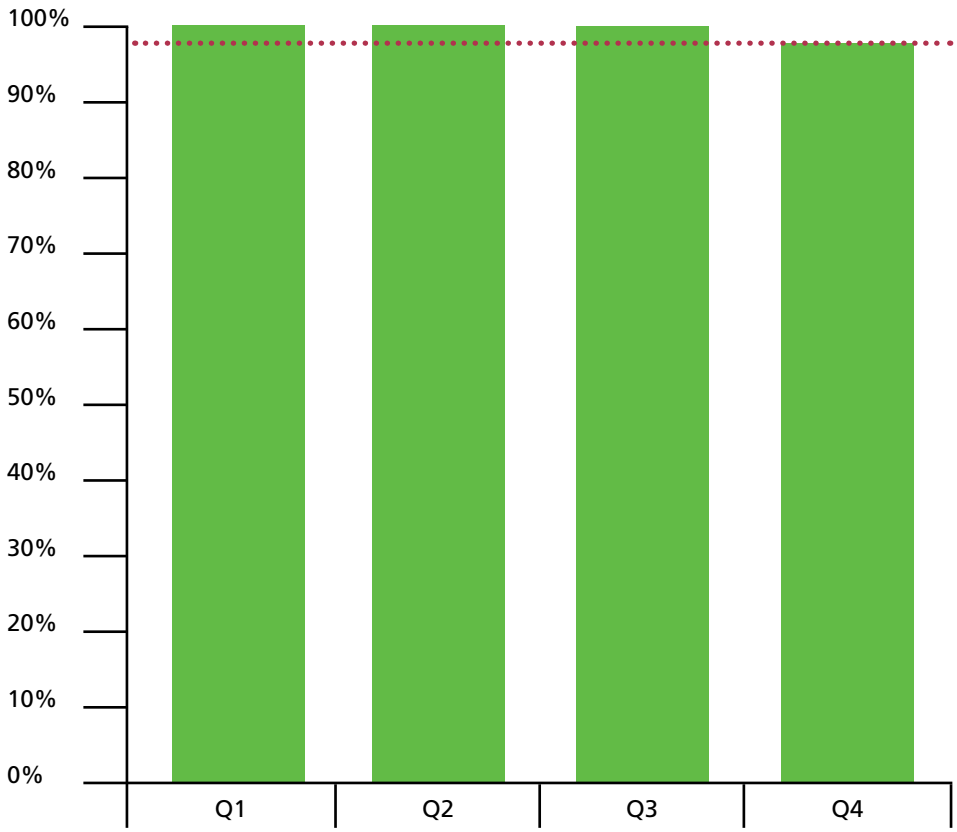
No. of patients on CPA (who are registered with a GP) identified as having Diabetes, CHD, COPD, hypertension and/or obesity.

Reporting

This measure is completed via quarterly audit of electronic patient records.

Annual physical health checks

Target 2014/15: 98%



The Trust has performed well on this ambitious target during the year, and has met the target each quarter. Despite remaining above the 95% target, we are currently investigating a small dip to 98% in Quarter 4 of the year.

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

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

Numerator

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

Denominator

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

Performance

Trust scores remain on a par with the National Average for this indicator.

Table 2: Performance figures

Year	Trust Score	National Median
2008	92%	97%
2009	90%	97%
2010	98%	97%
2011	94%	97%
2012	96%	98%
2013	92%	92%
2014	90%	90%

Remaining consistent with the national average on this measure is a good result for the Trust. However, this is something that we would like to improve in 2015/16, as the Trust has undertaken work to increase rates of incident reporting throughout the year. Ongoing work in this area includes development of the incident reporting system to facilitate effective reporting, and highlighting the importance of incident reporting at Trust induction.

1.2 Effectiveness

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

1. The proportion of service users receiving a weekly review of their inpatient care plan;
2. The proportion of inpatient service users whose stay was 100 days or more;

Recovery rate in Improving Access to Psychological Therapies (IAPT).

1.2.1 Frequency of review of care plans in inpatient services

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

Numerator

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

Denominator

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

Action plan

The Trust's historical performance differs across teams and divisions for this indicator. Performance against this measure is monitored on a team-level at monthly divisional performance meetings, with action plans developed and implemented to ensure rapid improvement at times when performance is reduced. A summary of performance since 2010 is given in the table and chart below.

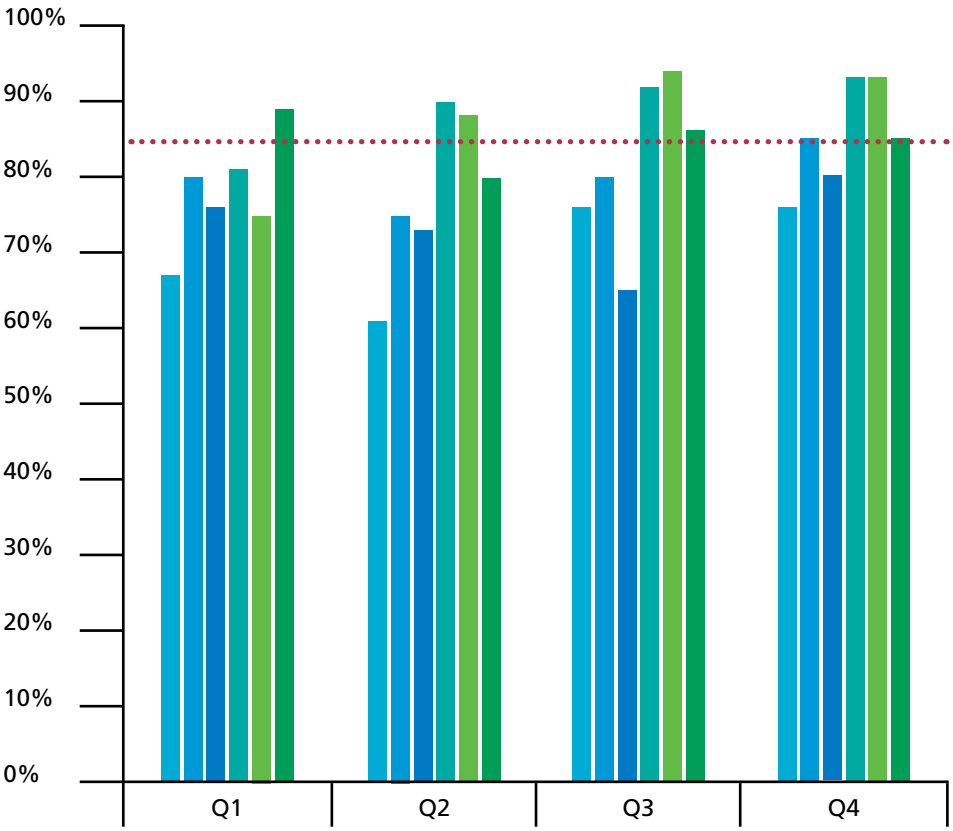
The Trust exceeded the 85% target in three of four quarters in 2014/15, and will continue actively working on this measure in 2015/16. Any teams not meeting this target are identified each quarter, and action plans are submitted to and monitored through divisional performance meetings. Steps in place to ensure the Trust continues to meet this target and improves on the current score in 2015/16 include: improving cover for primary nursing duties when staff members are on leave, discussion and development of care planning in supervision and the use of weekly audit tools.

Table 3: Performance figures

Year	Q1	Q2	Q3	Q4
2009/10	67%	61%	76%	76%
2010/11	80%	75%	80%	85%
2011/12	76%	73%	65%	94%
2012/13	81%	90%	92%	93%
2013/14	75%	88%	94%	93%
2014/15	**89%**	**80%**	**86%**	**85%**

Frequency of review of care plans in inpatient services

Target 2014/15: 85%



1.2.2 Average length of stay – stays of three months or more

The Trust monitors its average length of stay for inpatient care spells to ensure that there is effective provision of care across inpatient and community-based services. As one aspect of average length of stay monitoring, in 2011/12 the Trust set, through a review of historical and benchmarked bed usage, an internal target of no more than 20% of inpatient stays being 100 days or longer. This is part of the process of ensuring that people do not stay in hospital longer than needed, and are supported to return to the community.

