Quality Account
2016-2017

Promoting hope and wellbeing together

West London Mental Health NHS
NHS Trust

Contents

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

Welcome to our quality account for 2016/17.

Improving quality is central to everything we do. Everyone has a role in it, from occupational therapists and healthcare assistants to cooks, security staff and senior managers. Within this report, we describe the work we are doing to improve patient safety, clinical effectiveness and the experiences of people using our services. 2016/17 was another year of significant change and challenges that have led to real positive achievements. The Trust could not report on these successes without the collective effort of our staff and I would like to thank everyone who works here for another year of hard work and commitment.

Our continued focus will always be to improve the quality of services we provide to our service users and carers. The Trust has made positive steps towards building a culture of continued quality improvement, using a recognised quality improvement methodology. This year we have come a long way and we are excited to see how this new driver will contribute to improving the quality of our services.

Our Trust was re-inspected by the Care Quality Commission (CQC), less than 2 years after our first inspection under a new inspection regime in November 2016. We can be proud that the inspection team found significant improvements across a broad range of areas, from much improved staff morale to the work we have done to embed better physical healthcare for our patients. The CQC recognised a better incident reporting culture and improved medicines management practices, alongside a wide range of other areas. However, the CQC also rightly recognised that we have not yet completed our quality improvement journey. Although we have made a positive start to our redevelopment work for the new Broadmoor Hospital, further work is required to embed improvements in the culture.

The CQC also recognised that we, like many other NHS Trusts, have a particular challenge recruiting and retaining substantive qualified nurses. Although this is a challenge we face across the organisation, it is one we feel particularly acutely at Broadmoor Hospital. We have already begun to implement a number of measures to improve our recruitment and retention. These include better development opportunities for new and recently qualified staff, relocation allowances for nurses moving to the area and much improved support in the first few weeks with us. However we know that we cannot solve this problem overnight and work will continue well into 2017/18.

The CQC also found that work to build capacity in the community is on-going and that will be central to alleviating some of the pressures in the our acute inpatient wards. This work forms part of our crucial transformation programme which will also continue into 2017/18.

This year saw us continue our ambitious investment programme. Building work on the new Broadmoor Hospital has continued and it is clear that the investment will bring significant improvements to our patients and staff. We have also continued to invest in the much improved section 136 facilities following feedback from the last CQC report. The new Thames Lodge, men's medium secure unit at St Bernard's Hospital, has been open a year with both patients and staff alike reporting significant benefits.

We are proud of many of the new and innovative services launched this reporting year which includes One You Ealing, Ealing Home Ward and the Community Independence Service in Hammersmith and Fulham, which are all settling in well. Additionally, the Trust's new Perinatal Mental Health Service, which was launched in February 2016, offers assessment, care and treatment for women with severe and complex mental health problems from preconception, throughout pregnancy until 6 months postpartum.

The service was reviewed by the Royal College of Psychiatrists Centre for Quality Improvement Perinatal Quality Network in December 2016. This assesses how well the service is performing, based on nationally agreed quality standards. We are very proud of the feedback we have received so far and there is no better feedback than that of the people using the services. It is great to see that the friends and family test results showed that 96% of women are "extremely likely to recommend" the service. Lastly, I would like to thank our commissioners, both the Clinical Commissioning Groups and NHS England for their continued interest, commitment and support in working with us to ensure our quality account addresses these important quality improvement challenges. We look forward to continuously working in partnership to improve the quality of the services we provide for all our service users.

> "Thanks to Dr Barrett and the team for all their help with care and treatment."

> "Thankful for the support that has been provided."

Part 2: Priorities for improvement

Looking back - our quality priorities 2016/17: What were they, how did we do?

Patient safety

Quality Priority 1:

To reduce the use of restrictive interventions including: physical restraints, seclusion and long term segregation.

Why did we focus on this?	To reduce the use of restrictive practices across the organisation.
What did we aim to do?	Review and monitor the current usage of restrictive interventions.
What did we expect to achieve?	• Restrictive practice nurse consultant to deliver a training programme across all Local Services wards on developing reducing restrictive practice action plans. • Monitor restrictive practice in Local Services through the Safety Steering Group. • Develop monitoring arrangements for determining the frequency of primary, secondary and tertiary physical intervention in the Forensic Services.
How did we plan to monitor and report?	• Nurse consultant to provide a detailed update report to the governance structure meeting, training records of staff members and notable reduction in the use of restrictive practice. • Achieve CQUIN targets.
How well did we do?	• CQUIN reducing restrictive practices within adult low and medium secure services – all targets have been met. • We worked collaboratively with patients through service user forums and ward based community meetings to identify restrictive practices. • Peer reviews were conducted and action plans were devised where the progress was reported on monthly. • Local training opportunities have been developed which reflect our aim to support staff to implement changes in our approach to conflict and restrictive intervention reduction. • All wards in Acute Inpatient Local Services were represented at a 2-day reducing restrictive practice workshop. Approximately 35 staff attended each 2-day workshop including consultants, clinical team leaders and healthcare assistants. • It is particularly positive that we have achieved a 63% reduction in the use of episodes of enforced medication this year compared to last, and there was a 17% reduction in the use of restraint in our London Forensic Services. You can read about all of the other work the Trust has been doing over this reporting year to reduce restrictive practice on page 91.

What next?	The Trust still has much more to do to continue to reduce the variation of restraint, which the CQC assessed as a MUST do action. We have a quality improvement plan in place where the Director of Nursing will be responsible for providing a six monthly update to our board of directors on progress against service line's SMART reducing restrictive practice plan and escalate any issues of concern. There is a quality improvement project being undertaken by one of our new improvement advisors (you can read about these roles in the delivering our quality improvement programme section **on page 17**. We know as an organisation how much more we need to improve which is why it remains one of the Trust's quality priorities for 2017/19 and will be closely monitored through this process.

Quality Priority 2:

To ensure that there is a positive and open culture of reporting incidents, and implementing and embedding the lessons that are learnt

Why did we focus on this?	We know that we are under reporters compared to other NHS organisations and we also know that organisations that are higher reporters have safer services. We want our staff to feel confident in reporting an incident and we want to learn lessons from these incidents.
What did we aim to do?	We aim to increase the amount of incidents recorded so we can review them and learn lessons from them.
What did we expect to achieve?	• Ensure staff have embedded the newly revised incident reporting and management policy across the services and offer training where needed. • Maintain weekly serious untoward incident (SUI) clinic. • Disseminate learning lessons via case studies. • Review current method for learning lessons from incidents.
How did we plan to monitor and report?	• Monitor the number and type of incidents through a board level report. • Deliver training across the organisation on how to report incidents. • Hold a learning lessons conference to share the learning from incidents.

How well did we do?	Even though we still have a significant gap to close in the area of incident reporting, as evidenced through the fact that we have come up again as one of the lowest reporters, there have been positive steps towards improving and embedding the lessons learnt: • Training programme implemented across the organisation focusing on how and why it is important to report incidents. • Staff induction now includes a section on incident reporting. • Themes and trends from incidents inform the development of mandatory training sessions. • Launch of the updated incident reporting and management policy which includes guidelines on what and how to report incidents with a clear section outlining how we learn from incidents reported. • Development and launch of an electronic updated incident reporting system, linking the reporting form to RIO (our electronic patient record system), providing automatic feedback to staff reporting the incident and allowing staff to track incidents that they have reported. • Easy access to 'how to guides' and the incident reporting and management policy. • Team managers now have easy access to dashboards providing information relevant to their areas allowing local focus on areas for improvement. These dashboards are used as part of clinical team meetings and clinical improvement groups.
What next?	It is clear that low incident reporting figures is a complex problem with many underlying factors with no 'quick fix', and an on-going multi-faceted approach is required. Work on improving incident reporting and learning will continue throughout 2017/18.

Patient experience

Quality Priority 3:

To improve communication with service users by providing them with timely information regarding their care including: clearly identified people who are working with them and collaborative risk management planning

Why did we focus on this?	We sought to achieve better patient and staff engagement by providing them with good quality care plans and working in collaboration with the service user on their risk assessments, this would enhance the patients relationship with the staff and aid the recovery and transition through our services.
What did we aim to do?	To improve collaborative care plan and risk management planning so service users feel included in their care.
What did we expect to achieve?	Collaborative care planning including risk management.
How did we plan to monitor and report?	• Through setting the standard and monitoring it through supervision. • Conducting workshops to support service users in collaboratively working with staff to plan their care.
How well did we do?	• Our West London Forensic Services have been working with patients to improve patient engagement in CPA's (Care Plan Approach), a workshop was held for service users and carers to support them. Patients have been chairing their own CPA's in some cases and positive feedback was reported in the 'Inside Out Magazine' a patient and carer led newsletter. • There is a course running for service users at the Recovery College on collaborative risk planning which is well attended. • The Cognitive Impairment and Dementia Service (CIDS) have received funding to undertake the memory services national accreditation programme, part of this process will be to review care planning and risk management planning. • Local Services introduced the new documentation audit in 2016 which includes assessing the quality of the patient records ensuring they are up to standard, explaining the risks by client / family / carers and ensuring they are clear, concise and self-explanatory. This audit assesses whether the risk management plans have been updated appropriately to the current situation this is being used across some of our Local Services wards and senior staff have been trained in using the tool within clinical supervision. • We also updated our Trust's CPA policy in November 2016
What next?	The Trust will continue to review the quality of the care plans and working towards these being collaboratively produced with the service users.

Quality Priority 4:
To ensure that our service users and patients are treated in the best possible clinical environments and these are at all times clean, safe and therapeutic

Why did we focus on this?	It is our duty to provide an environment that is clean, safe and therapeutic and we want to identify where we fall short so we can improve the services we provide.
What did we aim to do?	To undertake the independent Patient Led Assessments of the Care Environment (PLACE) audits and implement any actions as soon as possible.
What did we expect to achieve?	We expect to achieve an improved environment which service users deem to be clean, safe and therapeutic at all times.
How did we plan to monitor and report?	• We plan to review the environments to see if they are clean, safe and therapeutic. • Undertake regular ligature audits to ensure safety is monitored through the risk registers.
How well did we do?	• PLACE audits were undertaken across the services and the action plans are monitored in the infection control meetings. • Hammersmith and Fulham Improving Access to Psychological Therapies (H&F IAPT) undertook an operational perinatal risk assessment of their facilities after increasing the service to include therapies for pregnant/postnatal women, as a result of this assessment the service now have plans confirmed to create 4 additional clinic rooms. • Ligature audits were undertaken across Local Services and an annual report was produced which RAG rates level of risk for each ligature point identified.
What next?	Continue monitoring services on whether they are clean, safe and therapeutic.

Clinical effectiveness

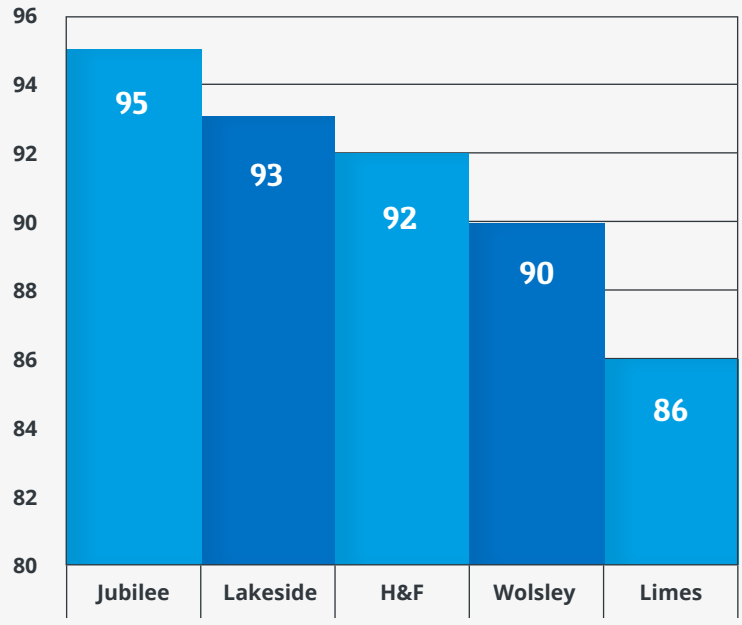
Quality Priority 5:

To improve the physical health of our service users, patients and staff through the implementation of smoke free services.

Why did we focus on this?	Smoking is one of the main causes of physical ill-health and focussing on providing smoke free services will increase life expectancy and improve mental health symptoms.
What did we aim to do?	Since the Trust went smoke free in January 2016, it's vital that staff and patients feel supported to give up smoking.
What did we expect to achieve?	• Staff trained at Level 1 smoking cessation. • Agree a range of nicotine replacement therapy products available to patients. • Agree policy and procedural arrangements for implementation of E-cigarettes for use by service users.
How did we plan to monitor and report?	• Continue with the smoke free meetings set up across the services supported by our smoke free Ealing team. • Develop implementation plans which involve training staff in smoking cessation. • Organising ward based activity programmes and ensuring nicotine replacement therapy is widely available.
How well did we do?	Our services became smoke free in January 2016. The Trust has made some good progress this year: ◦ All wards from Hammersmith and Fulham, Hounslow and Ealing got involved in creating unique promotional materials, supporting events and running new activities for the wards. ◦ The stop smoking facilitator at the Trust has produced a National Guidance for Public Health England on implementing smoke free practices for all mental health services in England. ◦ The Trust now has a policy in place on the use of e-cigarettes. ◦ Staff are now trained at level 1 smoking cessation.
What next?	• The Trust will be working towards training staff in smoking cessation at level 2. • The Trust will continue to support patients and staff in giving up smoking and provide advice on nicotine replacement therapy.

To improve the physical health of our service users, patients and staff through the implementation of improved physical health monitoring and awareness

Why did we focus on this?	The CQC carried out an inspection of the Trust and published their report in November 2015. The report identified a number of areas for improvement in relation to physical healthcare. These included: • Review the current physical healthcare standards and policies. • The need to ensure that patients had physical healthcare observations completed post rapid tranquillisation. • The need to improve physical healthcare assessment.
What did we aim to do?	Carry out a training needs analysis and determine what education and training staff required in order to provide safe effective care.
What did we expect to achieve?	To review the treatment and care we provide so we can offer the best possible support to the service users we treat.
How did we plan to monitor and report?	• Create physical healthcare standards. • Training on the use of the national early warning score (NEWs). • Monitor the care and physical observations following rapid tranquillisation. • Delivering on the national CQUIN 'delivering excellence in physical healthcare'.
How well did we do?	• The physical healthcare policy was ratified at the end of the reporting year. • 91% of staff are now trained in NEWs.



How well did we do? (continued)	• Student nurses joining the Trust on placement are now receiving physical healthcare training on induction. • Medical staff joining the Trust are now receiving physical healthcare training on induction. There are also plans to deliver further training on physical healthcare whilst medical staff are on placement. • The NEWs procedure has been reviewed and now has three levels of escalation. This is in line with the Royal College of Physicians three levels of clinical risk. • Escalation pathways have been written and incorporated within the procedure to take account of different services. • The Trust has agreed to use the Situation, Background, Assessment and Recommendation, Decision (SBARD) tool to facilitate effective communication of clinical concerns. • This is recommended by the NHS institute for innovation and has proven to improve safety in clinical practice. The SBARD tool is now used to escalate clinical concerns, improve safety during transfer of care and also during handovers. • There have been some untoward incidents in the Trust because of sub-optimal management of diabetes. The physical healthcare nurse consultant has worked with colleagues to develop a diabetes procedure to enable medical nursing and other staff to provide the best possible care to people with diabetes. • The Trust have met all of the requirements for the national CQUIN 'delivering excellence in physical healthcare'
What next?	Future work includes: • Pressure ulcer prevention and treatment. • Treatment of lacerations and skin tears. • Bowel care protocol. • Training staff on falls procedure. • Development of chronic obstructive pulmonary disease (COPD) procedure. • Plans to provide physical healthcare for community staff are being developed. This would incorporate an update on physical observations, training in capillary blood testing and ECG training.

"I am very pleased with the response from the team. They are very polite and extremely helpful. I cannot fault them."

Looking forward - our quality priorities for 2017/18: What they will be and how we will know if we have achieved them?

The Trust introduced a model of clinical leadership in 2014/15 based around seven service lines to improve the engagement of clinical staff and their teams in leadership roles to drive quality improvements. The changes were implemented to develop a leadership and management structure that makes WLMHT more accountable to its stakeholders including patients, carers, commissioners and staff. The service line structure is settled and the new arrangements are developing the organisation to be more efficient, leaner and transparent.

The Trust is spread across 7 service lines with appointed clinical directors leading the services:

- High Secure Services
- West London Forensic Services
- Access and Urgent Care
- Liaison and Long Term Conditions
- Primary and Planned Care
- Cognitive, Impairment and Dementia Services
- 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.

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 Carers' Trust 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.

In 2015/16 the Quality Committee delegated responsibility to the Central Governance Team to monitor the implementation and progress made by each area in achieving their selected milestones and targets to ensure successful completion; this was achieved and this monitoring process continues in 2017/18.

In the tables below you will read about the targets we have set out for 2017/18:

Priority	Key milestones Q1	Key milestones Q2	Key milestones Q3	Key milestones Q4	Reporting Method
Patient Safety					
We will be proactive in monitoring the physical healthcare of service users and respond appropriate-ly when a risk is identified Linked to CQC Should Action AUCr17 Linked to Local Services CQUIN '3a Improving physical healthcare to reduce premature mortality in people with serious mental illness' Linked to CQC MUST Action PPr01	• Plan setting up physical healthcare (PHC) screening clinics • Matrons will ensure that standards and resulting actions are clear to all ward staff completing NEWS. Matrons will escalate areas of concern to the PHC Committee. • CQUIN - Cardio metabolic assessment and treatment for patients with psychoses • Appointment of matron for community services with remit for PHC	• Implementation of PHC clinics • Conduct regular NEWS audits • NEWS exceptions report to PHC committee • Collate and review NEWS audit data • Follow the quarterly targets set out for the CQUIN • Progress report to the PHC committee of work undertaken by the newly appointed PHC matron	• Monitor effective ness of PHC clinics • Produce an action plan for areas identified from the NEWS audit • Follow the quarterly targets set out for the CQUIN • Update report to the PHC committee of work undertaken by the newly appointed PHC matron	• Provide a 6 monthly update report on the progress of the implementation of the PHC clinics • Implement action plan for areas identified from the NEWS audit • Follow the quarterly targets set out for the CQUIN • Update report the PHC committee of work undertaken by the newly appointed PHC matron	Progress update report on PHC clinics • Audit report • Evidence submitted to the CCG fo CQUIN PHC committee exception reports
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 Linked to CQC Quality Improvement Plan in 2015 Should do action WLFS04b	• Continue monthly rapid tranquilisa tion audit • Support nursing teams to undertake medication competency assessment and required actions	• Review recommen-dations from rapid tranquilisation audit and implement • Present findings at the restrictive interventions reduction review and monitoring committee • Assess results from competency assess-ment and devise an action plan where necessary	• Monitor the implementation of recommendations • Implement actions from the competency assessments action plan	• Re-audit to see if recommendations have made a difference in practice • Produce a report which clearly identifies improve ments in care	• Audit report for rapid tranquilisa tion • Competency assess ment report • Restrictive interventions reduction review and monitoring committee minutes

Priority	Key milestones Q1	Key milestones Q2	Key milestones Q3	Key milestones Q4	Reporting Method
To ensure that the Trust has a positive and open culture of reporting incidents and implementing and embedding the lessons that are learnt	Ensure staff have embedded the newly revised Incident Reporting & Management Policy across the services and offer training where needed Maintain weekly Serious Untoward Incident clinic Disseminate learning lessons via vignettes – through clinical leads/service directors & Clinical Director Newsletter Review current method for learning lessons from incidents	Increase incident reporting across the organisation Monitor number of incidents reported and compare against Q2 in 2015/16 Maintain positive reporting trend Agree methods for sharing learning lessons based on finding of review in Q1 and measure impact. Pilot arrangements	Monitor number of incidents reported and compare against Q3 in 2015/16 Maintain positive reporting trend Implement agreed systems for sharing learning. Evaluate pilot	Monitor number of incidents reported and compare against Q4 in 2015/16 Maintain Positive reporting trend Roll out revised methods for sharing learning lessons to all wards	Senior Management Team Minutes Training record Increase Incident Reporting Review Report Review and highlight staff survey results around incident reporting Paper: Pilot evaluation and confirmation of roll out
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 Linked to CQC MUST Action QICQCr01	• Audit toolkit to be designed and Lead identified • Evaluate whether all supervisors are trained in the process of recording supervision on RiO	• Audit on Personal Development Reviews/Supervision compliance will take place in August 2017 • Proposal to Quality Committee to include Manchester Clinical Supervision Scale (MCSS) in annual PDR to measure the quality of supervision	• Audit results will be shared at the Senior Management Team meetings and action plan implemented as required • Progress roll out use of MCSS	• Action plan reviewed and updated and a progress report submitted • Evaluate findings of use of MCSS	• Audit report • Action plan • Progress report
Effective:					
Clinical services will measure the effectiveness of treatment against clearly defined outcome measures	Service managers and pathway leads will identify all current outcome measures	Review and agree current outcome measures including those reported externally to the CCG's	Implement agreed outcome measures	Produce a end of year report which reports on the implementation of the outcome measures across the services	- Progress update report - End of year report

Priority	Key milestones Q1	Key milestones Q2	Key milestones Q3	Key milestones Q4	Reporting Method
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	• Identify all current care pathways across the organisation • Develop operation-al policies for all services with clear referral route and identified care pathways	• Undertake a review of services without appropriate care pathways	• Develop care pathways for services which have been identified in the review	• Document care pathways within the appropriate operation policies	6 monthly care pathway progress report
Caring:					
Using the Triangle of Care the Trust will improve the inclusion of carers Linked to CQC Should Action QICQCr02	• Launch Triangle of Care to raise awareness • Continue member-ship of collaborative Trust-wide Triangle of Care forum involving service users and carers	• Completion of Triangle of Care self-assessment tool for all inpatient wards	• Develop action plan following comple tion of Triangle of Care self-assess ment tool on wards	• Report progress against action plan and provide a forward view of the next steps	• Self-assessment report • Action plan • Progress report
Services will work collaboratively with service users to reduce the use of restrictive interven-tions including physical restraint, seclusion and long-term segrega-tion Linked to CQUIN Reducing restrictive practices within adult Low and medium secure services Linked to CQC Must Action QICQCr27b	The following targets are part of a 2year CQUIN which started in 2016/17: • Compare full year of data and utilise in planning • Share experiences and finalise best practice guidance for all areas • Update plan for year 2 and repeat patient experience measures Appoint a lead for reducing restrictive practice	• Develop robust governance and evaluation to ensure long term sustainability • Disseminate practice nationally through a conference event which is co-pro duced by service users The lead for reducing restrictive practice will support service lines to develop a SMART plan detailing: • The approach to reducing restrictive practice, • What will be measured as an outcome.	• Benchmarking visits and review of each hospitals practice • Complete evaluation and full report on project including future recommendations Provide a 6 monthly progress update report on SMART plans	• Presentation of report, to each hospitals manage-ment team and other relevant forums Implement any actions leading from the SMART plans	CQUIN report CQC Quality Improvement Action Plan Progress update report

Delivering our quality improvement programme

The Trust's continuous driver has always been to improve the quality of services it provides to the community it serves and therefore the Trust has made some positive steps towards building a culture of continuous quality improvement, using a recognised quality improvement methodology.

Following a diagnostic review by the Institute for Healthcare Improvement (IHI), the Trust has taken several initiatives to increase the knowledge and capacity to be able implement quality improvement methodology within the Trust.

