Quality Account
2017-2018

Promoting hope and wellbeing together
# Contents

## Part 1: Statement on quality from the Chief Executive, Carolyn Regan

- Quality Account 2017 - 2018

## Part 2: Priorities for improvement

- Looking back – our quality priorities 2017/18: What were they, how did we do? 4
- Looking forward – our quality priorities 2018/19: What will they be and how will we know if we have achieved them? 11
- Continuing to deliver our quality improvement programme 15
- Statements of assurance from the board 16
- National confidential enquiries 24
- Internal audit reports 26
- Participation in clinical research 28
- Commissioning for Quality and Innovation (CQUIN) 29
- Care Quality Commission (CQC) compliance 31
- Quality indicators 33
- Quality indicators – other indicators 40

## Part 3: Other information - review of quality performance

- Message from the Medical Director, Dr José Romero-Urcelay 44
- What service users, carers and the public say – key messages and actions taken during 2017/18 45
- Complaints 47
- Patient Advice and Liaison Service (PALS) 50
- Compliments 52
- Examples of key messages and actions taken in response to incidents and serious incident 53
- Coroners Rule 28 56
- Health and Safety Executive (HSE) 56
- Safeguarding children and adults at risk 57
- Nursing quality improvements and initiatives 60
- Medicines management 62
- Other quality and improvement initiatives 64
- Initiatives and improvements in Local Services 68
- Initiatives and improvements in Forensic Services 78
- Reducing restrictive practice 81

Annex 1: Stakeholders’ feedback statements  
Annex 2: Statement of Directors’ responsibilities  
Annex 3: Independent auditors’ limited assurance report
Welcome to our quality account for 2017/18.

2017/18 has been a strong year for West London Mental Health NHS Trust, with much to celebrate.

I’m particularly proud of the work which the Trust has done to improve services for patients, service users and carers. The work set out in this Quality Account and our Annual Review, as well as the evidence of its impact, stands as testament to the dedication of our staff to quality improvement and care.

This last year has seen us continue our relentless focus on improving the quality of our services. We have established a Quality Service Improvement and Redesign (QSIR) programme to focus on improving quality improvement skills and project delivery, with over 150 staff completing training.

We are also making significant improvements in how we support carers, with good progress made on our Triangle of Care programme. This programme, a quality priority for this year and 2018/19 is described in this Quality Account.

The Care Quality Commission (CQC) carried out a re-inspection of our acute wards and psychiatric intensive care unit this year, highlighting good practice and progress, as well as areas for improvement and learning.

Broadmoor Hospital was also re-inspected. The CQC recognised the improvements in the therapeutic activities available to patients and nursing levels at the hospital. The significant improvements meant the lifting of the previous year’s Warning Notice for these areas, which represents tremendous achievement in a relatively short space of time and against the context of a challenging recruitment and retention environment.

Our work to transform our Local Services across Ealing, Hammersmith & Fulham and Hounslow has continued at pace. We have taken important steps forward in improving the bed management and patient flow in our inpatient services. An important area of progress is our work with Local Authority partners to reduce delayed transfers of care, with the introduction of a daily review of activities to improve the flow of patients.

This is linked to several other initiatives in bed management and effective care, strong clinical engagement and involvement, ensuring the path to safe discharge is smooth and timely. We continually review changes to our services, which are aligned with the Five Year Forward View for Mental Health: The Single Point of Access, Perinatal Mental Health Service and our Recovery House in Ealing in particular are providing a more responsive service for patients.

Over the past year, we have demonstrated how we respond to challenges and deliver considerable progress. This puts us in a strong position for 2018/19 – as the NHS celebrates its 70th anniversary – with our continued commitment to transform Local Services and the opening of the new Broadmoor Hospital.

I would like to thank our staff, patients, service users, carers, stakeholders, partners and the Board for their support in delivering our achievements this year.
Part 2: Priorities for improvement

Looking back - our quality priorities 2017/18: What were they, how did we do?

Patient safety

Quality Priority 1:
We will be proactive in monitoring the physical health care of service users and respond appropriately when a risk is identified

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>This quality priority has been ongoing since 2016/17. We focused on this because it has been identified as an area for improvement in our CQC inspections, although there has been significant progress there is still areas in which require progression.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did we aim to do?</td>
<td>Improved patient safety by rapid identification and escalation of acutely deteriorating patients of all ages.</td>
</tr>
</tbody>
</table>
| What did we expect to achieve? | • We aimed to develop physical assessment clinics for the delivery of health assessments for Ealing community residents  
• We aimed to enable inpatient staff to identify and escalate acutely deteriorating patients |
| How did we plan to monitor and report? | • Nurse consultant to provide quarterly updates of physical illness to a patient  
• Review any incidents at least weekly and more often if clinical governance escalates concerns, patients are reviewed and staff are involved in this  
• Nurse consultant co-ordinates NEWs audits and reports quarterly to the Physical Health Steering Group  
• NEWs reviewed by consultants on ward rounds |
| How well did we do? | • Worked with Rio team to develop an electronic National Early Warning Score (NEWs)  
• The NEWs policy has been revised to include Situation Assessment Background, Recommendation and Decision (SBARD) tool to facilitate escalation  
• It includes the Maternal Early Warning Score to enable accurate assessment of pregnant women who are inpatients  
• It also includes the Paediatric Early Warning Score (12+) to enable accurate assessment of young people aged 12-16  
• Audits show steady improvements in recording and escalating concerns |
Why did we focus on this?
Following our CQC inspection in November 2016 the Trust was issued a 'Must Do' action to ensure that the use of rapid tranquillisation medication is clearly stated on patients’ medication charts and that the necessary physical health checks take place and is recorded after this medication has been administered.

What did we aim to do?
Monitor the use of rapid tranquillisation.

What did we expect to achieve?
Assess the frequency, duration and reasoning behind administering rapid tranquillisation.

How did we plan to monitor and report?
Undertake an audit measuring against best practice. Participate in the National Rapid Tranquilisation audit commissioned by the Royal College of Psychiatry.

How well did we do?
We have evidence that assures us within our High Secure Services that we are documenting mental and physical state monitoring within RIO as well as reporting this procedure as an incident on our IR1 system.

What next?
• We will continue to monitor within our High Secure Services to investigate areas for improvement
• National Audit of rapid tranquillisation has been commissioned through the Prescribing Observatory of Mental Health (POMH)
**Well-led**

**Quality Priority 3:**
We will ensure that all staff are supported with good quality supervision that promotes high quality, individualised care based on recovery principles and supports professional development

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>We focused on this because one of the areas highlighted for improvement within our CQC inspections was to ensure that the processes for staff supervision are implemented consistently across the services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did we aim to do?</td>
<td>Increase the uptake of supervision and assess the quality of the supervision provided as well as ensuring it is recorded.</td>
</tr>
<tr>
<td>What did we expect to achieve?</td>
<td>We expect to raise awareness throughout the services of the importance of good quality supervision. This should increase the amount and quality of Clinical supervision throughout the organisation.</td>
</tr>
<tr>
<td>How did we plan to monitor and report?</td>
<td>Undertake an assessment of the frequency of supervision; each of the service lines undertook individual analysis of supervision. CIDS have embedded supervision templates to not only support the supervisor but also to ensure staff know what to expect and gain from good quality supervision.</td>
</tr>
</tbody>
</table>
| How well did we do?                                                                    | • Nursing supervision within West London Forensic Services has significant assurance  
• The Exchange recording system was updated to enable junior doctors medical supervision to be identified, this has already increased the amount of supervision recorded within the medical profession  
• LLTC homeward have acted as the pilot for LLTC, this has increased the amount of supervision within the service scoring 86% in December |
| What next?                                                                             | • Supervision will continue to be a standing agenda item within the local management meetings, the controls will be monitored through the Trust Clinical Governance Group  
• Peer supervision is being considered  
• LLTC will undertake a service review of supervision in 2018/19  
• CAMHS are planning on undertaking an exercise to increase the recording of supervision throughout the next reporting year. The objective is to undertake a staff survey to explore staff of views of the quality of the supervision they receive and the reasons behind under reporting |
**Effective**

**Quality Priority 4:**
Clinical services will measure the effectiveness of treatment against clearly defined outcome measures

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>The Trust measure outcomes for patients to see how patients are progressing. The Trust focused on this quality priority this year so we could establish which outcome measures are being used.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did we aim to do?</td>
<td>The Trust aimed to review outcome measures across all of the service lines.</td>
</tr>
<tr>
<td>What did we expect to achieve?</td>
<td>For the Trust to have a better understanding of what outcome measures clinical services are using and identify areas where outcome measure are not being regularly used.</td>
</tr>
<tr>
<td>How did we plan to monitor and report?</td>
<td>Monitoring for outcome measures is undertaken at the Senior Management Meetings.</td>
</tr>
<tr>
<td>How well did we do?</td>
<td>Over the last 6 months CAMHS have made a concerted effort to embed and sustain the use of an outcome measure for Time 1 – First Appointment, Time 2 – Discharge.</td>
</tr>
</tbody>
</table>

**What next?**

This quality priority will continue into 2018/19, outcome measures which have been implemented will continue to be monitored and reported on through the Trust Clinical Governance Group meetings.
Responsive

Quality Priority 5:
Clinical services will have clearly defined care pathways that ensure that service users can access the support they need, in an appropriate setting without unnecessary delay and that transfers across services will be seamless

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>The Trust focused on care pathways to coincide with the opening of a number of new services, also to ensure that all of our clinical teams have clearly defined care pathways in place.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did we aim to do?</td>
<td>The Trust aimed to review clinical pathways across all of the service lines.</td>
</tr>
<tr>
<td>What did we expect to achieve?</td>
<td>For the Trust to have a better understanding of what clinical pathways are formally in place and identify areas where there is a need to implement.</td>
</tr>
<tr>
<td>How did we plan to monitor and report?</td>
<td>The monitoring of data on clinical pathways is reported through the quarterly quality priority plans to the Trust Clinical Governance Group.</td>
</tr>
</tbody>
</table>
| How well did we do?        | • WLFS New Models of Care are going live on in April 2018; this will be closely monitored and reviewed during 2018/19  
• Delayed Transfer of Care will be captured within the within the low secure model, this will be evaluated and presented to the Senior Management Team in June 2018  
• The under 65's care pathway in CIDS has been refined and improved  
• Transition of Care – monthly monitoring meetings between CAMHS and Adult Mental Health Services |
| What next?                 | This quality priority will continue into 2018/19, outcome measures which have been implemented will continue to be monitored and reported on through the Trust Clinical Governance Group meetings. |
### Why did we focus on this?

The Triangle of Care membership scheme offers a structure to support implementation and monitoring of the Triangle of Care, which sets out how carers, service users and professionals should work together to promote safety and recovery, and to sustain wellbeing in mental health by including and supporting carers.

### What did we aim to do?

The Triangle of Care was introduced to address the clear evidence from carers that they need to be listened to and consulted more closely. The guidelines outline key ways to achieve this as well as examples of good practice. The Trust aims to implement the standards through using the self-assessment tool and developing action plans to address areas for improvement based on good practice locally and nationally.

### What did we expect to achieve?

All inpatient services and crisis teams to undertake a Triangle of Care self-assessment and develop corresponding action plan.

### How did we plan to monitor and report?

The Trust Service User and Carer Experience Meeting monitors progress against the Triangle of Care delivery Plan and all services report to this group. Wards undertake a self-assessment, and as a result an individualised (team/ward level) action plan is created to address areas identified during that assessment in need of improvement. Evidence of compliance against standards is also collated and good practice shared via the Triangle of Care Working Group, which supports local leads and carer champions.

### How well did we do?

All inpatient services and crisis teams have undertaken their self-assessment; action plans have been developed to improve areas where the Triangle of Care standards have not been met. Other achievements include:

- Board ‘Carer Champion’ appointed
- Trustwide guidelines for information sharing with carers have been co-produced
- Team/Ward Triangle of Care champions being identified and training developed to support the champion role
- Film developed to raise awareness of the Triangle of Care project
- Carer Awareness Training has been co-produced and work is underway to roll-out the training for staff trust wide

### What next?

All of our community services will be undertaking the Triangle of Care self-assessment and action planning process during 2018/19. Local leads to support this work are being identified.
**Why did we focus on this?**  
The Trust is continuing the work initiated in 2015 to reduce the use of restrictive interventions and this will continue to be a focus until assured that these types of interventions are only used when absolutely necessary.

**What did we aim to do?**
- WLFS focused on blanket restrictive practises
- HSS participate in MH3 Reducing restrictive practices CQUIN

**What did we expect to achieve?**
- WLFS expected to evidence blanket restrictive practices and review those identified
- HSS expect to minimise the use of restrictive practices

**How did we plan to monitor and report?**
- WLFS introduced a blanket restriction reduction action plan
- The monitoring plan is set out within the CQUIN

**How well did we do?**
- One of the key improvements is that patients on unescorted leave from Pearl, Barron, Solaris and Tennyson Ward now have access to smart phones
- Benchmarking work has been undertaken with other HSS in the 3 monthly segregation reviews, and also in the quarterly joint National Conference

**What next?**
- WLFS will monitor the implementation of Smart Phone usage
- The lessons learnt for HSS during the collaborative working with the CQUIN being the objective and the implementations already embedded will be closely monitored

---

**Quality Priority 7:**  
Services will work collaboratively with service users to reduce the use of restrictive interventions including physical restraint, seclusion and long-term segregation.
The Trust settled into a model of clinical leadership in 2014/15 which is based around 7 service lines each with an appointed clinical director:

- High Secure Services (HSS)
- West London Forensic Services (WLFS)
- Access and Urgent Care (AUC)
- Liaison and Long Term Conditions (LLTC)
- Primary and Planned Care (PPC)
- Cognitive, Impairment and Dementia Services (CIDS)
- Child and Adolescent Mental Health Services (CAMHS) and Developmental services

In 2016/17, the Trust agreed on seven quality priorities for 2017/19 which supports our CQC quality improvement plan and are interlinked to the CQC’s 5 domains.

We began work towards improving practice within these areas in 2017. Each of these key priorities have targets to achieve and each service line has their own specific targets, when the quality priority is applicable to the service line.

Our 7 quality priorities for 2017/19 are:

- We will be proactive in monitoring the physical healthcare of service users and respond appropriately when a risk is identified
- Any patient who receives medication in an emergency (rapid tranquilisation) will have their psychological state and physical healthcare closely monitored to keep them free from harm
- We will ensure that all staff are supported with good quality supervision that promotes high quality, individualised care based on recovery principles and supports professional development
- Clinical services will measure the effectiveness of treatment against clearly defined outcome measures
- Clinical services will have clearly defined care pathways that ensure that service users can access the support they need, in an appropriate setting without unnecessary delay and that transfers across services will be seamless
- Using the Triangle of Care the Trust will improve the inclusion of carers
- Services will work collaboratively with service users to reduce the use of restrictive interventions including physical restraint, seclusion and long-term segregation

Looking forward - our quality priorities for 2018/19: What they will be and how we will know if we have achieved them?
In 2015/16, the Quality Committee delegated responsibility to the Trust Clinical Governance Team to monitor and oversee the implementation and progress made by each area in achieving their selected milestones and targets. Progress is then reported via the Trust Clinical Governance Group meeting.

In the tables below you can read about the targets we have set for 2018/19:

<table>
<thead>
<tr>
<th>Priority</th>
<th>Key milestones Q1</th>
<th>Key milestones Q2</th>
<th>Key milestones Q3</th>
<th>Key milestones Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Safety:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We will be proactive in monitoring the physical health care of service users and respond appropriately when a risk is identified</td>
<td>CQUIN 3a Improving physical healthcare to reduce premature mortality in people with serious mental illness. CQUIN - Cardio metabolic assessment and treatment for patients with psychoses. Improved recording of patients physical exercise uptake. We will signpost patients to services that will enable them to reduce risks and improve health such as the Smoking cessation services in Ealing, Hounslow and Hammersmith &amp; Fulham and programmes aimed to increase physical activity such as “healthy walks”. Improve the recording of patients physical exercise uptake. Introduce bespoke physical exercise plans for patients who have specific needs. One You Ealing will continue the delivery of health assessment clinical in the community during 2018/19. One You Ealing to undertake a whole service review of activity delivered in 2017/18.</td>
<td>Continue with quarterly CQUIN Targets. Provide a phase 1 progress report on: • Recording • Access • Bespoke exercise plans Provide staff with additional training and share best practice of training around alcohol, physical activity questions into our health trainer service so they can provide a more comprehensive service.</td>
<td>Continue with quarterly CQUIN Targets. Gather data and draft a phase 2 progress report on: • Using principles of co-production and co-delivery roll out training for staff and patients • Using principles of co-production and co-delivery roll out being to roll out physical exercise opportunities for patients Ensure staff undertake competency test around the intervention delivery of training around alcohol and physical activity.</td>
<td>Continue with quarterly CQUIN Targets. Complete phase 2 report. News 2 to go live March 2019.</td>
</tr>
<tr>
<td>Any patient who receives medication in an emergency (rapid tranquillisation) will have their psychological state and physical health care closely monitored to keep them free from harm</td>
<td>Monthly pharmacy report to be presented at the WLFS Governance Group. HSS to review current monitoring requirements and to develop audit of current practice and against best practice. Present national audit findings of the Rapid tranquillisation audit commissioned by the Royal College of Psychiatry to the Trust Clinical Governance Group.</td>
<td>HSS to undertake audit to identify the gaps. Services to share the National Audit findings and develop an action where necessary.</td>
<td>HSS to present findings of the audit and create an action plan. Services to monitor implementation of the National Audit findings action plan.</td>
<td>HSS to implement actions from the audit undertaken in Q2 and Q3.</td>
</tr>
</tbody>
</table>
## Well led:

We will ensure that all staff are supported with good quality supervision that promotes high quality, individualised care based on recovery principles and supports professional development.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Key milestones Q1</th>
<th>Key milestones Q2</th>
<th>Key milestones Q3</th>
<th>Key milestones Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>LLTC SMT will undertake a deep dive of the directorate around supervision methods and rates.</td>
<td>LLTC to develop a supervision template that can be incorporated across the services.</td>
<td>LLTC will monitor levels of recorded supervision data.</td>
<td>LLTC Senior Management Team will review staff satisfaction outcomes.</td>
<td></td>
</tr>
<tr>
<td>Identify a lead within the service line to gain regular feedback on the satisfaction of staff regarding their supervision.</td>
<td>The service to embed protected time and supervision into practice.</td>
<td>Implement a monitoring system for regular staff feedback on the quality of supervision.</td>
<td>Review the new monitoring system.</td>
<td></td>
</tr>
<tr>
<td>Develop an audit plan of supervision.</td>
<td>Review supervision audit results.</td>
<td>Review supervision audit results.</td>
<td>Undertake an annual review of reflective practice and supervision.</td>
<td></td>
</tr>
</tbody>
</table>

## Effective:

Clinical services will measure the effectiveness of treatment against clearly defined outcome measures.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Key milestones Q1</th>
<th>Key milestones Q2</th>
<th>Key milestones Q3</th>
<th>Key milestones Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>One of the Liaison Psychiatry Service to pilot FROM-LP RIO tabs.</td>
<td>Provide feedback to Trust Clinical Design Group regarding pilot of FROM-LP RIO tab.</td>
<td>Liaison Psychiatry Service will record FROM-LP in RIO tab.</td>
<td>FROM-LP monthly reporting will be collected via FROM-LP RIO tab.</td>
<td></td>
</tr>
<tr>
<td>WLFS to share and review the results from the DREEM Survey.</td>
<td>Refine specification with RiO team to if there is any need to alter FROM-LP RIO tab.</td>
<td>HSS to draft clinical model for consultations.</td>
<td>Repeat DREEM Survey.</td>
<td></td>
</tr>
<tr>
<td>To ensure regular use and audit of outcome measures in PPC recovery teams.</td>
<td>HSS to define additional outcome measures.</td>
<td>END of PPC monitoring system.</td>
<td>Produce an end of year audit which reports on the implementation of the outcome measures across PPC.</td>
<td></td>
</tr>
<tr>
<td>HSS to review current outcome measures</td>
<td></td>
<td></td>
<td>HSS to implement newly defined outcome measures.</td>
<td></td>
</tr>
</tbody>
</table>