Numerator

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

Denominator

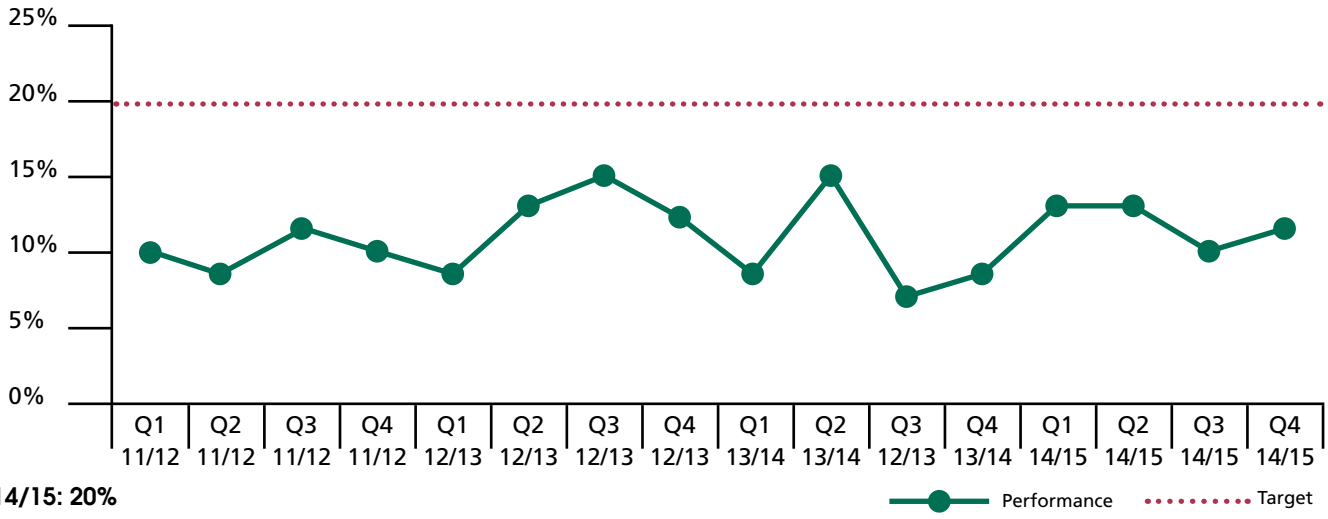
Number of inpatient discharges per quarter.

Table 4: Performance figures

Year	Q1	Q2	Q3	Q4
2010/11	12%	11%	9%	9%
2011/12	10%	9%	11%	10%
2012/13	9%	13%	15%	12%
2013/14	9%	15%	8%	9%
2014/15	**13%**	**13%**	**10%**	**12%**

Target 2014/15: <20%

Average Length of Stay
- Stays of three months or more



Target 2014/15: 20%

The target for percentage of admissions over 100 days was set within the Trust for the balanced scorecard programme at <20%. ALOS and LOS over 100 days have remained consistently below 20%, and across the four quarters are at similar levels to previous years.

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

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

Numerator

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

Denominator

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

Table 5: Performance figures

Target 2014/15: 45%

Year	2010/11	2011/12	2012/13	2013/14	2014/15
Camden	631/1706 (37%)	603/1622 (37%)	680/1684 (40%)	582/1512 (38.5%)	43.02%
Islington	675/1740 (39%)	786/2053 (38%)	701/2009 (35%)	701/1909 (36.7%)	47.30%

The recovery rate target was exceeded in Islington, and narrowly missed in Camden in 2014/15. Both boroughs showed improved scores on this measure from previous years. The Trust also provides an IAPT service in Kingston. At year end, the Kingston recovery rate was 39%. Recovery rates across all three IAPT sites have improved in 2014/15. This is the result of intensive work across the year from all three teams.

1.3 Patient Experience

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

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

1.3.1 Advice and services to carers

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

Numerator

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

Denominator

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

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

Table 6: Performance figures

2011/12	Target	Performance
Camden	30%	28%
Islington	25%	26%
2012/13	Target	Performance
Camden	35%	25.91%
Islington	27%	26.5%
2013/14	Target	Performance
Camden	35%	19%
Islington	28%	26%
2014/15	**Target**	**Performance**
Camden		**TBC**
Islington	**35%**	**26.3% (Q3 position)**

This measure remains a challenge, although performance in Camden has seen a substantial improvement this year. This is something the Trust will continue to work alongside local authority colleagues to improve in 2015-16.

1.3.2 Provision of activities in inpatient teams

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

Numerator

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

Denominator

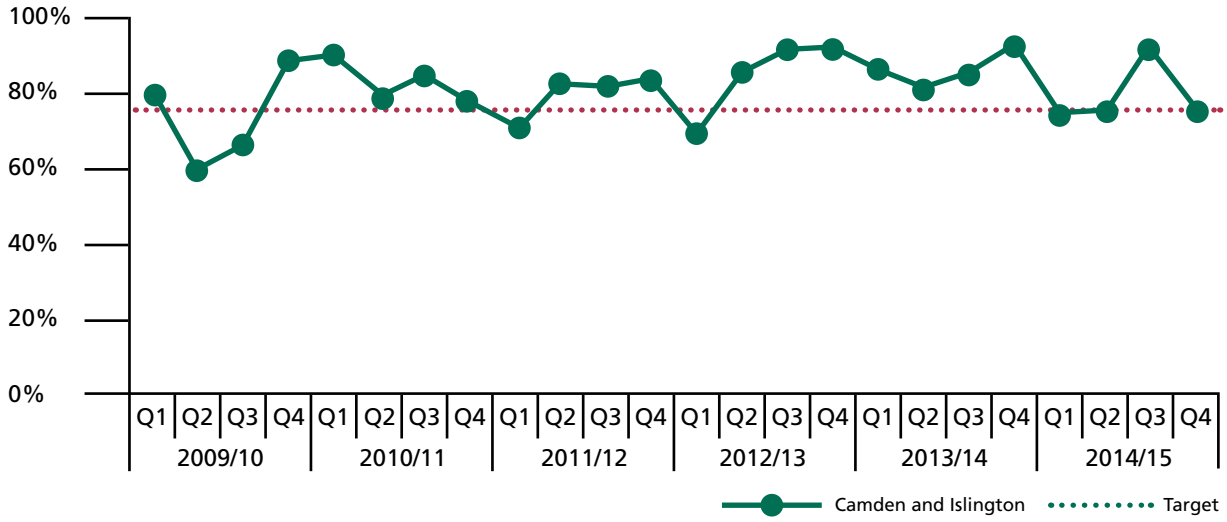
The number of service users currently admitted to inpatient services at the time of audit.

The Trust has remained above target on this measure for all quarters in 2014/15. In 2015/16, the Trust will be working to improve provision of activities further as this was identified as a 'should do' in the CQC report and therefore is incorporated in the comprehensive action plan. The Trust will also be working to ensure that data remains more consistent throughout the year by ensuring the availability of supernumerary activity workers.

Table 7: Performance figures

Year	Q1	Q2	Q3	Q4
2009/10	80%	60%	67%	86%
2010/11	88%	79%	85%	79%
2011/12	77%	83%	82%	84%
2012/13	74%	86%	89%	88%
2013/14	85%	81%	85%	87%
2014/15	**77%**	**78%**	**90%**	**78%**

Provision of activities performance chart



1.3.3 PLACE (Patient-Led Assessments of the Care Environment) assessment scores

In April 2013, the Department of Health (DoH) introduced new Patient-Led Assessments of the Care Environment (PLACE) to replace the previous Patient Environment Action Teams (PEAT) inspections.

The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical criteria which impact on the service users experience of care: cleanliness; the condition, appearance and maintenance of healthcare premises; the extent to which the environment supports the delivery of care with privacy and dignity; and the quality and availability of food and drink.

PLACE assessments are undertaken annually to support other external quality indicators. The criteria included in PLACE assessments are not standards, but they do represent those aspects of care which patients/service users and the public have identified as important, and good practice, as identified by professional organisations e.g. The Hospital Caterers Association. Although PLACE is a non-technical assessment, the views expressed come from service users or ex-service users, who are or have been recipients of services in Trust premises. Notwithstanding the non-technical nature of the assessments they are nonetheless published widely and form a publicly available assessment of health care conditions.

The Trust completed this year's round of PLACE inspections in June 2014, which were conducted in line with national guidance and led by a team of service user representatives, supported by estates and facilities managers, matrons and infection control colleagues. The most recent PLACE results (2014) are very positive.