During 2016/17, the Trust has invested in four members of staff to undertake the Improvement Advisor (IA) training. This intensive and in-depth 10 month professional development programme run by the IHI offers training in the science of quality improvement and requires on-going investment from the IA and the Trust to utilise the wealth of expertise gained through this training.

For the duration of the IA training each trainee has been expected to devote a minimum of 20% of their time to the course whilst developing skills through project work. The Trust has further invested in four additional places on this programme next year (2017/18).

The Trust also supported two senior staff undertaking the Quality Service Improvement Redesign (QSIR) Practitioner and Teaching Associate training with the Advancing Change and Transformation Team at NHS Improvement. This is was an intensive course to train staff to be able to deliver quality improvement training. The trainers have commenced delivery of the practitioner programme within the Trust and have completed training for cohort 1. Thirty-five staff have been trained working in eight project groups to deliver a quality improvement project within their service area or ward. The Trust is investing in training additional teaching associates to enable roll out of the programme further. Cohort 2 will commence in May 2017.

The Trust is excited about the quality improvement projects currently underway through the IA and the QSIR practitioner programme and expects an increase in the number projects through additional cohorts of QSIR training. The Trust is aiming for 30-50 registered and coached QI projects by 2018. We are eager to share this learning across our organisation. Some examples of the current projects underway include; reducing restrictive practice and violence reduction.

The Trust has committed to the delivery and participation of teams in the QSIR practitioner programme. This is a practical development programme that gives staff the skills and confidence to roll out proven service and quality improvement techniques. This programme will help support the development of our Trust's quality improvement capability and capacity by providing staff with the know-how to design and implement more efficient and productive services. The programme has been designed to help both clinical and operational staff across the NHS to deliver the quality agenda.

The Trust has also invested in a one day data presentation workshop facilitated by the IHI to teach and train staff in the use of statistical process control which also supports quality improvement capability and capacity. The Trust followed up this one day workshop with a half day workshop presented by the Trust's improvement advisors and there are plans to run this workshop on a quarterly basis.

During this whole process the Trust has made a number of links with other organisations including the Collaboration for Leadership in Health Research and Care (CLAHRC), Imperial College London, East London Foundation Trust, NHS Improvement and IHI, and our staff are involved in a number of initiatives including the London wide MH Improve.

We are more than pleased with the progress made at this early stage of our quality improvement methodology journey and we are happy with the enthusiasm and commitment this has already generated within our Trust. We look forward to reporting our progress in our quality account in 2017/18.

Statements of assurance from the board

Review of services

During 2016/17 the WLMHT provided and/or sub-contracted 10 relevant health services.

The WLMHT 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 2016/17 represents 100 per cent of the total income generated from the provision of relevant health services by the WLMHT for 2016/17.

Participation in clinical audits

During 2016/17, 5 national clinical audits and 1 national confidential enquiry covered relevant health services that WLMHT provides.

During 2016/17 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.

The national clinical audits and national confidential enquiries that WLMHT was eligible to participate in during 2016/2017 were as follows:	
National clinical audits	Prescribing Observatory Mental Health-UK (POMH-UK): Prescribing in mental health services.
National confidential enquiries	The National Confidential Inquiry into Suicide and Homicide for People with Mental Health Illness (NCISH).

> "They were friendly and happy"

National Clinical Audits

Prescribing Observatory Mental Health-UK (POMH-UK): prescribing in mental health services:

- POMH-UK QIP 11c: Prescribing antipsychotic medication for people with dementia.
- POMH-UK QIP 7e: Monitoring of patient prescribed lithium.
- POMH-UK QIP 16a: Rapid Tranquillisation.
- POMH-UK QIP 1g and 3d: Prescribing high dose and combined antipsychotics.

The national clinical audits and national confidential inquiries that WLMHT participated in, and for which data collection was completed during 2016/17, 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.

Name of National Clinical Audit	Number Submitted	%
POMH-UK QIP 11c: Prescribing antipsychotic medication for people with dementia	144	100%
POMH-UK QIP 7e: Monitoring of patient prescribed lithium	26	50%
POMH-UK QIP 16a: Rapid Tranquillisation	Tbc*	Tbc*
POMH-UK QIP 1g and 3d: Prescribing high dose and combined antipsychotics	Tbc*	Tbc*
Name of National Confidential Inquiry		
The Confidential Inquiry into Suicide and Homicide by People with Mental Illness (CISH)	9	93%

**We have not received the report from the Prescribing Observatory for Mental Health (POMH-UK) for this project yet*

The reports of 2 national clinical audits were reviewed by the provider in 2016/17 and WLMHT intends to take the following actions to improve the quality of healthcare provided:

1. **POMH-UK QIP 11c:** Prescribing antipsychotic medication for people with dementia
   Data collection: April 2016
   Report due: December 2016
   Lead: Phillip Morris

Audit standards:

- The clinical indications (target symptoms) for antipsychotic treatment should be clearly documented in the clinical records
- Before prescribing antipsychotic medication for behavioural and psychological symptoms in dementia (BPSD), likely factors that may generate, aggravate or improve such behaviours should be considered
- The potential risks and benefits of antipsychotic medication should be considered and documented by the clinical team, prior to initiation
- The potential risks and benefits of antipsychotic medication should be discussed with the patient and/or carer(s), prior to initiation
- Medication should be regularly reviewed, and the outcome of the review should be documented in the clinical records. The medication review should take account of:
  - Therapeutic response
  - Possible adverse effects.

Actions taken prior to re-audit:

- Report presented at the Local Services Clinical Audit Committee.
- Documentation of clinical reasons for prescribing antipsychotics was consistently good across all three audits and practice was generally in line with NICE dementia guideline recommendations – this was communicated across the service line as good practice.
- There was documented discussion of the risks and benefits of antipsychotic treatment with the patient and/ or carer in three-fifths of cases. The service line is working on improving this result.

2. **POMH-UK QIP 7e:** Monitoring of patient prescribed lithium
   Data collection: September 2016
   Report due: February 2017
   Lead: Clare Harris

Audit standards:

- The following tests/measures should be completed before initiating treatment with lithium:
  - Renal function tests; e-GFR or creatinine clearance
  - Thyroid function tests (TFTs) and serum calcium
  - Weight or BMI
- The following tests/measures should be conducted during maintenance treatment:
  - Serum lithium level every 6 months
  - Renal function tests (e-GFR), serum calcium, and thyroid function tests every 6 months
  - Weight or BMI during the last year

Actions taken prior to re-audit:
Section to be completed by Friday 21st ready for the consultation

The reports of 9 local clinical audits were reviewed by the provider in 2015/16 and WLMHT intends to take the following actions to improve the quality of healthcare provided.

3. **POMH-UK QIP 16a:** Rapid Tranquillisation
   Data collection: November 2016
   Report due: June 2017
   Lead: Priscilla St.Croix

Audit standards:
Following an episode of rapid tranquillisation:

- There should be a prompt debrief, involving, as a minimum, a nurse and a doctor, to identify and address physical harm to patients or staff, on-going risks and the emotional impact on patients and staff, including witnesses.
- Within a week, the patient's written care plan should address the management of episodes of disturbed behaviour.
- Within a week, a patient's written care plan should acknowledge his/her preferences and wishes should they become behaviourally disturbed again.

- Intramuscular haloperidol should not be used as part of rapid tranquillisation in the absence of a recent ECG. for Mental Health (POMH-UK) for this project
- Following rapid tranquillisation, the patient should be monitored at least every hour on the following measures, until there are no further concerns: mental and behavioural state (behaviourally disturbed/agitated, asleep or awake, impairment of consciousness);
- Physical observations (pulse, blood pressure, respiratory rate, temperature).
- Such monitoring should occur every 15 minutes if any of the following apply:
- British National Formulary (BNF) maximum dose has been exceeded;
- The patient appears to be asleep or sedated, has taken illicit drugs or alcohol, has a pre-existing physical health problem and/or has experienced any harm as a result of any restrictive intervention.

Actions taken prior to re-audit:

- Report presented at the local clinical audit committees
- The number of cases submitted for this project was low, one of the recommendations is to submit more data in the re-audit to gain a representable sample of the prescribing practice across the Trust
- Individual results were shared with the teams which submitted data

4. **POMH-UK QIP 1g and 3d:** Prescribing high dose and combined antipsychotics
   Data collection: March 2017
   Report due: July 2017
   Lead: Priscilla St.Croix

Audit standards:

- The dose of an individual antipsychotic should be within its SPC/BNF limits
- Individuals receive only one antipsychotic at a time
- Where high-dose antipsychotics are prescribed, there should be a clear plan for regular clinical review which includes safety monitoring

Actions taken prior to re-audit:

- Awaiting report from the Prescribing Observatory for Mental Health (POMH-UK) for this project.

The reports of 9 Trust-wide clinical audits were reviewed by the provider in 2016/17. *(Described in the table below)*

Audit	Lead	Actions & Audit Frequency	Standards	Areas
NICE Infection control Trust-wide	Director Of Nursing and Patient Experience and Infection Control Lead	Actions not yet available	NICE Clinical Guideline 139	Annual
Hand Hygiene	Director Of Nursing and Patient Experience and Infection Control Lead	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	Standards for this audit are taken directly from the Hand Hygiene Policy ICP5	Trust-wide
NICE guideline 29 pressure ulcer	Director of Primary Care	Report not yet available Adhoc	NICE guideline 29 pressure ulcer	Trust-wide
Clinical coding annual primary and secondary IC10 coding Inpatients	Medical Director	Recommendation set out by the London Clinical Coding Academy was to employ a coder – this action was followed	Primary and secondary IC10 Coding	Inpatients

Audit	Lead	Actions & Audit Frequency	Standards	Areas
Senior nurse walkabout checklist	Director of Nursing and Patient Experience	Local leads are to ensure that the checklist is completed monthly for each ward and areas of concerned are acted upon immediately Monthly	The standards within this audit are derived from National and Trust-wide safety polices, guidelines and procedures and local ward operational polices	Inpatients
MRSA	Director of Nursing and Patient Experience + Infection Control Lead	Further training on completion of audit tool following discrepancies within data submitted Quarterly	ICP12 MRSA Policy Section 7	Inpatients
Community survey	Director of Nursing and Patient Experience	Quality improvement plan complete Annual	Survey	Community services
Inpatient survey	Director of Nursing and Experience	Quality improvement plan complete Annual	Survey	Inpatient services
Omitted doses	Chief Pharmacist	Findings are disseminated to service lines for development of local action plans and implementation Annual	100% of prescription charts will have all administration boxes for regular medication completed with either a code or a signature	Trust-wide
Allergy status completion on inpatient prescription charts	Chief Pharmacist	Findings and action plan disseminated to service leads for implementation	00% of inpatient prescription charts will have allergy status completed	Inpatients
Medicines management compliance audit	Chief Pharmacist	Annual		Trust-wide
Audit of antimicrobial prescribing	Chief Pharmacist	Annual		High Secure Services, Liaison and Long Term Conditions, Cognitive Impairment and Dementia Service, West London Forensic Services, Planned and Primary Care
Controlled drugs audit	Chief Pharmacist	Quarterly		High Secure Services, Liaison and Long Term Conditions, Cognitive Impairment and Dementia Service, West London Forensic Services, Planned and Primary Care

Audit	Lead	Actions & Audit Frequency	Standards	Areas
Rapid tranquilisation	Chief Pharmacist	Findings and action plan disseminated to service leads for implementation Annual	100% compliance to standards outlined in the Trust rapid tranquilisation policy (R10)	High Secure Services, Liaison and Long Term Conditions, Cognitive Impairment and Dementia Service, West London Forensic Services, Planned and Primary Care
NICE Clinical Guideline 138	Information Governance Manager	To increase communication to staff, patients and service users around the need to share information and actively involve patients and service users in their care and management of their data.	NICE clinical guideline 138 Quality standard 15 statements 12 and 13 Annual	Trust-wide

Accreditation Programmes

The Trust was involved in 6 service accreditation programmes in 2016/17 which have all been accredited, 5 of our services have been awarded with excellence.

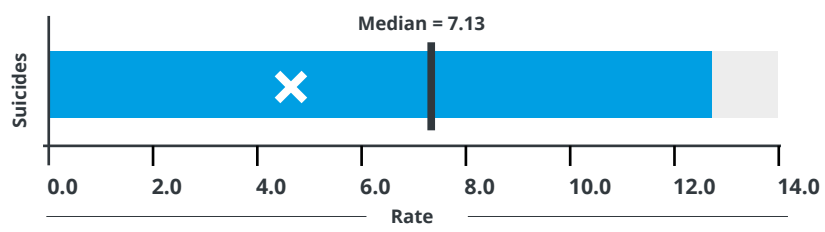
Service Accreditation Programmes WLMHT has been involved in	
MSNAP: Memory services national accreditation project	2 services
PLAN: Psychiatric liaison accreditation network	2 services
ECTAS: Electro convulsive therapy accreditation service	1 service
QNIC: Quality Network for Inpatient CAMHS (Child and Adolescent Community Mental Health Services) in mid accreditation process	1 service
AIMS PICU: Psychiatric intensive care units	1 service
AIMS Rehab: Rehabilitation wards	2 services

National Confidential Enquiries

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.

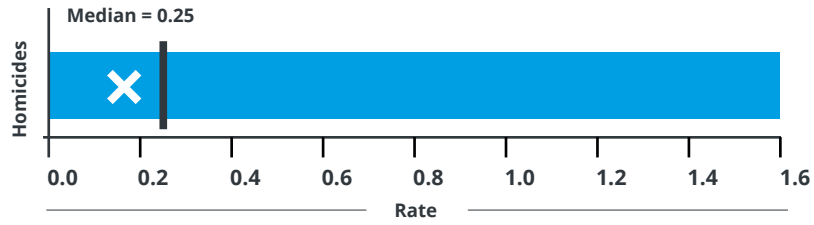
The information in the scorecard is based on data that the Trust provided NCISH. The scorecard consists of 6 indicators: suicide rate, homicide rate, rate of sudden unexplained death (SUD), patients under the care programme approach (CPA), staff turnover and NCISH questionnaire response rate. The CPA 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: 2012/2014 for suicides, homicides and sudden unexplained deaths (SUD), 2015/16 for people on the care programme approach (CPA), 31 October 2015 – 31 October 2016 for non-medical staff turnover and 2012/16 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 4.3 (per 10,000 people under mental healthcare) between 2012-14.

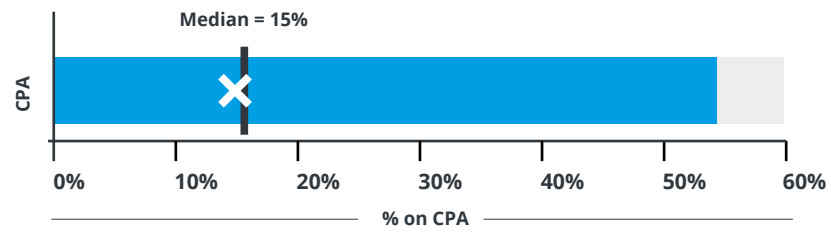


Homicide rate

The homicide rate was 0.1 (per 10,000 people under mental healthcare) between 2012-14

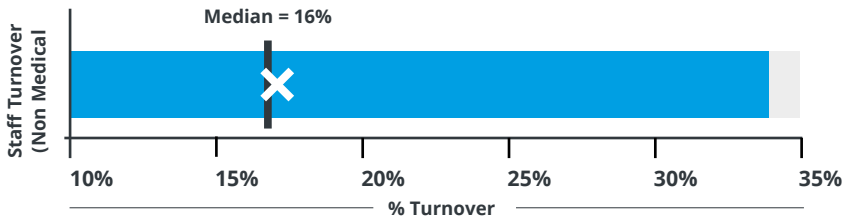
Sudden unexplained deaths (SUD)

The SUD rate was 3.8 (per 10,000 hospital admissions) between 2012-14



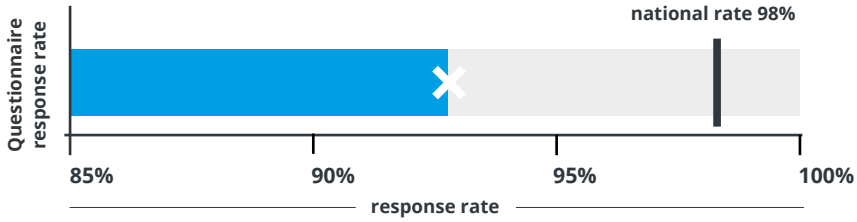
% on Care Programme Approach (CPA)

The % of patients on CPA was 14% in 2015-16.



Staff Turnover

Non-medical staff turnover was 16% between 31 October 2015 – 31 October 2016.



NCISH questionnaire response rate

You have returned 93% of NCISH questionnaires between 2012-16.

Internal audit reports

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:

No assurance:
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.

Partial assurance:
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.

Reasonable assurance:
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.

Substantial assurance:
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.

Temporary Staff and Rostering
The result from this audit produced a Reasonable 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.

The Trust has produced a list of approved agencies which is maintained and reviewed on a regular basis by the Head of Temporary Staffing and the Head of Procurement.

In total two low priority recommendations were made for improvement.

Lone Working – Local Services CSU
The result from this audit produced a Partial Assurance rating.

During the re-inspection of the Trust, the CQC raised an issue with non-compliance around the use of devices. In order to support the management of lone workers, loan worker devices have been obtained as part of a Government scheme in order to provide additional support to staff seeing patients in a community setting.

In total 6 medium and 2 low priority recommendations were made.

In response, a Lone Working Policy has been produced and a data cleanse will be carried out to ensure the Trust isn't paying for devices that are non-operable or unused. .

Serious Incident Action Management and Reporting
The result from this audit produced a Partial Assurance rating.

The review focused predominantly on identifying the root cause of serious incidents, how many gaps were actioned and how these actions were monitored for implementation and outcomes desired.

In total, 1 high, 4 medium and 1 low priority recommendations were made.

The audit concluded that it did not identify the effectiveness of action plans in place to prevent future incidents, just that action points have been developed and are being monitored for implementation and that the Trust has analysed the effectiveness of implementing those.

Risk Management and Board Assurance Framework
The result from this audit produced a Partial Assurance rating.

The audit was carried out and out of the 19 risks on the BAF, 8 were rated as extremely high risks (red) and 11 were rated as high risks (amber).

In total, six medium rated management actions were raised in relation to the design and application of the control framework.

Home Ward Ealing Service
The result from this audit produced a Partial assurance rating.

The service has been set up with the aim of helping patients through a period of severe or sudden illness or when they have been discharged from a general hospital so that they can recover and remain well at home. The audit was carried out as the service was not meeting targets agreed in key performance indicators and was exceeding the budget. 8 KPIs were monitored against a performance target, 1 was exceeding the target set and 7 showed performance below target.

1 high, 2 medium and 1 low priority actions were raised in relation to the design of the control framework. 1 high priority action was raised in relation to the application of and compliance with the control framework.

Medical Job Planning
The result from this audit produced a Partial assurance rating.

The Trust's target for 2016/17 was set at 85% for Consultants and Specialty and Associate Specialist Doctors to have job plans in place. Due to the Trust achieving 72% of the target, a review was carried out.

1 medium priority action was raised to reflect this issue.

> "Visiting students expressed their thanks to the Centralised Groupwork Service for making their trip " a uniquely unparalleled experience "

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by WLMHT in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 611 (839 in 2015/16).

Throughout the year, the Trust has been involved in 90 studies (66 in 2015/16); 62 were funded (32 in 2015/16) of which 10 were commercial trials (3 in 2015/16), and 28 were unfunded (34 in 2015/16).

Over the past year researchers associated with the Trust have published 53 articles (68 in 2015/16) in peer reviewed journals.

The comparative data above shows there to be a significant fall in patients in trials in 2016/17 this was because of the early and unexpected closure of the largest Alzheimer's drug trial last year, however we have a number of other trials in the pipeline which will show a significant increase during 2017/18.

The number of trials overall has bounced back. The number of published articles is lower: WLMHT is working with Imperial to recruit to clinical academic posts, as anticipated in their mental health research strategy review in 2015. This has taken longer than the Trust has originally hoped.

Commissioning for Quality and Innovation (CQUIN)

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 will work with our local commissioners to ensure that plans are aligned with local commissioning strategies.

A proportion of WLMHT income in 2016/17 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 2016/17 and for the following 12 month period will be available on our Trust website: **www.wlmht.nhs.uk/**

Local Services

The following CQUIN targets were set for Local Services in 2016/17, including 1 national and 1 regional CQUIN and this is how they measured.

Local Services CSU Ealing, Hammersmith & Fulham and Hounslow	**Q1**	**Q2**	**Q3**	**Q4**
N2: Delivering excellence in physical healthcare:	Met	N/A	N/A	N/A
Agreement of clinical tools to be utilised against evidence base and for clinical setting – the Trust has initially suggested the National Early Warning System (NEWS) and SBARD (Situation, Background, Assessment, Recommendation, Decision)	Met	N/A	N/A	N/A
Description of the training required to meet standards	Met	N/A	N/A	N/A
Description of policies and procedures to be modified	Met	N/A	Awaiting final confirmation from CCG	N/A
Service user consultation on standards of care they can expects as inpatients	N/A	Met	Awaiting final confirmation from CCG	N/A
80% of trained nurse and healthcare assistants employed in inpatient services to be trained in tool (NEWS current proposal)	N/A	Met	Awaiting final confirmation from CCG	N/A
Baseline audit of the tool's usage on inpatient wards to monitor effective scoring and appropriate use of the tool	N/A	Met	Awaiting final confirmation from CCG	N/A
NEWS tool practice audit completed, compared against baseline with recommendations for improved practice (on-going)	N/A	N/A	N/A	Evidence recently submitted

Local Services CSU Ealing, Hammersmith & Fulham and Hounslow	Q1	Q2	Q3	Q4
Development of an audit to assess the effective use of the SBARD tool in handover on inpatient wards. (For SBARD an observational audit will be developed and agreed in Q3 for completion in Q4*)	N/A	N/A	N/A	Evidence recently submitted
Physical healthcare guideline reviewed	N/A	N/A	N/A	Evidence recently submitted
Draft diabetes guideline in place	N/A	N/A	N/A	Met
R2: Caseload Review: Agreement and pilot of checklist criteria	Met	N/A	N/A	N/A
Agreement of SSoC baselines	Met	N/A	N/A	N/A
Review of CPA caseloads (all clusters) started	Met	N/A	N/A	N/A
Review of LPC caseloads – cluster 3, 4, 11 started	Met	N/A	N/A	N/A
100% of CPA caseloads (all clusters) completed	N/A	Met	N/A	N/A
90% of all LPC caseloads – cluster 3,and 4 completed	N/A	Met	N/A	N/A
Review of LPC caseloads – cluster 5 and 6 started	N/A	Met	N/A	N/A
90% of all LPC caseloads – cluster 11, 5 and 6 completed	N/A	N/A	Awaiting final confirmation from CCG	N/A
90% of all LPC caseloads – cluster 7, 8 and 12 completed	N/A	N/A	Awaiting final confirmation from CCG	N/A

West London Forensic Services

The following CQUIN targets were set for West London Forensic Services in 2016/17, including 1 national and 2 local CQUINs and this is how they measured.

West London Forensic Services	Q1	Q2	Q3	Q4
Reducing Restrictive Practices within Adult Low and Medium Secure Services	Met	Met	Met	Met
Improving CAMHS Care Pathway Journeys by Enhancing the Experience of Family/Care	Met	Met	Met	Met
Medium and Low Secure	Met	Met	Met	Met

High Secure Services

The following CQUIN targets were set for High Secure Services in 2016/17, including 3 national and 1 local CQUIN and this is how they measured.