## Responsive:

Clinical services will have clearly defined care pathways that ensure that service users can access the support they need, in an appropriate setting without unnecessary delay and that transfers across services will be seamless.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Key milestones Q1</th>
<th>Key milestones Q2</th>
<th>Key milestones Q3</th>
<th>Key milestones Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit a lead to agree on the methodology to undertake an evaluation of the transition of care for service users from CAMHS to Adult Mental Health Services.</td>
<td>Undertake and complete the transition of care pathway evaluation in CAMHS.</td>
<td>Share results and devise action for the pathway evaluation between Adult and CAMHS Services.</td>
<td>Implement actions and recommendations leading from the evaluation.</td>
<td></td>
</tr>
<tr>
<td>WLFS evaluation of low secure model to be presented to the Senior Management Team in June 2018.</td>
<td>WLFS to develop strategy.</td>
<td>All services to share their report on current care pathways to the Trust Clinical Governance Group.</td>
<td>End of year action plan to be embedded.</td>
<td></td>
</tr>
<tr>
<td>Priority</td>
<td>Key milestones Q1</td>
<td>Key milestones Q2</td>
<td>Key milestones Q3</td>
<td>Key milestones Q4</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
<td>------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Caring:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using the Triangle of Care the Trust will improve the inclusion of carers.</td>
<td>CAMHS to prepare for their self-assessment.</td>
<td>CAMHS to complete self-assessment.</td>
<td>Implement actions from the CAMHS self-assessment.</td>
<td>Review implemented actions.</td>
</tr>
<tr>
<td></td>
<td>WLFS have completed the self-assessment which is currently being reviewed.</td>
<td>All non-inpatient services to complete self-assessment.</td>
<td>All non-inpatient services to develop action plan following completion of Triangle of Care self-assessment tool.</td>
<td>Report progress against action plan and provide a forward view of the next steps.</td>
</tr>
<tr>
<td></td>
<td>PPC Carer awareness training for staff to be rolled out across the services.</td>
<td>Development of a carers register via the CIDS website.</td>
<td>Implementation of carer attendance to Clinical Improvement Groups in our 4 community teams with them included in minute circulation.</td>
<td>Full implementation of ‘Johns campaign’ in CIDS new build unit to allow carer facilities to sleep overnight should they desire to do so.</td>
</tr>
<tr>
<td></td>
<td>Identification of carers to attend local Clinical Improvement Groups in our 4 community teams.</td>
<td>Carer awareness training to be promoted for staff.</td>
<td>Carers champions to progress the Triangle of care self-assessment phase and identify any short falls.</td>
<td>Carers champions will have devised an action plan following the self-assessment phase of Triangle of care.</td>
</tr>
<tr>
<td></td>
<td>To identify a member of staff in each team.</td>
<td>To scope the role of the carers champion in each team.</td>
<td>Staff to attend carer awareness training.</td>
<td>70% of CIDS staff to have successfully completed carer awareness training.</td>
</tr>
<tr>
<td>Services will work collaboratively with service users to reduce the use of restrictive interventions including physical restraint, seclusion and long-term segregation.</td>
<td>Service User Improvement Lead post being developed within WLFS.</td>
<td>Recruitment of Service User Improvement Lead post within WLFS.</td>
<td>New post to review current practices in WLFS and identify improvement.</td>
<td>Provide detailed report to evaluate pilot and showing what changes in practices have occurred. This should include a description of any good practice initiatives that have occurred from the introduction of the strategy, and monitoring data (as per expected outcomes).</td>
</tr>
<tr>
<td></td>
<td>Develop a collaborative working group responsible for developing the overarching strategy which includes service user representation.</td>
<td>Development and implementation of action plan including: engagement, training of staff, evaluation plan.</td>
<td>Develop a draft framework including an implementation plan to address issues arising across service providers.</td>
<td>Develop a research partnership to evaluate the efficacy of the strategy across the services.</td>
</tr>
<tr>
<td></td>
<td>Facilitate workshops to formulate service challenges and strengths in relation to reducing LTS and to build clinical engagement.</td>
<td>Provision of training in accordance with strategies to reduce LTS to ensure staff are committed to and have the necessary skills and competencies to deliver change.</td>
<td>Pilot strategy within the service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measure the application of best practice guidelines which were developed by the 3 hospitals as part of CQUIN in 2016.</td>
<td>Progress report on action plan.</td>
<td>Evaluation report of staff/patient engagement process.</td>
<td></td>
</tr>
</tbody>
</table>
We have four members of staff which have completed the Improvement Advisors Training with the Institute of Health Improvement.

Our improvement Advisors (IA) are devoted to helping identify, plan, and execute improvement projects throughout an organisation, deliver successful results, and spread changes across the entire system. It is recognised that organisations that achieve multiple and sustained improvements usually have the invaluable leadership of an IA at the helm of their improvement initiatives. To effectively meet the demands of the job, IAs need more than just an interest in improvement work. They need a solid foundation, advanced knowledge and skills in the art and science of improvement, plus the ability to work with and coach front-line teams in achieving and maintaining successful changes. IAs must also be able to communicate effectively with senior management to summarise progress on improvement projects and clearly articulate needed sponsorship and support when projects stall.

Five more members of staff will graduate as IHI trained improvement advisors in the Spring of 2018. Recurrent funding has been allocated to develop and implement a Trust-wide quality improvement program. The new post of the Trust Quality Improvement Lead (AFC 8b) was advertised nationally and following a comprehensive selection the post was appointed to. Following this appointment we will advertise QI Coordinator role (AFC 6) and a new post that it will be advertised nationally.

We have just advertised a training opportunity with the Institute for Healthcare Improvement’s (IHI’s) Improvement Coach Professional Development Program. This 12-week experiential program gives participants the skills needed to successfully coach and facilitate improvement teams, while supporting the implementation of improvement strategies throughout the organisation. Funding has been agreed for 8 places on the course.

We have established a Quality Service Improvement and Redesign (QSIR) programme to focus on improving quality improvement skills and project delivery within the Trust. The programme has seen over 150 staff trained in the NHS Improvement approved methodology.
Review of services
During 2017/18, WLMHT provided and/or sub-contracted 10 relevant health services. The Trust has reviewed all the data available to them on the quality of care in 10 of these relevant health services.

The income generated by the relevant services reviewed in 2017/18 represents 100 per cent of the total income generated from the provision of relevant health services by WLMHT for 2017/18.

WLMHT reviews the quality of the care provided through the Trust Quality Committee which is chaired by a non-executive director and reports directly to the Trust Board.

Participation in clinical audits
During 2017/18, 3 national clinical audits and 1 national confidential enquiry covered relevant health services that WLMHT provides.

During 2017/18 WLMHT participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

National Clinical Audits
Prescribing Observatory Mental Health-UK (POMH-UK): prescribing in mental health services:
- POMH-UK QIP 17a: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention
- POMH-UK QIP 15b: Prescribing valproate for bipolar disorder
- National Clinical Audit of Psychosis

The national clinical audits and national confidential inquiries that WLMHT participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry.

<table>
<thead>
<tr>
<th>Name of National Clinical Audit</th>
<th>Number Submitted</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>POMH-UK QIP 17a: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention</td>
<td>122</td>
<td>100%</td>
</tr>
<tr>
<td>POMH-UK QIP 15b: Prescribing valproate for bipolar disorder</td>
<td>Tbc*</td>
<td>Tbc*</td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis</td>
<td>88</td>
<td>44%</td>
</tr>
<tr>
<td>The Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)</td>
<td>Tbc*</td>
<td>Tbc*</td>
</tr>
</tbody>
</table>

* Reports unavailable at time of publication

The national clinical audits and national confidential enquiries that WLMHT was eligible to participate in during 2017/2018 were as follows:

<table>
<thead>
<tr>
<th>National clinical audits</th>
<th>National confidential enquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing Observatory Mental Health-UK (POMHUK): Prescribing in mental health services (17a and 15b described below)</td>
<td>The National Confidential Inquiry into Suicide and Homicide for People with Mental Health Illness (NCISH).</td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis (NCAP)</td>
<td></td>
</tr>
</tbody>
</table>

The national clinical audits and national confidential enquiries that WLMHT was eligible to participate in during 2017/2018 were as follows:

<table>
<thead>
<tr>
<th>National clinical audits</th>
<th>National confidential enquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing Observatory Mental Health-UK (POMHUK): Prescribing in mental health services (17a and 15b described below)</td>
<td>The National Confidential Inquiry into Suicide and Homicide for People with Mental Health Illness (NCISH).</td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis (NCAP)</td>
<td></td>
</tr>
</tbody>
</table>
The report of 1 national clinical audit was reviewed by the provider in 2017/18 and WLMHT intends to take the following actions to improve the quality of healthcare provided:

1. **POMH-UK QIP 17a**: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention (baseline audit)

   **Data collection**: June 2017
   **Report due**: December 2017
   **Lead**: Priscilla St.Croix

   **Audit standards**:
   **Care Plan**:
   - A patient's care plan should be accessible in the clinical records
   - There should be documented evidence that the patient was involved in the generation of their care plan
   - A patient's relapse ‘signature’ signs and symptoms should be documented in the care plan
   - The care plan should include a crisis plan
   - The care plan should include a clinical plan for response to default from treatment, i.e. if a patient fails to attend appointment for administration of depot injection or declines depot injection.

   **Depot/long-acting injectable antipsychotic medication: Prescription and review**
   - A clear rationale for initiating a depot/long-acting injectable antipsychotic medication should be documented in the clinical records
   - Review of antipsychotic medication should be conducted at least annually by the prescriber/psychiatrist in the responsible clinical team
   - Medication review should include consideration of therapeutic response, adverse effects and adherence.

   **Actions taken prior to re-audit**:
   - Report presented at the local clinical audit groups.
   - Individual results shared with the teams that participated in the project.
   - Obtain feedback from the services.

2. **POMH-UK QIP 15b**: Prescribing valproate for bipolar disorder

   **Data collection**: October 2017
   **Report due**: March 2018
   **Lead**: Priscilla St.Croix

   **Audit standards**:
   **Derived from NICE guidelines**:
   - Do not routinely prescribe valproate for women of childbearing age
   - If valproate is prescribed for a woman of childbearing age, there should be documented evidence that the woman:
     - is aware of the need to use adequate contraception and
     - has been informed of the risks that valproate would pose to an unborn baby

   Prior to initiating treatment with valproate, the following should be documented in the clinical records:
   - Weight and/or BMI, the results of liver function tests (LFTs), and a full blood count (FBC)
   - Patients prescribed valproate should receive written information about the use of this medicine specifically for treating bipolar disorder
   - Patients prescribed valproate should have an early, on-treatment review that includes screening for the common side effects of the medication (e.g. weight gain, nausea, tremor)
   - Body weight and/or BMI, blood pressure, plasma, glucose and plasma lipids should be measured at least annually during continuing valproate treatment

   **Treatment target**:
   - Serum valproate levels should not be routinely measured unless there is evidence of ineffectiveness, poor adherence or poor tolerability/toxicity.

   **Actions taken prior to re-audit**:
   Awaiting report from the Prescribing Observatory for Mental Health (POMH-UK) for this project.
3. National Clinical Audit of Psychosis

Data collection: October-November 2017
Report due: June 2018
Lead: Priscilla St.Croix

Audit standards:
The following physical health indicators have been monitored within the past 12 months:

- BMI, blood pressure, use of tobacco, use of alcohol, substance misuse, measure of glucose control, lipids, history of cardiovascular disease, diabetes, and hypertension or hyperlipidaemia in members of the service user’s family.

When monitoring within the past 12 months has indicated a need for intervention, the following have been offered to the service user or the treating clinician has made a referral for the service user to receive:

- Advice about diet and exercise, aimed at helping the person to achieve and/or maintain a healthy BMI, treatment for hypertension, treatment for diabetes, treatment for dyslipidaemia, help with smoking cessation, help with reducing alcohol consumption and help with reducing substance misuse.

- The service user has been provided with evidence-based, written information (or an appropriate alternative), in an accessible format, about the antipsychotic drug that they are currently prescribed.

- The service user was involved in deciding which antipsychotic was to be prescribed, after discussion of the benefits and potential side-effects.

- The service user is currently only prescribed a single antipsychotic drug (unless they are in a short period of overlap while changing medication) If receiving more than one antipsychotic, a rationale for this has been documented.

- The current total daily dose of antipsychotic medication does not exceed the upper limit of the dose range recommended by the BNF. If it does, the rationale for this has been documented.

- If the patient is currently not in remission and has received trials of two (or more) different antipsychotic drugs then there should be evidence that a treatment trial of clozapine has been considered and/or given. If, in these circumstances, clozapine is not being prescribed a rationale for this should have been documented at an appropriate place in the patient’s records.

- CBTp has been offered to all service users; Family intervention has been offered to all service users who are in close contact with their families.

- Each service user has a current care plan.

- There is evidence that each service user has been given information about how to contact services if in crisis.

Actions taken prior to re-audit:
Awaiting final report from the NCAP Team for this project.
## Trust-wide audits

The reports of 22 Trust-wide clinical audits were reviewed by the provider in 2017/18 and WLMHT intends to take the following actions to improve the quality of healthcare provided (described in the table below).

<table>
<thead>
<tr>
<th>Audit</th>
<th>Lead</th>
<th>Actions &amp; Audit Frequency</th>
<th>Standards</th>
<th>Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control Audit</td>
<td>Director of Nursing &amp; Patient Experience and Infection Control Lead</td>
<td>Discussed at the local infection prevention and control meetings and Trust Integrated Physical Health and Environment Group</td>
<td>NICE Clinical Guideline 139</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Therapeutic Engagement and Observation (TESO)</td>
<td>Director of Nursing &amp; Patient Experience</td>
<td>Reported to the Trust Nursing Leadership Meeting Meeting Quarterly</td>
<td>Enhanced Engagement &amp; Observation Policy O1</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>Director of Nursing &amp; Patient Experience and Infection Control Lead</td>
<td>Findings are submitted to relevant Trust committee meetings upon request Action plans will be developed and monitored via clinical improvement groups and local infection control groups. Monthly</td>
<td>Standards for this audit are taken directly from the Hand Hygiene Policy ICP5</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>NICE guideline 29 pressure ulcer</td>
<td>Director of Primary Care</td>
<td>Report not available Ad Hoc</td>
<td>NICE guideline 29 pressure ulcer</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Clinical coding Annual Primary &amp; secondary IC10 Coding Inpatients</td>
<td>Medical Director</td>
<td>Recommendation set out by the London Clinical Coding Academy was to employ a coder – this action was followed Annual</td>
<td>Primary &amp; secondary IC10 Coding</td>
<td>Inpatients</td>
</tr>
<tr>
<td>Senior nurse walkabout checklist</td>
<td>Director of Nursing &amp; Patient Experience</td>
<td>Local leads are to ensure that the checklist is completed monthly for each ward and areas of concerned are acted upon immediately Monthly</td>
<td>The standards within this audit are derived from National and Trust-wide safety policies, guidelines and procedures and local ward operational polices</td>
<td>Inpatients</td>
</tr>
<tr>
<td>Audit</td>
<td>Lead</td>
<td>Actions &amp; Audit Frequency</td>
<td>Standards</td>
<td>Areas</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>MRSA</td>
<td>Director of Nursing &amp; Patient Experience and Infection Control Lead</td>
<td>Members of the Integrated Physical Health and Environment Group have been asked to monitor the completion of the audit to ensure staff are working to best practice as outlined in the policy. Quarterly</td>
<td>ICP12 MRSA Policy Section 7</td>
<td>Inpatients</td>
</tr>
<tr>
<td>Community survey</td>
<td>Director of Nursing &amp; Patient Experience</td>
<td>Quality improvement plan complete Annual</td>
<td>Survey</td>
<td>Community services</td>
</tr>
<tr>
<td>Inpatient survey</td>
<td>Director of Nursing &amp; Experience</td>
<td>Quality improvement plan complete Annual</td>
<td>Survey</td>
<td>Inpatient services</td>
</tr>
<tr>
<td>Audit of Omitted Doses of Medication</td>
<td>Chief Pharmacist</td>
<td>Findings are disseminated to service lines for development of local action plans and implementation Annual</td>
<td>100% of prescription charts will have all administration boxes for regular medication completed with either a code or a signature</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Medicines Reconciliation entries on admission to West London Mental Health NHS Trust</td>
<td>Chief Pharmacist</td>
<td>Findings are disseminated to service lines for development of local action plans and implementation Annual</td>
<td>Medicines reconciliation policy (M11)</td>
<td>Inpatients</td>
</tr>
<tr>
<td>Medicines management compliance audit</td>
<td>Chief Pharmacist</td>
<td>Findings are disseminated to service lines for development of local action plans and implementation Annual</td>
<td>100% compliance with storage requirements for medicines 100% compliance with storage requirements for controlled stationary</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Audit</td>
<td>Lead</td>
<td>Actions &amp; Audit Frequency</td>
<td>Standards</td>
<td>Areas</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
</tbody>
</table>
| Point Prevalence Antimicrobial Audit       | Chief Pharmacist      | Feedback results to Trust ICPEG meeting. Review first line treatment for cellulitis as not specified in local guidance – must review.  
Work with infection control nurse and doctor to formulate an action plan.  
Feedback to service lines through SMT and discuss implications of potential action plan.  
Feedback to pharmacy team  
Highlight the importance of educating prescribers on using the guidelines when prescribing antimicrobials.  
Review Antimicrobial policy and consider the inclusion of other anti-infectives as well as advice on when cultures and sensitivities are required.  
Bi-annual | 100% of patients prescribed an antimicrobial will have:  
The indication documented on the prescription chart  
The indication documented in the electronic record  
The review/stop date documented on the prescription chart  
A 48 hour review documented in the notes  
Rational documented for prescribing duration > 7 days  
Indication in line with antimicrobial guidance  
Evidence of micro approval when required | Trust-wide             |
| Controlled drugs audit                     | Chief Pharmacist      | Findings are disseminated to service lines for development of local action plans and implementation  
Quarterly | Controlled Drugs Safe Management and Standard Operating Procedures Policy (C31) | Trust-wide             |
| Rapid tranquillisation                     | Chief Pharmacist      | Findings and action plan disseminated to service leads for implementation  
Annual | 100% compliance to standards outlined in the Trust rapid tranquillisation policy (R10) | Trust-wide             |
<table>
<thead>
<tr>
<th>Audit</th>
<th>Lead</th>
<th>Actions &amp; Audit Frequency</th>
<th>Standards</th>
<th>Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clozapine Prescribing Procedure</td>
<td>Chief Pharmacist</td>
<td>Report not yet available</td>
<td>Clozapine Prescribing Procedure: C36p</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Self-administration</td>
<td>Chief Pharmacist</td>
<td>Report not yet available</td>
<td>Self-Administration of Medication by Inpatients; S30p</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Uploaded discharge to take away (TTA) on RiO</td>
<td>Chief Pharmacist</td>
<td>Report not yet available</td>
<td>Medicines Policy (M2)</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Audit of High Dose Antipsychotic prescription and monitoring</td>
<td>Chief Pharmacist</td>
<td>Report not yet available</td>
<td>The Use of High Dose Antipsychotic Therapy (HDAT): H9p</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Audit of Discharge Medication Summary Forms</td>
<td>Chief Pharmacist</td>
<td>All discharge prescriptions must be written on the editable letter ‘discharge medication summary &amp; 7 day follow up available on RiO. All completed discharge prescriptions must be uploaded onto RiO within 24 hours after having been screened by a clinical pharmacist and supplied by pharmacy. Ad-hoc</td>
<td>Medicines policy (M2) and Procedure for discharging inpatients (D14p)</td>
<td>Inpatients</td>
</tr>
<tr>
<td>Audit of Nutritionally Vulnerable Inpatients</td>
<td>Physical Healthcare Consultant Nurse</td>
<td>Audits of nutritionally vulnerable patients are carried out on a quarterly basis and reported to the Trust-wide Physical Health Group</td>
<td>NICE and British Association of Parenteral and Enteral Nutrition (BAPEN)</td>
<td>Inpatients</td>
</tr>
<tr>
<td>No safeguarding adult concerns raised between September 2017 &amp; November 2017</td>
<td>Safeguarding Adults Named Professional Trust-Wide</td>
<td>Report not yet available</td>
<td>The Care Act 2014 Safeguarding Adult Duty</td>
<td>Trust-wide</td>
</tr>
</tbody>
</table>
## Accreditation Programmes

The Trust was involved in 4 service accreditation programmes in 2017/18:

<table>
<thead>
<tr>
<th>Service Accreditation Programmes WLMHT has been involved in</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Network for Forensic Mental Health Services</td>
<td>1</td>
</tr>
<tr>
<td>Quality Network for Inpatient CAMHS</td>
<td>1</td>
</tr>
<tr>
<td>ECTAS: Electro convulsive therapy accreditation service</td>
<td>1</td>
</tr>
<tr>
<td>AIMS Rehab</td>
<td>1</td>
</tr>
</tbody>
</table>
The safety scorecard is a recent NCISH development in response to the request from our commissioners, the Healthcare Quality Improvement Partnership (HQIP), for benchmarking data to support quality improvement.