PLACE Scores 2014

Site	Cleanliness (%)	Food (%)	Privacy, dignity & wellbeing (%)	Condition, Appearance & Maintenance (%)
HMHC	97	93	90	95
St. Pancras Hospital	96	94	89	91
Stacey Street	98	90	80	92
Drayton Park	100	87	83	97
Daleham Gdns.	100	94	70	100
154 Camden Road	100	-	76	97
Average C&I Score	97	93	88	95
Comparative Trusts	97	90	90	92

1.4 Review of Monitoring Processes

Progress to achieve our priority areas for improvement for 2015/16 (as set out at 1.3) will be monitored, measured and reported through our on-going monitoring processes detailed below.

Balanced scorecard process

The Trust has completed its thirteenth year of balanced scorecard service improvement work. Each year, the performance indicators included in balanced scorecards are reviewed to ensure that they measure meaningful, relevant information and support development and monitoring of high quality service provision. Balanced scorecards are produced for the vast majority of clinical teams. Many of the quality indicators featured in the Quality Accounts are monitored at an individual service level through the balanced scorecard process. Balanced scorecard data is provided by teams, analysed and reported by the Clinical Audit Team and discussed at local and trust-wide forums. Where balanced scorecards show that improvements are needed, action plans are developed and monitored at monthly performance meetings.

Performance framework

During 2014/15, the Trust has followed its performance framework, which sets out the key performance indicators and targets the Trust is expected to achieve. This framework has provided an effective way of monitoring performance, and has provided transparency about the Trust's delivery on key measures.

Monthly divisional performance meetings

Each division has a monthly performance review meeting with the Trust's Chief Operating Officer. In this meeting, the measures from the performance framework are reviewed, and any necessary actions to improve or stretch performance are identified. These meetings are attended by members of the divisional team, as well as representatives from governance, clinical audit, human resources, finance and information teams.

Quarterly performance reports

The Trust Board receives a quarterly performance monitoring report covering all national indicators and assessment processes, agreed quality indicator sets for commissioning bodies and locally derived quality measures. Performance reports are made available on the Trust website, and are discussed in detail with key stakeholders.

Electronic performance dashboards

All staff across the Trust can access online quality and performance management dashboards. These dashboards provide real-time performance information on key issues, extracted from the Trust's record systems. For example, clinicians can see any key clinical documentation that requires review or completion, and managers can view their team's performance at a glance.

Quality reports to commissioners

In addition to the activity reports provided to commissioners, 2014/15 saw the continuation of quarterly quality meetings and quality reports to the Trust's lead commissioners at the six-weekly Clinical Quality Review Group (CQRG). Performance against CQUIN targets, contractual quality, and service development improvement plan indicators are monitored along with reviews of learning from incidents and complaints. Camden and Islington Clinical Commissioning Groups (CCGs) have significant input into deciding priorities for quality improvement and in setting quality indicator targets.

Electronic patient experience & clinical audit data

In 2014/15, the Trust implemented an online system for capturing data about patient experience, and to support online completion of some of the Trust's audits, including Balanced Scorecards. The Trust now receives results for key surveys, such as the Friends and Family Test, via this method, as well as information from surveys designed by service users for service users. This gives real-time data, and removes the need for administration and data-entry time.

Team of the Year:
Special Commendation: Jasper Ward

Across the UK, smoking prevalence has consistently decreased over the past 50 years… However, for our service users, tobacco addiction rates have not changed for 30 years.

1.7 Key Quality Initiatives in 2014/15

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.

1.1 Sign up to Safety Campaign

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

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

The Trust's Commitment

In order for the Trust to sign up campaign there are five commitments:

1. The Trust will set out the actions that the organisation will undertake in response to the five Sign up to Safety pledges (see below) and will publish this on the Trust website for staff, patients and the public to see;
2. The Trust will commit to turn the proposed actions into a safety improvement plan which will show how the organisation intends to save lives and reduce harm for patients over the next 3 years;
3. Within the safety improvement plan the Trust will identify the patient safety improvement areas that we will focus on;
4. The Trust will engage with the local community, patients and staff to ensure that the focus of the plan reflects what is important to the community we serve; and
5. The Trust will make the plan public and regularly update progress against it.

The five Sign up to Safety pledges

Trusts that sign up to the campaign commit to setting out actions they will undertake in response to the following five pledges:

1. Put safety first. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

C&I will:

1. Commit to reducing avoidable harm
2. Identify key areas of avoidable harm and take action to reduce
3. Publish our safety goals and improvement plans on the C&I website
4. Continually learn. Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

C&I will:

1. Learn from all levels of incident reporting, complaints, feedback and claims
2. Use learning lessons workshops following serious incidents to ensure learning is shared across the organisation.
3. Implement action plans following incidents of avoidable harm
4. Continue to develop and circulate internal patient safety alerts in immediate response to patient safety concerns
5. Follow the After Action Review process after incidents
6. Honesty. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

C&I will:

1. Be open and accountable to our patients and their families
2. Support staff to be open and honest when something goes wrong
3. Continue to offer face to face meeting with patients and relatives to feedback investigation findings.
4. Make patient safety everyone's responsibility
5. Meet our responsibilities under Duty of Candour
6. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

C&I will:

1. Work in partnership with CCGs, other providers and patient/carer groups on key patient safety initiatives.
2. Participate in regional and national patient safety collaborative network meetings.
3. Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

C&I will:

1. Provide staff members with clinical and management supervision
2. Hold debrief sessions to support staff following incidents
3. Be open and supportive to patients, families and carers following an incident
4. Make sure that staff involved in incidents are offered management and occupational health support as appropriate following incidents
5. Ensure staff members are well-trained, and that they are able to access development opportunities to ensure that they have the right skills to provide good quality care
6. Ensure staff are supported and protected when raising concerns at work.

1.2 Smokefree

Across the UK, smoking prevalence has consistently decreased over the past 50 years, and was 18.5% in 2014. However, for our service users, tobacco addiction rates have not changed for 30 years. Of people with mental health problems, 40-80% smoke. Death rates from respiratory diseases are ten times higher for people with schizophrenia, and the average life expectancy is equal to the general population in the 1950's. The primary cause of this unacceptable 'mortality gap' is the disproportionate smoking prevalence, which has excluded people with mental illnesses from realising the health and quality of life improvements afforded to the rest of society.

C&I first introduced 'smoke-free' sites in 2007, a year before the legal requirement for mental health services to remove all indoor smoking areas. At this time, it was common practice across almost all mental health trusts to provide smoking areas within hospital gardens. Access to these smoking areas was facilitated by nursing staff on a timetabled basis throughout the day, to help patients to continue to smoke. What we now know is that this practice has led to a continuation of a 'smoking culture' within psychiatric care, which provides social incentives to smoke, and undermines efforts to promote smoking cessation. Tobacco smoke is a 'Class A' carcinogen, for which there is no safe level of exposure. Licit and illicit smoking in Trust sites results in exposure by staff and service users to second-hand smoke, breaching the right of staff and service users to work or be treated in an environment free of harmful substances.

In 2014 C&I received funding from Islington CCG to employ a Matron for one year to begin to implement revised NICE guidelines on smoking cessation in secondary care, which clearly address the disparity in the management of nicotine dependent service users between different types of NHS services.

During a scoping exercise in Q1 2014/2015 the smoking prevalence for inpatient service users in C&I was 63%, and 26 hours of nursing time each day was being spent facilitating smoking within 10 of the 11 gardens at our inpatient sites. A month-long engagement exercise was held to coincide with the Public Health England 'Stoptober' initiative, where the views of staff and service users on the management of smoking in Trust services were sought through a combination of survey, focus groups, engagement with strategic and peer representative groups, and trade union representatives.

In December 2014 a revised 'nicotine management policy' was developed, between the Trust and service user representatives, acknowledging nicotine dependence as a substance use disorder, and bringing clinical treatment protocols in line with the management of other substance use disorders. This policy delivers compliance with NICE guidelines by ensuring that smoking areas and facilitated smoking arrangements are removed, inpatients are provided with access to nicotine replacement therapies 24 hours per day, and all service users have access to smoking cessation support, wherever they are in the care pathway. In addition, following feedback from service users, and a review of the evidence base, the policy contains measures to safely support service users who wish to use electronic cigarettes in their bedrooms while being cared for in a 24 hour care setting.

From January to March 2015 high profile communication about the changes occurred across the Trust, access to smoking areas for inpatients was incrementally reduced, training in managing nicotine dependence commenced for all inpatient staff, and nicotine replacement therapy began being widely prescribed across the wards. Registered inpatient nurses are being trained to supply a limited range of nicotine replacement therapies at the point of admission without need for a prescription, using a patient group direction, to ensure support is offered from the point that it is needed.