High Secure Services	Q1	Q2	Q3	Q4
MH1 Patient ward communities, implementing "sense of community" in high secure wards	Met	Met	Met	Met
MH2 Innovations to improve physical health for patients in high secure services	Met	Met	Met	Met
MH3 Improve service user experience and maintain safe services in high secure services – 2 year CQUIN scheme.	Met	Met	Met	Met
MH4 Training and development of nursing staff in dealing with physical health needs of patients in high secure services.	Met	Met	Met	Met

Care Quality Commission (CQC) compliance

WLMHT is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without conditions'.

The Care Quality Commission issued one enforcement action against West London Mental Health NHS Trust during 2016/17. This was issued in December 2016 and outlines significant improvements that need to be made within 6 months by high secure services in relation to staffing and how this impacts on patient care.

WLMHT has not participated in any special reviews or investigations by the Care Quality Commission during this reporting period.

During 2016/17 the CQC inspectors visited 27 of our services areas across the Trust. Of these visits 17 of them were unannounced and 10 of them were announced:

- 20 London sites
- 7 Broadmoor Hospital

In November 2016 the Care Quality Commission (CQC) carried out its planned re-inspection of the Trust, which resulted in the Trust receiving an overall rating of 'requires improvement'. You can see the CQC rating grid below for further detail.

The CQC report outlines clear improvements that the Trust made following the June 2015 inspection, however it also highlights areas that require prompt focus to further improve the services we provide.

You can read our full report on the Care Quality Commission website by clicking on this link: **http://www.cqc.org.uk/provider/RKL**

The Trust has developed a quality improvement plan in response to the CQC's findings; there is an overarching Trust-wide plan, which is underpinned by local service line quality improvement plans. The action plan arising from the June 2015 CQC inspection has been reviewed and any outstanding long terms actions have been incorporated into the new plan. The quality improvement actions have been developed in collaboration with staff, service users and partners, and fully respond to the CQC's recommendations and requirements. Our central governance team is responsible for overseeing the quality improvement plan and has a robust system in place to monitor its delivery.

Out of the 169 actions we have chosen 4 'must do' actions from our quality improvement plan which are linked to the key areas which the CQC identified as requiring improvement.

Overall Rating	Requires Improvement	
Safe	Requires Improvement	
Effective	Requires Improvement	
Caring	Good	
Responsive	Requires Improvement	
Well-led	Requires Improvement	

Safe

Status	Must do action
Report findings	The Trust must continue to work to reduce the variation in the use of restraint and the numbers of prone restraint used across the Trust.
Summary of action	The director of nursing will provide a six monthly update to the Board of Directors on progress against service line's SMART reducing restrictive practice plan and escalate any issues of concern.
People will experience...	The Board will have good oversight of the nature and number of restraints across the Trust.
Responsible Lead	Interim executive director of nursing
Date for completion of process action	Process phase deadline June 2017
Date for implementation of practice change	Practice change deadline June 2017
Date of embeddedness review	Embeddedness phase deadline Dec 2017

Effective

Status	Must do action
Report findings	The Trust must ensure the processes for staff supervision are implemented consistently across the directorates, to ensure this happens regularly, covers the appropriate areas for discussion and is recorded for future reference.
Summary of action	The supervision policy and relevant supporting documents will be reviewed by the deputy director of nursing (corporate). One outcome of the review will be an implementation plan of how quality standards will be implemented and monitored in each service line.
People will experience...	Staff will experience consistent high quality supervision
Responsible Lead	Deputy director of nursing (Corporate)
Date for completion of process action	Process phase deadline February 2017
Date for implementation of practice change	Practice change deadline June 2017
Date of embeddedness review	Embeddedness phase deadline November 2017

> "MC - Pt thanked staff for the care they show her. She has had poor physical health of late and expressed thanks to staff for their efforts in doing everything possible to ensure she stays well."

Responsiveness

Status	Must do action
Report findings	The Trust must ensure that sufficient beds are available for patients on each ward and patients are not admitted to one ward and then sleep on another ward during their admission.
Summary of action	The head of inpatient care will be responsible for eliminating the practice of sleepovers from acute beds by April 2017.
People will experience...	Patients will have a bed in the appropriate setting on admission without unacceptable delay.
Responsible Lead	Head of Inpatient Care
Date for completion of process action	Process phase deadline March 2017
Date for implementation of practice change	Practice change deadline March 2017
Date of embeddedness review	Embeddedness phase deadline June 2017

Well-Led

Status	Must do action
Report findings	The Trust must review the arrangements for ward and team managers to receive timely, accurate information, presented in a meaningful format to support them with the management of their areas of responsibility.
Summary of action	• The head of knowledge management will take responsibility for the development of an 'Information Exchange Page' to sign post staff to information currently available within the organisation and key contact leads for data/information. • Through a series of workshops with staff, the head of knowledge management will identify from each CIG/Ward/Team level - what type and level of information is required. A format of reports will be agreed to support managers working alongside Quality Improvement leads. Reports will also need to align to key priorities identified within service line action plans. • The head of knowledge management will take responsibility for the development of self-access business intelligence reports (this is subject to the approval of the business case proposed). A phased approach is planned based on data warehouse development – 1st phase is focusing on clinical dashboards. Outputs from action QICQC(r)24b will help scope initial phase reports required.
People will experience...	Staff will have ready access to meaningful data about their service.
Responsible Lead	Head of knowledge management
Date for completion of process action	Process phase deadline June 2017
Date for implementation of practice change	Practice change deadline December 2017
Date of embeddedness review	Embeddedness phase deadline March 2018

The governance arrangements to make improvements from this plan are robust and the process of implementation provides significant assurance in relation to the governance oversight of the quality improvement plan.

Duty of Candour

We have continued to build on Duty of Candour in 2016/17. To that end we are working with colleagues to ensure that the way we implement the Duty of Candour is meaningful and sensitive to people's needs at a time when things have gone wrong.

In April 2016 we launched our new incident reporting and management policy in which we included our duties and responsibilities in regards to the Duty of Candour.

The intention of the Duty of Candour is to ensure that providers are open and transparent in their communication with people in relation to care and treatment, specifically when things go wrong so that people are provided with reasonable support, truthful information and an apology.

The Trust wants to make this duty a reality for people who come into contact with our services. We want to ensure there is clear, strong organisational support for staff in being open and honest with patients, to reinforce our development of a wider culture of safety, learning and improvement.

Clinicians also have an ethical Duty of Candour under their professional registration to inform patients about errors and mistakes. The Trust fully supports the individual professional duty but is also placing an obligation on the Trust not just individual healthcare professionals to be open with patients when harm has been caused.

All staff must inform patients (and their carers subject to consent) of any incidents that have occurred with their care within 48 hours or as soon as is practicable, a full explanation of what has occurred and what actions are being taken to prevent re-occurrence is also given. Compliance with the duty is monitored via the Trust's incident reporting system, which now includes a mandatory field on the Duty of Candour. Additionally the governance leads support staff to ensure our duty is met. Compliance is reported via the serious incident reports which are presented to the Trust board and serious incident reports which are submitted and presented to the CCG clinical quality review groups.

During 2017/18 we aim to review our being open policy (which incorporates the Duty of Candour) in line with the latest recommendations from the CQC report 'Learning, candour and accountability' and the 'National Guidance on Learning from Deaths form the National Quality Board.

> "Wonderful, efficient & caring service. Many thanks to Jane for her calm professionalism, clear explanations and encouraging humour."

Quality indicators

The following section of the quality account describes how we have performed against a core set of indicators as set out NHS (quality accounts) amendment regulations 2012 related to NHS outcomes framework domains. We have reviewed these indicators and are pleased to provide you with 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.

	2016/17				2014/15			
	Q4*	Q3	Q2	Q1	Q4	Q3	Q2	Q1
WLMHT	95.00%	93.45%	94.59%	94.29%	96.69%	97.33%	95.66%	95.38%
National Average	n/a	96.72%	96.20%	96.79%	97.23%	96.91%	96.80%	97.00%
Highest Nationally	n/a	100%	100%	100%	100%	100%	100%	100%
Lowest Nationally	n/a	73.30%	76.90%	28.60%	80.00%	50.00%	83.40%	88.90%
WLMHT Annual Outturn	94.33%				96.27%			
Target	95%				95%			

Data Source: **http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/**
**n/a – data not available at date of publication ** taken from internal system as national data not available at date of publication*

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.

	2016/17				2015/16			
	Q4*	Q3	Q2	Q1	Q4	Q3	Q2	Q1
WLMHT	94.2%	91.8%	92.0%	94.4%	94.55%	95.75%	97.73%	97.42%
England Average	n/a	98.66%	98.40%	98.11%	98.18%	97.48%	96.97%	96.32%
England Highest Performer	n/a	100%	100%	100%	100%	100%	100%	100%
England Lowest Performer	n/a	88.30%	76.00%	78.90%	84.30%	61.90%	48.50%	18.30%
WLMHT Annual Outturn	93.49%				96.36%			
Target	95%				95%			

Data Source: **http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/**

**2016/17 Qtr-4 is reported via internal reports as published data is not available yet*

WLMHT considers that this data is as described for the following reasons: the data has been extracted from central Department of Health 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 and clinical services have undertook an in house audit and leading from the results and have begun a review of the current processes.
- VSMR (CPA 7 day follow ups and admissions via crisis resolution) process review will be completed in quarter 1 of 2017/18.

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 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 10% target.

	2016/17*	2015/16	2014/15	2013/14
0 to 14 years	0%	0%	0%	0%
15 years or over	7.5%	7.4%	6.7%	7.2%
Target	<10%	<10%	<10%	<10%

**2016/17 excludes Mar 2017 data*

WLMHT considers that this data is as described for the following reasons: the WLMHT figure is sourced locally from our clinical 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:

- Continue 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 2016 and is considered a reliable data source.

Measure	WLMHT Performance 2016	WLMHT Performance 2015	National average for MH Trusts	Highest MH Trust Score
Staff recommendation of the Trust as a place to work or receive treatment	3.55/5	3.46/5	3.62/5	3.96/5

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

- Continuing to be clear and consistent about our vision and strategy so that staff understand what the Trust is aiming to achieve and how their role contributes.
- Maintaining senior line management visibility through visits and listening forums.
- Furthering the work in engaging and developing managers to adopt a positive management style which encourages and rewards staff rather than one which restricts and controls.
- Embedding our values from the top down – through role modelling our values from the top of the organisation.
- Promoting and improving staff health and wellbeing within the workplace through a number of initiatives.
- Monthly Chief Executive blogs on our internal intranet page.
- Focusing on tackling unfairness, discrimination and bullying.

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.

CQC National Community Mental Health Service User Survey	2016	2015	Highest	Lowest
Did this person listen carefully to you?	7.6	8.0	9.2	8.2
Did this person take your views into account?	7.1	7.5	8.9	7.9
Did this person treat you with respect and dignity?	8.1	8.1	9.5	8.6
Were you given enough time to discuss your condition and treatment?	7.1	7.6	8.8	7.4
Overall, how would you rate the care you have received from NHS Mental Health Services in the last 12 months?	6.3	6.6	7.4	6.2

At the start of 2016, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 207 people at WLMHT.

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

- Posters will be displayed to help increase the response rate
- An action plan in relation to the 2016 survey has been co-produced with the Trust and West London Collaborative focussing on:
  - Care planning.
  - Staff communication.
  - Establishing a person centred approach.
  - Implementation of the Triangle of Care were action plans will be monitored at the Service User and Carer Experience (SUCE) meetings.

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.

Indicator	Performance	2016-17 Q3/Q4	2016-17 Q1/Q2	2015-16 Q3/Q4	2015-16 Q1/Q2
Severe harm/death	WLMHT	0.68% (15)*	0.62 (13)*	0.8% (17)	1.4% (29)
	National Average	n/a **	n/a **	Data not available until Apr	0.3% (492)
	Highest MHT	n/a **	n/a **	Data not available until Apr	2.5% (51)
	Lowest MHT	n/a **	n/a **	Data not available until Apr	0%

Data source: **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.

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

- Following up on the actions and recommendations from the review of the severe harm and death incidents.
- Improving system processes for quality checking and timeliness of reported date.
- Launch our new internal reporting system which simplifies the processes.
- WLMHT continues to hold learning lessons events where reporting incidents is the key theme throughout the day.

> "Wonderful, efficient & caring service. Many thanks to Jane for her calm professionalism, clear explanations and encouraging humour."

Quality indicators – other indicators

Delayed transfers of care

This indicator measures the percentage of inpatients 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. In 2016/17 there has been an increase in the percentage in our delayed discharges from 5.66% to 6.78%, still remaining within the target of <7.5%.

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

	2016/17*	2015/16	2014/15	2013/14	Target
% Delayed Transfers of care	6.60%	5.66%	3.91%	5.72%	<7.5%

**2016/17 excludes Mar 2017 data*

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 will be taking the following actions to improve data quality:

- The data quality managers continue to ensure data is complete and correct by working closely with clinicians to improve data recording processes and effective use of our clinical systems.
- On-going review of our information assurance framework which identifies gaps in controls or assurance with subsequent action plans.
- We will continue to review and monitor our internal and external benchmarking data.

> "Very happy with the services. Nurses are very caring and supportive."

NHS Number and General Medical Practice Code Validity

WLMHT submitted records during 2016/17 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:

- 98.9% for admitted patient care;
- 99.6% for outpatient care; and
- N/A for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care;
- 99.9% for outpatient care; and
- N/A for accident and emergency care.

Improving staff engagement

The Trust continues to hold regular listening events led by the chief executive and other executive directors where staff can talk through issues that concern them. There is a chief executive's blog, which attracts active feedback. The chief executive and other directors undertake regular 'walkabouts' and in the 2016 staff survey the percentage of staff reporting good communication between senior managers and staff has increased by 8%. The Trust will continue with this approach.

Workforce strategy

The Trust has a workforce strategy action plan which includes plans to:

- Develop and implement a recruitment and retention strategy that enables the Trust to compete successfully for shortage occupations.
- Ensures that there is a diverse and representative workforce at all levels of the organisation.
- Enables the Trust to focus on leadership and development that strengthens middle management and enhances the Trust's reputation as a place to thrive.
- Identify and implement opportunities for workforce development.
- Identify and implement opportunities for workforce efficiency and productivity gaining full benefits from electronic rostering and maximising size of staff bank.
- Implement a simple engagement plan and reduce bullying.
- Implement a patient centred workforce planning approach across the services and support transformation programmes.

There are a number of the above that have part of the overall action completed and the action plan should be fully embedded by December 2017.

Speak Up Guardian

In response to the national requirements to appoint a speak up guardian, the Trust has appointed the chair of the workforce and development committee, Professor Sally Glenn, non-executive director, has been appointed as speak up guardian. She has regular surgeries on all Trust sites. The Trust will also recruit a network of champions to support Sally.

National Staff Survey results

The national staff survey took place between September and November 2016 with the publication of results taking place in early March 2017. 1495 staff at WLMHT took part in this survey.

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

Trust score 2016	Trust score 2015	National average for mental health	Best 2016 score for mental health
36%	38%	33%	24%

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

Trust score 2016	Trust score 2015	National average for mental health	Best 2016 score for mental health
76%	71%	87%	94%

In the 2016 staff survey the Trust scored well on the following questions:

- Staff satisfaction with the quality of work and care they are able to deliver.
- Percentage of staff feeling unwell due to work related stress in the last 12 months.
- Quality of non-mandatory training, learning and development.
- Percentage of staff reporting good communication between senior management and staff.
- Quality of appraisals.

Staff experience had also improved in the following questions:

- Organisation and management interest in and action on health and wellbeing.
- Percentage of staff satisfied with the opportunities for flexible working patterns.
- Staff satisfaction with resourcing and support.

The Trust scored badly in the following areas:

- Percentage of staff experiencing physical violence from staff in the last 12 months.
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month.
- Percentage of staff experiencing discrimination at work in the last 12 months.
- Percentage of staff reporting most recent experience of violence.
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

Staff experience has deteriorated in the following areas:

- Percentage of staff attending work despite feeling unwell because they felt pressure from their manager, colleagues or themselves.
- Percentage of staff experiencing physical violence from patients, relatives or the public 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 concerning that the Trust continues to struggle with levels of bullying and discrimination reported through the staff survey. In addition the increase in reports of staff physical violence is of very grave concern. The Trust is reviewing the sources of information previously gathered including the detailed study undertaken by Middlesex University in 2008 and reviewed in 2011 and focus group work that has happened recently to understand the root of these concerns.

The staff survey information shows that the focus should be on inpatient wards and in the registered and unregistered nursing workforce. In 2008 staff spoke of cliques and favouritism and subtle but constant behaviour, largely from colleagues or managers. The Trust will find ways to address these everyday experiences for staff by training ward managers, managing shift allocation in a fair way and providing support to staff that have recently joined the Trust. The Trust will be actively supporting the UNISON call to action in response to bullying across the NHS.

Trust Partnership Forum

The Trust has reviewed the terms of reference for the Trust partnership forum and this now meets on a quarterly basis. Regular informal meetings also take place with staff side members and there is staff side representation on the dignity at work group.

> "Made me feel wanted. Good communication. Made me feel comfortable. Gave me confidence. They don't get enough credit."

The terms of reference for the Local Negotiating Committee, a forum with the British Medical Association (BMA), are being reviewed. The Trust continues to work with trade unions to deliver the workforce strategy action plan and in order to achieve:

- Delivering improved services to patients.
- Improved mutual understanding.
- An opportunity for partners to contribute their experience and ideas to the development and implementation of the workforce implications of policy on health.
- More effective implementation of policy and procedures.
- Ensuring high standards of employment practices.
- Providing a transparent and streamlined structure for Trade Union, employer and staff engagement.
- In addition local staff side monthly meetings are held in each CSU.

Leadership Forum

Quarterly leadership forums take place with the Trust's wider leadership team in order to shape the Trust's strategic direction and to share examples of quality improvement and innovation across the Trust.

Information Governance Toolkit

Information Governance is a combination of legal requirements, policy and best practice designed to ensure information capture, processing and storage are of the highest standards and protected from inappropriate disclosure.

Information Governance consists of the following:

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

Our self-assessment in 2016 using version 14 of the IG toolkit demonstrates the following compliance to level 2.

Assessment	Stage	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 13 (2016-2017)	Published	68%	Unsatisfactory	n/a	n/a
Version 12 (2015-2016)	Published	77%	Satisfactory	n/a	n/a

Out of the 45 IG toolkit requirements WLMHT has met:

- Level 1 for 1 requirement.
- Level 2 for 40 requirements and,
- Level 3 across 4.

We have put in place measures to ensure that the Trust hits the mandatory IG training target of 95% by 31st March 2018 and we will continue to work hard to move as many requirements as possible from level 2 to level 3.

Grade Key

Unsatisfactory	Not evidenced attainment Level 2 or above on all requirements.
Satisfactory with Improvement Plan	Not evidenced attainment Level 2 or above on all requirements but improvement actions provided.
Satisfactory	Evidenced Attainment Level 2 or above on all requirements.

Part 3: Other information - review of quality performance Message from the Medical Director, Dr José Romero-Urcelay

This year the Trust welcomed the Care Quality Commission (CQC) for our re-inspection. The outcome of this inspection was 'Requires Improvement' which again we felt was a fair assessment. They recognised the improvements we had made since we were last inspected. Staff have worked hard to improve our services over this reporting period and this was clearly documented throughout the CQC report.

The Trust has developed a new quality improvement plan in response to the CQC's findings, the quality improvement plan arising from the June 2015 CQC inspection has been reviewed and any outstanding long term actions have been incorporated into the new plan.

This year we set new quality priorities for 2017/18, these priorities are interlinked with our CQC quality improvement plans and we were pleased to receive the recognition for this from our commissioners who review our quality account.

We know as an organisation the importance of undertaking research as it is essential for us to develop and improve the care we provide. The Trust have been involved in some really interesting projects this year, and we made a commitment in making the opportunity to participate in research available to as many service users as possible. We recruited more service users in the SCANMOVE study than any other project, and you can read about this interesting study further on within the account.

In June 2016, our Trust was selected as one of a number of Trusts to be visited as part of the review by the CQC on investigating deaths across NHS mental health, acute and community settings. The Secretary of State for Health asked the CQC to undertake this review into the investigation of deaths in NHS Trusts in response to the Mazars report into deaths at Southern Health NHS Foundation Trust.

Their review visit to the Trust took place in August 2016, with their findings published in the 'Learning, Candour and Accountability Report' in December 2016. We have included these recommendations in our programme of work for 2017/18. Further tools and guidance are due to published during the spring of 2017 with the intention of improving practice.

Ahead of the further guidance and tools we have implemented some key improvements to our systems by revising our incident reporting and management policy which states that all patient deaths irrespective of cause constitute an incident initially and must be reported internally. We have also established a weekly mortality review group with the purpose of developing the internal governance processes for mortality review and to review selected cases for further consideration or a thematic review if required.

We continue on a journey to improve the quality of care we provide at Broadmoor Hospital, to enhance our services and create a more suitable and therapeutic environment for all patients. I am pleased to report that the redevelopment of Broadmoor Hospital is progressing well and is due to be completed in 2020.

Quality improvements have been clearly documented throughout this quality account and with the new innovative initiatives we have in the pipeline for 2017/18 I can only be excited about how much further we can progress in improving the quality of our services in the coming year. I personally would like to thank our staff, service users and stakeholders for their continued support; we can only succeed if we continue to work together.

What service users, carers and the public say - key messages and actions taken during 2015/16

We actively welcome feedback from service users and carers as we believe this helps to make improvements to the services we deliver. Following the review of our feedback mechanisms last year we have now settled in the Care Opinion as our main feedback source for service users and carers.

Care Opinion

Care Opinion is used by many NHS organisations to gather feedback about services. It is completely independent from the NHS therefore anyone can share their story about their experience which is then published on the Care Opinion website. The Trust is then able to respond to the comments within three working days. We are mindful that many of our patients do not have access to the internet so paper questionnaires are widely available; these are then returned to Care Opinion and published straight onto the website. There is a free telephone number which people can call, Monday to Friday between 9am and 5pm if they would prefer to give their feedback verbally, before it is posted on to the website.

In the reporting period 1st April 2016 to 31st March 2017, a total of 150 stories have been posted on Care Opinion. Compared with the previous year this is an increase of 116% (n=110). To date, the stories have been viewed on Care Opinion 24,350 times in all.

Avenue House – my mental illness and treatment

"I have a mental illness. My treatment is based at Avenue House, WLMHT. I've known my current psychiatrist since January 2015. I'm happy with my treatment. I'm always seen at the given time I. e. I've never had to wait in reception for long waiting to be seen. This promptness lowers my anxiety. My psychiatrist listens to me and respects my opinion. He advises me on the management of my mental illness. His advice helps to make my life easier. We get along well. Patients manage their mental illness better when they and their psychiatrist get along."

Butler House – my story

"My illness first surfaced in jail. I was abusing Class A drugs and I was a control problem. I was very paranoid when I was admitted to a top secure hospital. Many times I used violence towards members of staff and other patients. I hurt people that were closest to me. My illness is now under control through medication and a new approach to life. I am very well balanced and have learned good eye contact, good manners and know how to talk to people properly. I am now in a pre-discharge ward and looking forward to moving on soon."

Claybrook Centre - variable services over time, but currently v good

"I've found services to be variable depending on who you get to see, but the psychiatrist I'm seeing at the moment is brilliant and the staff at the Claybrook are always really friendly and helpful."