The information in the scorecard is based on data that the Trust provided NCISH. The scorecard consists of 6 indicators: suicide rate, homicide rate, rate of sudden unexplained death (SUD), patients under the care programme approach (CPA), staff turnover and NCISH questionnaire response rate. The CPA and staff turnover figures are taken from the data sent to HSCIC data.

The figures give the range of results for mental health providers across England, based on the most recent available figures: 2013/2015 for suicides, homicides and sudden unexplained deaths (SUD), 2016/17 for people on the care programme approach (CPA), 31 October 2016 – 31 October 2017 for non-medical staff turnover and 2012/17 for Trust questionnaire response rates. ‘X’ marks the position of the Trust. The rates have been rounded to the nearest 1 decimal place and percentages to whole percentage numbers. The solid black line shows the median score nationwide.

### Suicide rate

The suicide rate in your Trust was 5.88 (per 10,000 people under mental health care) between 2013-15.

### Homicide rate

The homicide rate was 0 (per 10,000 people under mental health care) between 2013-15.

### Sudden unexplained deaths (SUD)

The SUD rate was 5.5 (per 10,000 hospital admissions) between 2013-15.
% on Care Programme Approach (CPA)
The % of patients on CPA was 10% in 2016-17.

Staff Turnover
Non-medical staff turnover was 15% between 31 October 2016 – 31 October 2017.

NCISH questionnaire response rate
You have returned 95% of NCISH questionnaires between 2012-17.
What RSM, (our internal auditors) said: “The scope of all the audits was to evaluate the adequacy of risk management and control within the system and the extent to which controls have been applied, with a view to providing an opinion”.

**RSM use the following rating scale for the outcomes of the audits:**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No assurance:</strong></td>
<td>Taking account of the issues identified, the Board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Action needs to be taken to ensure this risk is managed.</td>
</tr>
<tr>
<td><strong>Partial assurance:</strong></td>
<td>Taking account of the issues identified, the Board can take some assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. However we have identified issues that, if not addressed, increase the risk materialising.</td>
</tr>
<tr>
<td><strong>Reasonable assurance:</strong></td>
<td>Taking account of the issues identified, whilst the Board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective, action need to be taken to ensure this risk is managed.</td>
</tr>
<tr>
<td><strong>Substantial assurance:</strong></td>
<td>Taking account of the issues identified, the Board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.</td>
</tr>
</tbody>
</table>
Temporary Staff and Rostering
The result from this audit produced a ‘Partial Assurance’ rating.

The audit was carried out as there has been significant overspend in the temporary staffing budget at the beginning of the financial year. Procedures to manage the booking of temporary staff were put in place.

In total 6 medium and 1 low priority recommendations were made.

Reports will be run from Healthroster to monitor approval and authorisations levels (AFC Bands). Any system control issues highlighted from reports will be raised to director level.

Complaints Performance Management
The result from this audit produced a ‘Reasonable Assurance’ rating.

The audit was carried out to assess the adequacy of the processes around data collection and validation, and further determine whether the data being collected on the complaints-related indicators met the following data quality dimensions: Accuracy, Validity, Reliability, Timeliness, Relevance and Completeness.

In total 2 medium and 1 low priority recommendations were made.

Adequate mechanisms and/or processes will be put in place to ensure that complaints-related Key Performance Indicator (KPI) data are appropriately validated for their accuracy, completeness and validity prior to reporting the data and performance in the Integrated Performance Report (IPR) for reporting to the Trust Board.

Board Assurance Framework
This was an advisory report so therefore an assurance position is not provided.

The review included the overall assessment of the design, controls and management of the BAF including a deep dive analysis on the following three risk entries detailed on the BAF reported to the Trust Board in July 2017.

Information Governance Toolkit (Version 14)
This was an advisory report so therefore an assurance position is not provided.

An audit of the Information Governance Toolkit (IGT) Version 14.1 was undertaken as part of the approved internal audit periodic plan for 2017/18

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance

Night Time Confinement
The result from this audit produced a Reasonable Assurance rating.

The audit was carried out to assess the adequacy of the processes of Night Time Confinement which was introduced to the Trust in 2012.

In total 2 medium and 1 low priority recommendations were made.

Management will review the policy and provide clarity around the patient’s right to appeal within the NTC process. General out of hours’ observations will be audited quarterly. Where issues are identified, this will be reported in the hospital safety and safeguarding meeting.
Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by WLMHT in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 445 (611 in 2016/17).

Throughout the year, the Trust has been involved in 40 studies (90 in 2016/17); 28 were funded (62 in 2016/17) of which 6 were commercial trials (10 in 2016/17), and 12 were unfunded (28 in 2016/17).

Over the past year researchers associated with the Trust have published 61 articles (53 in 2016/17) in peer reviewed journals.

The comparative data above shows there to be a significant fall in the number of patients involved in trials in 2017/18, this was because the previous research strategy was reliant on dementia commercial studies and there has been a significant reduction in the number of these worldwide due to failure of trials in this area to produce the anticipated results.

Going forward, the research strategy has been revised with the incoming R&D Director expected to adapt to the shift in priorities and to offer more patients the opportunity to take part in research in other areas of the Trust. Clinical research leads have been appointed in key areas (forensics, personality disorder, the interface between physical and mental health, mood and psychosis and dementia) to drive forward new research in these areas.
CQUIN is a payment framework which enables our commissioners to reward excellence, by linking a proportion of our income to the achievement of local quality improvement goals, securing improvements in quality of services and better outcomes for patients, whilst also maintaining strong financial management.

Our commissioners plan challenging but realistic CQUIN schemes which are set out in a standard contract. There are also a number of national CQUIN schemes and non-participation in any should result in non-payment of that proportion of CQUIN funding. Whilst the minimum requirements for providers are set nationally, we work with our local commissioners to ensure that plans are aligned with local commissioning strategies.

A proportion of WLMHT income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between WLMHT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the commissioning for quality and innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period is available on our Trust website: www.wlmht.nhs.uk/

Local Services
The following CQUIN targets were set for Local Services in 2017/18, including 5 national and 0 regional CQUIN, which were measured as shown below.

<table>
<thead>
<tr>
<th>Local Services CSU Ealing, Hammersmith &amp; Fulham and Hounslow</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1 Improving staff health and wellbeing</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>TBC</td>
</tr>
<tr>
<td>N3 Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>TBC</td>
</tr>
<tr>
<td>N4 Improving services for people with mental health needs who present to accident and emergency</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>TBC</td>
</tr>
<tr>
<td>N5 Transitions out of Children and Young People’s Mental Health Services (CYPMHS)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>TBC</td>
</tr>
<tr>
<td>N9 Preventing risky behaviours - alcohol and tobacco</td>
<td>Met</td>
<td>Met</td>
<td>Awaiting Report</td>
<td>TBC</td>
</tr>
</tbody>
</table>
West London Forensic Services
The following CQUIN targets were set for West London Forensic Services in 2017/18, including 3 national and 1 local CQUINs which were measured as shown below.

<table>
<thead>
<tr>
<th>West London Forensic Services</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement of information flow across the justice pathway to improve patient outcomes</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>TBC</td>
</tr>
<tr>
<td>Recovery colleges for medium and low secure patients</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>TBC</td>
</tr>
<tr>
<td>Reducing restrictive practices within adult low and medium secure services</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>TBC</td>
</tr>
<tr>
<td>Medium and low secure repatriation and reduction in length of stay</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>TBC</td>
</tr>
</tbody>
</table>

High Secure Services
The following CQUIN targets were set for High Secure Services in 2017/18, including 2 national and 1 local CQUINs which were measured as shown below.

<table>
<thead>
<tr>
<th>High Secure Services</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH1: Patient ward communities, implementing “sense of community” in high secure wards</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>MH3: Reducing restrictive practices in high secure – 2 year CQUIN scheme</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Local: Meaningful activities</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>
WLMHT is required to be registered with the Care Quality Commission (CQC) and its current registration status is ‘registered without conditions’.

The CQC inspected the Trust in November 2016 with an overall rating of ‘Requires Improvement’. An enforcement order was issued against Broadmoor Hospital in relation to insufficient staffing at this time.

Broadmoor Hospital was re-inspected in July 2017. It was noted during this inspection that improvements relating to the enforcement order had been made and the warning notice was removed, being replaced with requirement notices. This inspection was not rated.

The outcome from the November 2016 inspection resulted in, 56 ‘Must Do’s’, and 31 of these ‘Must Do’s’ have now been achieved. The outstanding ‘Must Do’s’ are all partially completed with work in progress and clear processes in place to monitor performance and progress. It is of note that although there are a number of estate related actions that are being addressed, some of these require longer time scales to take effect.

<table>
<thead>
<tr>
<th>Overall Rating</th>
<th>Requires Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Effective</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Caring</td>
<td>Good</td>
</tr>
<tr>
<td>Responsive</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Well-led</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

The CQC re-inspected Local Services adult and Psychiatric Intensive Care Unit wards in January 2018. Although there were many areas of improvement and good practice, five regulation breaches were highlighted, and these are outlined below:

**Safe care and treatment**
- Continuing work needed to be undertaken to ensure that ward environments are safe and that the risk of blind spots are mitigated
- Work was not yet complete on improving the safety of access to seclusion rooms

**Safeguarding service users from abuse and improper treatment**
- Staff must have an understanding of the Trust policy in relation to safeguarding and use the policy in a consistent manner in order to protect patients effectively from abuse
Premises and equipment

• There was no effective system in place across all the wards and on all sites to ensure that urgent reports were carried out in a timely manner, including clinical equipment such as fridge thermometers, where there was a potential risk to the safety of patients and staff.

Good governance

• Part 1: The data quality was not of a robust standard to provide assurance within the Trust that there was an accurate oversight of the numbers of incidents of seclusion
• Part 2: Some staff did not have an understanding of all incidents which needed to be reported

Staffing

• There was a shortage of permanent nursing staff at St Bernard’s

Following the regulation breach notifications, a detailed action plan to address the areas highlighted was submitted by the Trust to, and accepted by the CQC.
Quality indicators

The following section of the quality account describes how we have performed against a core set of indicators as set out in NHS (quality accounts) amendment regulations 2012 related to NHS outcomes framework domains. We have reviewed these indicators and are pleased to provide our position against all indicators relevant to our services for the last two reporting periods (years).

1. Care Programme Approach 7 Day Follow-Up: Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during reporting period.

This measure enables us to ensure our service user's needs are cared for and remain safe following discharge from hospital to community care.

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th></th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q4*</td>
<td>Q3</td>
<td>Q2</td>
</tr>
<tr>
<td>WLMHT</td>
<td>95.89%</td>
<td>95.73%</td>
<td>95.04%</td>
</tr>
<tr>
<td>National Average</td>
<td>95.50%</td>
<td>95.40%</td>
<td>96.74%</td>
</tr>
<tr>
<td>Highest Nationally</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Lowest Nationally</td>
<td>96.15%</td>
<td>69.23%</td>
<td>87.50%</td>
</tr>
<tr>
<td>WLMHT Annual Outturn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


WLMHT considers that this data is as described for the following reasons: the data has been extracted from central Department of Health (DoH) repository and correlates with the data submitted by WLMHT during the reporting periods.

**WLMHT has taken the following actions to improve this percentage, and so the quality of its services by:**

- Compliance is monitored routinely via the Trust’s integrated performance report and the individual clinical service unit (CSU) scorecards to identify clients discharged and followed up and/or requiring action.
- Continued monitoring of non-compliance using the Trust’s business intelligence tools
- Identifying any areas of underperformance and feeding back for service improvements.
- The indicator is reviewed locally and via the Trust governance framework.
2. Crisis Resolution Gate Keeping: Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHTT) acted as a gate keeper during the reporting period.

The crisis resolution teams provide prompt and effective home treatment for people in mental health crisis and quickly determine whether service users should be admitted to hospital or if suitable for home treatment. It is important to our service users that they are treated effectively and promptly in the most appropriate settings of care.

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th></th>
<th></th>
<th></th>
<th>2016/17</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q4</td>
<td>Q3</td>
<td>Q2</td>
<td>Q1</td>
<td></td>
<td>Q4</td>
<td>Q3</td>
<td>Q2</td>
</tr>
<tr>
<td>WLMHT</td>
<td>99.35%</td>
<td>99.48%</td>
<td>99.65%</td>
<td>97.23%</td>
<td>94.19%</td>
<td>99.48%</td>
<td>99.65%</td>
<td>97.23%</td>
</tr>
<tr>
<td>England Average</td>
<td>98.70%</td>
<td>98.53%</td>
<td>98.64%</td>
<td>98.69%</td>
<td>98.76%</td>
<td>98.53%</td>
<td>98.64%</td>
<td>98.69%</td>
</tr>
<tr>
<td>England Highest Performer</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>England Lowest Performer</td>
<td>88.70%</td>
<td>84.35%</td>
<td>94.00%</td>
<td>88.85%</td>
<td>90.00%</td>
<td>84.35%</td>
<td>94.00%</td>
<td>88.85%</td>
</tr>
<tr>
<td>WLMHT Annual Outturn</td>
<td></td>
<td>98.93%</td>
<td></td>
<td></td>
<td></td>
<td>93.18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
<td>95%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


WLMHT considers that this data is as described for the following reasons: the data has been extracted from central DoH repository and correlates with the data submitted by WLMHT during the reporting periods. Compliance is monitored routinely via the Trust’s business intelligence tool which identifies clients who were gate kept on admission. This helps the service identify any areas where actions are required. Performance is monitored through the Trust’s governance framework.

**WLMHT has taken the following actions to improve this percentage, and so the quality of its services by**

- The central performance team are closely monitoring the new process which was embedded due to the audit undertaken by KPMG during the last review of the quality account. The results show that the process is being followed correctly.
3. Readmission Rate: The percentage of patients readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Readmission rates are monitored primarily to provide assurance that large numbers of service users are not being readmitted to the hospital post discharge within a short period of time. It is important for us to measure this so that we can monitor and review our clinical practice of safe discharge and as a reflection of how effectively we manage our service users within our community services. We are pleased to report our readmission rates within 30 days of discharge are below the 10% target.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2017/18</th>
<th>2016/17</th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 14 years</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>15 years or over</td>
<td>5.7%</td>
<td>7.5%</td>
<td>7.4%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Target</td>
<td>&lt;10%</td>
<td>&lt;10%</td>
<td>&lt;10%</td>
<td>&lt;10%</td>
</tr>
</tbody>
</table>

WLMHT considers that this data is as described for the following reasons: the WLMHT figure is sourced locally from our clinical records system (RIO). The percentage is based on all readmissions within 30 days as a percentage of all discharges including Local Services and West London Forensic Services. No comparable national benchmarking has been available.

WLMHT has taken the following actions to improve this percentage, and so the quality of its services by:

- Continuing to monitor and report routinely to all relevant areas across the Trust.
4. Staff recommendation of the Trust as a place to work or receive treatment

WLMHT considers that this data is as described for the following reasons: The data is taken from the national NHS survey 2017 and is considered a reliable data source.

<table>
<thead>
<tr>
<th>Measure</th>
<th>WLMHT Performance 2017</th>
<th>WLMHT Performance 2016</th>
<th>National average for MH Trusts</th>
<th>Highest MH Trust Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff recommendation of the Trust as a place to work or receive treatment</td>
<td>3.68/5</td>
<td>3.55/5</td>
<td>3.67/5</td>
<td>4.14/5</td>
</tr>
</tbody>
</table>

WLMHT has taken the following actions to improve this percentage, and so the quality of its services by:

- The Trusts workforce strategy was refreshed in 2017. The strategy is made up of seven programmes of work which you can read about further on within the account.
5. The Trust’s “patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period.

WLMHT considers that this data is as described for the following reasons: The survey is used to gain a better understanding of what service users think about their care and treatment provided by WLMHT. The data produced from this survey is included in the quality and risk profile which contributes to our compliance with the essential standards of quality and safety set by the government. The data is sourced from the CQC website.

<table>
<thead>
<tr>
<th>CQC National Community Mental Health Service User Survey</th>
<th>2017</th>
<th>2016</th>
<th>Highest</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did this person listen carefully to you?</td>
<td>8.3</td>
<td>7.6</td>
<td>9.2</td>
<td>8.2</td>
</tr>
<tr>
<td>Did this person take your views into account?</td>
<td>8.2</td>
<td>7.1</td>
<td>8.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Did this person treat you with respect and dignity?</td>
<td>8.1</td>
<td>8.1</td>
<td>9.5</td>
<td>8.6</td>
</tr>
<tr>
<td>Were you given enough time to discuss your condition and treatment?</td>
<td>7.6</td>
<td>7.1</td>
<td>8.8</td>
<td>7.4</td>
</tr>
<tr>
<td>Overall, how would you rate the care you have received from NHS Mental Health Services in the last 12 months?</td>
<td>7.2</td>
<td>6.3</td>
<td>7.4</td>
<td>6.2</td>
</tr>
</tbody>
</table>

At the start of 2017, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 199 service users at WLMHT.

WLMHT has committed to the following actions to improve this percentage, and so the quality of its services:

- The results of this survey will be discussed in the patient forums
- An action plan will be devised in collaboration with service users
6. The number and, where available, the rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

The purpose of this indicator is to help monitor shifts in the risk of severe harm or death to patients and to identify new emerging risks so that we are able to proactively identify potential impacts on patient care. Trusts that have high reporting figures have a better safety culture.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Performance</th>
<th>2017-18 Q3/Q4</th>
<th>2017-18 Q1/Q2</th>
<th>2016-17 Q3/Q4</th>
<th>2016-17 Q1/Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe harm/death</td>
<td>WLMHT</td>
<td>1.135 (21)</td>
<td>1.178% (22)</td>
<td>0.3% (15)</td>
<td>0.3% (13)</td>
</tr>
<tr>
<td></td>
<td>National Average</td>
<td>Data not available</td>
<td>n/a **</td>
<td>n/a **</td>
<td>0.3% (492)</td>
</tr>
<tr>
<td></td>
<td>Highest MHT</td>
<td>Data not available</td>
<td>n/a **</td>
<td>n/a **</td>
<td>2.5% (51)</td>
</tr>
<tr>
<td></td>
<td>Lowest MHT</td>
<td>Data not available</td>
<td>n/a **</td>
<td>n/a **</td>
<td>0%</td>
</tr>
</tbody>
</table>

Data source: [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=135586](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=135586)

* The figures in brackets represent the number of inpatient incidents reportable to the NPSA for severe harm or death to patient, as recorded on our internal system.
** The data was not available from the data source above at time of publication.