C&I implemented the nicotine management policy across all Trust sites on 11th March 2015, to coincide with national no smoking day, and are developing a programme of therapeutic activities to replace facilitated smoking within our wards.

1.3 Complaints event

In March 2015, the Trust hosted the National Complaints Group. This one day event was attended by representatives from across the country, and featured a keynote speaker from the Department of Health, sessions on good practice in complaints and an update from the Ombudsman service.

1.4 Integrated Practice Unit for people living with psychosis

Camden and Islington Clinical Commissioning Groups (CCGs) have committed to working with providers to improve the experience and outcomes of care for people living with psychosis, addressing both their physical and mental health needs and enabling people who live with psychosis to live "Longer, healthier, happier lives". CCG and provider Chief Executive Officers have agreed to use a value based commissioning approach to drive this, with payment based on achievement against a set of outcomes that have been agreed, by providers, commissioners and patients, as being important for people living with psychosis. A central aspect of value based commissioning is the reorganisation of selected services into an 'integrated practice unit' (IPU). This will enable greater integration of care, and improve patient experience and outcomes.

The IPU will offer as far as possible a 'one stop shop' model, supported by individual care planning and strong care coordination. A tiered approach will be taken to physical health support, which will be provided in partnership with GPs. Mental health support and preventative services will also be provided.

1.5 Quality improvement projects in Camden Crisis Houses

Camden Crisis Houses were established to provide an alternative to acute inpatient hospital admissions that places the person at the centre of all interventions and decisions about treatment and support. From the outset, they have been committed to evaluating their service provision in terms of user experience, satisfaction, clinical and demographic profiles, and care pathways.

Over the course of 2014/15, staff at both Camden crisis houses have undertaken audits monitoring access, outcomes and interventions, and have ensured that results of these are displayed within the houses. This helps to keep people who are staying, staff, and visitors informed about the services. They have also been running regular Service User Forums in both North and South Camden where past and current service users meet to discuss their progress and share ideas for further service improvement.

From November 2014 audits of referrals to the Jules Thorn and the North Camden Acute Day Units have been carried out. Team discussions of the findings from the audits have resulted in a revamp of the referral forms to more effectively inform both the referrer and the person about benefits of attending the Day Units and to encourage more collaboration on the interventions offered and strategies to engage more service users.

An evaluation is currently underway to examine the person pathway through the Camden Crisis Houses and Acute Day Units that will include interviews with staff and service users with the objective of exploring how the service and spaces work to treat and support people. This will potentially lead to exciting new developments in 2015/16.

1.6 Positive and Proactive Care

In 2014, the Department of Health published new guidance: Positive and Proactive Care: reducing the need for restrictive interventions. The publication of this guidance commenced a two year programme to address the way in which risk of harm is managed across mental health and learning disability services. The guidance requires mental health care providers to have policy, training and monitoring mechanisms in place that support least restrictive practice, in particular, reducing the use of restraint and seclusion.

Our goal at C&I is to reduce use of restraint, and to eradicate planned prone restraint within the two year programme. The positive and proactive approach is being led by the practice development nursing team, though its success really depends on collaboration across teams and services. Progress on this work is monitored by a monthly, multidisciplinary, cross-divisional working group. This work has already led to a reduction in the number of restraint incidents and an improvement in the quality of behavioural support planning and incident reporting. Feedback from NHS England is that our restraint use is in the lowest quartile compared to other Trusts.

In December 2014, C&I launched revised policies on prevention and management of violence and aggression (PMVA), seclusion and rapid tranquilization. We have also negotiated changes in the delivery of mandatory PMVA training, to increase the focus on de-escalation and the eradication of planned restraint. The implementation of Safe Wards has been incorporated into the positive and proactive care workstream, and in the past year a further six wards have worked with practice development nurses to implement the Safe Wards programme. The Trust has also been piloting the use of After Action Review as our preferred approach to post-incident debriefing. In the coming year, AAR training and support will be widely available across the Trust.

2.1 Nurse Consultant-led Training

2.1.1 Housing staff training

Over six sessions during 2014/15, training co-facilitated with Rethink has been provided to 123 members of housing staff. Of the 118 that completed feedback, 95% rated the course as 'good' or 'very good'. These participants worked in a variety of customer service roles within the London Borough of Islington Housing including the Antisocial Behaviour Service, Arrears collection, Housing information and tenancy management.

Table 8

Year	Rating before course	Rating after course	Mean improvement
Mean score of your **personal understanding** of what is meant by mental health	4.44	8.28	+3.37
Mean score of personal understanding of how **stigma and discrimination can impact** on people affected by mental health problems	5.41	8.31	+3.54
Average rate of confidence in **supporting someone who is in distress** due to their mental health problems	4.94	7.00	+3.39

2.1.2 Practice nurse training

Training sessions for GP practice nurses have been offered throughout the year by the Nurse Consultant, often co-facilitated with a Community Matron for Mental Health. This training includes four modules:

1. Mental health awareness
2. Behaviour change
3. Physical health in mental illness
4. Wellbeing.

These sessions were offered on ten occasions, though attendance has been poor, with only 14 participants. Feedback for those that have attended has been very positive. The ongoing plan is to offer shorter, bespoke sessions to practice staff at a time convenient to their schedule to maximise attendance, and to focus on the elements most important to them.

2.1.3 Other training

Further training was provided as an adjunct to the Long Term Condition Champions sessions being held in the borough. This was attended by Practice Nurses, Community Matrons and specialist Nurses. Training on client motivation and behaviour change was included for the nine champions attending a session on heart failure, and training on motivating clients towards medication concordance was delivered to 12 participants within a medications management session.

Mental health training was provided to councilors in Islington in November 2014, who have requested further skill-based sessions be delivered in 2015/16.

2.1.4 Further scoping

Further scoping has been undertaken to explore mental health training needs within primary care. This has involved soliciting ideas and feedback from district nurses, practice nurses, and community matrons, which will influence 2015/16 training. Scoping exercises have identified that training needs for primary care staff include support with mental health awareness and capacity to have conversations about mental health, skills training in engagement, behaviour change, working with clients with problematic or challenging behaviour, talking about risk and suicide, and involving clients with mental health problems in practice opportunities and patient participation groups.

In 2015/16, we will continue collaborating with other providers to meet the training needs identified in the scoping. The nurse consultant will continue to provide training for GP practice staff and there will be ongoing liaison with the Practice Nurse Forum to find creative ways to maximise attendance at educational opportunities for Practice Nurses.

2.2 Thematic review of unexpected deaths

Following 19 serious incidents involving patients in contact with C&I between November 2013 and May 2014, Wendy Wallace, Chief Executive, commissioned an independent thematic review in line with the Trust's Serious Incident Procedure. The purpose of the review was to determine whether the incidents formed a cluster linked by certain characteristics, and to identify any service related themes or issues associated with the incidents. The review was chaired by an external expert, with senior C&I colleagues joining the panel.

The spread of incidents, their relationship in time and place, and the lack of connections between the individuals involved does not suggest the presence of a cluster. The panel noted that the number of suicides identified in the review was greater than might be expected for the population in the time period, but also that it is difficult to make predictions from the 'expected' suicide rate (as predicted by the National Confidential Inquiry). Although there was no cluster identified in these serious incidents, this detailed analysis across a number of incidents provided valuable insight and learning for C&I. We are continuing to work to deliver action plans from recommendations of each serious incident investigation. More detail on ongoing work to ensure lessons are learned is given in section 1.6, page 45.

2.3 Quality Assurance Framework

In the 2013/14 Quality Accounts, we described the development of the Trust's internal Quality Assurance Framework (QAF). This framework provides a systematic approach for monitoring and addressing quality issues, identifying potential risks at an early stage and taking action to make improvements when needed. In 2014/15, this framework has gathered pace. We have trialled, reviewed and updated our methodology for conducting internal quality assurance visits to specific services, and recently conducted the first themed review focused on 'must do' themes of the CQC action plan in inpatient services. In response to learning from our first two rapid improvement plans, we have also revised this aspect of the framework. We have introduced two levels of improvement plan; standard and enhanced. The scope and governance of these plans is guided by the risk management strategy, the Trust's risk appetite and assessments of the risk presented by quality problems identified. Key areas for development over the next year include involving service users as experts by experience in quality assurance reviews, and continuing to implement standard and enhanced improvement plans at times that this is needed.