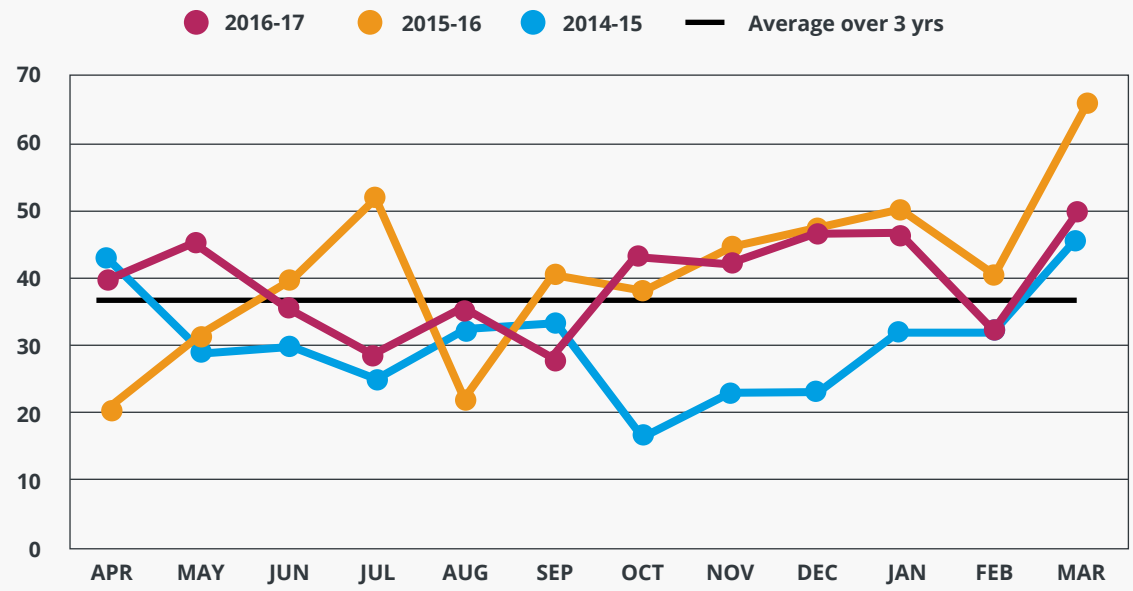
Ealing assessment team

"I needed to wait for an hour before I was seen due to an error regarding the previous appointment. This was not a positive start as it left me feeling very annoyed. Appointments should be carried out on time. If there is a delay, then patients should at the very least be telephoned before their appointment to make them aware. This definitely needs to be improved. It is a matter of respect. The waiting room is too hot, and the chairs are very uncomfortable so it felt like I was waiting for a lot longer than an hour.

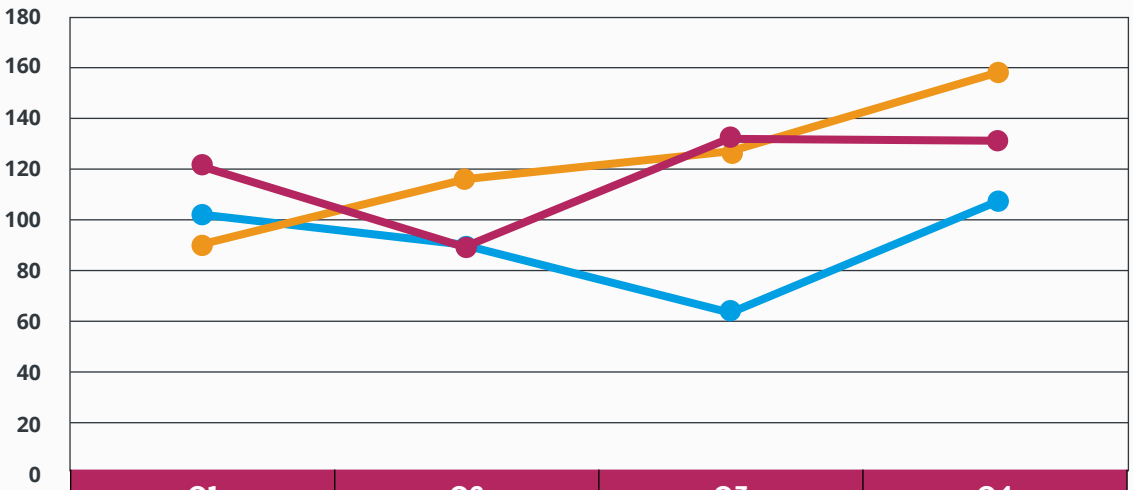
Complaints

During the reporting period, 1st April 2016 to 31st March 2017 a total of 472 complaints were raised compared with 484 in the previous year. This shows a slight decrease of 3% (n=12). The highest number of complaints received during 2016/17 was during quarter 3.

Number of complaints received over the last 3 years



Number of complaints received each quater



	Q1	Q2	Q3	Q4
2016/17	121	91	131	129
2015/16	90	112	126	156
2014/15	102	90	62	111

We consider it essential to respond to and seek to resolve complaints in a timely and effective way. Of the total 441 complaints investigated and closed to end of March 2017, 58% (n=254) were closed in time and 42% (n=187) were closed over the agreed timescale. Further work is needed to ensure all complaints are closed in time. A weekly report is produced for the executive director of nursing and patient experience highlighting all complaints raised, closed and overdue.

We aim to investigate all complaints thoroughly and provide responses within the agreed timeframe by providing complaint investigator training and closely monitoring the deadlines through reporting and benchmarking our performance against other Trust and national data.

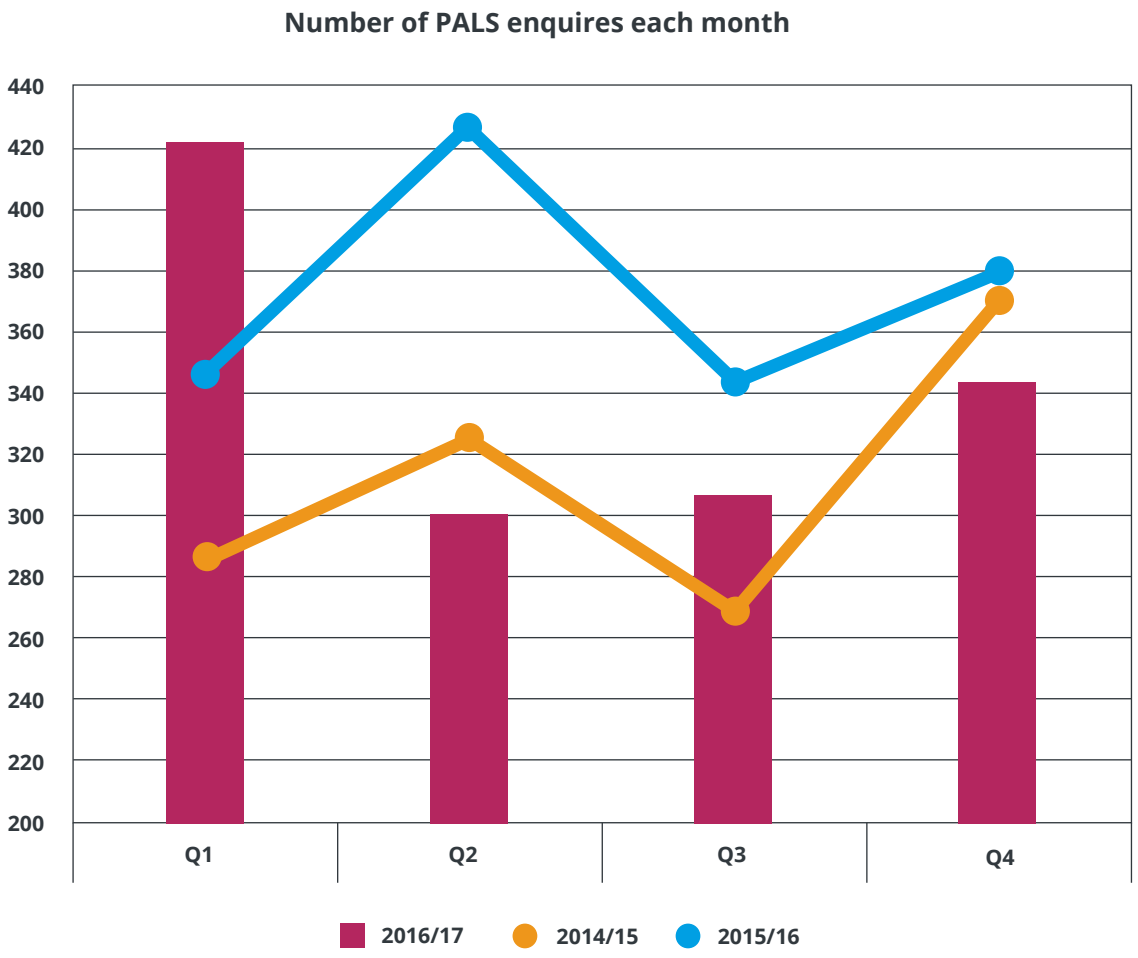
The highest number of complaint received are relating to two categories; 'All aspects of care and treatment' and 'staff attitude'. Further analysis of the data identified that the highest number of complaints under the category 'all aspects of care and treatment' were related to access to services. Staff attitude included complaints relating to unfair treatment from staff.

Example of complaints closed during 2016/17 is show in the table below:

Overview of complaint aspect	Transfer of this property has not been dealt with in a timely manner.
Outcome	Upheld.
Recommendation/s made and completed	Clinical nurse managers are to remind staff of the process that all property to be transferred within 24 hours and an overnight bag to be taken when the patient is transferred. This will be highlighted in the clinical nurse managers meeting.
Overview of complaint aspect	Member of staff placed a razor in another patient's bag. The razor could not be found the following morning when he requested it. This could have caused the patient issues on and off the ward and could have caused cross-contamination.
Outcome	Upheld.
Recommendation/s made and completed	Patient received a written apology letter. An IR1 has been written in retrospect and the patient was reimbursed for the item.
Overview of complaint aspect	Family weren't informed and updated so that they could manage patient's affairs such as housing, rent etc.
Outcome	Partially upheld.
Recommendation/s made and completed	Consent to share information is reviewed via the CPA process and there is evidence on record that the issue of sharing information is revisited periodically.
Overview of complaint aspect	Complainant rang the mental health help line about 12 or 14 times and this was not picked up by his doctor.
Outcome	Partially upheld.
Recommendation/s made and completed	Health advisors will email relevant teams to advise them of multiple contacts made by service users to the line to ensure they are aware.

Patient Advice and Liaison Service (PALS)

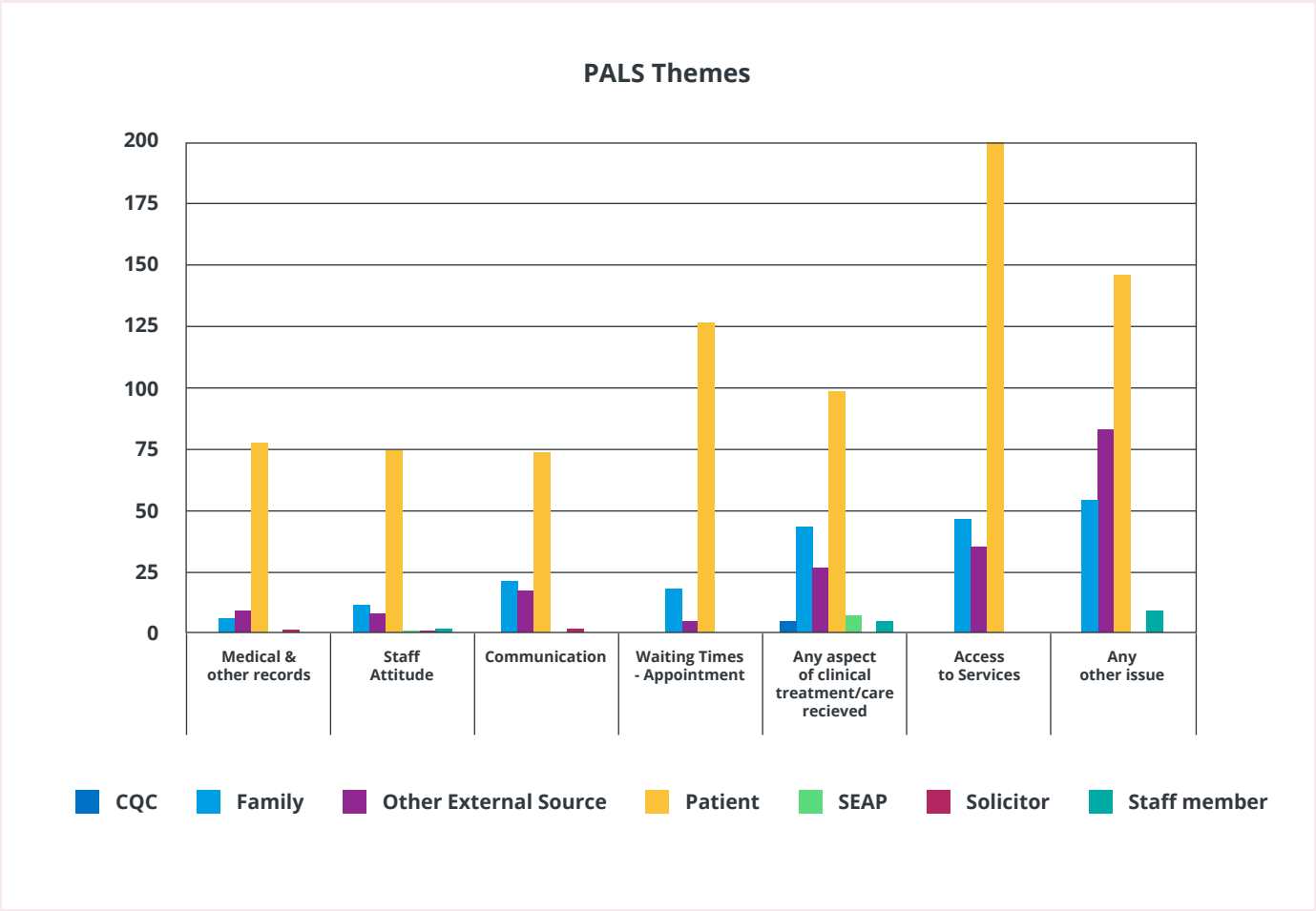
We employ a dedicated PALS officer to work with service users, carers, families and the public to seek answers or provide advice on initial concerns, in consultation with clinical services, advocates or other agencies as appropriate. This way of working has proved to be very effective and the service is being fully utilised across the Trust. However, we are aware that the PALS 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.



Trust wide PALS

	Q1	Q2	Q3	Q4
2014/15	424	301	308	344
2015/16	345	427	342	382
2016/17	283	326	265	372

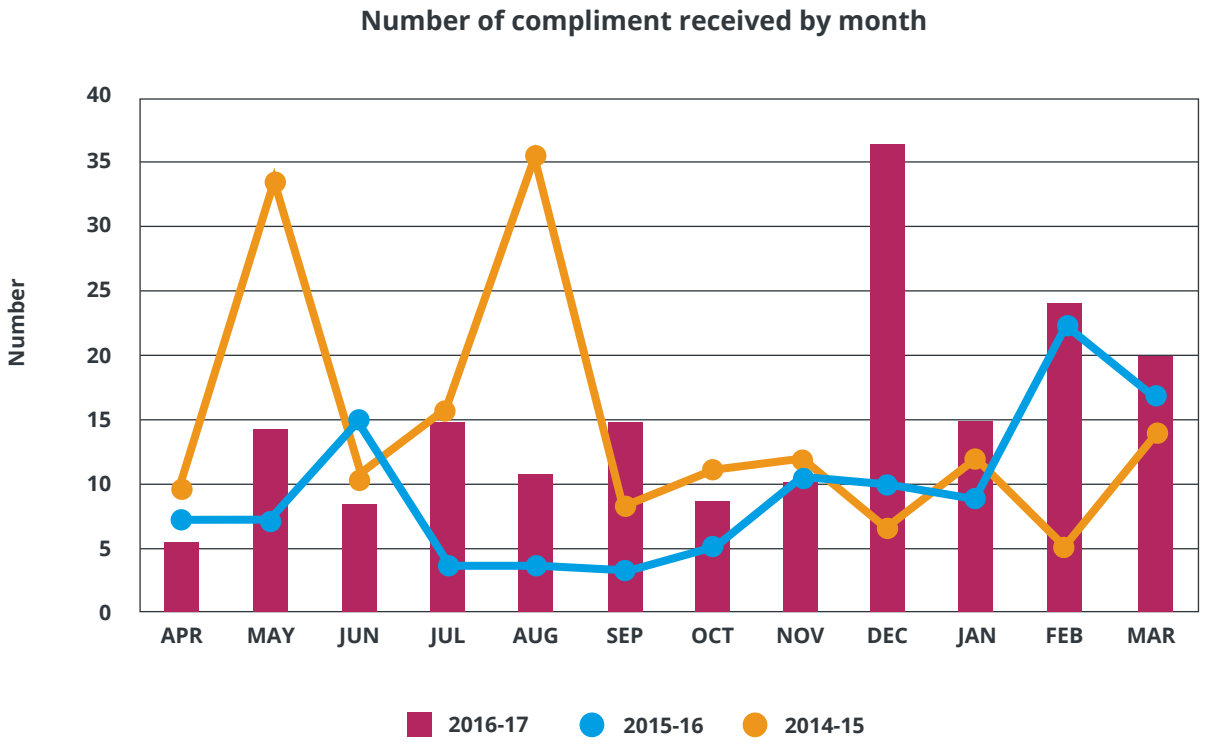
Owing to the fact that PALS concerns are varied and often come from members of the public who seek general advice, it is difficult to identify trends. The following tables highlight the majority of themes identified from the PALS enquiries received.



The highest number of queries raised during quarter 1, April to June 2016 are related to 'access to services'.

Compliments

Compliments in the form of cards, letters and verbal are logged on a Trust database. The following is a breakdown of the compliments that have been received and recorded.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-17	6	15	9	16	16	15	9	11	37	15	24	20
2015-16	7	7	15	4	4	4	5	11	10	8	22	16
2014-15	11	34	11	16	36	8	11	13	7	13	6	14

> "The rapid response team have been wonderful. We thought we were going to lose our dad. Although he is still confused he is 90% better and mobile thanks to your team"

Access and Urgent Care
• Thanks to Dr Scott and Hounslow CATT from a patient's wife
Cognitive Impairment and Dementia Services
• Thankful for the support that has been provided
Child and Adolescent Mental Health Services
• Compliment for Sandra Bailey
Liaison and Long Term Conditions
• "Thanks to therapist Mandy Hewey 'Thanks to my Therapist Mandy for all my EMDR therapy that changed my life forever. And finally thank you to the West London Mental Health Trust who used to help me during the worse time of my life and now I am standing on the other side and by joining the team I can move forward, gain experience and hopefully one day save a 'lost soul"
Primary and Planned Care
• "Compliment for an OT technician. Please see attached a thank you note from one of our occupational therapy clients in the Hounslow West team. The outcome for this client has been fantastic. Thanks to the input from Michelle Nielson, occupational therapy technician, Iona has been able to get a job and move on with her life
West London Forensic Services
• Patient left a thank you note on discharge addressed to Jo Dow and Eddie M'Mari
High Secure Services
• Occupational Therapist Sade Smith was praised by a service user for the hard work she does on Kent House

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 has resulted in a 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.

We have been working on increasing our incident reporting throughout 2016/17 and even though we have increased our reporting internally by 30% compared to the number of incidents recorded in 2014/15 we are still one of the lowest reporting Trusts compared to other Mental Health Trusts in the England.

The Care Quality Commission identified incident reporting as an area for development following their assessment in June 2015 and the WLMHT quality improvement action plan included a number of actions to improve this area, and the following action have been completed during 2016/17:-

- Training programme implemented across the organisation focusing on how and why it is important to report incidents.
- Staff induction now includes a section on incident reporting.
- Themes and trends from incidents informs the development of mandatory training sessions.
- Launch of the updated incident reporting and management policy which includes guidelines on what and how to report incidents, and a clear section outlining how we learn from incidents reported.
- Development and launch of an electronic updated incident reporting system, linking the reporting form to RIO, providing automatic feedback to staff reporting the incident and allowing staff to track incidents that they have reported.
- Easy access to 'how to guides' and the incident reporting and management policy.
- Team managers now have easy access to dashboards providing information relevant to their areas, allowing local focus on areas for improvement. These dashboards are used as part of clinical team meetings and clinical improvement groups.

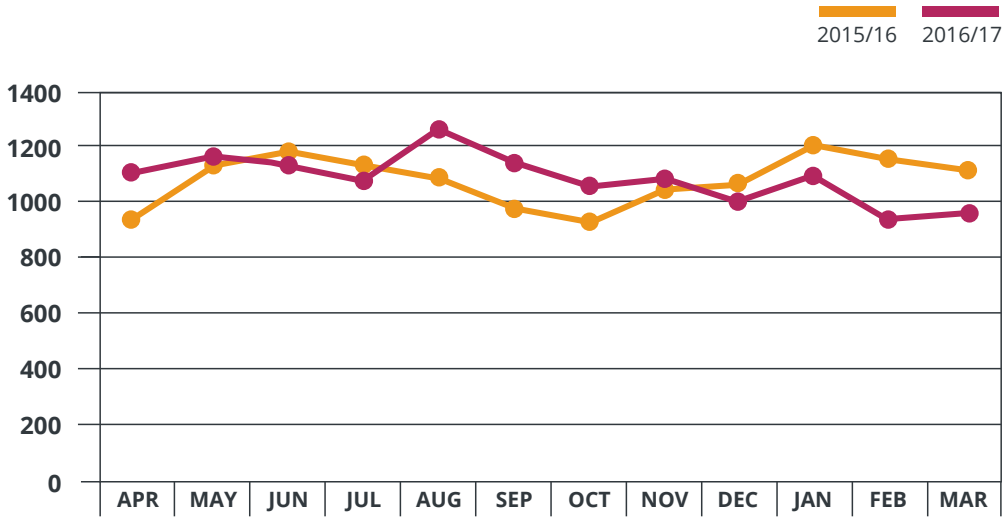
It is clear that low incident reporting figures is a complex problem with many underlying factors with no 'quick fix', and an on-going multi-faceted approach is required on improving incident reporting and learning will continue throughout 2017/18.

Incident reported data

	Q1	Q2	Q3	Q4
Q1-Q4 2016/17 Incident Total	**3385**	**3463**	**3087**	**2991**
Q1-Q4 2015/16 Incident Total 12953	**3266**	**3200**	**3022**	**3465**

A total number of incidents of all types and severity were reported across the organisation. This represents a decrease of 0.2% (27) on the number of incidents recorded for 2016/17.

Incidents reported by month



A total of 12926 incidents of all types and severity were reported across Local Services and Forensic Services and Corporate Services. This represents a decrease of 0.2% (27) on the number of incidents recorded for 2016/17.