WLMHT considers that this data is as described for the following reasons: The data for national figures is taken from the National Reporting and Learning System (NRLS) feedback reports. The national average and highest and lowest mental health Trust was provided by the NRLS in their six monthly feedback reports.

The table below provides a quarterly breakdown of incidents reported during 2017/18 and 2016/17.

<table>
<thead>
<tr>
<th>Trust-wide Incidents</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1-Q4 2017/18 Incident Total 12,000</td>
<td>3114</td>
<td>2762</td>
<td>3144</td>
<td>2980</td>
</tr>
<tr>
<td>Q1-Q4 2016/17 Incident Total 12,926</td>
<td>3385</td>
<td>3463</td>
<td>3087</td>
<td>2991</td>
</tr>
</tbody>
</table>

WLMHT has taken the following actions to improve incident reporting:
- Developing and improving its current in-house incident recording system
- Improving the incident investigation processes to ensure the quality of investigations and the timeliness of reviews are improved
- Reviewing incident training resources, including a review of the training needs of the investigators
7. Mortality indicator.

It is sad to report that during 2017/18, 364 WLMHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: in the first quarter; 83 in the second quarter; 87 in the third quarter; 97 in the fourth quarter 107.

<table>
<thead>
<tr>
<th>Mortality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Q1-Q4 2017/18</td>
</tr>
<tr>
<td>Total 364</td>
</tr>
<tr>
<td>Q1</td>
</tr>
<tr>
<td>112</td>
</tr>
<tr>
<td>Q1-Q4 2016/17</td>
</tr>
<tr>
<td>Total 406</td>
</tr>
<tr>
<td>Q1</td>
</tr>
<tr>
<td>83</td>
</tr>
</tbody>
</table>
Quality indicators – other indicators

Delayed transfers of care
This indicator measures the percentage of inpatient beds that are being used by service users who are ready to move on from the hospital environment once they are safe to be discharged.

We believe service users should receive the right care, in the right place, at the right time, and work closely with partner agencies to minimise the length of hospital stay for users ready for discharge.

The table below shows our Trust-wide performance over the last four years:

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2016/17</th>
<th>2015/16</th>
<th>2014/15</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Delayed Transfers of care</td>
<td>6.63%</td>
<td>6.60%</td>
<td>5.66%</td>
<td>3.91%</td>
<td>&lt;7.5%</td>
</tr>
</tbody>
</table>

The Trust recognises that good data quality is a key tool in ensuring the delivery of high quality and safe care and to help identify areas for improvements. Quality data is the foundation for provision of information and intelligence that supports decision making and improvements in our care.

As a Trust, we are continuously focusing on providing better and more accessible information to our staff who are encouraged to access relevant information and tools to monitor and improve practices.

WLMHT has committed to the following actions to improve data quality:

- To monitor its internal and external benchmarking data
- To establish the reasons behind the increase of delays in transfer of care and act accordingly

NHS Number and General Medical Practice Code Validity
WLMHT submitted records during 2017/18 to the secondary uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient’s valid NHS Number was:
  - 99.3% for admitted patient care;
  - 99.5% for outpatient care; and
  - N/A for accident and emergency care.

- which included the patient’s valid General Medical Practice Code was:
  - 99.9% for admitted patient care;
  - 99.9% for outpatient care; and
  - N/A for accident and emergency care.

Overdue Serious Incidents
The Trust has worked hard during 2017/18 to reduce the number of overdue Serious Incidents (SI), and is pleased to have made significant progress. Notwithstanding the reduction over the past twelve months, substantial effort continues to be directed towards clearing the remaining overdue investigation reports, and we are working closely with commissioners to ensure the SI investigation reports we submit are done so in a timely manner, and to the highest standard.

In order to further promote Trust-wide learning from SI investigations, work continues to review and analyse all our SIs and incidents, and we are working collaboratively with commissioners and stakeholders to ensure that learning can be targeted and supported both at the local Trust level, and across the wider health system.

As a Trust, we are committed to ensuring the quality of the SI investigations submitted to commissioners for closure is of the highest order, and as part of this, we have improved both the training and support for those undertaking investigations, simplified the investigation process and begun to address common themes identified in the investigation report process. This work will continue throughout 2018/19.
National Staff Survey results

The national staff survey took place between September and November 2017 with the publication of results taking place in early March 2018. 1356 staff at WLMHT took part in this survey.

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months:

<table>
<thead>
<tr>
<th>Trust score 2017</th>
<th>Trust score 2016</th>
<th>National average for mental health</th>
<th>Best 2017 score for mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>29%</td>
<td>31%</td>
<td>21%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion:

<table>
<thead>
<tr>
<th>Trust score 2017</th>
<th>Trust score 2016</th>
<th>National average for mental health</th>
<th>Best 2017 score for mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>78%</td>
<td>76%</td>
<td>85%</td>
<td>92%</td>
</tr>
</tbody>
</table>

In the 2017 staff survey the Trust scored well on the following questions:

• Staff satisfaction with the quality of work and care they are able to deliver
• Staff motivation at work
• Staff satisfaction with level of involvement and responsibility
• % of staff reporting good communication with senior management
• Recognition and value of staff by managers and the organisation
• Support from immediate line managers
• Quality of appraisals
• Staff health and well being

There are some areas where we believe we can still improve:

• Staff experiencing discrimination
• Staff experiencing physical violence from staff in the last 12 months
• Staff experiencing harassment, bullying or abuse from staff in the last 12 months

Although it is good to see improvement in overall staff engagement and pride in the quality of work that they are able to deliver, it is still concerning that staff continue to report unwanted levels of bullying and discrimination. The Trust is however pleased to see a 9% decrease in the number of staff reporting this during 2017.

The Trust has made significant improvements by updating the workforce strategy which gives a clear indication on how the Trust will work towards improving how staff feel about working for WLMHT.

The components of the current workforce strategy are:

• Develop a recruitment and retention strategy that helps the Trust compete with shortage occupations
• Ensure a diverse and representative workforce at all levels of the organisation
• Focus on leadership and development that strengthens middle management and enhances the Trusts reputation as a place to thrive
• Identify and implement opportunities for workforce development
• Identify and implement opportunities for workforce efficiency and productivity, gaining benefit from electronic rostering and maximising the use of the staff bank
• Implement a simple engagement plan to reduce bullying
• Implement a patient centred workforce planning approach across the services and support transformation programmes
The workforce strategy is made up of seven programmes of work:

1. Recruitment and retention
   The Trust has worked with NHSI and received funding from HEE to undertake a review of the causes of staff turnover and to develop a programme of work that supports retention. The programme includes clear processes for preceptorship, career frameworks that are clearly communicated to all staff and a new employee handbook. In terms of securing the supply of registered nursing staff, the Trust is very proud to be one of the few organisations in the country that is working in partnership with a local university to deliver nursing degree apprenticeships.

2. Diverse and representative workforce
   The Trust has a very well evaluated and reviewed BME leadership development programme that has successfully delivered 4 cohorts of future leaders, many of whom have gone on to be promoted. Diversity champions attend all recruitment selection panels for senior roles. The Trust has applied for Stonewall accreditation and there will be a renewed focus on supporting members of staff with disabilities in 2018.

3. Leadership development
   Recognising from staff survey responses in 2016 that a focus on line management skills is very important for positive staff experience, we have introduced a programme called Lead by Example, which gives an opportunity for managers to become more self-aware based on 360 feedback. The programme is supported by coaching.

4. Workforce development
   The Trust provides a very wide range of learning and development opportunities for all members of staff. The appraisal process provides the means for collating all training needs and for ensuring a fair and consistent method of allocating training resources. The Trust is proud of its high levels of mandatory training compliance, which is in excess of 90% for the majority of courses.

5. Engagement and reduction in bullying
   There are increasingly high levels of staff engagement with an active programme of listening events held by Carolyn Regan, Chief Executive and well received monthly and annual staff awards. The Trust recognises that it has more work to do in reducing bullying and a sense of unfairness. Work is taking place to ensure fair and consistent processes for shift allocation and to consider regular stress audits.

6. Workforce efficiency
   The Trust saved £6.5m in agency expenditure in 2017/18 through a programme of work that included increasing the size of the staff bank, directly employing AHPs and ensuring that all temporary requirements for administrative and clerical staff are met through the bank.

7. Workforce transformation
   The Trust has actively worked with Health Education England (HEE) to ensure that it is contributing to the development of the HEE mental health workforce strategy in North West London.
Information Governance Toolkit

Good information governance means the public can depend on their data being handled securely, and information within health and care can be shared safely and with confidence to improve the quality of care across the health sector. Information governance is the way in which the NHS handles all of its information, in particular the personal and sensitive information relating to patients and employees.

It provides a framework to ensure that personal information is dealt with legally, securely, efficiently and effectively.

Information Governance consists of the following:

- Confidentiality and data protection.
- Information security.
- Data quality.
- Records management and access.
- Freedom of Information.
- Caldicott principles.

A major change will occur on 25th May 2018 when the new General Data Protection Regulations (GDPR) comes into force. WLMHT has put in place a programme to ensure we implement the requirements during 2018. The GDPR strengthens the controls that organisations (controllers) are required to have in place over the processing of personal data, including pseudonymised personal data.

Grade Key

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Overall Score</th>
<th>Self-assessed Grade</th>
<th>Unsatisfactory</th>
<th>Satisfactory with Improvement Plan</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 14.1 (2017-2018)</td>
<td>Published</td>
<td>75%</td>
<td>Satisfactory</td>
<td>Not evidenced attainment Level 2 or above on all requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Version 13 (2016-2017)</td>
<td>Published</td>
<td>68%</td>
<td>Unsatisfactory</td>
<td>Not evidenced attainment Level 2 or above on all requirements but improvement actions provided.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Out of the 45 IG toolkit requirements WLMHT has met:

- Not relevant 1
- Level 1 for 0
- Level 2 across 33
- Level 3 for 11

Measures were put in place to ensure that the Trust achieved the mandatory IG training target of 95% for staff by 31st March 2018.
Part 3: Other information - review of quality performance
Message from the Medical Director, Dr José Romero-Urcelay

The Quality Account tells you our quality story for the year, how we have performed against the quality priorities that we set through consultation last year, and what we are going to focus on in this new financial year.

Delivery of our quality improvement programme has been a central priority over the year, with the appointment to the new post of Quality Improvement Lead ensuring that this focus continues over the coming months. The Trust has worked effectively with the Care Quality Commission (CQC), including during their re-inspections of our acute wards and psychiatric intensive care unit this year. As this was a focused inspection, the service was not re-rated. As well as areas for improvement and learning, the report highlights good practice and notes that ‘good progress had been made in some key areas’. The CQC also re-inspected Broadmoor Hospital. They found improvements in the amount of therapeutic activity made available to patients and in the number of substantive nurses employed at the hospital.

Over the year, we have put great emphasis on improving the quality of physical healthcare services which we deliver to patients. We have published our new physical healthcare policy to be followed by a physical healthcare strategy which we aim to publish in 2018/19, both documents have been created using NICE evidence-based guidance.

In recognition of the need to monitor and address the physical health of our patients as effectively as their mental health, the Trust introduced a 24-hour standard for undertaking and recording a physical healthcare assessment for newly-admitted patients (as compared to the 72-hour national standard). This has resulted in a significant improvement, with 95% of physical healthcare assessments being undertaken within 24 hours of admission.

Another area of improvement has been the work to increase our bed capacity. As from November 2017, the Trust has consistently maintained a minimum of 10 available beds per day, representing a significant shift in our previous position.

It has also been a successful year in terms of the recruitment of permanent consultant psychiatrists to all of our service lines and the appointment of a new director of research and development. Dr Samantha Scholtz’s previous role within the organisation was as a consultant psychiatrist who specialised in the management of obesity and related disorders within our Liaison and Long Term Conditions Service Line. Samantha is looking forward to progressing and developing the Trust’s research potential working towards establishing our Trust as one delivering excellent quality clinical research that directly translates to patient care.

The past year has brought new challenges, but the Trust has delivered across a range of quality improvements, on which we will continue to build over 2018/19. As ever, the commitment and collaboration of our staff, service users, carers and partners are central to this programme of improvement. I would like to personally thank you for your hard work and continued support.
What service users, carers and the public say - key messages and actions taken during 2017/18

Care Opinion
Care Opinion is used in West London Mental Health NHS Trust to encourage people to share their experiences of using Trust services in ways which are safe, simple and lead to learning and change.

Care Opinions mission is to provide a platform so that people can share honest feedback easily and without fear. Stories are directed to wherever they can help make a difference and everyone can see how and where services are listening and changing in response.

In the reporting period, 181 stories relating to the Trust have been published which is an increase of 31 compared with the previous year. To date, the stories have been viewed 14,843 times.

Care Opinion Comments

Claybrook Centre - He really listened to me and that allowed me to breathe
“I went to Claybrook in desperation. Before I entered the building I felt sick, my heart was pounding so strong I thought I was going to have a heart attack. Then I met this wonderful man that showed me kindness and human understanding but most of all, he really listened to me and that allowed me to breathe. I wish to thank Jonathan from the bottom of my heart for listening and truly understanding and helping me. You’re an outstanding man that went above and beyond your job. You’re someone that I will never forget, THANK YOU SO VERY MUCH.”
Chris Bench - Clinical Director Primary and Planned Care

“Thank you very much for letting us know about your experience at the Claybrook Centre. It’s great to hear that Jonathan was able to help you at a difficult time.”

Broadmoor Hospital - Excellent efficient staff

“I want to say how great the Ward A is and my time spent here. Staff are excellent and efficient and well. People are recovering from their experience and are communicating on their own level. All the best for the future.”

Terry Fegan - Nurse Consultant

“Many thanks for your posting; it’s really helpful to receive feedback on the services we provide. We work collaboratively with all our patients and always keep our patients central to the work we do. I will be very happy to feedback your experience to the Clinical Nurse Manager and staff on your ward. Thank you.”

The Cassel - The Therapy and Treatment That Changed My Life

Before being admitted to The Cassel I couldn't have ever really imagined just how much the treatment I would receive would change my life. Having had years of treatment and therapy's I felt that receiving psychoanalytical therapy was going to be the finally piece to the jigsaw of turning my life around.

Before I was admitted to The Cassel I had spent the previous two years on an acute ward and the previous 16 years in and out of hospital. The treatment was hard and challenging but definitely worth it.

The support given to me during my treatment was excellent even if I didn't always appreciate it at the time.

The therapy and my therapist was excellent and just what I needed.

The whole staff team really understand the group of patients they are working with and their support was consistent.

The psychoanalytical therapy and the psychosocial nursing works well together and provides the consistency needed to enable you to get the most out of the treatment at The Cassel as does living in a therapeutic community.

Since leaving The Cassel over 18 months ago I have gained employment and have now been in employment for over 8 months which is something I have previously not been able to do or thought possible. I am living independently and have remained hospital free which I have not previously been able to achieve since my health deteriorated 22 years ago.

I wouldn't have been able to achieve this without the amazing treatment I received at The Cassel. I would 100% recommend the treatment provided at The Cassel to anyone that needs it and would definitely recommend healthcare professionals referring patients to this service.

Amanda MacKenzie – Senior Nurse

“Thank you for taking the time to give us your feedback about how you experienced the Cassels' treatment programme. Your fight over the last 22 years to achieve so much is admirable and we are grateful to have been able to play a part in this. I think what is helpful to hear is that this work towards recovery takes time and that the work towards your goals i.e. employment after leaving treatment takes time. Sometimes the difficulty is trying to achieve just being good enough; sometimes understanding, other times grappling with trying to understand and sometimes getting it just plain wrong. What is important is that we are all trying to get there together.

Your message carries to staff and patients, who as you know, have to face the difficulties and challenges of everyday life a story of hope and perseverance. It reminds us all that this work, no matter how hard, is worth it! It renews our energy and perseverance. I wish you all the best and thank you again.”
Between the 1st April 2017 and 31st March 2018, a total of 382 complaints have been raised compared with 472 in the previous year. This shows a decrease of 90 complaints.

Of the complaints raised from 1st April 2017 to March 2018, the key department of health theme is related to ‘all aspects of clinical treatment’ which accounts for 125 of the complaints raised. Of the complaints raised under the theme of ‘all aspects of clinical treatment’, the majority are related to ‘access to services and facilities’.

378 complaints have been investigated and closed; 255 of these were closed within the agreed timescale and 120 were closed over the agreed timescale. The outcomes of the complaints investigated were: 62 upheld, 167 partially upheld, 146 not upheld and three are on hold. In addition, 27 complaints were withdrawn.
The complainant stated that although they had a pre-booked appointment they were kept waiting for three quarters of an hour with no explanation forthcoming from either the receptionist, or the female member of staff who met them in reception and accompanied them to the ward. They also felt that the non-verbal communication from this member of staff lacked any warmth and that they found her attitude quite hostile.

We apologised on behalf of the service and this issue has been raised in staff supervision sessions. It is incumbent on staff to provide a good service to all of our ‘customers’. The staff member will be undertaking customer training with one of our Service User Consultants.

The complainant was not satisfied with the visits procedure, particularly security elements and being delayed leaving the hospital impacting on their travel arrangements home.

The investigator found that the visitor had been delayed leaving the hospital due to a hospital security “spot check”. An apology was given and a request has been made to the Communications Team to update the visitors pack to highlight that when entering or exiting the hospital there is likelihood from time to time that they will be delayed because of emergency or security procedures or events.

The complainant said that he had made a compensation claim for a watch which was lost following a ward move, the claim was refused and the reason provided was that the complainant had “traded” the watch outside of agreed CTM processes. The complainant denied that the watch had been traded and stated that he had not been interviewed or his account taken during the claim process.

The investigator found that the complainant had made a claim for a watch which was refused on the grounds stated, but there was no evidence that the watch had been “traded”. The watch had been seen in another patient’s possession but not removed and an assumption was reached that the item had been voluntarily traded outside of the agreed processes by the claim investigator. The investigation recommended that ward staff must be reminded that if they find other patients property in another patient’s possession without the correct processes being followed it should be removed until ownership can be established. The complainant was compensated as a result of the complaint investigation.
The complainant disputed the facts that were contained in an IR1 that had been completed. The investigation found that CCTV footage did not support the content of the IR1.

An apology was given to the patient and it was recommended that the IR1 be redacted or rescinded to accurately reflect the incident. All staff were reminded about the importance of accurate record keeping and the Clinical Nurse Manager (CNM) of the ward spoke to the individual staff concerned about the accuracy of their record keeping. The IR1 was reworded to accurately reflect the incident and the CNM of the ward concerned is running sessions for staff on the ward about IR1 completion and the standards required.

Patient raised concerns in relation to the attitude and behaviour of named staff members around medication time.

The procedure for lunchtime medication was discussed with all staff. All staff were reminded that medication can only take place after meals have been completed.
We employ a dedicated PALS officer to work with service users, carers, families and the public to seek answers or provide advice on initial concerns, in consultation with clinical services, advocates or other agencies as appropriate. This way of working has proved to be very effective and the service is being fully utilised across the Trust. However, we are aware that the patient advice and liaison service needs to increase its visibility and this is something we continue to work on. Improvements include attendance at service user forums, carers meetings and ward community meetings.