2.4 Patient Reported Experience Measures (PREMs)

In 2014, the Trust again took part in the CQC Service User Survey. This year, response rates improved to 25% (200 participants) compared with a national response rate of 29%. Due to significant changes to the questionnaire in 2014, the data is not comparable with the survey undertaken in 2013.

The 2014 data again highlighted the diversity of the local population C&I serve, in comparison to other trusts across the country. On most measures, the Trust performed similarly to the national average (national summary available here www.cqc.org.uk/sites/default/files/MH14%20national%20summary%20v9%20with%20trust%20section%20FINAL.pdf). The overall national findings of over 13,500 participants were that two thirds of respondents rated their overall experience of community mental health services as seven out of ten or above, but that there is more to be done.

The Community Mental Health Survey results give each trust a rating of better, about the same or worse than other trusts. Encouragingly, C&I had no areas with 'worse' ratings, and 'better' ratings were given in seven areas:

1. Person seen most recently understanding how mental health needs affect other areas of life;
2. Receiving the help needed in a crisis;
3. For people receiving treatments or therapies other than medicine, being involved as much as service user wanted in deciding what therapies to use;
4. Help finding support for financial advice or benefits;
5. Help finding support for finding or keeping work;
6. Being supported in taking part in local activities; and
7. Feeling hopeful.

These results show the Trust is performing well in comparison to other trusts on these measures. However, assessing patient experience is a complex process, and we still have work to do in order to understand the experience of people using our services, and to ensure we make continuous improvements. A detailed results table is given on page 52. C&I's full results can also be viewed here. (www.cqc.org.uk/provider/TAF/survey/6#undefined).

In 2014/15, we began using our online system for capturing patient feedback. The Friends and Family Test is now available to all service users on our new website. (www.candi.nhs.uk/service-users-and-carers/friends-and-family-survey). We have also used this exciting technology to facilitate innovative patient experience projects. In the Acute Division, former service users have developed a service-user led audit tool to be completed by current service users on tablet devices. The former service users have been visiting acute division services to support the completion of these measures. The pilot of this project began on the St. Pancras site in March 2015 and interviews have been conducted with over 40 service users so far. Over the coming months, we will be continually sharing feedback with teams, taking actions in response to the feedback and keeping all of our staff and service users informed of the changes that they are making. In 2015/16, C&I will launch our patient experience strategy, which will provide our forward view on patient reported outcome measures, patient experience initiatives and patient experience priorities for C&I. This strategy is currently being developed in collaboration with staff, service users and other stakeholders.

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

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

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

2.6 Advice and Complaints Service

Depending on the complexity of the complaint, our internal Trust targets for responding to formal complaints are either 10, 25 or 45 days. The Trust has continued to face challenges meeting these timescales this year. The Trust received 180 formal complaints this year compared to 194 in the previous year. In addition 275 informal complaints and contacts were received compared to 216 in the previous business year. The team continue to work to support the informal resolution of complaints at an early stage. Whilst it is too soon to attribute the reduction in formal and increase in informal complaints to this work, this will be a continued focus for 2015-16. This will be supported by a programme of regular visits to Trust sites by the complaints team from June 2015 onwards.

Table 9

Local target: 80%

Complaints category	Q1	Q2	Q3	Q4
10 days	68%	47%	50%	56%
25 days	50%	42%	24%	24%
45 days	-	-	-	-
Total	61% (23/38)	44% (27/61)	36% (14/39)	43% (18/42)

Of the 180 formal complaints received, at the time of writing in April 2015, 169 have been responded to. Of these 169 complaints, 54% were responded to within the relevant timescale. The Trust recognises the importance of improving this indicator and the following actions have been put in place:

1. The Trust has recruited a substantive Complaints and Incidents Manager;
2. The Advice and Complaints Team send out a weekly status update to the divisions. Monitoring and tracking of complaints handling is now part of our Divisional Performance Meeting monitoring agenda;
3. The Quality Committee maintains oversight of divisional response rates;
4. A programme of training sessions is to be run by the Complaints and Incidents Manager for managers who are allocated to investigate complaints;
5. With increased capacity the Advice and Complaints Team will be able to provide a higher level of support to the complaints process. The team will also be rolling out a programme of site visits to support informal resolution of complaints;
6. Raising the profile of complaints within the Trust – the Trust hosted the National Complaints Managers Conference in March (Section 5.7_1.3, page 38).

2.7 Performance against key national indicators

2.7.1 Care Quality Commission (CQC)

The CQC have developed an intelligent monitoring system (http://www.cqc.org.uk/content/intelligent-monitoring-trusts-provide-mental-health-services-infographic) to gather together information on each provider registered with them. Under this system, each provider is assigned to a band of risk, with band 1 representing highest risk and band 4 lowest risk. Results for all Trusts were published in October 2014, which showed C&I in Band 4. The CQC are now revising the data set that makes up intelligent monitoring in response to stakeholder feedback. Revised intelligent monitoring data will be available in June 2015. Full data from C&I's most recent intelligent monitoring report is available here (www.cqc.org.uk/content/monitoring-trusts-provide-mental-health-services).

2.7.2 Monitor

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

	Target	Method	Q1	Q2	Q3	Q4
CPA - having formal review in the last 12 months	95%	**Numerator:** Number of adults in the denominator who have had at least one formal review in last 12 months. **Denominator:** Total Number of adults who have received secondary mental health services who had spent at least 12 months on CPA at the end of the reporting period or at the time of discharge from CPA.	95%	96%	96%	98%
CPA – follow up within 7 days of inpatient discharge	95%	**Numerator:** Number of people under CPA who were followed up either by face-to-face contact or phone discussion within 7 days of discharge from Psychiatric Inpatient Care. **Denominator:** Total Number of people under CPA discharged from Psychiatric Inpatient Care	96%	98%	95%	98%

	Target	Method	Q1	Q2	Q3	Q4
Admissions to inpatient care having access to Crisis Resolution Home Treatment Teams	95%	This indicator applies only to admissions to the foundation Trust's mental health psychiatric inpatient care. The following cases can be excluded: (i) planned admissions for psychiatric care from specialist units; (ii) internal transfers of service users between wards in a Trust and transfers from other Trusts; (iii) patients recalled on Community Treatment Orders; or (iv) patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. This includes CAMHS clients only where they have been admitted to adult wards. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission.	98%	100%	100%	100%
Minimising delayed transfers of care	<7.5%	**Numerator:** Number of inpatients (aged 18 and over upon admission) whose transfer of care was delayed during the quarter, per day. (For example, one patient delayed for 5 days would be 5) **Denominator:** Total Number of Occupied Bed Days during the Quarter.	1.80%	2.54%	0.50%	1.22%
Meeting commitment to serve new psychosis cases by Early Intervention Teams	95%	Quarterly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.	100%	100%	100%	100%
Mental Health Minimum Data Set:	97%	**Numerator:** Count of valid entries from the following; NHS Number, DOB, Postcode, Gender, GP Registration, Commissioner Code. **Denominator:** Total number of entries.	100%	100%	100%	100%

	Target	Method	Q1	Q2	Q3	Q4
Mental Health Minimum Data Set: Data Completeness Outcomes:	50%	**Employment Numerator:** The number of adults in the denominator whose Employment Status is known at the time of their most recent review. **Employment Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported quarter **Accommodation Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. **Accommodation Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported quarter. **HoNOS[1] Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **HoNOS Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.	66%	78%	82%	87%

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

2.7.3 Department of Health Indicators 2012/13

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

Table 10

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

Data for these measures for the reporting periods 2012/13 to present are provided over the page.