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

	2015/16 Q1	2016/17 Q1	2015/16 Q2	2016/17 Q2	2015/16 Q3	2016/17 Q3	2015/16 Q4	2016/17 Q4
Verbal abuse to staff	507	499	473	477	467	449	419	471
Security incidents	503	509	461	594	428	426	582	462
Self-injury to patient	199	240	238	253	151	240	226	187
Medication incidents	454	390	456	367	373	323	506	292
Physical assaults to staff	245	274	233	312	227	245	258	233

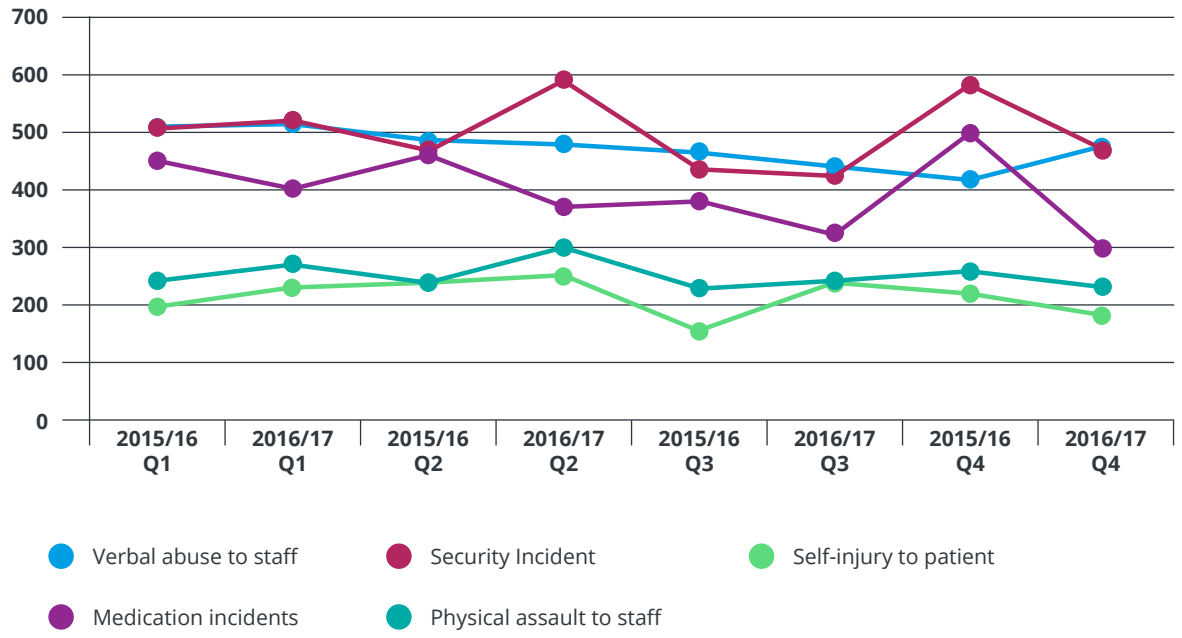
Verbal abuse towards staff has been highly reported in High Secure Services and staff across all areas of the organisation, it is continually encouraged to report all types of abuse to allow the identification of any themes and trends.

Physical assaults to staff differed throughout the year. However there is a notable decrease in Q4. This is because of the introduction of the early warning signs of verbal abuse a number of actions have been put in place to manage the threats of harm to staff and others.

This has been integral to identifying behaviours and early warning signs to allow immediate action and more timely assessments for care planning and risk.

Self- injury to patients' has increased 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 again increased this year compared with last, mainly for staff reporting more contraband items found on patients, particularly smoking related and also more incidents are being recorded for staffing levels on the wards.



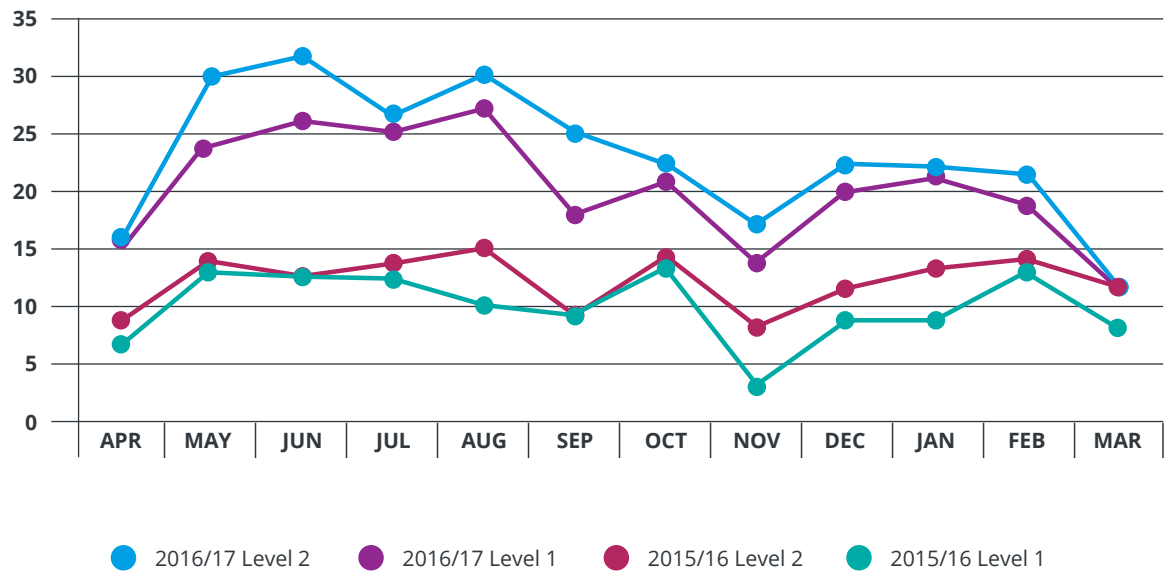
Trust-wide serious incident reviews

	Q1	Q2	Q3	Q4
Q1-Q4 - 2016/17 Incident Review Total	43	44	29	22
Q1-Q4 - 2015/16 Incident Review Total	35	38	33	38

The table shows that there has been decrease in the number of serious incident reviews commissioned in 2016/17 from the last financial year.

> "Nurses were encouraging, helpful and knowledgeable. treatment offered was effective. they were caring and respectful of my elderly mother who has dementia"

The Trust uses the reports from all serious incident 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 2017/18

Identify quick easy ways to report a number of similar incidents together, to ensure all are captured and reported.

> A plan will be developed and implemented that supports staff to understand:

- How to conduct an investigation/ review and share the outcome
- How to ensure learning from investigations/ reviews is implemented in practice
- Ensuring the involvement of families and carers in reviews/investigations is made clear

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 received 2 Rule 28's during the reporting period:

1) The Coroner issued a Preventing Future Death (PFD) report to Local Services. This stated that there was not a protocol or other written guidance of policy for the management of head injury to include frequency and range of general and neurological observations.

The Trust's response to this report was to:

- Review and implement the Trusts ' prevention of inpatient falls and care and treatment of patient following a fall or head injury' Policy.
- The medicines policy now provides clear guidance for all stages of medication management.

2) A PFD report was issued to High Secure Services raising concerns over the quality of the eyesight observation by staff and delays in attending a patient

The Trusts response to this report was to:

- Introduce a monthly check of all observation windows, which is recorded and reported to the estates department.
- Unannounced out of hours audits of observational practice.
- Clinical risk training with regards to engagement and supportive observations is now part of the mandatory training programme.
- Knowledge skills assessment introduced for all staff undertaking observations.
- Redesigned basic life support and automated defibrillator course.

Health and Safety Executive (HSE)

The HSE has issued no improvement or prohibition notices to the Trust during the last year.

Safeguarding Children and Adults at Risk

The Trust remains committed to the principles of safeguarding in all the services that the Trust provides. This commitment to safeguarding was endorsed by the Care Quality Commission in a re-inspection of the Trust's services in November 2016, who reported 'staff had a good knowledge of safeguarding and the safeguarding team were able to identify areas of low reporting so that additional support could be provided where needed'.

Safeguarding governance and quality assurance
Increasing community based service provision presents complex safeguarding challenges. Governance and reporting mechanisms for safeguarding continue to be reviewed and safeguarding is considered within the wider review of governance mechanisms to ensure the on-going safety of service users, patients and staff.

Safeguarding incidents are reviewed at various forums. These include the Safety and Security Steering Group and the strategic governance forums; Local Services and Forensic and High Secure patient safety and safeguarding groups. Incidents involving restraint and restrictive practice on the adolescent forensic unit are reviewed by safeguarding to provide additional assurance.

There is increasing reporting by service users of historical allegations of abuse. The results from a new data set that has collected information about the nature of allegations will be analysed in the coming year.

In February 2016 there was an expansion of tier 3 perinatal mental health services throughout the boroughs of Ealing, Hounslow and Hammersmith and Fulham. The service provides specialist assessment, treatment and support for women with current or previous moderate to severe mental illnesses who are pregnant, or have given birth within the past year. Regular meetings and effective communication takes place with partner health and social care agencies to jointly assess risk and intervene early with support and safeguarding plans. Both mothers and babies can be at very considerable risk at and after birth whilst mothers are unwell.

The national agenda to prevent violence against women and girls and the safeguarding of both adult women and girls has been a focus for the Trust. In respect of the Trust's mandatory requirement to report female genital mutilation (FGM), during January 2017 the Trust diversity lead facilitated a workshop with an external specialist to support the Trust to develop a culturally sensitive and appropriate question to ask of an adult patient who might have been or is at risk of being a victim of FGM. It is agreed that to remove stigma or prejudice, the question should be asked of all women. This question with be incorporated within the physical healthcare RiO patient record from May 2017. Where safeguarding arises, such as a girl under eighteen years of age reporting that she is a victim, or there is any concern that a girl has had or may be at risk of having the procedure, immediate reporting to children's Social Services is mandatory.

There is increasing awareness of the prevalence of domestic violence in the lives of people with mental health problems. Anecdotally, both enquiries to the safeguarding team and referrals made to both children and adult social care services have increased. Since September 2015 the Trust has benefited from expert training on domestic abuse, delivered internally by a representative from Standing Together (charity working against domestic violence) as part of a mental health and domestic abuse project. From March 2017 this provision will be strengthened with an honorary contract held with the Trust for a year. The project worker will be integrated within the safeguarding team to develop policy and expert practice, support leads in services; conduct audit activity and to provide general support and guidance in individual cases. Further developments are planned to build the in-house provision of specialist training and education in both domestic violence and FGM.

Increased awareness of the risks of radicalisation and extremism has also informed further developments in the Trust. The national requirements to roll out PREVENT awareness and workshops to raise awareness of PREVENT (WRAP) has been a priority and is included in the organisation's safeguarding training strategy.

We are on target for delivering training to staff in PREVENT; this is in line with the training program offered by the Trust. To further support the delivery of PREVENT, we have continued to work alongside the protect arm of the CONTEST strategy. As a result protect provide training to staff. We will be reviewing this work in April 2017 and agree how to continue this partnership agreement. The Trust partners on the channel panels in each borough, which continue to support the partnership working with other, represented agencies.

Relationships with stakeholder partners remain a key priority for the safeguarding team. There is continued participation in safeguarding boards and their sub-groups. In line with the Wood Report Review of the role and functions of Local Safeguarding Children Boards, (March 2016) there will be changes to Local Safeguarding Board (LSCB) functionality. Safeguarding Adult Boards (SABs) are newly established with independent chairs and the Trust has a partner on each board. The director of safeguarding chairs the case review sub-group in Hounslow safeguarding children board and continues to chair the training and education sub-group of the Hounslow safeguarding adult board. The Trust chaired a short-life work group on parental mental health and safeguarding for the combined safeguarding children's board of Westminster, Kensington and Chelsea and Hammersmith and Fulham, this is now completed.

The Trust continues to report quarterly to its commissioners on all safeguarding functions. The challenge provided through these forums supports our on-going development of quality in safeguarding.

Safeguarding Children

The Trust completes self-assessments of compliance with the requirements of section 11 of the children act 2004 for the LSCB's of all the boroughs where services are provided. An assessment for Hounslow safeguarding children board was completed in January 2017. Key strengths for the Trust included excellent leadership, organisational support and development of data metrics; an emphasis on diversity; and positive relationships with the patient/service user group leading to co-production of material and interest in safeguarding children matters. The results will be scrutinised and challenged by our LSCB partners and development opportunities identified will be progressed as part of an action plan over the coming year.

An unannounced joint targeted area inspection (JTAI) by Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMIP) took place in the borough of Hounslow between 21 March 2017 and 24 March 2017. The inspection of the multi-agency response to abuse and neglect included a focus on the response to children living with domestic abuse, engaging all Hounslow services in the Trust in a close review and scrutiny of its practice and partnership working in the interests of children. A CQC Inspector spent a full day in the Trust with children's safeguarding leads in adult services (Hounslow), and the wider CAMHS (Hounslow) clinical team reviewing cases and examining safeguarding practice. Throughout the week cases were discussed with the wider inspectorate and multi-agencies involved, as part of a 'deep dive' review. The experience was received as both constructive and positive and we are awaiting the final report. An immediate action was taken, that was to ensure there was Trust representative on the monthly multi-agency risk assessment conference (MARAC) in the borough. The function of the MARAC is to ensure a co-ordinated approach to the safety of victims of significant domestic violence.

A Joint interagency protocol setting out partnership arrangements for cases referred between adult services in the Trust and children's social care services in our three London boroughs was reviewed and updated in October 2016. Following agreement with the LSCB of Hammersmith and Fulham, Kensington and Chelsea and Westminster, in line with recommendations by that board's short life work group on parental mental health, a further audit will take place in collaboration with the local authority, in Q1 of the 2017-18 cycle.

National and local changes to guidance, legislation and learning from serious case reviews are disseminated to staff through training. Our in-house training has been bench marked against other health Trust across London and rated amongst the highest performing of those reviewed for compliance with mandatory training.

The Trust follows the guidance set out in the Intercollegiate Guidance - Safeguarding Children and Young People: Roles and Competences for Healthcare Staff, in March 2014, when determining levels of safeguarding children training for staff. All staff complete an approved level of safeguarding children training (from a level 1 to 3).

From March 2016 all clinicians in CAMHS; the liaison psychiatry teams and the developing maternal mental health teams have been expected to have completed level 3 specialist safeguarding children training as a mandatory requirement because they have direct contact with children and young people, or have contact with pregnant women with mental health issues. Other services joining the Trust, such as OneYou in Ealing are included as they undertake direct work with children. These staff groups also take part in reflective practice and case discussion within teams where safeguarding is addressed. They also attend seminars with specific topics linked to safeguarding, such as prevention of suicide, on-line child exploitation and other forms of harm to children, for example. The learning generated and time spent in this additional safeguarding activity is currently not captured, and there is an urgency to invest in a process whereby this can be achieved; and this will be addressed.

There is a robust audit forward plan, results of which influence training content and themes for supervision/ reflective practice, a practice now embedded across Local and Forensic Services. From May 2017 there will be a regular monthly audit of a small random sample of case records where referrals to children's social care have taken place. The aim is to identify good practice and areas for improvement in respect of documentation and the sharing of information.

The action plan relating to a serious case review commissioned by Hounslow LSCB is nearing completion. A joint strategy to involve CAMHS, education services and the local authority is being progressed to ensure educational support is provided for all young people with mental health problems.

All Trust policies relating to children are in date. Policy C18C (children who fail to attend appointments) was reviewed in March 2016. Commissioners of CAMHS services are advised of the policy and response to children who do not attend, through regular data reporting. The safeguarding team incorporated guidance from national learning into the Trust's physical healthcare policy, to include best practice when undertaking physical healthcare checks on children and young people under eighteen years, in respect of chaperoning.

Safeguarding adults

The safeguarding adults named professional supports and advises with individual cases, the referral pathways, reviewing the data, supporting local safeguarding adult clinical groups and supporting the flow of communication between the local authorities and the Trust, working in partnership with each of the local authorities and the local safeguarding adult leads in the Trust to review and develop practice and continues to support the reflective practice sessions available to all Trust staff directly or indirectly employed. The model of reflective practice has been reviewed and a very practical approach adopted to meet staff needs, as safeguarding is very complex.

A staff handbook and threshold guidance in respect of safeguarding adults was produced in conjunction with the London Borough of Hammersmith and Fulham (LBHF). A review of thresholds is due in June 2017 by LBHF and once reviewed WLMHT will utilise the handbook as a further resource to support staff engagement with safeguarding adult practice.

The safeguarding adults assessment tool (SAAT) was reviewed last year and presented to the challenge event in Hounslow earlier this year 2017. The tri-borough (Hammersmith and Fulham; Kensington and Chelsea; and Westminster) has requested a summary of good practice and challenges which will be presented in the new financial year 2017/18.

Student nurses meet members of the safeguarding team prior to commencing their first clinical placement in the Trust. A bespoke educational package was developed to increase student confidence and engagement in safeguarding adults practice. This has been positively received by the students who feel supported in this function.

The safeguarding adults training package was reviewed following feedback from staff, the CQC inspection and learning highlighted from Incidents and safeguarding cases. The revised intercollegiate guidance on safeguarding adult competencies for health staff is awaited before the training content is further developed. All staff complete safeguarding adult training, in class based sessions or through an online training programme.

Vignettes for the class based sessions are updated monthly to reflect current cases and highlight areas of concern and good practice. Last year's focus was highlighting high risk groups, such as people suffering with dementia who are at significant risk of abuse and neglect and 'blanket restrictions', which contribute to restrictive practice. This year (2017) we have seen the similar high risk groups. However, in relation to abuse, the category reviewed more in depth has been domestic abuse. We have noted a steady increase in the number of safeguarding concerns raised and enquiries to the safeguarding team in relation to domestic abuse. Domestic abuse affects both adults and children and we encourage a think family approach when it is present.

There has been further discussion with the Trust acute care and restrictive practice nurse consultant about raising awareness in respect of the physical and emotional abuse experienced by service users, where the person casing harm is also a service user. The nurse consultant will work with staff to reduce these incidents and support the service users with their recovery.

The Trust contributes to the work of all the adult case review sub-groups of safeguarding boards where it has membership. Where relevant contributions are made to support multi-agency learning, e.g. in cases where physical and mental healthcare needs have been subject to learning for the professional partnership.

Ealing safeguarding adults partnership board commissioned a safeguarding adults review following the death of a patient in hospital who had also been known to Trust services. The Trust submitted an internal management review (IMR). The learning and recommendations are yet to be approved. Once complete this will be circulated and disseminated to staff. A domestic homicide review was commissioned in Ealing (safer communities team/standing together) in March 2017 and the Trust is completing a level 2 review internally.

A review was commissioned by Richmond safeguarding adult partnership board for a case the Trust has limited involvement with. The Trust supplied information to the board but no further involvement was requested. The Trust will be kept informed of any learning from the case that can be shared to improve working practices in safeguarding.

Broadmoor Hospital has devised safeguarding closure forms and exit interview questionnaires. This is in order that we can start to measure safeguarding outcomes more effectively using the principle of making safeguarding personal. The Trust-wide safeguarding adult patient leaflet is distributed to patients at Broadmoor Hospital. The hospital has continued to develop its safeguarding adult practice in relation to patient involvement and as such has convened case conferences on the wards where patients can attend and contribute if they wish to do so. In line with the Care Act duties, independent mental health advocates attend strategy discussions and case conferences to support patients who have been assessed as having a "substantial difficulty" in understanding the safeguarding process.

The London multi- agency safeguarding adult policies and procedures, launched in February 2016 were updated in August 2016. The updated Trust safeguarding adults (S28) policy was published in June 2016. The policy reflected changes in Hounslow safeguarding adult structures. The London multi-agency safeguarding arrangements state that only where partnership agreements within S75 exist, can appropriately trained managers within mental health Trusts undertake the safeguarding adult manager role on behalf of the local authority. It was agreed in March 2016, with the Hounslow safeguarding adult board support, that the local authority (Hounslow) would undertake all safeguarding adult manager roles and enquiry officer's roles. Trust staff within Hounslow would be responsible for raising concerns and cooperating with the safeguarding process.

Safeguarding quality and performance indicators April 2016 – March 2017

Target / Measure	Performance			
	Local Services		Forensic Services	
	Adult Services	CAMHS	West London Forensic	High Secure Services
Safeguarding children activity Number of referrals to children's social care	Q1 - 55 Q2 - 90 Q3 - 103 Q4 - 92	Q1 - 17 Q2 - 20 Q3 - 19 Q4 - 27	Q1 - 0 Q2 - 7 Q3 - 1 Q4 - 2	Q1 - 2 Q2 - 1 Q3 - 0 Q4 - 0
Number of child visits made	Q1 - 29 Q2 - 84 Q3 - 73 Q4 - 9	Q1 - 0 Q2 - 0 Q3 - 0 Q4 - 0	Q1 - 20 Q2 - 23 Q3 - 23 Q4 - 5	Q1 -3 Q2 - 6 Q3 - 9 Q4 - 4
Number of children admitted to adult wards	Q1 - 1 Q2 - 5 Q3 - 3 Q4 - 4	Q1 - 0 Q2 - 0 Q3 - 0 Q4 - 0	Q1 - 0 Q2 - 0 Q3 - 0 Q4 - 0	Q1 - 0 Q2 - 0 Q3 - 0 Q4 - 0
Number of allegations referred to LADO (safeguarding children)	Q1 - 0 Q2 - 0 Q3 -1 Q4 – 0	Q1 - 0 Q2 - 0 Q3 - 0 Q4 – 0	Q1 - 1 Q2 - 1 Q3 - 0 Q4 - 0	Q1 - 0 Q2 - 0 Q3 - 0 Q4 - 0
Safeguarding adult activity Number of safeguarding adult referrals	Q1 - 127 Q2 - 155 Q3 - 194 Q4 - 118	Q1 - 0 Q2 - 0 Q3 - 0 Q4 - 0	Q1 - 16 Q2 - 15 Q3 - 7 Q4 - 9	Q1 - 6 Q2 - 14 Q3 - 18 Q4 - 15

Mortality review

In December 2015 the Secretary of State for Health asked the CQC to undertake a review into the investigation of deaths in NHS Trusts in response to Mazars report into deaths at Southern Health NHS Foundation Trust.

In June 2016 our chief executive officer received a letter from the CQC to inform them that the Trust had been selected as one of a number Trusts to be visited as part of the review by the CQC on investigating deaths across NHS mental health, acute and community settings.

Their review visit to the Trust took place on 9th and 10th of August 2016, with their findings published in Dec 2016. Further tools and guidance are due to published during the spring of 2017 with the intention of improving practice. The CQC report 'Learning, Candour and Accountability' was published in December 2016 and the Trust has included the recommendations made in their programme of work for 2017/18.

Learning Disabilities Mortality Review (LeDeR) Programme

The Learning Disabilities Mortality Review (LeDeR) programme was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, and is being delivered by a team based at the University of Bristol.

The programme supports local reviews of deaths of people with learning disabilities aged between 4 and 74 years of age across England. A confidential telephone number and website enables families and other key people to notify the LeDeR team of the death of someone with learning disabilities.

An initial review of the death will take place by a local reviewer, which should provide sufficient information to be able to determine if there are any areas of concern in relation to the care of the person who has died. The LeDeR programme will be rolled out across organisations from 1st April 2017. On Friday 17th February 9 members of staff from across the Trust attended the LeDeR training programme delivered by NHS England.

The aim of the training was to enable local reviewers to feel skilled, confident and competent to undertake reviews of the deaths of people with learning disabilities using the LeDeR review process, ensuring that the Trust is prepared implement the programme on time.

Current system in place

In April 2016 a revised incident reporting and management policy was implemented across the Trust. The policy states 'All patient deaths irrespective of cause constitute an incident initially and must be reported via the Exchange on the Trust electronic incident reporting form'

The intention is to ensure that the organisation is aware of all deaths of its service users and is assured that all deaths are reviewed as appropriate. By requiring staff to report ALL deaths it eliminated the confusion surrounding what deaths to report and what not to report.

The Trust established a mortality review group which is chaired by the medical director and the director of nursing and patient experience and has been meeting on a weekly basis reviewing all deaths of those service users that have died within 6 months of their last contact with the Trust. The purpose of the group is to both develop the internal processes for mortality review also to review selected cases for further consideration or a thematic review if required.

The Mortality Review Group is constituted as a sub-group of the quality matters committee and it is accountable to the quality committee, which is a sub-committee of the Trust board.