From 1st April 2017 to 31st March 2018, a total of 891 PALS enquiries were received into the Trust taking 459.92 personnel hours. This is a decrease of 484 compared with the same reporting period last year. The following graph shows the number received each quarter including the previous year’s figures for comparison.
Communication/information is the top theme accounting for 29% (n= 189) of the total PALS enquiries received. This is expected, as one of the key roles for PALS is to provide accurate information to patients, carers and families, about the Trust’s services.
Compliments

The Trust records all verbal and written compliments onto a database and report on this in the patient experience quarterly report. This does not include any data from surveys or questionnaires. During the reporting period a total of 178 compliments were logged. This is a decrease of 18 compared with last year.

Some of the compliments made:

- Taken from an incident review, a wife stated that she wanted to inform staff that her husband had died peacefully at home and wanted to thank staff for the help and support they gave in keeping her husband comfortable and entertained.

- A compliment given to low secure forensic, community and OT department with regards to the support provided during his time as a patient and the way in which staff carried out their duties and the compassion shown.

- Compliment to Berry ward following the transfer of a patient to CNWL rehabilitation services for their continued advice, guidance on management and monitoring risks. The team at CNWL wanted to acknowledge the work carried out in the interest of the patient and patient pathway.

- Patient thankful for the kindness and understanding of Dr Cherian.

- Patient and her cousin are very grateful for the care and kindness of the CATT team.

- Mother of patient would like to applaud Fiona Burke for the dedication, empathy and understanding she showed them at a meeting.

- Wife of a patient says that all the nursing staff were fantastic.
Examples of key messages and action taken in response to incidents and serious incidents

Organisations that report more incidents usually have a better and more effective safety culture. Knowing where the problems and challenges are supports us to take steps to learn and improve our services.

The Trust has continued taking steps to improve the rate of its incident reporting and learning as a result of incident reviews. This is contributing to the Trust’s sustained improvement in our reporting rate and number of days taken to report incidents to the National Reporting and Learning System (NRLS).

Our highest priority at WLMHT is to provide high quality care to our patients. This must be effective and centred around the patient but above all it should be safe. The safety of patients, staff and visitors is paramount. In order to learn from incidents and improve patient safety we must identify incidents.

The Care Quality Commission identified incident reporting as an area for development following their assessment in June 2015 and their assessment in November 2016. The WLMHT quality improvement action plan included the following actions during 2017/18:

- The Trust has planned training programmes implemented across the organisation focusing on how and why it is important to report incidents as well as how to use the reporting system in place.
- Themes and trends from incidents informs the development of mandatory training sessions.
- Further developments to the electronic incident reporting system, strengthening links to the reporting form to RiO, providing automatic feedback to staff reporting incidents and allowing staff to track incidents that they have reported.

Incident reported data

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1-Q4 2017/18 Incident Total 12,057</td>
<td>3114</td>
<td>2762</td>
<td>3144</td>
<td>2980</td>
</tr>
<tr>
<td>Q1-Q4 2016/17 Incident Total 12,926</td>
<td>3385</td>
<td>3385</td>
<td>3087</td>
<td>2991</td>
</tr>
</tbody>
</table>
A total number of incidents of all types and severity were reported across the organisation. This represents a decrease of 7.2% (926) in the number of incidents recorded for 2017/18, which occurred because the incident reporting system was improved during this reporting period.

The graph above shows monthly reporting of all incidents reported during 2017/18 in comparison to 2016/17.

The most frequently reported incidents Trust-wide by type per quarter have been:

- **VERBAL ABUSE TO STAFF**
- **SECURITY INCIDENTS**
- **SELF-INJURY TO PATIENT**
- **MEDICATION INCIDENTS**
- **PHYSICAL ASSAULT TO STAFF**
Verbal abuse towards staff has been highly reported in High Secure Services and staff across all areas of the organisation. It is continually encouraged to report all types of abuse to allow the identification of any themes and trends.

Physical assaults to staff have remained consistent throughout the year. The number of this type of incident has gradually decreased throughout the year.

Self-injury to patients has decreased in the last 12 months.

Suicide and self-harm reduction steering groups and strategy have been introduced across the Trust and the monthly audits completed on enhanced engagement and observations continues.

Security incidents have steadily decreased this year compared to the last two years reporting figures, this could be because last year staff reported more contraband items found on patients, particularly smoking related, with the new e-cigarette policy fully embedded there are less of these type of incidents reported.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal abuse to staff</td>
<td>499</td>
<td>430</td>
<td>477</td>
<td>403</td>
<td>449</td>
<td>454</td>
<td>471</td>
<td>387</td>
</tr>
<tr>
<td>Security incidents</td>
<td>509</td>
<td>451</td>
<td>594</td>
<td>432</td>
<td>426</td>
<td>475</td>
<td>462</td>
<td>470</td>
</tr>
<tr>
<td>Self-injury to patient</td>
<td>240</td>
<td>196</td>
<td>253</td>
<td>189</td>
<td>240</td>
<td>219</td>
<td>187</td>
<td>204</td>
</tr>
<tr>
<td>Medication incidents</td>
<td>394</td>
<td>340</td>
<td>367</td>
<td>250</td>
<td>323</td>
<td>282</td>
<td>292</td>
<td>274</td>
</tr>
<tr>
<td>Physical assault to staff</td>
<td>274</td>
<td>220</td>
<td>312</td>
<td>201</td>
<td>245</td>
<td>219</td>
<td>233</td>
<td>252</td>
</tr>
</tbody>
</table>
Trust-wide serious incident reviews

The Trust uses the reports from all SI reviews to identify and take action to prevent emerging patterns of incidents, and it supports clinicians to learn about why patient safety incidents happen within their own service area, and what they can do to keep their patients safe from avoidable harm.

Key areas for action 2018/17

Work that is underway to address the quality of serious incident investigations:

- Reviewing the training need of the investigators
- Reviewing all training resources/packages offered to investigators
- Simplifying the incident investigation process
- Simplifying the incident investigation supporting materials
- Trust Serious Incident Learning Framework Paper reviewed by the Clinical Quality Group, designed to support the learning process

Coroners Rule 28

This rule gives coroners the power to make reports to the organisation where the coroner believes action needs to be taken to prevent future deaths and where the organisation may have the power to act. The coroner announces his intention at the end of the inquest hearing.

The Trust did not receive any rule 28's during 2017/18.

Health and Safety Executive (HSE)

The HSE has issued no improvement or prohibition notices to the Trust during the last year.
The Trust's commitment to the principles of safeguarding children and adults at risk has been endorsed by the CQC in its review.

The Trust-wide safeguarding team consists of the director for safeguarding and two clinical leads (Named Nurse for Children and a Safeguarding Adult Lead Professional) and are supported by two respective advisors/practice development leads who maintain safe levels of training, reflective practice and safeguarding clinics across the Trust. All new staff at Induction receives training, thus reinforcing a Trust-wide safeguarding culture.

Practitioners have ready access to advice and guidance from the Trust-wide safeguarding team and local safeguarding leads within hours; during ‘out of hours’ there are Trust managers on call and the emergency duty teams in local authorities are available for advice.

The Trust is represented on all local Safeguarding Children and Adult Boards and their sub-groups continue to enhance and support a multi-agency approach to safeguarding. The function of the LSCB’s is under review nationally and this may affect future Trust responsibilities. Trust representation at specific Panels such as the MARAC (Victims of Domestic Abuse) and Channel (clients who are seen to be engaged in radicalising activity) has been strengthened to demonstrate consistent contribution by the Trust.

**During 2017/18 the Trust focused on a number of key safeguarding concerns:**

Our safeguarding children level 3 ‘specialist’ training was particularly low at 60% at the beginning of the year; this has now risen to 86% with sufficient ‘in-house’ provision and monitoring. This is training for staff who work directly with children and young people, which are mainly our CAMHS teams, but also include liaison and perinatal teams.

The national initiative to prevent Violence against Women and Girls and the safeguarding of both adult women and girls remains a focus for the Trust this year; we had secured an honorary contract with Standing Together against Domestic Violence (STADV). This is a time-limited project.

As a consequence, the Trust wished to reinforce the response to Domestic Abuse before the project ends. STADV have provided additional training to staff who have expressed a commitment to support Domestic Abuse and has resulted in a number of Domestic Violence Champions that are placed within clinical services. The training will be supported by establishing and maintaining relationships with external Domestic Abuse agencies.

**Safeguarding children**

In March 2018 as part of a CQC Inspection of Children's Safeguarding and Looked After Services in the Borough of Ealing our CAMHS and adult services in the Borough were reviewed.

Early initial feedback has been received that is good: our partnership with Children's Social care was found to be strong. Ealing CAMHS were commended as strong contributors to Early Help services in Ealing, enhancing support to children and their parents, ensuring emotional health and well-being are central to children's care.

Children are seen in a timely way by our CAMHS ‘out of hours’ service; and a new protocol for transitions to adult services was seen to work effectively.

The adult team were commended for a strong Think Family approach to their work with clients, where children are considered right through from the SPOC (Single Point of Contact) and assessments. Processes to consider risks were commended. ‘There is good management oversight of children of adults, the daily Zoning board and safeguarding activity’ and our perinatal services were good, with robust and consistent services that safeguard children.

We are awaiting the initial draft report. There are areas where we know we can improve, such as in our internal processes in support and supervision with staff, and we look forward to receiving the full inspection report.
Safeguarding adults
The Safeguarding Adults Named Professional's principal role is to establish and develop structures, pathways and relationships internally and externally to support safeguarding adult practice Trust-wide. A further resource to support practice is the availability of both the Named Professional and Advisor/Practice Development Lead to provide advice to practitioners with individual cases.

To further understand how the Trust responds to safeguarding and the concerns raised, the data is reviewed monthly. This highlights the current needs and emphasises where the safeguarding focus is required. As a consequence, we are delivering bespoke training to address identified needs and ensure all practitioners are equipped with knowledge and tools to respond to the concerns. Feedback of the data and safeguarding needs is circulated and discussed in each of the services governance forums.

To reinforce the chief principle of making safeguarding personal, we have started attending the local services community teams. This provides inpatients with the opportunity to discuss safeguarding, their views and experiences of this directly to the safeguarding team.

We have also commenced ‘Safeguarding Clinics’ in the three London boroughs to make the team more available to clinical staff for the same.

Safeguarding is embedded within the Trust serious incidents and complaints team. We have developed a ‘Think Incident Think Safeguarding’ to remind the governance team and the practitioners of the requirement to consider safeguarding. We are also reviewing the reports of serious incidents to ensure a safeguarding response is addressed as appropriate.

Safeguarding key development plans
The 2017/18 cycle was the final year of the three-year strategy (agreed in December 2014) to develop safeguarding in the Trust. The strategy focused development of safeguarding along four key lines.

Progress on the four areas for development was achieved:
- Organisational intelligence
- Partnership working
- User and carer involvement
- Safeguarding resource

Going forward into 2018 - 2021 key areas include:
- Strengthening of safeguarding governance and assurance
  - A Trust wide safeguarding group has been created, chaired by the Medical Director – (executive lead for safeguarding), to give oversight to safeguarding matters across the Trust
  - Stronger pathways between the safeguarding team and internal governance structures
- Development of a strategic response to domestic abuse (policy, procedures and training)
- Learning from CQC visits and recommendations from local and national SCR’s and SAR’s; to be formalised
### Safeguarding quality and performance indicators April 2017 – March 2018

<table>
<thead>
<tr>
<th>Target / Measure</th>
<th>Performance</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Local Services</strong></td>
<td><strong>CAMHS</strong></td>
<td><strong>West London Forensic</strong></td>
<td><strong>High Secure Services</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Adult Services</strong></td>
<td><strong>CAMHS</strong></td>
<td><strong>West London Forensic</strong></td>
<td><strong>High Secure Services</strong></td>
</tr>
<tr>
<td><strong>Safeguarding children activity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of referrals to children's social care</td>
<td>Q1 - 128</td>
<td>Q1 - 18</td>
<td>Q1 - 1</td>
<td>Q1 - 0</td>
</tr>
<tr>
<td></td>
<td>Q2 - 90</td>
<td>Q2 - 15</td>
<td>Q2 - 0</td>
<td>Q2 - 0</td>
</tr>
<tr>
<td></td>
<td>Q3 - 84</td>
<td>Q3 - 16</td>
<td>Q3 - 2</td>
<td>Q3 - 0</td>
</tr>
<tr>
<td></td>
<td>Q4 - 103</td>
<td>Q4 - 13</td>
<td>Q4 - 10</td>
<td>Q4 - 0</td>
</tr>
<tr>
<td><strong>Number of child visits made</strong></td>
<td>Q1 - 17</td>
<td>Q1 - 0</td>
<td>Q1 - 12</td>
<td>Q1 - 5</td>
</tr>
<tr>
<td></td>
<td>Q2 - 36</td>
<td>Q2 - 0</td>
<td>Q2 - 4</td>
<td>Q2 - 7</td>
</tr>
<tr>
<td></td>
<td>Q3 - 35</td>
<td>Q3 - 0</td>
<td>Q3 - 4</td>
<td>Q3 - 3</td>
</tr>
<tr>
<td></td>
<td>Q4 - 49</td>
<td>Q4 - 0</td>
<td>Q4 - 4</td>
<td>Q4 - 10</td>
</tr>
<tr>
<td><strong>Number of children admitted to adult wards</strong></td>
<td>Q1 - 4</td>
<td>Q1 - 0</td>
<td>Q1 - 0</td>
<td>Q1 - 0</td>
</tr>
<tr>
<td></td>
<td>Q2 - 2</td>
<td>Q2 - 0</td>
<td>Q2 - 0</td>
<td>Q2 - 0</td>
</tr>
<tr>
<td></td>
<td>Q3 - 0</td>
<td>Q3 - 0</td>
<td>Q3 - 0</td>
<td>Q3 - 0</td>
</tr>
<tr>
<td></td>
<td>Q4 - 2</td>
<td>Q4 - 0</td>
<td>Q4 - 0</td>
<td>Q4 - 0</td>
</tr>
<tr>
<td><strong>Number of allegations referred to LADO (safeguarding children)</strong></td>
<td>Q1 - 0</td>
<td>Q1 - 0</td>
<td>Q1 - 0</td>
<td>Q1 - 0</td>
</tr>
<tr>
<td></td>
<td>Q2 - 0</td>
<td>Q2 - 0</td>
<td>Q2 - 0</td>
<td>Q2 - 0</td>
</tr>
<tr>
<td></td>
<td>Q3 - 0</td>
<td>Q3 - 0</td>
<td>Q3 - 0</td>
<td>Q3 - 0</td>
</tr>
<tr>
<td></td>
<td>Q4 - 0</td>
<td>Q4 - 0</td>
<td>Q4 - 0</td>
<td>Q4 - 0</td>
</tr>
<tr>
<td><strong>Safeguarding adult activity</strong></td>
<td>Q1 - 146</td>
<td>Q1 - 2</td>
<td>Q1 - 7</td>
<td>Q1 - 6</td>
</tr>
<tr>
<td>Number of safeguarding adult referrals</td>
<td>Q2 - 133</td>
<td>Q2 - 1</td>
<td>Q2 - 7</td>
<td>Q2 - 5</td>
</tr>
<tr>
<td></td>
<td>Q3 - 133</td>
<td>Q3 - 1</td>
<td>Q3 - 7</td>
<td>Q3 - 4</td>
</tr>
<tr>
<td></td>
<td>Q4 - 154</td>
<td>Q4 - 0</td>
<td>Q4 - 10</td>
<td>Q4 - 6</td>
</tr>
</tbody>
</table>
Nursing quality improvements and initiatives

Engagement events
Central engagement events, aimed at final year students on placement with us, were piloted by the nursing directorate in 2017. The engagement events provide services with the opportunity to showcase and recruit to their Band 5 Staff Nurse vacancies with newly qualified nurses who have experience of and want to work within our Trust. Our most recent engagement event was held on 1st March 2018. The event was well attended and we were able offer the majority of the attendees a substantive staff nurse post in an area of their preference.

Nursing degree apprenticeships (NDAs)
WLMHT and Central and North West London have joined forces with Bucks New University to launch the new nursing degree apprenticeship, which was launched on the 28th March 2018. This exciting new programme gives healthcare support workers the opportunity to pursue a career in nursing through a fully funded apprenticeship programme.

Both Trusts have worked together to form a cohort of staff ready to progress onto their nursing degree apprenticeship within the field of Mental Health Nursing and in doing so WLMHT is one of the first Trusts in London to offer the degree level apprenticeship.

The apprentices are being hosted by wards and teams from across our clinical service units and work is underway to ensure we provide high quality learning environments that support ‘on the job’ learning as well as make sure we support all those involved in the apprentice’s journey.

Capital nurse foundation programme
The Trust currently has 18 nurses on the Health Education England - North West London Capital Nurse Foundation Programme. The programme, aimed at supporting the recruitment and retention of nurses, has continued to grow and develop throughout 2017/18 and a further cohort is planned for 2018/19.

Nurses within one year of registration complete three six-month rotations in each of our clinical service units, with a ‘wrap-around’ package of exclusive development and support opportunities.

The wrap-around package includes the provision of a ‘supermentor’, a clinician at Band 8a (or equivalent) or above.

The supermentor facilitates access to development opportunities, and has ‘career conversations’ with their corresponding capital nurse.

The package also includes bespoke events and action learning sets as well as support to complete our well established preceptorship programme.

Overseas recruitment
As a supplement to our broad and dynamic approach to recruitment, 2017 saw the launch of our overseas recruitment campaign in the Philippines. Working in partnership with a recruitment consultancy a small team of nurses went to the Philippines to promote the Trust and conduct candidate interviews. We have made a significant number of employment offers and a project board has been established to manage the next steps.

Nursing conference – celebrating good practice
This year’s Nursing Conference focussed on celebrating and sharing good practice from across the Trust. The successful event saw nursing colleagues come together to share ideas and developments from across the organisation as well as attend wellbeing sessions and/or quality improvement workshops.
Nursing clinical supervision and reflective practice
During 2017/18, the Trust has worked to build upon and expand the opportunities for nurses to engage in clinical supervision and reflective practice.

Clinical supervision in the Trust (individual or group): is viewed as a formal process of facilitated reflection, professional support and learning that enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance patient protection and safety of care in a wide variety of situations.

Nurses within the Trust will experience some or all of the five main forms of local supervision:

- Clinical supervision
- Managerial supervision
- Caseload management
- Reflective practice groups
- Modality specific supervision

This multi-model approach alongside clinical incident reviews and case reviews and discussions with other professional colleagues provide continuous opportunities for reflection on practice.
Improving patient experience
Pharmacy has undertaken further work with West London Collaborative this reporting year. Surveys have been conducted to determine service user and prescriber views and experiences on supported decision making for medication. Pharmacists continue to undertake a review of all medicines, efficacy, adverse effects and provide support for service user supported decision making through 1:1 consultations.

In addition to recovery college sessions, pharmacists provide frequent carer and service user education sessions on medicines use such as the bespoke clopazine teaching sessions arranged for the Hestia housing project.

The Trust Consultant Pharmacist has undertaken quality improvement projects co-produced with service users on making healthier choices on medication. This work was recognised and well received at the International Quality and Safety in Healthcare Forum.

Service users were able to design a making healthier choices booklet which supported and promoted self-management of the physical health related side effects of medication and demonstrated greater service users and staff satisfaction.

The Consultant Pharmacist also undertook a study to determine service users views, attitudes and experiences of Voluntary PRN medication, and how this could be used in the prevention and management of violence and aggression, leading to improved patient and staff safety and experience.

The Trust has recruited and trained further non-medical pharmacist prescribers, following from last year’s pilot the non-medical pharmacist prescriber led medicines review clinic in Hounslow has continued, this is now being expanded to provide medicines review to patients with Learning Disabilities in the community.

Pharmacists provide training to doctors to improve knowledge of medicines safety. Pharmacy staff provide in-house and external teaching on a number of medication related topics, including management of controlled drugs and safe and secure handling of medicines.