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

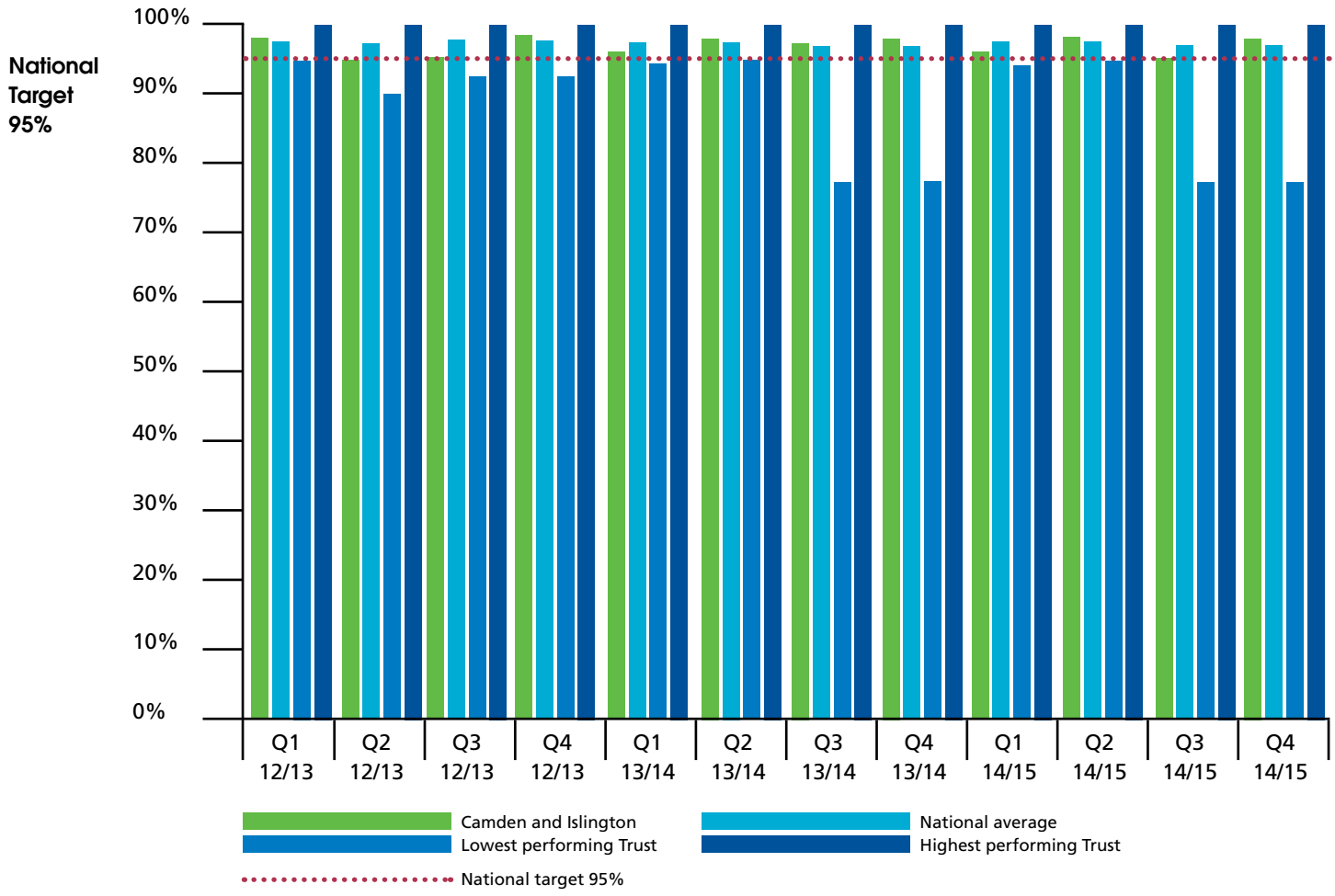
Table 11

Trust	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15
Camden and Islington	97.8%	94.9%	95.3%	98.5%	96.0%	98%	97.4%	98%	96%	98%	95%	98%
National average	97.5%	97.2%	97.6%	97.6%	97.4%	97.5%	96.7%	96.7%	97.4%	97.5%	96.7%	96.7%
Lowest Performing Trust	94.9%	89.8%	92.5%	92.5%	94.1%	94.7%	77.2%	77.2%	94.1%	94.7%	77.2%	77.2%
Highest Performing Trust	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
National Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

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

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

Percentage of patients on CPA followed up within 7 days



Assurance statement

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

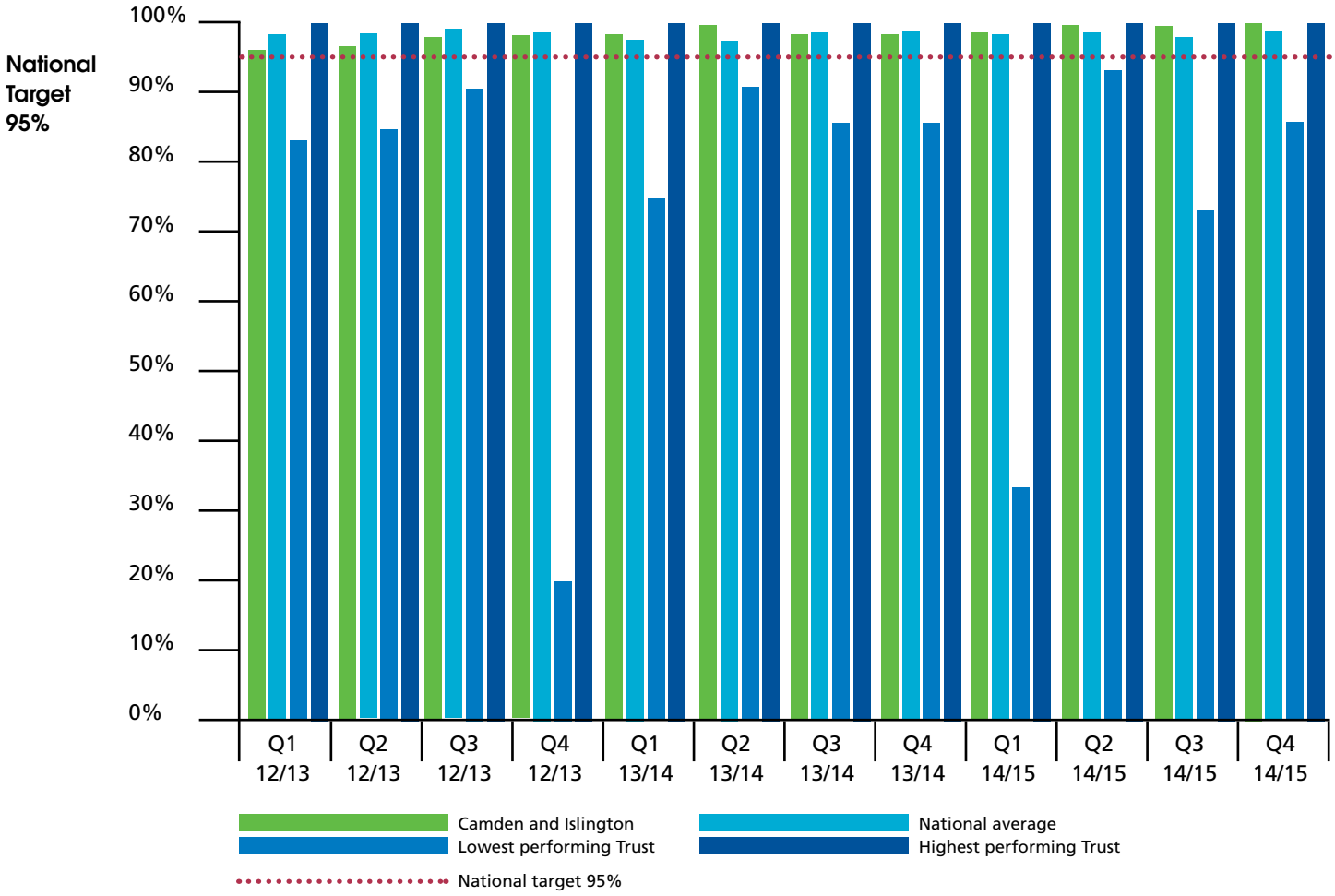
1. Benchmarking Trust performance and commissioner level targets set for other Mental Health providers to understand the definitions and methodology used to calculate and report their position.