Other quality and improvement initiatives

Medical Revalidation

Medical Appraisal and Revalidation 2016/17

The Trust continues to comply with medical revalidation statutory requirements introduced by the General Medical Council (GMC) in 2012. The Board maintains oversight of the revalidation process with the Responsible Officer providing an annual Responsible Officer report. In addition, the chief executive completed the annual statement of compliance, and the responsible officer submitted the required assurance data to NHS England on time.

Revalidation requires all doctors with a prescribed connection to the Trust to engage with annual appraisal as a contractual obligation. At the end of 2016/17 cycle there were 127 doctors with a prescribed connection, 119 (93.7%) completed appraisal on time, 6 (4.7%) did not have an appraisal for the following reasons: career break, maternity leave and sick leave, 1 doctor had an appraisal but did not sign off due to sudden serious illness, 1 doctor did not engage in appraisal, the non-engagement will be addressed in line with NHS England Medical Appraisal Policy - Annex E.

In addition, the responsible officer made a revalidation recommendation to the GMC for 7 doctors. The low number reflects Year 4 of a five year cycle. Cycle 2 commences in 2018.

Research and development

SCANMOVE study: Screening antipsychotic-induced movement disorders
A novel diagnostic screening procedure for antipsychotic-induced movement disorders

Our SCANMOVE team recruited more service users into a research study than any other study in the past year, in line with the Trust's commitment to making the opportunity to participate in research available to as many service users as possible.

The study was funded by the National Institute for Health Research (NIHR) and was part of their research for patient benefit programme.

Movement disorders such as difficulty in initiating movement, stiffness in muscle groups and tremor are unfortunately common side effects particularly of older antipsychotic medication. These side effects may be uncomfortable, disabling, stigmatising and may lead to premature treatment discontinuation, and relapse of illness. Existing assessment and rating scales are not routinely used in clinical practice as they are often complicated and time-consuming. Our failure to document these disorders allows us to overlook them in clinical practice.

The purpose of the study was to test a new assessment tool to identify movement side effects in patients who are prescribed antipsychotic medication. A new brief and simple procedure was developed by a group of neurologists, psychiatrists and nurse specialists which involves observations and simple physical examination. The study looked into whether nurse specialists who have been trained in the new procedure can use it to correctly identify movement side effects in patients prescribed antipsychotic medications and if they can be as effective as specialist neurologists in diagnosing these physical side-effects.

A total of 147 patients were recruited across Local Services, making it the highest recruiting study in the Trust last year, and making WLMHT one of the highest recruiting participating sites for the study, which was open across the country. The success was mainly due to the fact that dedicated psychiatric nurses had allocated research time; a model that validated the importance of ownership of research projects by clinical services.

The results of the study are expected next year, good research takes time.

Making inpatient care safer with technology: partnership between Broadmoor and Oxehealth

At Broadmoor Hospital it is not unusual to have to manage very unwell patients behind locked doors. A problem arises in being unable to monitor the physical wellbeing of an uncooperative patient who may stay under a blanket out of sight, or who may seek to harm himself between periods of nursing observation. A chance conversation between a senior doctor at Broadmoor and a trainee psychiatrist with knowledge of some medical technology developments in Oxford has led to a fruitful partnership between the Trust and Oxehealth. http://www.oxehealth.com/

Our research partnership demonstrated that by using ordinary videocameras located in secure housings with Oxehealth's innovative analytic software, we could monitor the heart rate and breathing rate of research subjects in conditions of darkness approximating to the real life situation staff experience while undertaking observation. Patients and staff both report positively on this technology. Staff can have much more confidence in the wellbeing of their patients:

"knowing your patient is alive would take a great pressure off" (healthcare assistant)

"it would mean the patients would no longer need to be disturbed by overnight checks and if physically unwell/in need of urgent medical assistance this would immediately be picked up" (trainee doctor)

Patient volunteers are even more positive

"I get very upset when I am unwell and staff are constantly staring at me, putting on the lights in the middle of the night." (patient volunteer 1)

"I like the idea that the machine can see I am breathing and my heart rate, and staff do not enter to touch me and upset me when I am agitated." (patient volunteer 2)

This is important because suicide by hanging for inpatients in psychiatric hospitals remains an important problem:

Deaths by hanging on the ward are usually from low-lying ligature points (i.e. strangulation). 20-30 deaths per year still occurred on the ward by hanging. (National Confidential Inquiry into Suicide and Homicide, October 2016)

Broadmoor Hospital worked with Oxehealth for the past two years to test this technology, the "D" in research and development, to support its preparation for submission for Certified Medial Device (CMD) status. These trials have been presented at a variety of conferences and have generated very substantial interest. We anticipate that if CMD status is awarded then this is potentially a substantial advance in patient safety in mental health inpatient settings. We hope to install this technology in the new Broadmoor Hospital when it opens.

HEADWAY Study

The Trust was the first site in the UK to include a participant in the HEADWAY study, the first commercially sponsored study looking at a treatment for Lewy Body Dementia.

Lewy Body Dementia is the third most common cause of dementia in the UK but has no licensed treatments, unlike Alzheimer's disease. It is often misdiagnosed on initial exam and patients can be seen either in psychiatry or neurology clinics.

The study sponsored by Axovant aim is to investigate if a daily dose of medication is able to improve cognition and reduce hallucinations experienced by patients with this diagnosis when compared to a placebo. The study runs for 6 months and is followed by a 6 month period during which participants will have access to the study medication without any placebo. The study is being run in 7 countries with 10 centres open the UK.

The Trust have identified 8 possible participants for the study and have now included 3 participants in the study with a potential 4th recruit being considered before the study closes in May 2017. With only a small number of potential participants with the diagnosis of Lewy body dementia known within the Trust the research team used their contacts both within and outside of the Trust to achieve recruitment to the study, receiving referrals from all 4 memory clinics in West London, neurology clinics in Imperial College Healthcare NHS Trust, colleagues in the Surrey and Borders Partnership Trust, local GP surgeries and using Join Dementia Research (an online research register). As an under researched area the study generated great interest from patients and professionals alike. The last patient is due to finish the 6 month study in November 2017 and we look forward to hearing the results of the study in early 2018.

Psychology and Psychotherapy Services

Improving patient experience

Psychological therapists have particularly addressed the need to improve access over the last year. Reduction of waiting times has been a priority in the recovery teams in our Local Services. This is being achieved for patients and carers through careful assessment and the sponsoring team formulations of need; then routinely offering and delivering individual sessions for inpatients and outreach/ groups for those discharged.

We offer dialectical behaviour therapy (DBT) groups and individual sessions Trust-wide with the aim to engage those with high ambivalence about talking to us and patients who may decide to drop out of their connection with us. Our forensic DBT service was highly commended this year for its longevity in providing care to some of the most troubled men in the country. We have also almost concluded a research study on Metallisation Based Treatment (MBT) which is the first of its kind in secure services. A review of our referrals for trauma work this year has highlighted the extent of expertise and success in using effective interventions (such as eye movement desensitisation and reprocessing EMDR therapy) where traumatic experience is impacting on mental health.

Much work has been undertaken this year to improve the pathway experience of our service users so that ultimately they will move through (shorter) inpatient admissions, through recovery-oriented services towards a hopeful and meaningful re-engagement in life thereafter. As part of the transformation agenda we are documenting patient experience and increasing our productivity. Evidence of this is beginning to show in the reduced length of our waiting lists which in turn has allowed staff scope to deliver of key 'early' interventions (particularly for psychosis) and offer more of the most effective treatments to more of the people who are referred.

Clinical effectiveness

Through the forum of the psychological therapists group chaired by the Trust-wide strategic lead all disciplines: clinical health and neuropsychology, children and adolescent services, family therapists, forensic and clinical psychologists and psychotherapists, have representation at Trust management meetings, and present periodically to the Trust Board. This has improved our presence in governance meetings where we can closely monitor the effectiveness of our interventions and provide accountability for clinical decision making in relation to patient well-being. Psychologists work closely with social work colleagues in safeguarding panels.

Patient safety

Psychological therapists are an integral part of the multidisciplinary teams providing input to ensure the safe and effective use of psychological interventions and systemic formulation-based review. In inpatient services psychology-based staff joins with nursing and occupational therapy colleagues to promote the health and well-being of patients, reduce restrictive practice, increase hope: support patients via psychologically informed systemic practice and direct intervention: sponsor a sense of community, promote safe conflict management: and increase opportunities for repair where there has been harm. We have taken a lead role in developing trauma-informed care practices to share learning and skills with colleagues who are working with those in high distress, so that we can tailor our interventions appropriately for those with a history of harm.

Less directly but of equal importance psychological therapists are extensively involved in staff supervision via groups and training, which is ultimately sponsoring patient well-being.

We have aligned training initiatives entirely with guidance from recovery oriented practice and co-facilitate with service users and colleagues on autistic spectrum disorder, psychological interventions, reflective practice (a textbook edited and authored by Trust clinicians, and other literature on supervision and staff well-being have been published this year), and the role of research – we hold a bi-annual R&D forum for clinicians, linking theory to practice in the interests of excellent clinical outcomes.

Nursing quality improvements and initiatives

Enhancing nursing development and career progression opportunities through the NWL Capital Nurse Foundation Programme

During the year WLMHT was successful in a bid to host 24 newly qualified nurses on Health Education England (HEE) North West London (NWL) Capital Nurse Foundation Programmes. The programmes aim to address a combination of local recruitment and retention needs and national workforce priorities.

Through our locally delivered Capital Nurse Foundation Programme we are providing high quality workplace based rotations with educational support that aims to develop and retain nurses for onward career progression as well as ensure; the skills, knowledge and behaviours essential for the delivery of high quality care are embedded into their practice. The programme that is aimed at nurses who have less than 1 years post registration experience, commenced in February 2017.

Uju applied for the scheme with a "desire to learn more" and started in February. "When I first heard about being a Capital Nurse, I was told it would expose me to new areas and enhance my skills. So far I'm really enjoying it as it's all about experiencing new things. I really want to improve my skills, and I think the programme will help with my career progression."

Gillian Kelly, Corporate Deputy Director of Nursing, said: "The Capital Nurse Foundation Programme is the perfect way to kick-start a nursing career and is creating structured career pathways within mental health. It's a fantastic opportunity for anyone starting out as a mental health nurse in London; being a Capital Nurse is about delivering genuine, person-centred care in a diverse and vibrant city."

Developing new nursing roles as a fast-follower test site for trainee nursing associates

Health Education England (HEE) has established a number of test sites to implement the nursing associate role. The two year programme aims to test the ability of education and service provider partnerships to deliver a high quality work based learning programme for trainee nursing associates. The 11 first wave test sites commenced training programmes in January 2017. A further 24 fast follower test sites have now been identified and are required to commence training in April 2017.

The nursing associate role will sit alongside existing nursing care support workers and offer support to registered nurses thus being pivotal in developing a nursing workforce fit for the future.

This year WLMHT's Broadmoor Hospital has been working with the Thames Valley Partnership fast follower test site in developing the traineeships and is proud to have employed 6 nursing associate trainees who commenced training in April 2017.

Nursing quality improvement with WLMHT's first nursing Darzi fellowship

In 2016/17 we hosted our first nursing Darzi Fellow on the prestigious and high profile London Darzi Fellowship Programme.

Marcia Tharp, our nursing Darzi Fellow, has been developing a Nursing Assessment and Accreditation Tool (NAAT), which has been adapted from The Nursing Assessment and Accreditation System (NAAS) which has been used in the Salford Royal Foundation Trust since 2008. It is designed to help nurses in practice by measuring the quality of the nursing care that teams deliver, and ensures that patients are at the centre of their care.

The Darzi Fellowship has provided a dedicated and skilled resource to support this important quality initiative. As part of the programme, Marcia has been supported by a bespoke leadership development programme PG Cert Leadership in Clinical Leadership (Darzi. This has provided coaching, project consultancy and the opportunity to develop the organisational and leadership capabilities necessary for the role of a clinical leader and is accredited by London South Bank University.

In addition to specific project work, our nursing Darzi Fellow has provided learning and development opportunities to our wider nursing workforce through the provision of workshops, training days and action learning sets.

"Being part of the Darzi Fellowship has been an incredible experience in terms of my personal and professional development. It has enabled me to explore the wider systems in healthcare, taught me to be creative and brave, and reinforced my passion for quality care. Throughout this Darzi year I have also been able to involve ward teams/ service users/carers and student nurses in my project and have been encouraged by the enthusiasm they have shown to be involved." Marcia Tharp –Nursing Darzi Fellow

Healthcare assistant and support worker conference and awards ceremony: recognising and celebrating our healthcare support workforce

Healthcare assistants and clinical support workers make up a third of clinical staff in the Trust and are vital to the people who use our services. We held our 4th annual healthcare assistant and support worker conference with awards ceremony in June 2016.

The conference programme included a guest speaker from the editor of the British Journal of Healthcare Assistants on Career Pathways for Support Workers and presentations on; the Management of Restrictive Practices, the Band 2-4 Development Programme, the Role of the Assistant Practitioner and the Contribution of Healthcare Assistants in a Ward Pilot Project. In addition to plenary presentations the popular event included a number of interactive and developmental workshops.

The award ceremony recognised and celebrated excellence and innovation in practice across the Trust, with winners in all three categories; Excellence, Service User and Carer Experience and Safety.

Apprenticeships supporting our healthcare support workforce

Apprenticeships play a key role in qualifying staff and providing progression opportunities, resulting in a motivated and flexible workforce that are encouraged, recognised and valued for their contributions to individual service users and service delivery more generally.
This year apprenticeships have supported the development of our existing, and newly recruited staff, to a national standard, whilst maximising the funding and training provision available.

We are pleased to have been able to support staff to commence the higher apprenticeship in health (assistant practitioner) as well as the apprenticeship in health and social care; both of which play an important role in bridging the gap between our healthcare assistant and registered nurse roles and are critical in ensuring we have a workforce fit for the future.

Physical healthcare practice development

Over the last 12 months the nurse consultant physical healthcare has been working to improve education and clinical practice in relation to physical healthcare. This work formed part of a Commissioning for Quality Innovation (CQUIN) worth £232,000. All CQUIN targets were met.

The work involved:

- Developing standards on physical healthcare for inpatients within Local Services.
- Developing an equipment list for inpatients and community sites.
- Revising the National Early Warning Score (NEWs) policy and developing local escalation protocols to enable staff to recognise and escalate deteriorating patients.
- Developing a diabetes procedure to improve diabetes management.
- Revising the falls policy to ensure it was in line with national guidance.
- Training staff on NEWs, Situation Background Recommendation and Decision Tool (SBARD), diabetes and other aspects of physical healthcare.
- Developing and collating audits.

92% of registered nurses and HCAs working in the inpatient units have been trained in NEWs. All new staff attending the Ealing induction are trained as part of induction. staff are now using the electronic NEWS on Rio. Around 500 staff including staff in WLFS have been trained and assessed on NEWS. The NEWS training incorporates training on care of a person following rapid tranquillisation. A NEWs audit tool was developed, four audits were carried out a Red, Amber Green (RAG) rated score card was introduced and shows steady improvement.

SBARD aims to enable staff to communicate effectively especially in emergency situations and at handovers.
Now 85% of staff have been trained in SBARD. An SBARD RAG rated audit was developed and an audit of patient handovers showed excellent results.

The prevalence of diabetes in mental health settings is at least twice that of general hospitals and caring for people with diabetes can be challenging when a person is unwell. A diabetes procedure was developed and 90% of registered nurses trained in care and treatment of a person with diabetes. The training encompasses diabetic emergencies. Now all new staff attending the Ealing induction are trained as part of induction.

The nurse consultant has worked with the RiO team to develop the physical healthcare portal, electronic NEWs chart and physical healthcare assessment documentation. A physical healthcare documentation audit tool was developed and RAG rated. Four audits have been carried out and show steady improvement in documentation.

All registered nurses and healthcare assistants now receive training on induction on NEWS, SBARD, Falls, dysphagia and those in Local Services are also trained on wound care and pressure ulcer prevention. Student nurses and new doctors also receive physical healthcare training on induction.

The nurse consultant has written a paper on her work within the Trust and this has now been accepted for publication. She has also lectured on her work at a recent national conference on physical healthcare in mental health. Her work on managing diabetes mellitus has also been published.

Advanced physical healthcare skills

Staff at band 6 and above have access to venepuncture courses at Ealing hospital, as part of collaboration. Relevant registered nurses at all levels have access to a one day course in urinary catheterisation run at Ealing hospital by the nurse consultant in physical healthcare. Staff who have completed the course then work in Ealing hospital and are supervised and enabled to gain competency in urinary catheterisation. Details of this collaborative work across acute and mental health and our achievements in physical healthcare will be published in the Nursing Times.

Medicines management

Improving patient experience

Pharmacy continues to work in collaboration with West London Collaborative on a work stream to improve 'supported decision making in medication'. Workshops are being carried out with staff, service users and carers to develop tools to support teams to be able to embed shared decision making in practice.

Pharmacists have furthered the work to improve access for patients and carers to pharmacy advice and carry this out in many ways including: offering 1:1 sessions for inpatients, facilitating carer group and patient education sessions in inpatient units and in the community and contributing to patient led recovery college workshops.

A pharmacist non-medical prescriber has set up a pilot pharmacy medicines review clinic in Hounslow. The clinic takes both self-referrals and referrals from other professionals. The pharmacist undertakes a review of all medicines, efficacy, adverse effects and patient's experience and in consultation with the service user and the team may make changes to medicines based on the outcome of the review.

The Trust's consultant pharmacist has been integral in the promoting health and wellbeing for patients on clozapine and other high risk psychotropic medicines programme. This is an initiative to provide additional support for patients on clozapine and other high risk medicines by helping to manage and prevent many of the adverse effects and physical health management problems associated with being on these psychotropic medicines.

Clinical effectiveness

The chief pharmacist has worked closely with colleagues in business technology to develop electronic processes within the electronic patient record to support the management of over 450 clozapine outpatients. A clozapine portal has been developed to enable staff easy access to recording of physical health information. A clozapine monitoring form has been devised to allow recording of blood test results and monitoring frequency. This also allows staff to view the current prescription and record what medicines have been given out. Clozapine outpatient's prescriptions are being prescribed electronically on the patient record system. This allows for real time access to information on prescribing and allows the process to become 'paperless' which provides a weekly report to support pharmacy in dispensing.

The 'Summary Care Record' SCR provides rapid access by NHS staff to an abbreviated GP record containing information on current regular medication prescribed by the GP, acute medicines and allergies. This helps to ensure patients receive the right medication on admission to hospital. Having already implemented SCR access for all pharmacy staff, pharmacists have undertaken a training program with doctors and nurses to ensure they have access to this important resource. This will become part of the induction program for all relevant staff.

Pharmacists are an integral part of the multidisciplinary team providing input to ensure the safe and effective use of medicines. The Trust is investing in developing pharmacist non-medical prescribers who will further support the team to improve patient care by improving access to medicines. The department now have three qualified non-medical prescribers and more in training.

The pharmacy continues to 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 and have been involved in the development of training on an electronic competency assessment for medicines management and optimisation for nurses. Pharmacists have also increased training to doctors to improve knowledge of medicines safety and Trust policies, procedures and guidelines.

Pharmacists continue to be regularly involved in virtual diabetic and respiratory ward rounds, and GP medicines reviews for forensic patients.

Pharmacists are members of the National Medication Safety Network and the Clinical Pharmacy Respiratory Network, this ensures that good practice is shared and embedded across organisations.

Pharmacy has continued to invest in staff development and has a program of training staff in clinical pharmacy, quality improvement, leadership and management training. This ensures staff have the skills to work as effectively and efficiently as possible. Two of the Trust's pharmacists have been re-credentialed with the College of Mental Health Pharmacy as practicing at an advanced level and we have had a successful applicant for the aspiring pharmacy leaders program.

Patient safety

The pharmacy team have developed and implemented a high dose antipsychotic therapy (HDAT) register. This allows staff to ensure that patients on high dose antipsychotic therapy are monitored in line with the Royal College of Psychiatrists recommendations.

The pharmacy team have also supported wards by identifying patients prescribed and administered rapid tranquilisation. This should enable ward staff to ensure appropriate post administration monitoring is completed.

Home Ward pharmacists have developed an electronic discharge summary on the services electronic patient record, to replace the previous handwritten document. This allows GPs to access the summary as soon as it has been completed on the electronic record, ensuring accurate information is available as soon as the patient has been discharged from the service.

Following reports of medical gases being at risk of theft the pharmacy department has implemented an oxygen register. This ensures that all oxygen cylinders to be tracked in the Trust and allows pharmacy to monitor expiry dates.

The pharmacy medicines management technicians have developed and implemented medicines management technician standards. This has ensured a consistent way of working across the Trust to ensure patient safety. Technicians record interventions and communicate these to the ward manager. This has resulted in a very positive change in ward staff practice resulting in fewer errors in inpatients individual medication trays, improved room and fridge temperature monitoring and improved signing for administration of medicines.

Pharmacy provide a bi-monthly Medicines Matters bulletin that is disseminated to all staff. This bulletin provides an update including new guidance on medicines in mental health, audits carried out on medicines in the Trust, news and reviews on medicines and learning lessons from medication incidents.

Pharmacy continue to carry out regular audits on safe and secure handling of medicines, controlled drugs management, and have audited omitted doses, medicines reconciliation, rapid tranquillisation and antimicrobial stewardship this year.

Pharmacy have also responded to and where appropriate taken action on alerts on medication including developing posters. The pharmacists have been working closely with the crisis resolution home treatment teams to improve recording of information on medicines and improving medication ordering processes to ensure timely provision of medicines.

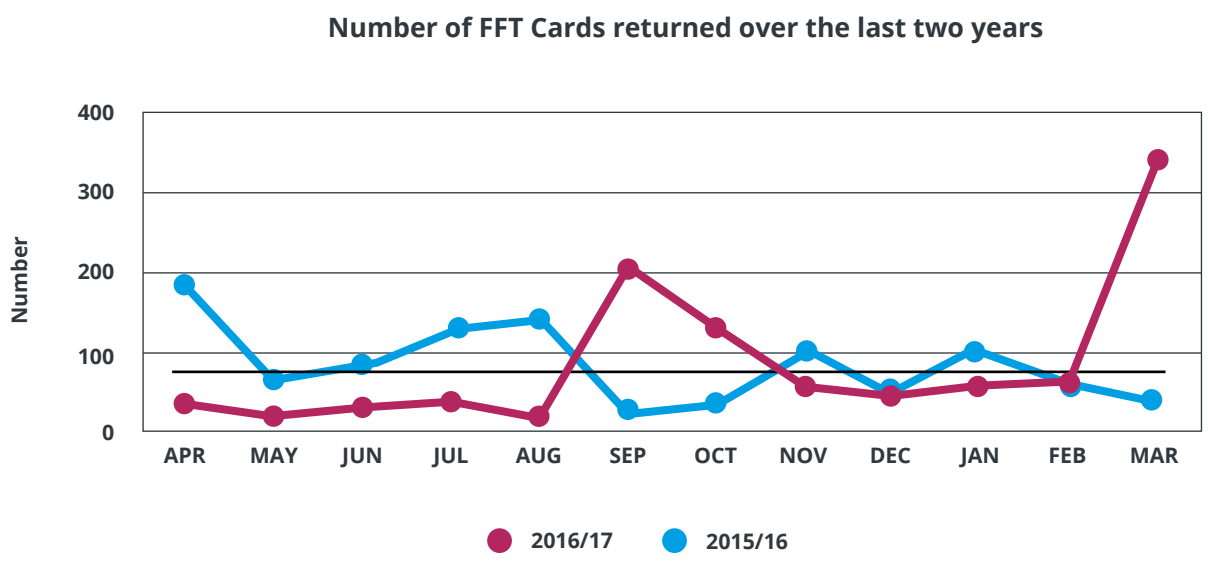
Pharmacists are working in collaboration with the modern matrons and senior clinical managers to improve safe and secure handling of medicines on inpatient wards and have developed a tool to support quarterly reviews.