Pharmacists are regularly involved in virtual diabetic and respiratory ward rounds and GP medicines reviews for forensic patients.

One of the Trust pharmacists has successfully completed the aspiring pharmacy leaders program and another is now enrolled into a future cohort.

Clinical effectiveness
Following identification that medicines are being stored outside the recommended temperature range, the Trust is in the process of moving to the use of digital thermometers which will facilitate and support regular alerts; this should allow a preventative management of medicines prior to any temperature breaches.

Pharmacy provides a monthly clinical improvement bulletin that is disseminated to all clinical staff. This bulletin highlights good practice in medicines optimisation, guidance for ensuring clinical effectiveness and sharing lessons learned from medicines incidents and also signposts staff to relevant guidance and informs them of any update policies procedures and guidance.

A community handbook which highlights good practice for medicines management and signposts staff to relevant policies, procedures and guidance relating to medicines optimisation for patients based in the community has been developed and will be disseminated shortly.

Quality improvement methodology has been adopted in the pharmacy with 4 quality Improvement projects being undertaken and completed this year;

- Making healthier choices whilst on medication
- Implementation of Healthier Choices booklet
- Reducing Pharmacy Related Patient Safety Incidents in the Pharmacy Dispensaries
- Improving Discharge Prescription Standards in Local Services

During the Improving Discharge Prescription Standards in Local Services Quality Improvement project, immediate improvements have been seen in the accuracy and timeliness of information transferred across the interface from secondary to primary care to GP’s when patients are discharged.
Patient safety
Pharmacists make a vital contribution to ensuring the safe and effective use of medicines, working with the multidisciplinary team to ensure systems and process are in place to support medication safety.

Recent initiatives in improving the safer use of medicines include a better cascade of medication safety alerts out-of-hours, the creation of a flow chart to aid decision making when patients refuse critical medicines and the use of short and simple memos to increase awareness around medication safety initiatives. Information leaflets have been developed and are now available from pharmacy for patients and carers on how to identify medicines related patient safety incidents.

Pharmacists are involved with the National Medication Safety Network which ensures that good practice is shared and embedded across the Trust. The learning and experience in improving medicines safety in a Mental Health Trust by the pharmacy department has been highlighted nationally at Patient First Conference (National) Medicines safety and has also been published.
Research and development

De-escalating conflict behaviours in mental health settings (The EDITION study)
The Trust will be hosting a study to develop a gold-standard training intervention for de-escalating conflict behaviours (e.g. aggression, self-harm) in mental health settings.

A Health Technology Assessment (HTA) grant has been awarded by the National Institute of Health Research (NIHR) to develop and evaluate an evidence-based de-escalation training package for adult acute and forensic mental health inpatient settings. The study is led by Dr Owen Price, who is a mental health nurse with a clinical background in forensic psychiatry. He will work in collaboration with Peter Turner (Violence Reduction Specialist, Broadmoor Hospital), Jimmy Noak (Deputy Director of Nursing) and Professor Elizabeth Barley (Professor of Health and Wellbeing, University of West London).

De-escalation techniques provide staff with a potential means of managing conflict behaviours such as aggression and self-harm without restrictive practices. As such, all NHS staff receive training in de-escalation at considerable expense to the NHS. The content, duration, delivery methods and update-frequency of this training varies between healthcare organisations and there is no model of training with proven effectiveness.

Evidence-based training may contribute to enhanced consistency in the delivery of de-escalation training, improved clinical safety and effectiveness and reduced costs. This two and a half-year study involves three work packages to design, develop and implement the training package in ten adult acute and forensic wards. We will assess the impact of the training on: de-escalation performance, frequency of conflict and use of restrictive practices, staff attitudes and expressed emotion, patient distress associated with restrictive practices and cost-effectiveness.

‘De-escalation is an important intervention in helping to reduce unsafe behaviour and the use of restrictive interventions that can be harmful to both patients and staff,’ Dr Price says. ‘There is a huge amount of untapped expertise on de-escalation in clinical practice. We intend to access this knowledge by speaking to staff and patients and standardising good practice through the development of a new training package. The EDITION study is an opportunity to develop the gold-standard in de-escalation training in West London and help make wards safer places for staff and patients in the UK and internationally.’

Mind really matters in trying to beat obesity: West London Mental Health Trust will be hosting the first UK study into whether mindfulness-based therapy is effective in helping to promote long-term weight maintenance and psychological health after bariatric surgery.

A research for patient benefit (RfPB) grant has been awarded by the National Institute for Health Research (NIHR) to look at the postoperative psychological management of bariatric surgery, using acceptance and commitment therapy (ACT).

The study will be run by Dr Samantha Scholtz, who is a consultant psychiatrist specialising in the management of obesity-related disorders and bariatric surgery and also R&D director at the West London Mental Health NHS Trust. She will work in collaboration with Professor Elizabeth Barley, (Professor in health and wellbeing at the University of West London).

The study has been collaboratively developed with Georgina Hayman of the patient charity BOSPA (British Obesity Surgery Patient’s Association), who is also a co-investigator on the study.

A quarter of patients experience significant weight regain after bariatric surgery, along with the return of the associated obesity related issues – including psychological problems and stigma. The three-year trial, which starts in May this year, will look at participants’ weight, psychological indicators of depression, eating behaviour, and acceptability of a mindfulness based intervention. Patients will be followed up for two years after the intervention. The results of the randomised controlled trial that will follow will feedback directly into the clinic in terms of post-operative support for patients and will provide much needed evidence for national guidelines on post-operative management of bariatric surgery patients.
“This is a group of patients that is stigmatised and faced with a lack of information and misunderstandings about the physiology of obesity,” Dr Scholtz says. “The assumption that people just need to exercise a bit more and eat a bit less, then they’ll lose lots of weight, is patently wrong. I strongly feel that we need to be supporting patients by giving them psychological interventions with the right type of support so that they keep the weight off long-term and prevent re-operations, which are a huge cost for the healthcare system.”

**Asking young people about the acceptability of using wearables and social media to assist in detecting deteriorating mental health**

The Trust is collaborating with Imperial College’s NIHR Imperial Patient Safety Translational Research Centre (PSTRC). The PSTRC has researchers from a specialised set of research groups working together with patients to improve patient safety and the quality of healthcare services.

There is a high use of both wearables (e.g. fit bits) and social media amongst young people. Many young people do not consider who is monitoring the information which is collected through these technologies (e.g. Google). Some studies have looked at this technology as a way of detecting health conditions, including mental health problems. However, the views of both young people and healthcare professionals about the potential use of these technologies for this purpose, has not yet been explored.

Researchers Professor Paul Aylin and Lindsay Dewa are working in partnership with young people in the Trust to explore the acceptability of using wearables and social media to assist in detecting deteriorating mental health. The results from this project, will help to understand which kinds of technologies are acceptable to young people to use to detect mental health problems.

The project works closely with the McPin Foundation, an organisation that aims to transform mental health research by putting the lived experience of people affected by mental health problems at the heart of research methods and the research agenda. Young people from the existing groups at the McPin Foundation are involved in the development of the research questions, project design, ethical approval, co-researching and the dissemination of results. They will be provided appropriate support and training (including payment).

**Psychology and Psychotherapy Services**

Expansion has been a key driver in the planning for the delivery of psychological services at the Trust over the last twelve months. We have been working to develop connections between psychological professionals across the organisation and in our external partnerships. These professions include clinical, forensic, counselling and health psychologists, cognitive behavioural therapists, psychological wellbeing practitioners, and child, adult, family and systemic psychotherapists. There has been a particular emphasis on assertively reaching out to those who present with multiple or complex needs in physical and emotional domains. Co-location of workers with psychological skill sets alongside existing team expertise in some of our local services has enabled this process to commence, and for us to really listen to what makes a difference to the experience of care our service users receive.

Overall, our strategy for 2017 moving into 2018 has been to make preparations to be more proactive and preventative, and to target support to specific groups such as young parents (in our perinatal teams, offering Enjoy your Baby and Circle of Security group sessions), young people (via the transformational multi-agency work and the Brighter Futures agenda within our CAMHS teams), the most vulnerable (those under detention orders in our (forensic) in-patient services), and those whose diverse needs may be overlooked (such as older adults in same sex partnerships in contact with Cognitive Impairment and Dementia services). The priorities in service provision by psychological professionals have been to emphasise prevention (e.g. educational film material for General Practitioners in Early Intervention in the Psychosis pathway); assessment and formulation (shared maps of the presenting problems to be accessible and well-written within our clinical records), and the full range of interventions that make a measurable differences to people’s lives and well-being.

Increasingly, the value of psychological skill sets (consultation, liaison including co-production, and supervision) in clinical leadership has been evident in the Trust’s appointments to senior roles in our boroughs, forensic and local services. We have also supported the process of recruiting and appointing research and governance leaders within the organisation.
Building on access targets of 2016/17, we have set out to maintain the lowest waiting lists possible in all services, through offering more therapy options (such as psycho-educational group-work), and/or a better trained workforce (such as the open dialogue workshops that have been co-facilitated by experts by experience), or, in forensic services, a more targeted provision of our resource at critical periods in our pathways. A good example of this is the community-based groups (called New Horizons) that take place in a Quaker Meeting house at the end of the working week. The forum allows for acknowledgement that discharge from (forensic) hospital is a key stage in the recovery pathway that is riddled with potential challenges. The groups provide a space for peer learning and exchange of information, support and reflection, combining the experience of in and out-patients to foster hope and optimism when it is particularly needed.

Another example of access improvement has been piloted without our IAPT services, who established a tri-borough digital wellbeing service in 2017, offering computerised Cognitive Behavioural Therapy (CBT) available 24/7 with the support of therapists who have expertise in working with anxiety and depression. The co-location of IAPT workers with other specialists, and vice versa, (e.g. perinatal and clinical health psychologists) has also had a positive impact on access for some groups (e.g. young mothers with babies and people with longstanding conditions such as diabetes).

By way of illustration of the training initiatives that have embedded fully this year, the workshops on Dialectical Behaviour Therapy (DBT) in our local services for all disciplines have been running for five years. Feedback from staff about the value of this training and how it is translated into clinical work is very encouraging. Similarly, broadening conversations and clinical thinking have been widely sponsored by colleagues at The Cassel who have offered seminars on positive and outstanding mental health practice throughout the year. Developing standards for environments which enable is on-going across three in-patient sites in the Trust with expertise in working with complex needs (Broadmoor Hospital, The Orchard and The Cassel). We are working towards application for formal accreditation of our ‘living and learning’ communities based on psychosocial principles.

Improving quality and effectiveness through clinical strategy

Quality can be regularly measured via standardised approaches to data collection on the delivery of care and treatment. Psychological services set out, and now also report on standards of practice, and where our data tells a story of inconsistency, we have sought to address this. For example, given that substance misuse was noted as implicated in a number of serious incidents across the Trust, psychologists and psychological therapists representing every service line led on the New Trust Strategy for Co-morbid Mental Health and Substance Use. This has been widely shared this year, with training plans accessible to all staff. An award winning audit of risk assessment was undertaken by psychology in our high secure services which has led to revision of the way we document our working case summaries and should generate a sustained focus on good safety care planning and risk management.

Similarly, our work with Restorative Practices (informed by victim-led restorative justice principles) has been developed, now reaching local as well as forensic services, and underpinned by a new policy for best practice. We continue be able to offer our service users an option for repairing harm where this has happened to them and upset their progress towards recovery, and for staff who experience harm in the workplace to have an option to more clearly voice their preferences in the process of making a return to work. For our inpatients, restorative processes can assist in repairing impasses created by conflict and enable pathway progression to get back on track.

This year's summary would not be complete without reference to the major tragedies that beset the capital in 2017 via fire in Kensington and terrorism in Parsons Green, and the impact these events had on so many lives in West London. From a staff perspective, we learnt to share our resources in joined up humanitarian assistance programmes, to refine and expand our capacity to work with trauma, and to communicate information about what to expect and how to cope when the unexpected happens. Teams of leaders addressing present and future safety, well-being and health have come together across the
capital to pool resources and collaborate in the face of sudden loss. Planning for emergencies in West London has been reviewed with all this learning in mind, and a focus on how, when, and when not, to consider intervening. In addition to the trauma that is generated by major incidents, the Trust has been working this year to incorporate our understanding of the many equally influential inequities, abuses and adversities that we know many of our clients face or have experienced. The Trust-wide Personality Disorder Group, commissioned by the Medical Director, has brought into an integrated forum expertise on working with complexity. Members of this group have contributed to helpful national guidance on working with Personality Disorder (PD), via review of sobering statistics illustrating the role of PD in poor, or worse, outcomes. The value of collaborative working as pioneered by the Managed Clinical Network in local services, and co-production with former users of our forensic services, has been evident in projects directed at understanding PD, and contributing to the sense of community in inpatient settings. The importance of trauma-Informed care and treatment was raised via conference events throughout the year, in our leadership forum, and a series of workshops and open dialogue sessions. Strategic work to embed the principles of trauma-informed care should help us to respond better to survivors of abuse and other traumatic experiences.

**Patient safety: addressed by creative, individually-tailored interventions**

Whilst psychological therapists remain an integral part of most of the multidisciplinary teams, there are not enough to go around in all settings. Addressing these realities with service model and design has prompted us to join with nursing and occupational therapy colleagues who equally aim to reduce restrictive practice, to increase hope and opportunity, and to provide evidence based treatment for those hardest to reach. Arts therapists have found ways of including the most isolated of our clients with music in corridors, art in groups, combined therapy sessions (e.g. music and Dialectical Behaviour Therapy) groups, and Koestler award-winning competition entries.

Speech and language therapists have targeted their unique resource towards communication and swallowing difficulties to enable colleagues to be highly attuned to early warning signs of airway distress. Psychological therapists work alongside medical and allied health professional colleagues to sponsor a plethora of interventions, including healthy eating programmes, medication compliance, diabetes management, reducing self-harm and promoting sleep hygiene. Psychological therapists using a range of therapeutic modalities continue to offer staff supervision via (reflective) groups and training, ultimately sponsoring patient well-being, and looking after the Trust’s most vital resource (its staff) simultaneously. This year the Trust published a basic booklet outlining how staff can access reflective practice in our forensic services, building on the recent publication of a psychotherapeutic-analytic framework for exploring team and organisational practices for remaining resilient and professional in approach. Themes including relational security, attachment and mentalisation inform this work and enhance the patient’s journey through communication to enable needs to be met, since positive interpersonal relationships are central to good mental health.
Cognitive impairment and dementia services

Community teams
The business cases for Ealing and Hounslow have been fully implemented with the Dementia Link Worker Service fully embedded into practice with access to System One. This has led to a reduction in community team caseloads and capacity to assess new patients has increased. A similar model has been developed for Hammersmith & Fulham and is in the implementation phase.

Care pathways workshops have led to a more efficient assessment and diagnostic process which in turn has increased diagnostic capacity. We have developed a more robust post diagnostic process which encompasses the development of a clear patient focussed care plan to include future planning, lifestyle advice, financial signposting and support service availability. We are now in a position to offer more group support such as ‘newly diagnosed’ groups, cognitive stimulation groups and carers groups. We plan to develop regular drop in sessions for people who use our service and their relatives / carer. We have increased access to cognitive stimulation to people whose primary language is not English.

Ealing and Hounslow community team have continued with MSNAP accreditation and are currently in the process of reaccreditation. This assures patients, carers, staff, commissioners and regulators of the quality of service being provided, and is endorsed by the CQC. Hammersmith & Fulham community team will be included in this accreditation cycle.

Inpatient wards
There is an ongoing estates strategy to improve the environment on the Limes and Jubilee ward for the people who use our services. This will lead to a less restrictive environment and a better quality experience as the environment will be more dementia friendly. There is a longer term estates strategy for the relocation of the Limes and Jubilee ward. Particular emphasis has been placed on reducing restrictive practices including ‘Johns campaign’ and ward environments. We have developed bespoke PMVA training for staff in reducing patient distress.

We have reviewed the service line governance process and have put further checks in place to ensure that learning from incidents is embedded in practice. We have improved the range of leaflets available to people who use our service including deprivation of liberty safeguards. A range of leaflets are now available in a variety of languages.

The Johns Campaign is a national drive which recognises the right of a person with dementia to have a carer with them at any time. We identify the patients carer/loved one/relative and offer open visiting, provided that it is safe to do so. We encourage carers to visit at lunch times especially at the Limes as many patients eat better if they have a loved one with them. We support carers/relatives loved ones to be with patients who are at the end of their life.

Child Adolescents Mental Health Service

CAMHS New model of care project
As part of NHS England’s New Model of Care programme, WLMHT is working in partnership with Central and North West London NHS Foundation Trust to provide better integrated care and treatment for children and young people.

Main principles of the project are to:
- Reduce the number of patients placed at significant distance from home for their mental healthcare
- Decrease the time young people spend in inpatient units
- Avoid unnecessary admissions
- Improve access to community support

The programme has had continued success this year and multi-professional teams have worked together in partnership with young people and their families to avoid unnecessary hospital admissions and reduce the length of time young people have spent in in-patient care. This programme is now aligned with the newly agreed crisis care pathway across North West London.

Integrated 24/7 CAMHS crisis support
Following the development of the nurse-led CAMHS out of hours service which continues and the work undertaken as part of the New Model of Care Project, the Trust have been
commissioned to deliver an extended service to improve access for children and young people so that they may receive 24/7 high quality crisis care and support.

A new team of specialist nurses have been recruited led by an experienced crisis care team manager. The new staff have been undergoing an intensive training programme and have been working alongside existing CAMHS teams to offer children and young people intensive outreach support in the community. It is expected that the new service will become fully operational integrating both day and night provision later in 2018.

Benefits of this integrated service include:
- Improved health outcomes through means of rapid assessment at a place most suited for the child or young person
- Improved quality of life through greater continuity of care and coordination of services over a 24 hour period
- Reducing avoidable hospital admissions
- Reducing disruption to school, family and social life

**CAMHS eating disorders service**
The newly funded service has been fully operational for almost 2 years and is now seeing almost double the expected numbers of children and young people. This service provides evidence-based treatment interventions for both the young people who need these services, and their carers and families too.

The service continues to deliver on the access and waiting time indicators - young people at high risk are now being seen within a week and an overall wait at four weeks for all young people.

A smooth transition pathway has been developed between CAMHS and adult services so that those young people who continue to need support once they have reached 18 years of age experience seamless care provision.

The service is now working in partnership with Healthwatch Ealing and Healthwatch Hounslow to evaluate the experience of young people and their families. A video is planned which will capture these experiences.

**Transforming neurodevelopmental services**
Working in partnership with the commissioners, CAMHS are trialling a new way of working in Ealing to address the challenges associated with the increasing demand placed upon neurodevelopmental services. This has led to long waiting times for assessment for children, young people and their families.

Aims of the waiting list initiative pilot project:
- To reduce the waiting list for assessment in the Ealing CAMHS Neurodevelopmental Service
- To incorporate computerised systems to facilitate neurodevelopmental assessments
- To analyse the impact of introducing skill mix within a Neurodevelopmental Team
- To reduce the clinicians’ time dedicated to assessment and the length of the assessment process
- To ensure data accuracy in relation to the Neurodevelopmental Service

To date an additional Child and Adolescent Psychiatrist has been recruited to work as part of the expanded team along with band 5 and band 6 staff.

A newly developed assessment process which utilises computerised systems has been implemented, and takes into consideration the skills and knowledge of the expanded team.

Some of the children, young people and their families who have had the longest wait have been contacted and invited to begin the assessment process. Whilst it is early on in the project, early indications suggest that this will make a difference, but the extent of impact will not be known until later on in 2018.

The project is being fully evaluated so that if it proves to be successful the learning can be utilised to transform services across the boroughs of Ealing, Hounslow and Hammersmith & Fulham.