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

Table 12

Trust	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15
Camden and Islington	96%	96.5%	95.1%	97.8%	98%	99.6%	98%	98%	98.3%	99.5%	99.5%	100%
National average	98%	98.1%	98.4%	98.7%	97.7%	97.5%	98.6%	98.6%	98%	98.5%	97.8%	98.6%
Lowest Performing Trust	83%	84.4%	90.7%	20%	74.5%	90.7%	85.5%	85.5%	33.3%	93%	73%	85.5%
Highest Performing Trust	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
National Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

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



Assurance statement

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

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

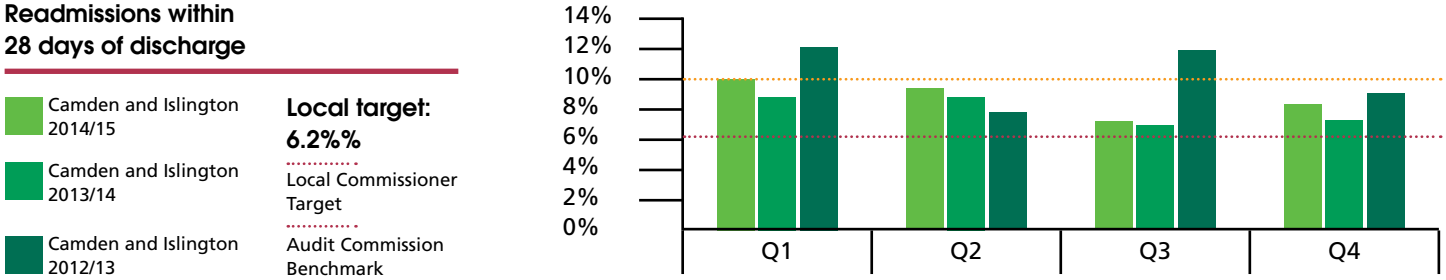
Percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital[1]

Table 13

	Q1	Q2	Q3	Q4
Camden and Islington 2012/13	12.10%	7.80%	11.80%	9%
Camden and Islington 2013/14	8.30%	8.80%	6.83%	7.10%
Camden and Islington 2014/15	10%	9.20%	7.20%	8.2%
Local Commissioner Target	6.20%	6.20%	6.20%	6.20%
Audit Commission Benchmark	10%	10%	10%	10%

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

Readmissions within 28 days of discharge



Although readmissions occur for a variety of reasons, which can include service users being readmitted to hospital shortly after leaving as part of a care pathway, one potential inference drawn from higher rates is that the readmission results from ineffective treatment in hospital, in addition to poor or badly organised readmission or support services following discharge, consequently it is important for the Trust to measure and monitor readmission rates. The Trust is actively working to reduce readmission rates, though at Q4 did not meet the local target of 6.2%. Work on this important issue will continue under the Crisis Care Concordat. The Trust has a readmissions working group, chaired by the Clinical Director for the R&R Division, which continues to support work to ensure people can remain well in the community after discharge.

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

Assurance statement

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

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

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

The Trust score from the 2014 annual CQC Staff Survey in 2013 was 3.57 out of 5 which is a slight increase on the score for 2013 (3.56).

Table 14

Service	Score
Camden and Islington Foundation Trust 2014	**3.57**
Camden and Islington Foundation Trust 2013	**3.56**
Camden and Islington Foundation Trust 2012	3.23
Camden and Islington Foundation Trust 2011	3.25
National Average 2013 (MH/LD Trusts)	3.55
Best 2012 score (MH/LD Trusts)	4.07
Lowest 2012 score (MH/LD Trusts)	3.01

Our staff Friends and Family Test results are similar to last year, and to national scores. Next year we will be offering staff the opportunity to complete FFT online, which will help maximise response rates and will ensure the survey can be accessed by all staff, thereby improving the reliability of this measure.

Assurance statement

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

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

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

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

Table 15: C&I results from this year's survey

	Section score	Item	Item score (/10)	Comparison to other trusts
Health and Social Care Workers	8.2	Listening	8.7	About the same
		Time	8.0	About the same
		Other areas of life	7.9	Better
Organising care	8.5	Being informed	7.5	About the same
		Contact	9.7	About the same
		Organisation	8.4	About the same
Planning care	7.3	Agreeing care	6.5	About the same
		Involvement in planning care	7.4	About the same
		Personal circumstances	4.9	About the same
Reviewing care	7.8	Care review	8.0	About the same
		Involvement in care review	7.6	About the same
		Shared decisions	7.7	About the same
Changes in people who see	7	Continuity of care	7.5	About the same
		Information	6.5	About the same
Crisis care	7	Contact	6.8	About the same
		Support during a crisis	7.1	Better
Treatments	7.7	Involvement in decisions	7.1	About the same
		Understandable information	7.4	About the same
		Medicine review	8.3	About the same
		Other treatments and therapies	8.1	Better
Other areas of life	6.1	Help finding support for physical health needs	6.0	About the same
		Help finding support for financial advice or benefits	6.0	Better
		Help finding support for finding or keeping work	5.7	Better
		Help finding support for finding or keeping accommodation	5.8	About the same
		Local activities	5.9	Better
		Involving family or friends	6.8	About the same
		Information on support from others	4.6	About the same
		Understanding	6.8	About the same
		Support	6.7	About the same
		Feeling hopeful	6.8	Better
Overall views and experiences	7.5	Contact	6.9	About the same
		Overall view of mental health services	7.3	About the same
		Respect and dignity	8.4	About the same

Table 16: C&I results from this year's survey

Section/ Question	C&I	West London	SLAM	BEH	CNWL	East London	South West London	Oxleas	NEL	Selected London Average
Health and Social Care Workers	8.2	7.6	8.1	7.5	7.7	7.6	7.9	7.8	7.8	7.8
Listening	9	8	9	8	8	8	8	8	9	8.3
Time	8	7	8	8	8	8	8	8	8	7.9
Other areas of life	8	7	8	7	7	7	7	7	7	7.2

Discussion of the overall survey results is given in section 1.7_2.4, page 42.

Assurance statement

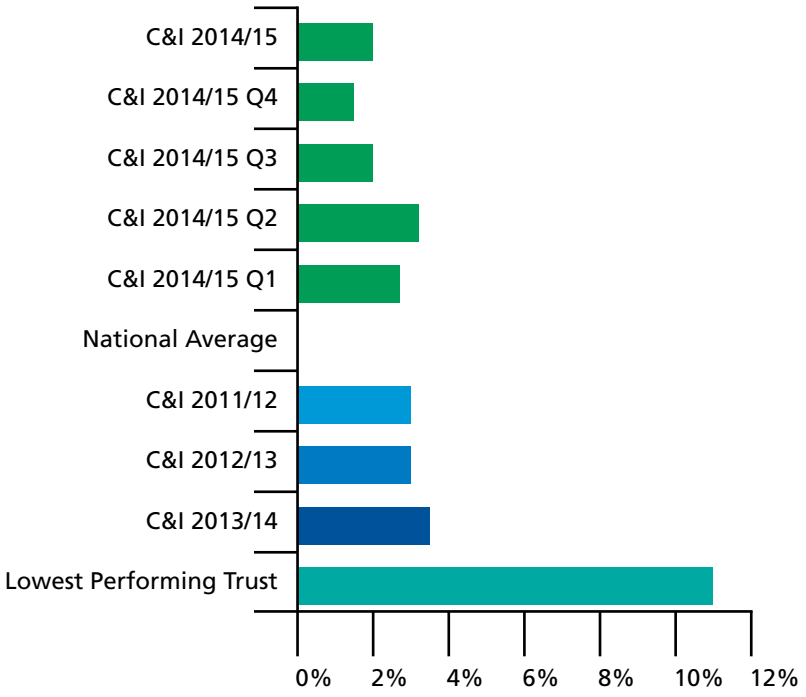
Camden and Islington Foundation Trust considers that this data is as described for the following reason: that the data is subject to monthly monitoring and is regularly audited internally to assure its accuracy. The Trust will take the following actions to improve this indicator, and so the quality of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

1. Addressing improvement in service user experience through real time tracking and response to patient feedback.

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

This measure has been selected by Trust Governors as a local quality indicator. In 2014/15, staff reported a total of 2,234 patient safety incidents. From this total, 49 were related to severe harm or death. There were 95,707 occupied bed days in the Trust in the same period. This equated to 23 patient safety incidents per 1,000 occupied bed days, with 2.2% leading to severe harm or death.

Percentage of patient safety incidents resulting in severe harm or death



After a substantial amount of work to improve incident reporting, the Trust now scores in the mid-range nationally for the reporting of patient safety incidents. This is a marked improvement as the Trust was previously the lowest national reporter. The Trust also scores highest in London and joint highest nationally for timeliness of reporting of patient safety incidents to the National Reporting and Learning System (NRLS).

1.8 2013/14 Quality Priorities - Progress

This section describes the Trust's progress against the quality priorities that we set the previous year. The Trust 2013/14 Quality Accounts set out five quality priorities for 2014/15.

1.1 Priority Areas 1&2: Physical Health

In our last Quality Accounts, we highlighted the national and local priority for improving quality of physical healthcare in mental health services. This priority has applied across services and across professional disciplines. Over the past 12 months, the Trust has continued implementing the MEWS tool (Modified Early Warning Scores) to quickly calculate the state of service users' physical health. We have also ensured monitoring of a range of KPIs & CQUINs to support this, the results of which are given below. Q4 results are provisional and subject to change in data refresh. Whilst substantial improvement was seen in communication with GPs between Q2 and Q4, there remains scope for further improvement, and this is included in the quality priorities for 2015/16, as described in section 1.4, page 12.