Friends and Family Test

Patient

The Trust made the decision to bring the Friends and Family Test in-house in May 2016 as they experienced several problems with the company contracted out to manage the process and reporting. the difficulties were relating to the quality of the reporting, the timing of the reporting and the inability to make regular changes to the additional questions. This meant that service users who are being cared for by the Trust for a long period of time were asked the same questions on a regular basis. This change over meant that the Trust made a cost saving of £4552 per annum.

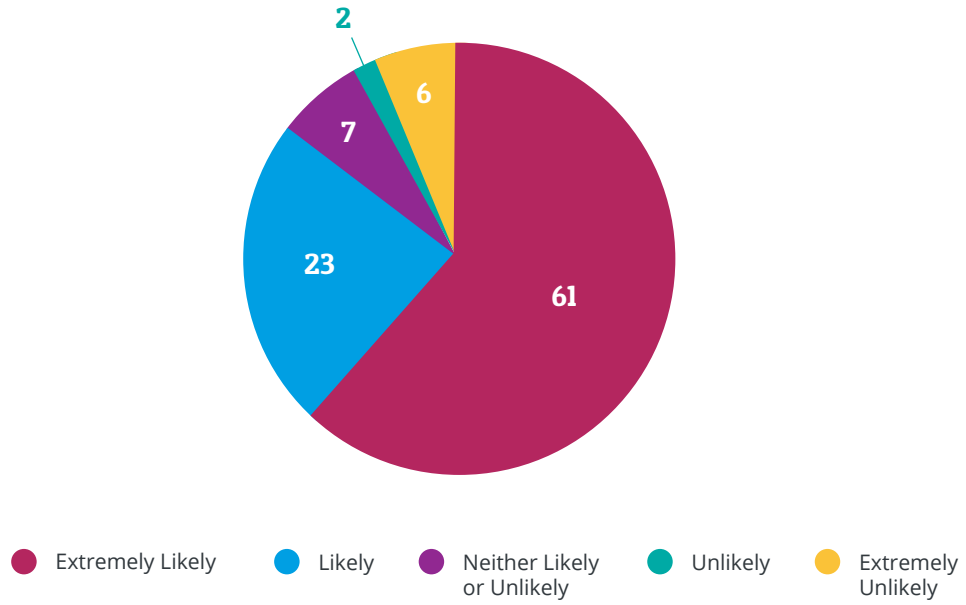
The following graph shows the number of Friends and Family Test cards that have been returned over the year with the previous year included for comparison.



The following chart shows the overall annual percentage breakdown of the results which highlights that the majority, 61% of responders, would be extremely likely to recommend our services to friends and family.

The increase in the number of cards returned in September 2016 and March 2017 was due to a return of cards that had been sent to the provider who previously managed the process and reporting. The data was entered the month that they were received back into the Trust.

Percentage of responses to the question how likely are you to recommend our services



The Friends and Family Test cards have a text box to enable the patient to give the reason for their response. Below is a small selection of some of the comments received.

Cognitive Impairment & Dementia Services
Because I can always talk easily with them they are always helpful and very caring and my husband loves coming to this centre As a carer I am a regular visitor to the limes and from what I have observed the care given to my mother is exemplary Waiting times too long
Child and Adolescent Mental Health Services
As I feel it is a long process to get anyone to listen/understand where you are coming from. Took over 3 years before anyone listened to us as a family The staff and doctors are kind, helpful and efficient I have had a lot of help with my children
High Secure Services
Because its Broadmoor which is high secure so obviously I wouldn't be much of a friend to recommend a high secure unit to them Better than Ashworth. More productive things to look forward to. Clean and tidy and looks new Not sure. I'd like to thank the staff. Well done thank you
Liaison and Long Term Conditions
I'd like to make it clear that I'm really happy with service as I feel it makes a positive change in my life Haven't had much experience of it yet Staff very unhelpful. They are rough when dealing with me. Encouraged by senior staff. Foreign staff cause problems.

Primary and Planned Care
Very professional and effective Not on time with meds and meetings always late don't give notice on lateness and reschedule of appointments Although running late sometimes I always get the help and care I need
West London Forensic Services
All staff very experienced and understanding I don't believe in the institution/psychiatry it is anti- religion. I am a catholic in the power of Christ to heal At times good and at times bad 50/50 left a thank you note on discharge addressed to Jo Dow and Eddie M'Mari
Access and Urgent Care
Care coordinator very nice guy The meal options should always include fruit and veg. With every meal there should be salad. These two things have not happened so far. My mum is cold at night although I've been offered extra blankets by staff! I think it's the windows

Staff

We implemented the staff Friends and Family Test in April 2014 when the Department of Health introduced it to NHS Acute Services. This is an opportunity for staff to feedback their views on the organisation at least once per year. It is hoped that staff FFT will help to promote a big cultural shift in the NHS, where staff have further opportunity and confidence to speak up, and where the views of staff are increasingly heard and are acted upon.

Quarter 4 Data	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total
How likely are you to recommend this organisation to friends and family if they needed care or treatment?	36	117	62	19	20	11	265
How likely are you to recommend this organisation to friends and family as a place of work?	46	91	48	46	31	2	264

The table above indicates that the staff who completed the Friends and Family Test are more likely than unlikely to recommend the Trust to friends and family if they needed care or treatment and as a place of work.

Sign up to safety campaign

The Trust signed up to the Sign up to Safety campaign in January 2015. We introduced quality improvement plans after our CQC visit in June 2015 to monitor the progress of the actions we agreed. We decided in 2015/16 to embed the Sign up to Safety actions within this new robust system.

Initiatives and improvements in Local Services

Cognitive impairment and dementia services (CIDS)

CIDS community teams

Community business case implementation

The cognitive impairment and dementia service have successfully implemented the business cases for Ealing and Hounslow. This has facilitated the safe discharge of 680 patients to primary care via the dementia link worker service. This is having a positive effect on nursing caseloads, which allows the clinicians to provide improved quality of care and significant post diagnostic care.

The business case for Hammersmith & Fulham has been agreed and full implementation will begin in August 2017. The Hammersmith & Fulham community business case will allow the Hammersmith & Fulham team to reflect the service provision in Ealing and Hounslow, with particular emphasis on the introduction of the dementia link worker service to the borough.

The following improvements will be implemented in Hammersmith and Fulham by September 2017:

- Targeted support will be provided by the dementia link worker for patients and carers discharged from secondary care.
- Quick referral back to secondary care facilitated by the dementia link worker as appropriate.
- The dementia link worker role will provide a single point of contact for patients and carers.
- The dementia link worker role will provide continuity for patients and their carers.
- Provides an intermediate tier of specialised targeted community support, placed between primary and secondary care for patients and their carers.
- Facilitates increased information sharing between primary and secondary care.
- The introduction of the dementia link worker will provide increased capacity for secondary care to undertake initial assessments, specialised assessments, post diagnostic support, specialised groups and crisis management.
- Improved targets for diagnosis (9 weeks from referral to diagnosis).

Care pathways

A number of working groups have been established to review the patient and carer journey through the assessment, diagnostic and post diagnostic phases of the CIDS community pathway. The objective of these working groups in collaboration with patients and carers is to:

- Improve patient and carer experience.
- Identify efficiencies and streamline the processes.
- Shorten waiting times for initial assessment and diagnostic appointments.
- Increase capacity for initial assessments and diagnostic appointments.
- Standardise information provided to patients and carers.
- Embed post diagnostic care and support in all teams.

Memory service accreditation

The Ealing & Hounslow community teams are still accredited by the Memory Services National Accreditation Programme which assures patients, carers, staff, commissioners and regulators of the quality of service being provided, and is endorsed by the Care Quality Commission. The implementation of the Hammersmith & Fulham business case will allow the team to commence the accreditation process, ensuring quality will be assured in all CIDS community services.

CIDS inpatient services

Both Jubilee Ward and The Limes Unit have been successfully registered with 'John's Campaign' which allows for increased carer involvement and carer/patient contact whilst their relative is an inpatient with CIDS.

Jubilee Ward has recently undergone a skill establishment review which will allow for improved quality of care for patients and improved support for carers. The establishment review has provided for the introduction of specialised psychology support, increased speech and language therapy input and the introduction of the assistant practitioner role. The Limes Unit is currently undergoing a similar process.

We reviewed the prevention and management of violence and aggression training needs for Jubilee Ward and The Limes and identified that bespoke training could meet the needs of our service users. Training has been developed which will be delivered over one day (rather that current 5 day teamwork course). The new training schedule will commence in June 2017 and will be evaluated.

We have been awarded charity funding to develop an indoor garden room at The Limes to enhance the therapeutic environment. Work is underway and we hope that it will be in use by June 2017.

Liaison and long term conditions

Tri-borough WLMHT Improving Access to Psychological Therapies (IAPT) services

This year the 3 services have collaborated to commission and launch an online computerised CBT package. The teams partnered with MindDistrict in order to provide evidence-based treatments that can be accessed 24/7 and provide support at a time that is convenient to our service users. There are a number of different treatments that can be delivered including depression, mindfulness, low self-esteem, stress and other specific anxiety disorders. The treatments are always guided by a therapist and the teams have completed training on how to deliver online treatments in the most effective way. The next stage will be to start writing our own bespoke online modules to reflect community languages and local priorities.

H&F Improving Access to Psychological Therapies (IAPT) service

This year H&F IAPT has carried out a significant building project to consolidate the team from 2 into 1 administrative base. This has involved two separate phases of development on the Gloucester House site. The first stage was to create new clinical space within the existing building and the second stage was to redevelop and extend a disused garage to provide office accommodation, a self-contained meeting room and manager's office. As a result of careful planning and collaboration with the capital projects team and the building contractors the service has been able to continue operating throughout the building works. There has been no disruption to the delivery of a clinical service throughout the year. The new buildings will be fully occupied from April 2017 and will provide a more efficient service because the team no longer needs to staff, maintain and run 2 separate team bases.

Hounslow Improving Access to Psychological Therapies (IAPT) Service

It has been a productive, exciting year for Hounslow IAPT with continued expansion and development of the service. The service focused on two areas which were the development of the long term conditions programme, and a project on enhancing staff wellbeing.

The team have introduced a group therapy programme for those living with long term health conditions and they have started to work closely with other specialist health teams focussing particularly on diabetes, respiratory conditions and cardiology. They have developed a 6 week programme for diabetes, and are now offering psychological wellbeing workshops alongside one of the community respiratory teams. They have also identified long term health champions while also meeting regularly with the other services at H&F and Ealing to share ideas and develop the programme further. The next steps are to enhance the current programme and start work on the cardiology initiative which will involve working with a cardiac rehabilitation team at a local hospital. Staff training in this area will become of focus in the coming months.

Staff wellbeing has also been an area of development at Hounslow. Alongside the daily clinical and personal supportive structure embedded in the service, a staff mindfulness course has been completed by 10 members of the team. This was reviewed very positively by the participants and another course will be arranged to train further staff soon. Other developments in this area include the formation of a staff wellbeing committee who arrange regular events for the team, a reflection group for staff, monthly staff awards and a makeover of our base at Isleworth to improve the working environment. Work in this area will continue to evolve and develop in line with the expansion of the service with regular feedback from staff a prominent feature.

Ealing Improving Access to Psychological Therapies (IAPT) service

This year the Ealing IAPT service focused its attention on increasing access to talking therapies in the borough. Historically the service struggled to get enough people through the door to meet its service objective; However 2016-17 saw a dramatic change, following the implementation of various initiatives. Concerted efforts

were made in areas such as GP engagement (to increase referrals) and community workshops which proved effective. However, one drive which appeared to support the process of access rates to our service was utilising the brilliant feedback the service received in a bid to challenge the stigma associated with accessing talking therapies and fostering hope for those who are reluctant to engage in treatment. Patient Opinion provided a useful platform for this and the service set about making all the patients who access the service aware of this. With some stories being read by over 1000 people we believe that it goes some way in contributing towards increased access into our service and managing patients' expectations. An added advantage is that it appears to contribute to staff morale and wellbeing following the recognition given to our therapists for the role they played in helping people recover from their difficulties.

Clinical health psychology and neuropsychology service at Imperial College Healthcare NHS Trust
Major Trauma Centre, St Mary's Hospital

Improved family/carer support, education and understanding of patients' needs
High levels of distress amongst families, friends and carers is common on the Major Trauma Centre. The shock of injury, witnessing a loved one with significant injuries, understanding the impact of these and what to expect for the future are frequently reported concerns. NICE guidelines for Major Trauma care include recommendations on providing support and information for family members and carers.

An initiative was agreed with ward staff and management to provide a psychology-led group to provide emotional support, education and information to family members and carers. This is an initial pilot project and outcome measurement includes both reports from staff and attendees to the group sessions.

Charing Cross neuro rehabilitation unit (CNRU), Charing Cross Hospital
Improving safety of patients, reducing distress, increasing engagement with treatment, and supporting staff

A major identified problem for the CNRU was the management of challenging behaviour in neurological patients with acquired brain injuries, e.g. individuals with post-traumatic amnesia. This was leading to increased risk for of harm to patients and staff, reduced engagement with treatment, increased distress for patients, their families and staff caring for them and high levels of reported burnout from staff.

Using an evidence-based approach, clear guidelines were developed for staff to implement on the CNRU. Both classroom and ward-based staff training sessions were delivered and continuous supervision is provided. Staff feedback has been overwhelmingly positive and reports of improved patient engagement are encouraging. The guidelines and their application continue to be reviewed.

Links with IAPT services
Provision of staff training to support IAPT expansion into working with long-term conditions (LTCs)

Recent developments in IAPT services include a drive to increase provision to individuals with anxiety and depression, with an expectation that a significant proportion of this expansion will be with individuals with long term physical health conditions. IAPT services have limited experience in working in this area and an area of need is for existing staff to be trained in work with individuals with LTCs and co-morbid depression and/or anxiety disorders. A high intensity IAPT worker was invited for a pilot 6 month placement within our service to provide a training opportunity to address this need. Specific cases where anxiety and/or depression was a prevalent feature were identified by a clinical health psychologist, who was able to provide supervision and training for the IAPT worker to adapt existing therapeutic interventions to working with individuals with LTCs. The IAPT worker has also had the opportunity to attend the diabetes multi-disciplinary meeting where diabetes consultants, a specialist diabetes nurse and a clinical health psychologist discuss patients' psychological needs and referrals for psychological intervention are identified. The pilot is on-going but outcome will be evaluated using the competency framework for working with people with persistent physical health conditions.

Perinatal mental health services
The Trust's new Perinatal Mental Health Service was launched on 29th February 2016. It offers assessment, care and treatment for women with severe and complex mental health problems from preconception, throughout pregnancy and until 6 months postpartum. Women are seen in antenatal clinics, maternity wards, children's

centres and at home. The service works in partnership with maternity staff, health visitors, IAPT, secondary care mental health services and children's social care.

The service was reviewed by the Royal College of Psychiatrist's Centre for Quality Improvement Perinatal Quality Network in December 2016. This assesses how well the service is performing based on nationally agreed quality standards. The review concluded:

- The service has a strong multi-disciplinary team.
- It is delivering a high quality of care.
- Waiting times are short.
- There are well established relationships with local teams, representatives of which praised the service for its accessibility and support.
- Patient feedback about the team was overwhelmingly positive. Comments included: "staff are passionate about their work", "clear communication" and "excellent care."

In 2016, perinatal mental health training has been delivered to over 600 professionals, including midwives, GPs, health visitors, IAPT and secondary care mental health professionals. Feedback has been overwhelmingly positive. Professionals reported increased knowledge and confidence in identifying and caring for with women in the perinatal period and a better understanding of the role of the perinatal mental health service, the referral criteria and care pathways, and the importance of joint working.

The Perinatal Mental Health Service's Clinical Psychologists have worked closely with IAPT services to provide training for IAPT staff and to ensure effective pathways so that women who need psychological therapy in the perinatal period are prioritised and seen rapidly. This work was recognised with an award for partnership working at the WLMHT quality awards.

The Friends and Family Test feedback showed that 96% of women are "extremely likely to recommend" the service. Service user feedback forums have been held in each borough.

The service was highly commended in the Positive Practice Awards 2016. The development of the service was also highlighted in "perinatal mental health services in London: Guide for commissioners" (January 2017) as an example of good practice.

An evaluation of the first 8 months of the service was presented to commissioners in February 2017 and this will form the basis for agreeing future recurrent funding.

Liaison Psychiatry Team
Secure funding to provide a more responsive service for people with mental health needs during out of hours at the Acute Hospital.

Liaison Psychiatry Services have been providing comprehensive assessment during operating hours for people who present to the acute hospital with mental health needs. To enable a more consistent service around the clock and maintain responsiveness to the people using the service, a collaborative bid with the north west sector, involving providers and commissioners, was put together to NHS England for funding for a 24/7 liaison service in all 3 of the services provided. Feedback from NHS England was very positive and the bid was a success. The roll out of the service will commence in April 2017.

Liaison Psychiatry Team at West Middlesex University Hospital
Improving safety of patients, reducing distress, increasing engagement with treatment, and supporting staff.

There has been a national drive to improve alcohol screening in clinical settings. Through active involvement of Liaison Psychiatry at the Alcohol Steering Group, the routine use of Audit-C alcohol screen tool was implemented in the acute hospital as part of a Commissioning for Quality and Innovation (CQUIN). The tool has been incorporated into medical admission clerking for the Acute Trust and all the assessment is done by Liaison Psychiatry. Training for acute hospital clinical staff was also delivered. The improved screening has translated into more frequent referrals for people who are in need for alcohol interventions, thus improving access to appropriate care for this cohort of patients.

Liaison Psychiatry Team at Charing Cross Hospital
Improving safety and reducing distressing for people under enhanced support engagement.

There are challenges in providing safe and high quality therapeutic engagement and supportive observation for people who are either at risk to themselves or others in the acute hospital setting. A business case was jointly developed between the liaison psychiatry team and the

Acute Trust to setup an enhanced support team where substantive staff were appointed to deliver the above intervention.

Weekly clinical review meeting with liaison psychiatry input allowed more timely review of the need for supportive observation. Risk management tools were jointly developed to improve the safety of people managed by the team. Communication systems and processes were developed for hospital security staff to prioritise their support to those who are more at risk. A range of structured activities and wellbeing initiatives were developed with the dementia nurses to improve care for older adults under supportive observation. Initial evaluation demonstrated cost saving for the Acute Trust, positive feedback from staff and a reduction of incidents related to aggression and falls.

Gender Identity Clinic

On 1st April 2017, after months of close working between the Trust and Tavistock and Portman NHS Trust, the interim management provider, the GIC staff and service users made a smooth and safe transition to their new organisation. This was a significant achievement given the on-going work to manage increasing referral rates and working on quality initiatives to address their CQC action plan. These include:

Developing and implementing a new service user involvement strategy with increased ways of getting feedback and having service users support the design of the new website, patient information and service design.

A robust clinical governance process has been embedded which has become part of the service's routine practice and has therefore been able to transfer seamlessly to the Tavistock and Portman NHST Trust structures.

The staff at the clinic worked on a number of strategies to improve flow of work including making a significant improvement to volume of rescheduled appointments from 30% to 11% in the space of a few months.

One You

Ealing CCG Severe Mental Illness and tobacco reduction project

One You Ealing has successful piloted a project to support the reduction in the number of people with severe mental illness (SMI) who are currently smokers in high prevalence GP surgeries. The project highlighted improved access for patients to attend their appointment in GP surgeries and increased access to the stop smoking service. The pilot project provided mood management strategies and harm reduction method. This has resulted higher quit attempts from this cohort of patients and their quit rates were comparable to general populations. The CCG is pleased that the project is contributing towards their premium quality target with the aim of making a significant difference to health, leading to long term improved health outcomes in Ealing.

Development of Ealing Data Capture Recording System (DCRS) database

In year 2016-17 One You Ealing worked with NHS West Midlands Commissioning Support Unit (CSU) to develop a localised database, the Ealing Data Capture Recording System, to capture and record patient interventions in primary care settings. The database is based on the process of intervention delivery and allows the service to tailor behavioural interventions more appropriately, whilst providing a more holistic service offering.

One You Ealing produced national guidance for PHE
The service has produced implementation guidance for mental health services in England. It gives detailed guidance for providers on how to go smoke-free in their organisations, detailing the benefits of a smoke-free environment for people's mental health, how to develop and implement smoke-free policies, and how to tackle common challenges. The Trust's experiences of implementing a smoke-free policy are referenced throughout the guidance as an example of good practice. Our use of the ITEP approach (International Treatment Effectiveness Project), which uses maps as a way of creating a visual 'hook' to challenge the way patients think about smoking, has been very effective, and has been used as a case study by NHS England.

Secondary care

NICE guidance PH48 recommends that all NHS funded secondary care sites should become completely smokefree. Based on the recommendation, One you Ealing started a smokefree working group to support the implementation. The working group consist of wide range of stakeholders to engage and in helping identify and address challenges, and communicating important messages.

The Trust went smoke free in January 2016. In light of learning from other mental health Trusts who have gone smokefree, including South London Maudsley NHS Foundation Trust (SLaM) and Cheshire and Wirral Partnership NHS Foundation Trust (CWP), the implementation focused on 4 areas which are support for service users, training for staff, estate and facilities and a communication strategy.

It is important to emphasise that we are committed to monitoring and strengthening our smoke free policy and improving our patients' experience, physical healthcare and mental health. The smoke free agenda has been embedded as part of the Trust physical healthcare priorities to share the best practise.

Primary and planned care

The wellbeing network, Hounslow 'Let's Connect'
The key aims of the Wellbeing Network Hounslow are to combat social isolation and improve the mental and physical wellbeing of the Hounslow community

It is a social network that connects people and organisations in order to improve the wellbeing of local residents. The network is available to adults by offering two key approaches to support people.

Firstly it brings people together through 'Let's Connect' meetings. These meetings include people within the borough of Hounslow to share their assets and strengths and to build relationships.

The other key area of work is to provide an opportunity to meet individually, offering, if required, a chance for members to map their social network. The social-mapping tool has been developed by the McPin Foundation and supports people to be able to see and consider their personal network, for example in terms of people they connect with and places they go to. It supports people to decide if and how they would like to develop or change that with support, where required. This works in a very visual way, producing a map that has the potential to develop and change, depending on the desired outcome of the person.

This network sits alongside the support service users receive from our services, it can have a very important preventative role for those who feel that social contact is lacking for a range of reasons. Please visit the website for further information http://www.wellbeing-network.org

Skills for Employment Programme (vocational recovery service)
The Skills for Employment (SfE) course is a programme that has been co-produced by WLMHT vocational recovery service staff (VRS) and peer trainers to help facilitate people in secondary mental healthcare get back into paid employment. Having run for three years across Ealing, Hammersmith and Fulham and Hounslow, there had been some minor changes made based on feedback from participants, but overall the 9 cohorts had been received well by those completing the course. This comprehensive review involved gathering both qualitative and quantitative data using previous feedback, speaking to VRS staff, peer trainers and previous participants, and conducting a peer trainer administered telephone interview.

From this feedback the main points raised were:

- The benefits session to be removed as all parties felt it did not meet student needs.
- Students would like to have a portfolio based course with a certificate issued at the end.
- Students liked the course being 7 weeks. .
- To still have a centralised intake system and telephone screening.
- Copies of the workstar to be taken in at the end of the sessions as an outcome measure.