**Transforming services through children and young people’s improving access to psychological therapies (CYP-IAPT)**
The three main components of this are: the delivery of evidence based interventions; the use of routine outcome measures; and service user involvement in service delivery and planning.

This has been a real focus for CAMHS this year with staff making best use of routine outcome measures to support care delivery and maximise improvements in mental health and well-being.

Workforce development in line with CYP-IAPT has led to the development of band 4 Children’s Wellbeing Practitioners who are trained at postgraduate level supported by band 8a Supervisors.

NHS

Quality Account 2017 - 2018
Over the last year, the Trust has employed 8 Children’s Wellbeing Practitioners who have been an integral part of the CAMHS teams in two boroughs.

They have been offering under intensive supervision – very successful high quality brief, focused evidence-based therapeutic interventions for children and young people experiencing mild to moderate mental health difficulties (low mood, anxiety and behavioural difficulties). They have also been offering support to families too.

This has enabled the fostering of much closer relationships with schools as the Children & Wellbeing Practitioners have been offering one to one sessions in both primary and secondary schools, as well as running groups on exam stress, self-esteem and resilience.

Given the successes of the first year, there are now plans to develop Senior Children and Wellbeing Practitioners posts - one working in Hammersmith and Fulham local service, one working in the Youth Justice Team in Ealing, and one specialising in patient participation across our three boroughs with an emphasis on training expert parents.

The Children’s Wellbeing Practitioners have also been key in supporting CAMHS staff with a range of service user involvement initiatives. These have included training service users to be a part of the interview panels for the new crisis team, supporting the redesign of waiting areas, and running separate monthly groups for both young people and parents/carers.

**Access and Urgent Care (AUC)**

**Removing non-clinical delays from patient pathways**
We have put a number of robust systems in place to ensure patients receive the treatment they need, at the time they need it. By continuing our focus on eliminating non-clinical delays from all of our clinical pathways, less patients will experience waiting times for the services they need, or non-clinical delays leaving hospital when they are well enough to do so. By shortening our length of stay in acute beds we have consistently been able to offer local acute beds to our most unwell patients at the time they need one.

**Single point of access and crisis assessment and treatment teams**
Our revised community teams and single point of access are now embedded and assisting several hundred patients per month. We have reviewed our community team skill mix and recruited accordingly in order to best assist the patients we see. Our crisis assessment and treatment teams have successfully managed rising demand, meet regularly with their key interfaces, and have achieved significant improvements in percentage of patients gatekept, to ensure all our patients have the best opportunity to receive their treatment and support from home.

**Co-produced ward standards**
AUC have co-produced a detailed set of standards for our new inpatient wards with patients, carers and key stakeholders, with the assistance of the West London Collaborative. These standards will be central to future patient experience and the level of service offered. We are currently auditing all of our current wards against these co-produced standards, in order to identify any areas in need of improvement.

**Enhanced focus on physical healthcare**
AUC have agreed a new set of physical healthcare standards for all our patients, and audit our practice against these standards. We have increased the number of consultants and middle grade doctors in our inpatient wards, and monitor adherence to early physical examination and assessment. Our nurse consultant delivers focussed training to our nursing teams, and provides clinical support for complex cases.

**Generic wards**
In response to feedback from patients, carers and staff, we have moved away from the assessment/recovery ward model to generic wards which will see patients through their entire inpatient journey from admission to discharge. We have strengthened our focus on delivering activities, and also reduced the operating size of our largest two acute wards.

**AUC Estate**
Our current estate presents some challenges to delivering timely, efficient, modern healthcare. We have set up a regular infrastructure meeting, improved our health based place of safety facilities, and are commencing an ambitious program of works, including building and reconfiguration work at our largest site; Hammersmith and Fulham’s Mental Health Unit.
Crisis assessment and treatment teams (CATT) psychology interventions

An initiative has been developed to enhance access to brief psychosocial interventions for service users experiencing crisis, the team have been developing a series of resources to compliment a training programme for the CATT teams. The focus is to enable and develop the CATT team members' skill set to deliver individual brief interventions such as improving wellbeing, increasing activity, sleep hygiene and safety planning.

In addition, a series of group workshops have been developed including coping with emotions in crisis and unusual experiences in crisis that will run on a rolling basis led by clinical psychologists and co-facilitated by members of the multidisciplinary team. The resources for this initiative have been developed with coproduction of service users, carers and CATT team members with the aim of delivering a truly useable and relevant brief intervention resource kit.

Planned and Primary Care (PPC)

Primary Care Mental Health Service (PCMHS)

The service line has created a band 7 specialist practitioner role in Hounslow to facilitate effective transfers of care from secondary to primary care. The role has involved developing a package of coaching and support for the doctors and other MDT professionals in the recovery team and liaison with both general practitioners (GPs) and the PCMHS team to develop a smoother pathway for our service users.

This role has also developed a non-medical prescribing clinic working with identified service users to review treatment as part of their preparation for transfer to primary care services. This role has been effective at reducing the delays in transfer from secondary care services to primary care and increasing flow of the caseload through the recovery team.

The effectiveness of this role will be assessed through a proposed QSIR project with the objective to further develop the role and to fully measure its impact upon the team.

West London eating disorders service

PPC run a recruitment campaign which has successfully filled all posts in the service. This has supported the development of a single point of referral for the Hounslow and Ealing Boroughs and reduced waiting times for assessment.

We have also established a first line NICE recommended intervention for binge eating - group CBT. For patients suffering from anorexia nervosa we have expanded the provision of treatments and deliver CBT-E and other MANTRA, NICE recommended interventions.

PPC have established links and improved partnership working with our CAMHS services, Tier 3 eating disorder services and local GPs. The latter involved a co-produced protocol for managing physical health within this patient group.

The recovery teams

The waiting list for psychology within the recovery teams were in excess of two years in 2016. Psychology launched a consultation clarifying job descriptions, job roles and job plans for all employees. The main changes were:

- The creation of evening clinics to screen those waiting in excess of 6 months
- The creation of additional group interventions in each pathway allowing rapid access to therapy for all those waiting in excess of 6 months
- The establishment of clear guidelines for face to face contacts
- The establishment of clear guidelines as to maximum therapy contract within each cluster group
- The establishment of maximum therapy contracts within each cluster group
- An increased provision of group intervention allowing more people to experience psychological perspective and interventions
- The establishment of a panel to review requests to extension of therapy contracts
- Regular performance reviews for all staff against job plan
- Maximum waiting times (6 month routine and 3 months urgent) agreed for offer of psychological intervention
- Work with RiO team in movement of all psychology spreadsheets to RiO under waiting list functionality (to ensure rapid escalation of any breaches)
- A successful recruitment campaign in psychological therapies has filled all our available psychology posts
- Psychotherapy services are continuing to develop of a range of therapeutic interventions including Dialectical Behaviour Therapy, mentalisation Based Therapy and Psychotherapy
**Community services transformation**

Through close liaison with the PCMHS and GPs in all 3 boroughs it is easier to transfer service users where appropriate to care with their GP. This has allowed us to focus treatment in secondary care on a smaller number of service users with the most complex needs.

Working closely with inpatient services and home treatment teams has enabled the development of shared standards for care which ensure that service users can be stepped down from acute care as quickly as possible. This has contributed to greatly improved bed availability and decreased length of stay since August 2017.

As a consequence of our work with PCMHS and GPs we have been able to stabilise the caseloads in the recovery teams so that they have either plateaued or are decreasing all teams. The relative reduction in caseloads has been a key component of the community transformation work, undertaken over the last 30 months. Through wide consultation and co-production we have developed 3 clearly defined care pathways for complex depression anxiety and trauma (CDAT) and personality disorder and psychosis. Most clinical staff are now working within one of these pathways.

To support this there has been an extensive programme of training provided over the year pertaining to evidence based interventions both within and across pathways. Additional training has been made available in working with service users with co-existing substance use.

**Electronic patient record (RIO)**

The service line has worked with the RIO team to effect modifications to the system to support pathway working:

- Development of a system to flag progress through the care pathway and completed / missing interventions or outcome measures.
- Modification of the physical health portal for community based service users, thereby facilitating the documentation of key physical health parameters and the identification of service users at high risk of cardiovascular disease.

**Specialist rehabilitation service**

The development of a single point of referral for the two specialist rehabilitation wards has reduced waiting times for assessments and reports. There has been considerable investment into improving the environment and patient facilities in Mott House.

**Managed Clinical Network**

The managed clinical network has appointed their first permanent service user consultant at Band 8a level. They have delivered 469 days of Knowledge and Understanding Framework (KUF) training to 163 individuals across the Trust. They have developed a managed clinical engagement training module which has been delivered to the personality disorder pathway teams in recovery teams across local services.

Outcome data was presented for the LATER programme (Recovery College) at the British and Irish Group for the Study of Personality Disorder (BIGSPD) annual conference in Cardiff. The Priory Hospital has asked the network to develop a training programme for the acute adult service line.

**The Cassel Hospital**

The Cassel sponsored and co-delivered a BIGSPD community of practice event in June 2017. They have also sponsored and co-delivered a national training event for higher psychotherapy trainees.

**Liaison and Long Term Conditions**

**Perinatal mental health services Ealing, Hounslow and Hammersmith and Fulham**

This service was reviewed by the Royal College of Psychiatrists Centre for Quality Improvement Perinatal Quality Network in December 2017. They assess how well the service is performing based on nationally agreed quality standards. This was the second review of the service since its launch in 2016; the review identified the following strengths:

- The feedback from the multi-agency discussion was very positive. They stated that the team was very responsive and easy to access. Agencies also stated that the team truly cared about their work and were very knowledgeable about the subject.
- The team’s quality improvement project (improving the accessibility and use of its website) is very innovative and demonstrates the team’s desire to improve the service and commitment to providing a high quality of care.
- Patient feedback was very positive, with patients saying that staff were excellent, accessible, very caring and highly knowledgeable.
- The team proactively manage complex cases.
The service has established an experts by experience group that meets bi-monthly to identify areas for service improvement and to co-produce solutions. This has included a focus on referrals to social services, inviting leads from children’s services and safeguarding within maternity to the group and an agreement from maternity services to develop an information leaflet for women referred to social care. Members of the group have delivered training with the perinatal mental health team to midwifery and feedback has been extremely positive. A quarterly newsletter is produced and circulated to women on our experts by experience database.

The service is taking part in the quality, service improvement and redesign training run by the Trust, and the project aims to improve the usability and access of the perinatal service’s website.

Care Opinion feedback has been extremely positive:

- “I didn’t feel anxious to talk about any of my problems”
- “I was made to feel comfortable and relaxed”
- “I wasn’t judged, my mental health was taken seriously, I didn’t feel a burden. My thoughts, feelings and emotions were listened to and I didn’t feel alone”
- “They gave me space to express my feelings”

Following a comprehensive evaluation which included positive feedback from service users and professionals, commissioners agreed the service would receive recurrent funding.

Clinical health psychology and neuropsychology
A major focus for this service has been the design and implementation of psychological care pathways for patients. The focus is to achieve integration of physical and mental health care as well as integration from acute to community services. By having members of the team working across settings and alongside physical health colleagues this has meant the service meets the psychological needs of patients as the challenges of their physical health condition have varied across the pathway.

This integrated approach has led to more efficient transfer of information and more effective use of resources. One example of this, improving identification of psychological distress of patients on the Imperial College Healthcare acute stroke wards. This has been celebrated as an example of excellent quality improvement in the most recent Sentinel Stroke National Audit Programme (SSNAP) report, which is commissioned by the Healthcare Quality Improvement Partnership.

The end of year audit has revealed 94% of our service users rating themselves as Extremely Satisfied with our service. The service also received two patient nominated Imperial College Healthcare Make a Difference awards for delivering over and above what patients had expected. Over the past year a feedback form was developed for referrers to rate their experience of the service, 100% satisfaction rating was achieved with 50% Extremely Satisfied, comments received from our Imperial College Healthcare colleagues including the following:

- “Excellent service. Hard working team. Good work prioritisation.”
- “Patients derive significant benefit from attending and often praise the clinicians.”
- “We would be unable to deliver a type 1 diabetes service without the support of the psychology service.”

Tri-borough IAPT
During 2017/18 our IAPT services have been involved in the Wave 2 IAPT-long-term conditions project, following the successful North West London wide bid for funding. The focus has been on developing better integration between physical health and psychological therapies service, with a particular focus on people with diabetes and respiratory conditions. New referral pathways have been established from physical health services to IAPT, both community and hospital based services. Some co-location sites have been set up in GP practices, hospital settings and local health centres. An IAPT-LTC implementation group has been set up across the service line and is attended by Clinical Health Psychology, Liaison Psychiatry and IAPT leads. IAPT staff have been attending training courses on long term conditions and have been receiving monthly clinical supervision from an in-house clinical health psychologist.

Each of the Trust’s IAPT services has continued to develop their online therapy platforms in partnership with Minddistrict. These are known as Ealing IAPT online, Back Online (H&F) and My Mind Matters (Hounslow). Over 400 patients have accessed online therapy across the three boroughs and outcomes have been very positive. Online therapy champions have also been involved in the creation of new therapy modules, including for worry, breathlessness and diabetes.
Partnership working with perinatal mental health services, children's centres and maternity units has continued successfully throughout 2017/18. Access rates for perinatal clients have been very high, and clients are being prioritised for assessment and treatment in line with NICE guidance.

One of the CBT therapists from the H&F IAPT service was awarded by the Trust with a Quality Award for his work with the Iranian community, and the H&F wellbeing project was cited as a good practice example in the IAPT Wellbeing webinar earlier this year.

**Home ward**

Home ward Ealing has undertaken a number of quality improvement projects over the last year. The 5 major projects were:

1. The **NAIC Audit for STR** for patient and carer feedback indicated that in 13 out of 14 areas the number of positive responses were 90% or more, with the 14th area having 70% positive feedback. As a result of involvement in the national audit STR developed a proposal for the Commissioners to consider changing the outcome measure from Goal Attainment Score to the Sunderland Outcome Measure which is more person-centred and focuses on levels of independence rather than limitations and disability.

2. The **LAS Referral Project** has resulted in fewer people taking “unnecessary” trips to A&E thanks to a pioneering scheme between the London ambulance service and rapid response teams. The service was the first Trust in North West London to offer training in December 2017.

3. Home ward Ealing working along with LBE, CNWL and other partners have been piloting a new acute hospital discharge pathway (discharge to assess - now known as Home First since May 2017) in line with the ambitions of the North West London STP to address rising pressure on acute hospitals and provide clinical benefits for patients, as well as NHS Improvement requirements to support non-elective flow particularly for older adult patients.

4. The home ward team leads took part in the first QSIR Cohort where the following project was undertaken: “To sustainably improve the quality of screening, triaging and signposting out of new referrals into each team in the Home ward Service”. A number of Change Ideas were then worked on to help achieve the aim of the project as well as meet the Trust Values by:
   - Bringing our teams together to work in collaboration (togetherness)
   - Empowering staff to lead and solve the problems in our own service (responsibility)
   - Reducing further the burden of non-elective admissions in our local hospitals by providing better quality care for more patients out of hospital (excellence)
   - Improving patient experience and safety, and the experience of our staff and referrers (caring)

5. The Home ward service improvement project “To be the Intermediate Care Service with the Happiest Staff and Patients in NWL by 2019” by ensuring:
   - The Service is high quality and safe
   - Care is patient centred
   - Staff Feel confident providing excellent care
   - Staff are valued

Very good progress has been made with a number of the mini-projects being completed already leading to service improvement.

**One You Ealing**

**Smoking cessation**

Nationally all mental health units are required to go smoke free by 2019. Therefore, we have worked in collaboration with forensic and local service staff to re-strengthen the policy throughout the year. In 2017/18, 48 clinical staff were trained as qualified stop smoking advisors in combination with their current role. This has equipped our staff in-house on every ward to have their own advisors to provide harm reduction and tobacco dependence support on the ward to service users.

As a Trust, we are committed to supporting our service users and quality of care, this will ensure that service users are supported during early stages of their admission. This year One You have also had many Trusts visit WLMHT to learn best practice around the e-cigarette implementation, as these have supported many service users in harm reduction of tobacco selling around 1000-2000 per week across the Trust.

**Health trainers**

The service led on a large campaign around self-care week achieving 327 footfall, of different communities engaging with our health trainers around key standardised self-care messages. This process raised the One You Ealing profile whilst rebuilding relationships with the community.
organisations. This great work led to partnership with various organisations for future workshops such as Neighbourly Care.

To enhance the quality of our care to our clients in the community, our health trainers have undergone health check training where they are qualified to target hard to reach groups, and provide assessments that include glucose and cholesterol blood tests, dementia screening and an overall Q Risk score (cardiovascular score). These assessments are now embedded into our health trainer interventions, where we can reduce the rates of poor physical health in the borough of Ealing and screen those at risk earlier on.

As such 180 community physical health assessments were undertaken in Ealing within two community centres. This allowed the team to pick up a number of health issues (diabetes, high blood pressure etc) for further intervention support.

**Child weight management**

Child weight management delivered 23 programmes for 5–13 years old. Across all programmes and 1:1s, 150 children completed the programme. There was a total of 93% of children who had reduced/maintained their BMI z-score. In line service changes the service was renamed to the healthy family programme and designed ALFIE as a mascot. ALFIE branded resources have been delivered and the delivery team have started to include these as incentives to support with programme SMART goals. These include water bottles, pedometers, frisbees and drawstring bags. The service implemented quality improvement ideas to support the completion for 150 children onto the programme. These include:

- New branding and promotional literature, this was also co-created with service users
- ALFIE resources to incentivise the programme are given at key points throughout the programme
- Offering junior gym memberships with GLL for all completers, this is highlighted throughout the programme to promote the opportunity
- Working very closely with schools with a high prevalence of childhood obesity, using NCMP/free school meal eligibility to map the schools with the highest rates
- Integration with the wider One You Ealing team and linking in with leads
• Holding quarterly team reflective sessions to inform future planning and service improvements (what has gone well, etc.)
• Carrying out service user mapping exercises to understand the different community groups we work with

Smoking Cessation in Secondary Care
North West London NHS Trust is currently preparing implementation of tobacco CQUIN, which includes, tobacco screening, brief advice, referral and medication offer. Smokefree Ealing is currently collaborating with our Trust executives and ICT to create and launch CQUIN for around May-July 2018. Smokefree Ealing specialist advisor is currently planning training and ongoing support to all Ealing Hospital staff on how to complete these indicators. All referrals to the service will continue to be processed within 48 hours. There are future plans to update and relaunch of Smoke Free Policy. Currently the specialist advisor is spreading awareness of the Smoke Free Policy that is already in place at every ‘Very Brief Advice’ (VBA) training event emphasising the importance that patients are aware of it. Over 30 hospital pharmacy staff members have been trained to deliver VBA and introduced to Stop Smoking medication available in the hospital. Liaising with hospital doctors and Respiratory consultants regarding wider service projects, such as COPD in primary care settings. In addition to regular referrals from clinical staff Urgent Care, Preoperative department and chest clinic patients are giving out referral cards and service leaflets for a quick self-referral within the hospital. Self-referral boxes to whole One You Ealing are also available in multiple hospital locations.

Smoking cessation specialist visits all inpatient wards minimum once a week, with a lot of opportunity to chat to patients who are the period of heightened motivation to quit. Being on the wards gives plenty of opportunities to spread awareness of the service and referral pathway.

Liaison psychiatry services

10 minute tutorials for acute hospitals
Our Ealing liaison psychiatry service experienced challenges to provide teaching to the acute hospital due to acute Trust staff having limited protected time for educational purposes.

We therefore developed an innovative programme namely ‘10 minute tutorials’ which is piloted for teaching the hospital on legal framework. These are Microsoft PowerPoint based tutorials which have been designed to be delivered within 10 minutes at the end of a variety of clinical meetings, with the aim of ‘drip feeding’ mental health knowledge to acute hospital staff in a way that is engaging, flexible and accessible.