Table 17

	Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness						
3.1	Cardio metabolic assessment for patients with schizophrenia	Y	Q4 - 90%	N/A	N/A	N/A	N/A
3.2	Communication with General Practitioners	Y	Q4 - 90%	N/A	44%	N/A	84%(P)
	Improving the Physical Health of Service Users with Mental Health Problems and Good Practice Communication						
4.1	Complete physical and mental health diagnostic coding (ICD 10)	Y	Q1 - 95% Q2 - 95% Q3 - 95% Q4 - 95%	95%	99%	95%	95%(P)
4.2	Completion of annual physical health check	Y	Q1 - 98% Q2 - 98% Q3 - 98% Q4 - 98%	100%	100%	100%	98%(P)
4.3	Reduction of medication errors through medicines reconciliation on admission to hospital	Y	Q3 - 95%	N/A	N/A	95%	N/A
4.4	Adequate and timely communication between primary and secondary care to ensure high quality care and patients safety - inpatient and primary care	N	Q1 - 95% Q2 - 95% Q3 - 95% Q4 - 95%	89%	95%	91%	92%(P)
4.5	Increasing the stop smoking offer in health services Care Planning for Smoking Cessation - At least 35% of service users are involved in agreeing and adopting a care plan intervention for smoking cessation.	Y	Q3 - 35% Q4 - 35%	N/A	N/A	35%	55%(P)

(P) Provisional data

1.1.1 Priority Area 3: Systematic and innovative ways of capturing feedback

The Trust has implemented an online patient feedback tool. This is discussed in more detail in section 1.7_2.4, page 42.

1.1.2 Priority Area 4: Recovery-oriented practice

In 2014/15, one of the CQUIN targets agreed with commissioners related to recovery-oriented and collaborative care planning. The CQUIN, audited via a sample of patient records, included service users on CPA and reviewed their CPA review. This audit is conducted annually in Quarter 4, with a target of 50% of service users' records showing evidence of collaborative care planning, at least two personal recovery goals with input given/invited from the GP. The Trust has achieved this target, with a score of 55% at the end of the year.

1.1.3 Priority Area 5: Smoking cessation

A summary of the Trust's smoke free work is presented in section 1.2. The Trust has exceeded the target of at least 35% of service users who are smokers having a care plan intervention for smoking cessation, with a score of 54% in Q4. We have been prioritising smoking cessation recording this for 88% of service users against a 75% target. An additional audit of 4 week quits is currently underway.

1. 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.

2.1 Trust staff

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

2.2 Healthwatch

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

2.3 Trust Governors

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

Priority Area 3: Systematic and innovative ways of capturing feedback

The Trust has implemented an online patient feedback tool. This is discussed in more detail in section 1.7_2.4, page 42.

2.1.1 Priority Area 4: Recovery-oriented practice

In 2014/15, one of the CQUIN targets agreed with commissioners related to recovery-oriented and collaborative care planning. The CQUIN, audited via a sample of patient records, included service users on CPA and reviewed their CPA review. This audit is conducted annually in Quarter 4, with a target of 50% of service users' records showing evidence of collaborative care planning, at least two personal recovery goals with input given/invited from the GP. The Trust has achieved this target, with a score of 55% at the end of the year.

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1.9 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.

1.1 Trust staff

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

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

An invitation to contribute to the process of the Quality Accounts was provided to Camden Healthwatch and the Camden HOSC. The organisations made a joint statement, given in section 1.2

1.3 Islington Healthwatch

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

1.4 Trust Governors

The Trust Governors have provided input to the Quality Accounts development and their suggestions have been included in these Quality Accounts. This includes the selection of the 'rate and percentage of patient safety incidents resulting in severe harm or death' by Trust Governors as a local quality indicator (section 2.7.3, page 53).

1.10 Stakeholder Statements

Lead commissioners

NHS
Islington
Clinical Commissioning Group

338-346 Goswell Road,
London
EC1V 7LQ

Tel: 020 3688 2900
www.islingtonccg.nhs.uk

Commissioners' Statement for 14/15 Quality Accounts

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

We confirm that we have reviewed the information contained within the Account and checked this against data sources where these are available to us as part of existing contract/performance monitoring discussions and is accurate in relation to the services provided. The account provides a comprehensive summary of the work done by the Trust in 2014/15 to improve safety for service users, the effectiveness of care offered to service users, and the engagement of service users in shaping the services. We have also continued to build on good relationships with the Trust since the CCGs became authorised in 2013 which has led to greater transparency over the past year.

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

This Account has been reviewed within NHS Islington, NHS Camden, and by colleagues in NHS North and East London Commissioning Support Unit.

We are pleased to see the eleven priority areas for improvement in 2015/16 and that they support the Health and Well Being Strategies in local boroughs. These are detailed through seven initiatives, four of which are CQUIN targets for 2015/16. The quality goals were developed with staff, service users, stakeholders and the local community.

We recognise that the Trust has continued to develop its services to patients. There has been a lot of public attention on the Trust with regard to the quality of care and the treatments it provides. Also this year the Trust has had an inspection by the Care Quality Commission (CQC) which highlighted a number of areas requiring improvement. As the lead commissioner we have responded to their findings and the public concerns and have worked with the Trust to support continued improvement in services. It is very encouraging to note that the Trust has picked up on these and have included them in their priority areas for improvement in 2015/16. We look forward to working with the Trust on these new developments in the forth-coming year.

Chair: Dr Gillian Greenhough
Chief Officer: Alison Blair

The CCG also wishes to acknowledge the effort that has been put into the key priorities last year especially the work that has been undertaken on making the hospital grounds a smoke-free zone

Overall we welcome the vision described within the Quality Account, agree on the priority areas and will continue to work with C&I to continually improve the quality of services provided to patients

Alison Blair
Chief Officer
NHS Islington Clinical Commissioning Group

1.1 Islington Healthwatch (LINks)

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

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

Camden Healthwatch and the Camden Health and Adult Social Care Scrutiny Committee (HOSC) welcome the opportunity to comment on Camden and Islington NHS Foundation Trust' (CIFT) Quality Account for 2014/15 and their priorities for quality improvements in 2015/16.

During 2014/15, CIFT came twice to Camden's HOSC. It updated the committee on progress against the areas for improvement identified by the CQC in their inspection in May 2014. The Committee has established a panel to look further at the Trust's response to the CQC and welcomes the Trust's positive response. We will be working in partnership with the Trust to improve the outcomes and experience of their service users and patients. We are pleased to see that the areas identified by the CQC where CIFT must do better are reflected in their key priorities for this year.

In 2014/15 there have been some positive areas of progress on quality improvement and for this the Trusts should be congratulated. For instance,

- on nutrition screening;
- on completion of physical health checks for patients on CPA with high risk physical health conditions;
- on review of inpatient care plans (although the Trust could helpfully say more about the variation across Trust Teams and what actions are being taken to reduce this); and
- with patient-led assessments of the care environment.

Whilst there are some positives in the report, we believe that the Trust could do more to make the report easy to follow for a public readership and thereby increase transparency and accountability. At present, it appears the report has been written for commissioners, regulators or other professionals with a technical knowledge that would very likely go beyond that of the general public. A separate Camden and a separate Islington perspective with the different issues each area faces would also be welcome.

Whilst there are some examples of patient and staff engagement in the report, there is little mention of how the public and staff were involved in the process of agreeing this year's quality priorities. We hope that in next year's Quality Accounts, the Trust does more to explain how it has engaged with the public, patients, Governors and local authority in setting its priorities.

We were disappointed that the Trust did not meet its targets on respite breaks for carers, and would like to see better progress on this topic in the coming year.

We would also like the Trust to say more in the report about its relationship with the Third Sector and the role Third Sector organisations play in providing many of the services to people referred by the Trust.

1.11 Feedback

If you would like to give any feedback on the Quality Accounts 2014/15, suggest measures for 2015/16, 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**.

Viv's nomination: "I feel Viv deserves recognition and a big thank you for all her hard work, dedication and kindness to staff and service users. Viv is unique and one of a kind. I think C&I would be at a loss without this type of integrity."

Support Worker of the Year:
Winner: Vivienne Stevens, Daleham Gardens Crisis Centre