We received very positive feedback with 80% of attendees preferred the concept of 10 minute tutorials to the conventional 1 hour lecture and 80% felt the tutorial would lead to an improvement in their clinical practice. 91% of respondents would like to receive further 10 minute tutorials. This piece of work has been accepted for an oral presentation at the RCPsych Liaison Psychiatry Faculty Conference.

Three borough service for individuals who frequently attend emergency departments
There are a very small group of individuals with unmet needs who frequently attend emergency departments and account for a disproportionately large amount of health care utilisation.

In Ealing, Hounslow and Hammersmith and Fulham liaison psychiatry works collaboratively with our colleagues in the acute trusts, primary care, social services, third sector and London ambulance service to support a small cohort of these individuals. The service includes a comprehensive needs assessment to inform a co-designed care plan which is shared with professionals and local emergency services that support these individuals.

Preliminary analysis suggests a reduction of attendance to emergency department in this cohort by 20-35% compared to their previous year attendance. There are plans to expand this project in this financial year to benefit a larger group of similar individuals.

Improvement in staff supervision
Hounslow liaison psychiatry has been keen to improve on the quality of clinical supervision for staff, a series of supervision audit was conducted for both nursing and medical staff. Following the audit, templates for supervision and robust action plans have been embedded. Re-audit infers better coverage of the different domains of supervision and staff have rated an average of 4.6 out of five satisfaction rating for supervision they received in the most recent re-audit.
Improve team responsiveness to referral
To better meet the needs of the acute trust and individuals we serve, Hounslow liaison psychiatry service has introduced referral record template which highlights the timeline of actions from the team to improve responsiveness of the service. The team has also introduced SBAR (situation, background, assessment, recommendation) to improve the quality and effectiveness of clinical discussions with the referrer. These measures have allowed the team to better manage its clinical priorities which translate to more appropriate allocation of resource based on the urgency and complexity of cases.

Improve clinical pathway for individuals with renal failure to access memory services
Cognitive impairment is a significant comorbidity with progressive kidney disease. This is also associated with poorer prognosis and higher mortality in this population group. Hammersmith and Fulham liaison psychiatry has worked collaboratively with the acute Trust and community dementia service to introduce a screening tool, Mini-COG in the renal service based in Hammersmith Hospital. Individuals scored below the threshold will receive further testing and if indicated, will be referred to their local memory service via their GP.

Improve assessment on fitness for interview
Fitness for interview is an area of frequent disagreement amongst professionals involved with individuals presented to emergency departments. To improve timeliness of assessment, transparency of decision making and working relationship amongst professionals, a pilot was conducted between liaison psychiatry and emergency department in Charing Cross Hospital on the use of an assessment tool to objectively determine fitness for interview.

Bariatric psychological support service
This year the psychiatry team at St Mary’s Hospital Imperial weight centre rolled out an innovative approach to preparing patients for bariatric surgery from a psychological point of view. In collaboration with patients we developed a pre-operative workshop to help patients understand how life will change after bariatric surgery, when food is no longer available in the same way for emotional regulation. The workshop uses psychoeducation, patient experiences in video format, mindfulness strategies and workbooks to help patients think collectively about how they will manage the changes and to promote self-management of their condition. The group approach has been welcomed by patients who felt they were more able to be honest about the role food played in their life. Our audit showed that they retained the information provided better than with the traditional approach of an individual assessment. They also felt less stigmatised and in keeping with the evidence base psychological factors were no longer seen as a barrier to accessing the most effective treatment for their obesity.

Dr Scholtz, the service lead has set up special interest group for clinicians working across the country in this area which has been instrumental in supporting the development of much needed national guidelines, which will be published this year by the British Obesity and Metabolic Surgery Society (BOMMS).

Community Independence Service (CIS)
CIS in Hammersmith and Fulham has been successful in progressing quality improvement projects this year:

1. Improving working practice across the 3 pathways of CIS namely - rapid response, rehabilitation and reablement. The improvement team were successful in reducing the wait times for inter pathway referrals and simplify the referral process.
2. Increasing the confidence of staff supporting people with mental health difficulties. The breadth of dual physical and mental health concerns seen by the team have been identified and based on this, appropriate support and training for staff is being accessed.

In addition to the quality improvement projects, the service has a strong ambition to improve care for people who are at risk of falls. The process has started by adapting the multi-disciplinary assessment form that is used across the service to ensure that assessing risk of falls is part of every initial assessment and the staff have shared their diverse skills in managing falls risk across the service.
West London Forensic Services (WLFS)

Embedding and evaluating the medium and low secure clinical models
The Men's Medium Secure Service was awarded a prestigious Patient Safety Award at the Health Business Awards in 2017, for the work that had been achieved in reducing restraint within the service. The results of the new model were also praised within the Health Service Journal who recognised a reduction in restraint by over 21% and a reduction in medication led restraint by 60%. It was noted that the service are using personalised recovery plans that are produced collaboratively with patients. These provide clear goals for patients to achieve before they move from assessment wards to rehabilitation wards and onwards to discharge. The low secure model has since been embedded and is currently under review.

Recovery College
Our recovery college offers a learning approach that complements existing patient education services provided within WLFS. Co-production is at the heart of the work of the Recovery College. Every course and workshop we offer is co-designed and co-delivered by trainers who have experienced mental health difficulties working alongside trainers from mental health professions. Course feedback is consistently positive and is rated highly by attendees.

Research
WLFS is involved in a number of research projects including a Qualitative Study with Imperial College on 'Staff Coping and Resilience in Mental Health Focussed on Self Harm as an Adverse Event'. A further project with the University of Manchester is looking at the development of a context-sensitive, manualised training package to reduce restrictive practices through enhanced de-escalation techniques, in adult acute and forensic mental health units. WLFS is leading on a study looking at an Outcome Evaluation of Liaison and Diversion (L&D) Schemes which has been the highest recruiting study in the Trust. The research will run from September 2016 to May 2019 and will compare reconviction rates, diversion outcomes and use of healthcare services for 12 months before, and 12 months after, implementation of the L&D service.

Developments within the occupational and vocational services
Over the last year service users have been co-facilitating the Trust Headquarters Café, as well as Café on the Hill. Both of these opportunities have helped to develop service users’ skills and confidence and have received positive feedback from staff and visitors. The service provides catering for hospitality and also snacks and hot food. Over the last year the technology hub has been developed in the Tony Hillis Wing allowing access to technology and supporting leisure groups. Within Thames Lodge the horticulture department has flourished and the produce from the gardens have been shared with service users and sold to staff. This has also supported the healthy eating agenda within the wards.

Technology
WLFS has been active in seeking to increase access to technology. This is viewed as important to enabling patients to live in the modern day and to support all aspects of their rehabilitation, including education opportunities. As a result, several protocols have been ratified across low and medium secure services to allow greater access to the internet and access to video calling with family members.

Safewards
WLFS has followed national best practice guidance and has already invested significantly in developing a culture where recovery is at the heart of everything we do. This increasingly includes co-produced initiatives with service users and carers. The psycho-socially informed interventions offered as part of the Safewards model aim to reduce conflict and restrictive measures within inpatient settings. The model offers an approach to care and provides simple tools that promote effective therapeutic relationships, improvements in the therapeutic milieu, encourage the development of calm, low expressed emotion environments which feel safe and are conducive to recovery. This approach has been embedded on wards within the low and medium secure men's directorates and the women's service. The service is currently undertaking an evaluation of the impact of the Safewards initiatives.
High Secure Services

Peer support (co-production/user involvement)
Leeds ward introduced a peer support role where patients provided introduction/orientation and support to new patients coming onto the ward. Both patients and ward staff have given positive feedback about the effect the role has had. Their work was published in a professional journal.
This initiative has also been introduced onto Folkestone ward with similar positive outcomes for staff and patients. Following a presentation of these two projects workshops are being developed by patients to extend the projects throughout the hospital. The project highlights effective co-production with patients and staff. It is envisaged that this will encourage peer support across the hospital.

Moving on group (pathways work)
Broadmoor Hospital has introduced a moving on group, this is co-produced and facilitated by an expert by experience (ex-patient). The group explores the transitions of moving on from the hospital including: anxieties, new environments, communication skills, safety planning and Q&A with staff from external units etc. The feedback has been very positive, patients have commented about how working with someone with real lived experience adds clarity and credibility to the group. The group aims to provide patients with skills, confidence and resilience to ensure their move out of a high secure environment is a successful transition.

Recovery (treatment and user involvement)
The recovery strategy was reviewed through a consultation with patients and staff, this has been overseen by the recovery implementation group which is co-chaired by a service user. We have recently completed an evaluation of recovery using the developing recovery enhancing environments measure (DREEM). The DREEM is a self-report questionnaire designed to evaluate the recovery orientation of a service from both the patient and staff perspective. The DREEM is considered as a quality indicator in relation to supporting recovery at an organisational level, (Shepherd et al, 2014). The December 2017 survey compares and tracks the recovery orientation of the service. The patient aspect of the survey (recovery markers) indicates patients (n=71), feel the service has shown an improvement in relation to recovery orientation. This has shown a general improvement since 2014. The patient narrative which also forms part of the DREEM suggests that they value the following: time with their clinicians, support and face to face contact with MDT, involvement in their treatment plan, having a positive mind-set and having activities. Patients reflected that recovery is an individual journey. This feedback is used for the organisation to look at how it provides services to individuals and to the hospital as a community.

Psychologically informed planned environments (PIPEs) (moving on pathways work)
Following a request from patients in relation to the PIPEs a collaborative workshop was developed and facilitated in the Recovery College. The workshop aimed to give an overview of the Prison Service PIPEs and took place in February. Presentations and discussion with Prison Service colleagues from HMP Frankland and HMP Send were positive and it gave an overview of the support available to patients if they transfer to this pathway. The workshop was attended by 16 patients and staff. This work supports the transitions and care pathways work.

Expert by experience training
We have introduced expert by experience for co-facilitation of violence reduction theory training, with the hospital. The session takes the theory of violence reduction and introduces a lived experience narrative. The first person testimony of service users has enhanced the knowledge and skills of participants. The sessions are well received by staff and external organisations with which we provide training.

Introducing hopes model and barriers to change checklist
We are introducing the HOPES Model and Barriers to Change Checklist in collaboration with Mersey Care NHS Foundation Trust, and Nottingham Healthcare NHS Trust. The work aims to enable teams to work with patients’ strengths, using existing and enhanced organisational capability. The work was developed by MerseyCare and aims to support patients to progress from long term segregation. Initial work on two QI projects has been positive, showing sustained improvements. Further work will be ongoing to scale up and spread the learning to other acute wards. Safewards interventions are also used to enhance team skills to reduce conflict and containment.

Service development

Remote patient monitoring (patient safety)
We are carrying out a 12 month pilot within the seclusion areas of two wards of the Oxecam remote patient monitoring system. This follows on from a successful trial that was completed within Broadmoor Hospital.
This revolutionary new technology enables staff to continuously monitor patients’ vital signs, especially whilst asleep, without having to disturb them. The cameras will be installed safely enclosed inside a ligature-proof secure housing within the rooms in the seclusion areas. The system does not need any additional sensors or physical contact with the patient. This will allow us to better monitor our patients’ physical health within these areas.

Research
Over the past year we have invested in a research lead who is a consultant already working within the hospital. We are developing a new research strategy which will focus on outcomes and trauma informed care. We continue to be involved in a number of research projects working with various universities.

Reflective practice
The importance of regular access to supervisory and reflective practices has been a focus for integrated nursing and psychological practice in high security this year. We produced a booklet to support staff in the challenge of working constructively with patients with complex needs, attending to the role and function of the ‘safety huddle’ on the wards. Introducing case profiles to ensure thorough handover of information, and ensuring staff have the time to engage regularly with multi-disciplinary team reflective practice. These structures provide the backdrop to allow staff in fast-paced and demanding settings some time to think about their connections with patients, relational security and the range of influences on the care they provide.

Promoting engagement
Collaborative working between nursing and psychology colleagues has been prioritised this year to bring evidence-based practice directly onto the wards. The complexity of needs in High Security demands integrated multi-disciplinary working and some good examples of this via the HOPES/RRP project have been evidenced this year. Whilst reflective practice sessions are offered routinely on a weekly basis for all staff, specific case work has incorporated ratings of staff morale and confidence in our working understandings of the needs of high risk patients.
Reducing restrictive practice

WLFS has continued to work on a CQUIN to reduce restrictive practices. Each area of the service has a restrictive interventions reduction action plan which is co-produced and monitored through local governance arrangements. WLFS have been responsive to service user requests with regard to reducing restrictive interventions and enhancing patient experience. We recognise that contact with friends and family is important and have developed specific protocols to allow access to smart phones and the internet for patients with unescorted leave. Access to electrical items within medium security has also been reviewed and is no longer a blanket restriction. They are now individually assessed and care planned accordingly.

WLFS have continued to progress the implementation of collaborative risk assessment and have embedded patient safety planning into routine practice. More recently we have developed a guide for patient chaired CPA meetings, which has been received positively by patients, particularly those in the Women’s Enhanced Medium Secure Wards.

High Secure Services

Predictive power of the dynamic appraisal of situational aggression (DASA): variations in rating method and time-scales

In 2016 we undertook a project to evaluate and explore the predictive validity of the DASA risk assessment tool in male patients admitted to the acute units in a High Secure Psychiatric hospital over 24 hours and over a single nursing shift. The DASA was completed, rating 43 male psychiatric inpatients over a period of six months. Data was compared to incident reports (IR1s) recorded over the same period and all IR1s were rated independently using the Modified Overt Aggression Scale (MOAS) to provide an assessment of the seriousness of the aggression recorded in the IR1.

The results revealed that DASA had moderate predictive ability for aggressive incidents occurring the next calendar day, whereas scores based on all three shifts (morning, afternoon and night) had excellent predictive ability. This project has demonstrated that DASA provides good predictive information about the likelihood of aggressive incidents amongst forensic psychiatric inpatients, especially if regular assessments are carried out across a 24 hour period and summarised as a mean or peak score. DASA can also provide predictive information about the likelihood of aggressive incidents from one nursing shift to the next.

DASA risk assessments could indicate when to intervene to prevent aggression, if interventions can occur prior to acts of aggression; and potentially reduce the use of restrictive interventions. In addition, it is also important to note that risk assessment might be particularly valuable for patients whose risk for aggression is rated low. A low risk rating should encourage staff to facilitate greater access to liberty and reduce restrictive interventions.

HSS are planning on exploring the impact of DASA risk assessments on aggression-prevention efforts, and delineating whether aggression-prevention interventions have a differential impact depending upon risk level. It is hoped that a future development of the DASA will provide guidance on appropriate interventions linked with levels of assessed risk. This will be extremely helpful in meeting the UK National Health Service’s stated goals of minimising the use of restrictive practices in the management of aggression. This will culminate in the development of an aggression prevention protocol.

This is a pragmatic approach, with a key emphasis on system-wide standardisation and the use of aggression parameters that are already routinely measured within forensic psychiatric hospitals.
Annex 1: Stakeholders’ feedback statements

WLMHT Quality account 17/18 Commissioners’ Review

NHS Ealing Clinical Commissioning Group (CCG) has reviewed the West London Mental Health NHS Trust’s Quality Account (QA) for the year 2017-18, with support from Hounslow CCG and Hammersmith & Fulham CCG, as associate commissioners.

We have reviewed the content of the Quality Account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health.

The Quality Account details a significant amount of effort and emphasis on quality, patient safety and safeguarding throughout the organisation. During 2017/18 commissioners have worked closely with the WLMHT, meeting regularly to review the Trust’s progress in implementing its quality improvements. The information provided within this account represents a balanced overview of the quality of care, patient safety and safeguarding at the Trust. The Quality Account evidences the work being done across the Trust and identifies where improvements are still needed.

Commissioners welcome the open and transparent declaration of progress in relation to quality priorities. It is heartening to see the progress on these, though it would be useful to have greater detail on achievements, particularly where there has been monthly monitoring, also on audit results.

This Quality Account provides a clear rationale for the planned quality improvements in 2018-19, linked with the CQC quality improvement plan and these are supported by commissioners.

We welcome the commitment to continuing focus on these quality priorities which support the CQC quality improvement plan.

We note the good progress with the reporting of outcome measures in CAMHS, though we require further assurance on the validity of waiting lists to ensure that back logs are reduced. We congratulate the Trust on the progress made on the improved efficiency/productivity of acute beds and DTOC through joint working across care setting and partners.

We note the joint agreement on the transition to an LPS 24/7 rota which is in the process of recruitment which will support wider integration with acute providers.

We are disappointed that there remain a number of outstanding investigation reports into Serious Incidents. Commissioners are keen to work jointly with the Trust on these to ensure aligned learning throughout the organisation. We look forward to seeing improvements in the identification and sharing of learning from incident reporting and investigation.

We are pleased to note the level of joint working with partner agencies on the completion of the NHS England Quality Risk Profiling Tool to confirm joint risks and mitigation processes.

Although it is good to see improvements in staff motivation and recognition and in the quality of appraisals, it is still concerning that the Trust continues to struggle with levels of bullying and discrimination reported through the staff survey, though we note the 9% decrease in this from the previous year. We welcome the Workforce strategy to address these areas.
Commissioners are keen to continue working collaboratively to ensure that the priorities for 2018/19 are progressed. We are looking forward to working closely with the Trust in the coming year to further transform services and ensure that we continue to champion the quality, safety and safeguarding agendas together, for the benefit of the patients for whom we commission services.

Tessa Sandall  
Managing Director, NHS Ealing Clinical Commissioning Group  

Dr Mohini Parmar  
Chair, NHS Ealing Clinical Commissioning Group
Annex 2: Statement of Directors’ responsibilities

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health issued guidance on the form and content of annual Quality Accounts (which incorporate the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012).

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

- The Quality Account presents a balanced picture of the Trust’s performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.
- The Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

Signed:

Signed:  

Tom Hayhoe  
Chairman

Signed:  

Dr Jose Romero-Urcelay  
Medical Director

Date:  28th June 2018  

Date:  29th June 2018
INDEPENDENT AUDITORS’ LIMITED ASSURANCE REPORT TO THE DIRECTORS OF WEST LONDON MENTAL HEALTH NHS
TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of West London Mental Health NHS Trust’s Quality Account for the year ended 31 March 2018 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following:

• Care Programme Approach (CPA): 7 Day follow up: Percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period; and

• Serious Incidents: The number and, where available, the rate of patient safety incidents reported within the reporting period, and the number and percentage of such patient safety incidents leading to severe harm or death.

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

• the Quality Account presents a balanced picture of the Trust’s performance over the period covered;

• the performance information reported in the Quality Account is reliable and accurate;

• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and

• the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.
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 Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance (“the Guidance”); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

- We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:
  - Board minutes for the period April 2017 to May 2018;
  - papers relating to quality reported to the Board over the period April 2017 to May 2018;
  - draft feedback from NHS Ealing Clinical Commissioning Group (CCG) dated 25 June 2018;
  - the latest inpatient survey dated 23 October 2017;
  - the latest community survey dated 2 August 2017;
  - the latest staff survey dated 6 March 2018;
  - the Head of Internal Audit’s annual opinion over the trust’s control environment dated 7 March 2018; and
  - the annual governance statement dated 23 May 2018.

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

This report, including the conclusion, is made solely to the Board of Directors of West London Mental Health NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and West London Mental Health NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement under the terms of the Guidance. 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 of the Quality Account to the requirements of the Regulations; and
• reading the documents.

A limited assurance engagement is narrower 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 impact 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 thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by West London Mental Health NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

• the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
• the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
• the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
London

27 June 2018
Promoting hope and wellbeing together