CAMHS

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 Trusts are working with inpatient providers to ensure psychiatric beds are available for North West London children and young people, which will make visits easier for their families, carers and local clinicians.

The programme has already had successes in bringing together young people, families, community teams, social workers and education professionals to agree goals of admission, facilitate discharges to community services and identify ways to manage crises in the community. This work has resulted in intensifying the input and engagement with children and young people and their families to reduce admissions and supported the principle of proactive planning for discharge at admission.

CAMHS out of hours service

Following the initial one year pilot and evaluation, the Trust have been commissioned to deliver the CAMHS out of hours service for a further two years, with extended core hours of 4.30pm to 9am Monday to Friday and 24 hours a day on a Saturday, Sunday and bank holidays (8.30am – 9pm).

Benefits of this service include:

- Improved health outcomes through means of rapid assessment.
- Improved quality of life through greater continuity of care.
- Reducing avoidable hospital admissions.
- Reducing disruption to school, family and social life.

This not only enables staff to be substantively recruited to both twilight week-day shifts (4.30pm – 9.30pm) and 12-hour weekend day (8.30am – 9 pm) and night shifts Monday to Sunday (8.30 pm – 9 am), but also facilitates a handover period between staff within the team and their colleagues who work in the day time service. The experience and expectation is that this operational shift model will attract the suitably trained staff.

In the longer-term this service model offers the opportunity through a process of consultation to integrate the week-day, weekend-day and twilight teams with the night service which would mean the Trust could then offer a fully integrated 24/7 service, so improving response to children and young people in crisis.

CAMHS eating disorders service

The newly funded service launched on 1st April 2016 and was fully recruited with substantive staff by December 2016. The service has delivered on the access and waiting time indicator - young people at high risk are now being seen within a week and an overall wait at four weeks for all young people. This new service provides evidence-based treatment interventions for both the young people who need these services, and their carers and families too.

Hammersmith and Fulham CAMHS schools link pilot

The taskforce report Future in Mind, published in March 2015 outlined a number of actions to help improve access to effective mental health input for children and young people. The actions included the establishment of a named point of contact within CAMHS and a named mental health lead within each school to enable closer relationships between schools and CAMHS and development of a joint training programme.

NHS England and the Department for Education ran a pilot to test this named lead approach and to trial a joint training programme for these lead roles. 22 CCGs were successful in the bid, Hammersmith and Fulham being one of them. The pilot ran from January 2016 to March 2017. The CAMHS link role was offered by 6 community CAMHS clinicians and 2 specialist CAMHS clinicians each covering one or two schools. There was a mix of schools from Hammersmith and Fulham who took part in the pilot including primary and secondary schools, alternative provision (pupil referral unit) and special schools for children with disability. Each school identified a mental health lead within their school staff. Each pilot school got 1 session per week of link CAMHS clinician time. This capacity was released by backfilling time in the CAMHS service.

The link clinicians used their time to:

- Offer training to mental health leads in school and school staff on various topics including media and mental health, anxiety, self-esteem, resilience, body image, anger management and autism spectrum disorder.
- Familiarise the school lead with CAMHS referral process, screening tools, outcome measures and evidence based interventions.
- Offer consultation and advice to school staff on referrals to CAMHS or other agencies.
- Offer parent sessions on positive parenting and the importance of play alongside school mental health link.
- Offer drop in sessions on exam stress or provide one to one clinical input to young people.
- Local evaluation of the pilot.

There were two days of joint training for CAMHS link clinicians and pilot schools aiming to:

- Raise awareness and improve knowledge of mental health issues amongst school staff.
- Improve CAMHS understanding of specific mental health and well-being issues within schools.
- Support more effective joint working between schools and CAMHS.

The feedback from the pilot schools involved was:

- Increased confidence to deal with mental health issues.
- Reassurance about their practice.
- Benefit from support and advice.
- Reflective practice.
- Better understanding of CAMHS referral process.
- Feedback on CAMHS involvement.

Transforming services through children and young people's improving access to psychological therapies (CYP-IAPT)

The three main components of this, which include delivering evidence based interventions, the use of routine outcome measures and service user involvement in service delivery and planning continues. Staff remain committed to training with CYP-IAPT at two levels, trainees (2 years) and supervisors (1 year). This knowledge continues to be embedded into the services. The use of outcome measures are routinely used to inform assessment and care planning with service users.

Workforce development in line with CYP-IAPT has allowed the development of band 4 children's wellbeing practitioners and the band 8a supervisors. The roles will be exciting and varied, with rotational placements in different teams on offer e.g. families first, schools, tier 2 CAMHS and early help, enabling the post holders to develop a range of skills and experience whilst studying at University College London for a postgraduate certificate in child and young person's psychological wellbeing practice.

The training will enable practitioners to deliver - under intensive supervision - high quality brief, focused evidence-based therapeutic interventions for children and young people experiencing mild to moderate mental health difficulties (low mood, self, anxiety and behavioural difficulties). This in turn will equip those in post to operate effectively in an inclusive, value driven mental health service.

Access and Urgent Care

Inpatients transformation programme

There is broad agreement that wherever possible, patients prefer more community based treatment, delivered closer to their home. The whole health and social care system is starting to think more and differently about the way healthcare is provided, with more focus on moving services into the community and closer to home.

This thinking is outlined in the NHS five year forward view for mental health, NHS Five Year Forward View for Mental Health, NHS England's Sustainability and Transformation Plans, and the North West London Collaboration of CCGs' Likeminded Strategy

From experience we know it is bad for patients to spend too long in an acute setting when they are fit and well enough to be discharged. Knowing that our patients are staying in beds longer than the national average (43.7 against a national average of 32.3), with over half of our patients staying in an acute inpatient ward for longer than 50 days, we believe there is a real need for change.

We want to transform our services to improve the quality of care we provide and to make it easier to discharge patients when it is right to do so and we plan to and to do this:

We aim to:

- Treat more people in the community; and treat them earlier so they avoid a mental health crisis in the first place.
- Keep people in hospital for as short a time as possible and allow patients to recover at home supported by friends and family rather than sitting in a hospital ward.

We need an inpatient service that is:

- Delivering high quality care.
- Providing improved patient experiences and patient journeys.
- Financially sustainable.

This transformation will be achieved through a programme of work that will be co-produced with service users, patients and carers and where co-production will be a theme running throughout this entire programme.

Our staff are key to developing and designing this change and we value the skills and expertise of the clinicians, nurses and allied staff responsible for delivering these services. This process will be an on-going conversation. All staff are encouraged to get involved in discussing and shaping this transformation process.

We are excited about the future of this programme and very much look forward to reporting our progresses towards this transformation project in our 2017/18 Quality Account.

> "Home Ward - the service was very good. I would not have been able to deal with the surgical drain myself. the staff were very knowledgeable and efficient . I was reassured by the health checks that were carried out by the professionals"

Initiatives and improvements in Forensic Services

West London Forensic Services (WLFS)

Personal protective equipment (PPE) responder's team

WLFS has recently developed its own personal protective equipment (PPE) responder's team. This is a cohort of 30 staff from a wide range of disciplines and backgrounds who have completed highly specialised training in the use of personal protective equipment so that they can be rapidly deployed to assist in the safe containment and resolution of any serious incident in which normal PMVA teams would be considered inadequate or unsafe to intervene. Traditionally WLFS have been dependent on a response from the police to deal with such incidents but this was less than ideal due to their own limited resources as well the owing reluctance of the police to get involved in incidents within mental health inpatient units. The advantage of having our own PPE service is that we have a team of mental health professionals who are familiar both with our service as well as the service users and who are able to respond and safely resolve serious incidents in a professional manner using their specialised training. This PPE service has the support of both the CQC and NHSE and there is a very robust governance process in place to ensure that it is used appropriately. As far as we are aware, we are the only medium secure service in the country that has its own PPE service.

Minimising restrictive practices

Over the last year in WLFS we have continued our focus on reducing restrictive practices in order to improve service user experience whilst maintaining safe services. From the start, we have worked collaboratively with patients through service user forums and ward based community meetings to identify restrictive practices, and prioritise them for reduction where appropriate. We have conducted peer reviews across the three directorates and devised action plans; the progress of which is reviewed monthly. There has been a particular emphasis on blanket restrictions that previously applied to all service users despite the level of security, as well as those practices which service users identified as having the greatest impact on their quality of life – lack of access to mobile phones being one such example. Amendments have been made to policy. In addition we have developed a number of local training opportunities which reflect our aim to support staff to implement changes in our approach to conflict and restrictive intervention reduction. It is particularly positive that by working together we have achieved a 63% reduction in the use of episodes of enforced medication this year compared to last, and a 17% reduction in the use of restraint.

Safewards

In order to achieve a reduction in restrictive practices we have placed a much greater emphasis on preventative measures that reduce the likelihood of conflict. Safewards is one of the key initiatives. The Safewards programme offers simple, practical, evidence based interventions and tools that aim to promote effective therapeutic relationships and calm, low expressed emotion environments which feel safe and which are conducive to recovery. The ward community - staff and service users - work together to implement interventions such as clear mutual expectations, soft words, calm down methods and bad news mitigation. Following a successful pilot on 6 of the WLFS wards, the programme has now been rolled out to eight further wards. Five bespoke training days have been held with excellent attendance from staff and service users and very positive feedback. A Safewards support and review group meets monthly to support implementation and share good practice. Progress is shared with WLFS governance groups. We are currently carrying out a qualitative analysis exploring the experiences of the Safewards intervention and its implementation. Feedback data will be collected via questionnaires, focus groups and one-to-one interviews with staff and service users.

Practice development unit programme

In October 2016 WLFS launched a collaborative practice development unit programme (PDUP) with the University of West London. Six of our wards have joined this programme and each is working with the university to develop standard criteria with regard to: supporting a client-centered approach to delivery of service ensuring service users real needs are addressed; empowering the Multi-disciplinary team (MDT), service users and their carers; increasing MDT networking which results in improved communication, supporting governance and promoting effective working practices; facilitating recruitment and retention of quality

staff and increasing commitment and productivity; and influencing organisational strategy in line with the national and local agenda. The university provides tailor-made support for the unit that draws on the expertise of a team of Practice Development Unit Consultants. Ultimately the unit will enjoy the status of Practice Development Unit Programme accreditation by the University which will boost our profile and aid with recruitment and retention of staff.

Service and practice outcomes

WLFS administers two measures of service user, carer and staff experience annually. The service user and carer experience survey (2016/17) shows that we have overall maintained improvements seen in 2015/16 when compared to a baseline survey in 2014/15. This survey asks service users and carers to rate level of courtesy, empathy, frequency of contact and degree to which staff demonstrate care and compassion.

DREEM

The developing recovery enhanced environments measure (DREEM) provides an important assessment of service user recovery experience and staff experience within WLMHT. In 2016 there appears to be a positive correlation between outcomes from the recovery marker survey, returned by service users, and the organisational climate survey completed by our staff. This suggests that well supported staff are likely to be more resilient and in turn provide a more recovery oriented service. This annual survey will be repeated in April/May 2017.

Primary nursing practice audit

The primary nursing practice audit is undertaken monthly by ward managers and is quality assured by practice development nurses; it measures primary nursing clinical practice against 21 standard criteria in four key areas (service user weekly meetings, CPA attendance, presence of care plans and quality of care plans). The most recent audit (March 2017) shows a significant improvement on baseline audit in September 2015 and an incrementally improved position since September 2016.

Research

We have been working hard over the past year to build our involvement in research. We are currently participating in two important and relevant studies. The first, entitled The Social Brain (Personality Disorders) Study is in collaboration with UCL and the Wellcome Trust. It is a computational psychiatry approach using functional Magnetic Resonance Imaging (MRI) as well as behavioural assessments to study aspects of the social brain in those with emotionally unstable or antisocial personality disorder. It is aimed at understanding psychological problems and how the mind works in order to improve treatments. The second research study is in collaboration with Imperial College London and funded by the National Institute for Health Research. Entitled - staff coping and resilience in mental health: A qualitative study focussed on self-harm as an adverse event, researchers are interviewing some of our nursing staff to understand how working within a mental health setting can affect staff members' well-being and resilience and what coping strategies are used to deal with negative experiences in the workplace. The translational outcomes of this study will be the development of local interventions to better support frontline staff members in coping and developing resilience in these areas.

A continuous emphasis on quality improvement

Following the Institute for Healthcare Improvement analysis of the Trust's culture, strategies, policies, and priorities around quality improvement in April 2016, WLFS have taken up the mantle. We have appointed four quality improvement (QI) advisors and a clinical l ead for QI. An increasing number of staff are being trained in QI methodology and there are a number of exciting QI projects on-going. One such example is the innovative promoting health and wellbeing for patients on clozapine and other high risk psychotropic medicines programme (now with the catchier title "health effects not side effects"). Staff and service users are working together to test a number of bespoke initiatives using plan do study act (PDSA) cycles to improve the health and well-being of patients treated with psychotropic medications. Following a successful bid we are also proud that Forensic Services are in the first cohort of the 'quality, service improvement redesign (QSIR) practitioner programme'. This is a practitioner level development programme of service improvement which aims to enable participants to initiate progress and work towards completing a service or quality improvement project through the development of their skills and knowledge. Our WLFS project is to review transfer and discharge processes across our forensic inpatient wards to identify barriers to discharge. Using driver diagrams and other QI methodology various internal service changes and initiatives with community and social care partners will be tested in PDSA cycles in order to achieve improvement in reducing length of stay in WLFS, delayed transfer of care and delayed discharges.

Care Programme Approach (CPA)
Following the introduction of the revised care programme approach (CPA) policy in July 2016, WLFS have held a series of workshops with a view to implementing the policy and improving the quality of CPA, as well as enhancing patient and carer experience. The most recent workshop held on 10th March 2017 was extremely well attended. There were a series of presentations as well as small group work. Service users and carers provided a particularly useful narrative and recommendations. We heard of the overwhelmingly positive experiences of WLFS patients who had been empowered to chair their own CPA meetings. The outputs from the workshop will now be taken forward with an emphasis on improving the timeliness and accessibility of reports, focussing the meeting on care planning and future goals, and improving IT and administrative systems and support for the meetings.

Occupational therapy clinical model implementation and service benefits in male medium secure services
In February 2016 following the move into the new build Thames Lodge, the Riverside Centre opened and is able to offer a much larger number and greater variety of vocational roles to service users. Whereas before the only vocational roles were shop server and pricing, in addition it is now possible for service users to work in stock management, café food preparation, finance, cleaning, IT roles, as a librarian, gym assistant or barista. The number of service users engaged in vocational roles has increased from three in January 2016 to 28 in September 2016. Café on the hill in the grounds of the hospital, and the café at WLMHT Trust headquarters have now come under the management of Occupational Therapy, which will provide further meaningful opportunities for patients.

In May 2016 the new horticulture unit opened in Thames Lodge. A basic and weekly horticulture group was established as well as ward based groups. The horticulture unit provides an opportunity for service users to engage in an activity which has a growing evidence base for improving health and wellbeing. The vegetables and herbs grown have been used during food preparation and healthy living groups on the wards. The community allotment project has been re-established in the last year, which provides a vocational role for service users to access during their recovery and transition into the community.

The first cohort of Tai Chi instructors have been trained and are facilitating sessions in Thames Lodge. Currently 6 service users attend weekly sessions of this health promoting exercise on a regular basis. The next cohort of instructors is now being trained so that ward based sessions can be offered to service users.

Education
Following a consultation in December 2015 the education department was incorporated into the occupational therapy team in April 2016. This has benefited service users in a number of ways. Tutors now work alongside service users within vocational roles to support learning and basic skill development. Tutors take the lead in developing and facilitating training sessions to complement the vocational program, for example, food hygiene training. The AQA award scheme has been introduced to enable service users to gain accreditation for the skills they are learning in vocational roles. For the first time since it opened in 2007 the Orchard Secure Service for Women now has an educational lead and a range of exciting educational opportunities.

Restorative justice
WLFS have launched restorative justice approach which a big step in promoting restorative practice for those who have been harmed by crime or conflict, and those responsible for the harm. The team aims to use restorative approaches to address the harm done to individuals by incidents and conflict as part of the process of recovery. This is done by setting up the opportunity for communication between all parties involved in the incident. The communication can be face to face or through individual meetings or letters. We look forward to reporting WLFS progresses within the 2017/18 Quality Account.

High Secure Services

Minimising restrictive practice
Over the past 12 months we have continued to work with Mersey Care and Nottinghamshire NHS Foundation Trust's to reduce restrictive practices. A steering group was set up between the 3 Trusts, which aims to ensure that any restrictive practice within the high secure setting will be legally and ethically justified, will be absolutely necessary to prevent serious harm and must be the least restrictive option.

Over the past 12 months, the group has developed a 2 year on-going strategic reduction plan to address the area of restrictive practice. The group has published best practice guidelines for patients managed under long term segregation and the guidelines are in `roll out` stages within Broadmoor Hospital.

The group has developed training with patient involvement in accordance with Positive and Proactive Workforce (2015) to ensure staff are committed to and have the necessary skills and competencies to deliver change. This training will be provided in the following areas for all staff:

1. Primary induction - service user led and delivered covering the positive and proactive and least restrictive option.
2. Prevention Management of Violence and Aggression (PMVA) - breakaway and refresher training covering the positive and proactive and least restrictive option.
3. Planning in place to develop service user led training in the Broadmoor recovery college; this will be in place to ensure all existing patients and staff receive training in 2 hour sessions regarding an overview of all aspects of restrictive practice.

Broadmoor Hospital has commissioned train the trainer training in the barriers to change and HOPES model. The training took place between 7th and 10th February 2017. It is considered that the training will equip the trainers with expert knowledge of the BCC and HOPES, to enable further pilot projects with review for efficacy.

The PMVA department has led on the development of a violence reduction and management manual. This has now been completed and has been endorsed by NICE. We believe this to be the first such manual in the United Kingdom.

The hospital continues to progress the principles and practice of Restorative Justice (RJ), being a leading side for mental health in this regard. We have trained staff from a range of disciplines to work together to repair harm and reduce the impact of conflict where it has occurred between patient peers, patients and staff, and between patients and others in the lives pre-admission. This year we have undertaken a number of restorative conferences between patients with a history of conflict with the goal of reducing on-site incompatibility safely. We are also offering training for ward staff in the concepts of restorative conflict resolution. Broadmoor Hospital is participating in the start-up of RJ in a number of other mental health sites.

Redevelopment

The construction of the new Broadmoor Hospital is going well and the move of patients, staff and service is planned in 2018. A number of staff have visited the new development and further visits are on-going. DVDs have been developed for patients, so that they can understand the new accommodation and facilities. Patients have also been involved in some of the art work within the new hospital, including the curtains and acoustic panels. The configuration of the wards has been agreed and the meticulous planning for the move is well developed.

Research is underway to study our transition and to develop the evidence base about the elements of the psycho-social environment that make a difference to patient outcomes in high secure forensic settings.

Physical Health

Remote Physical Health Monitoring of Patients

Oxehealth and Broadmoor Hospital have carried out a successful trial of Oxecam camera, which can monitor someone's movement, heart rate and breathing, even in the dark.

The revolutionary new technology enabled staff to continuously monitor patients' vital signs, especially while asleep, without having to disturb them. The cameras can be installed safely enclosed inside a ligature-proof secure housing in a seclusion room or patient's bedroom. The system does not need any additional sensors or physical contact with the patient.

During the trial, 7 patients at Broadmoor volunteered to be monitored overnight. Oxehealth, the company that makes the Oxecam cameras, collected 180 hours of data from the trial. The system correctly identified the patients as being safe 99.8% of the time with 94% of breathing rate estimates within 2 breaths per minute of a medically certified reference device.

LATCH

The sports and leisure department are implementing a new service to help meet the needs of patients who are gaining weight. The service is call the Lifestyle Approach to Changing Health (LATCH) and the aim of the project is to work with patients individually and in groups to help them to stop gaining weight, to reduce weight and to see some positive physical health changes.

Patients will be referred for LATCH therapy sessions with the small team of trained staff. Base level physical health markers will be gained. These physical health markers will be kept with the patient in an individual physical health passport/ log book. All health markers will be added to the book so each patient has complete ownership of their physical health data.

Weekly personal goals will be identified in the book with collaboration with the LATCH worker. Regular weight and physical health markers would be added to the patients' LATCH / health passport.

The LATCH team forms part of the new obesity management strategy that the hospital is introducing.

Management of minor injuries

One of our CQUINs this year has centred on reducing the number of emergency leaves of absence (LOA). As part of this we have liaised with Frimley Park Hospital who have provided a number of staff with training in the management of minor injuries and have also trained some staff in suturing. We have also developed a protocol for the management of minor injuries and acute physical health conditions. It is hoped that we will be able to reduce the number of leaves of absence from the hospital.

Psychological aspects of the management of self-harm injuries, which are over-represented in our LOA data, are also being reviewed by a multi-disciplinary team reporting in to the safety & clinical effectiveness forum to ensure that practice-based evidence about what works in this area is delivered and shared in all parts of the organisation.

Body worn cameras

The hospital introduced body worn cameras in December 2015. Body worn cameras are used to capture video footage of incidents within the hospital. Video footage is recorded into a securely encrypted unit that can only be accessed by a specific third party programme. Body worn cameras make staff and patients feel safer and in some cases have acted as a deterrent and a moderator of aggressive behaviour. The footage has assisted the hospital with incident reviews and has allowed us to better monitor incidents involving restraint.

Research

The Forensic Research and Development Group has completed and currently carrying out a number of high quality research projects within Broadmoor Hospital in 2016-17. Below is a brief description of each project.

Research projects completed and closed in 2016

Observational Safety Evaluation of Asenapine (OBSERVA) - Asenapine (Sycrest®) is a new antipsychotic medication. This study aimed to evaluate its short term safety when used by patients in the real-life setting. 7 service users from Broadmoor took part in this national study.

Research projects currently on-going

Patient ward communities project, implementing "Sense of Community" in High Secure Wards

This research project is part of the Commissioning Quality and Innovation (CQUIN) on implementing "sense of community". A rich intervention aimed at fostering/ developing/improving sense of community on the ward is being trailed at Broadmoor Hospital. The research project associated to it aims at measuring the effects of the intervention at different time point

Emotional facial expression decoding in personality disorders

The aim of the study is, to investigate how patients with psychopathic personality traits differ in how they perceive emotional facial expressions. Specifically, the main aim on this project is to test two hypotheses regarding variance in facial expression decoding: 1) To compare different types of motivations in the context of emotional facial expression decoding in order to investigate if fast and slow processes of emotion decoding are affected by motivational state. 2) To compare 2 conditions of emotional facial expression decoding, one where the emotional content of the face is task-relevant and one where the emotional content of the face is task-irrelevant. During both tasks we will record eye-movements to investigate attentional aspects by tracking the gaze. 20 service users at Broadmoor have already completed the study.

Molecular genetics of adverse drug reactions (MolGen Study)

This study looks at two adverse reaction to the atypical antipsychotic clozapine. Clozapine has superior efficacy compared to conventional antipsychotics. Recipients also show reductions in suicidality, all-cause mortality and extrapyramidal side effects. However around 0.8% of people treated with clozapine will develop agranulocytosis, with around double that experiencing neutropenia. Work undertaken in Australia has also shown that clozapine treatment comes with a notable risk of myocarditis. By identifying the genes that pre-dispose individuals to these reactions, genetic tests could be introduced to ensure the drug is only administered to patients who are safe to receive it. One service user from Broadmoor has taken part.

Genetics of severe personality disorder and mental illness

This study aims to determine if next generation sequencing can lead to clinically relevant genetic diagnosis in extreme personality disorder and mental illness. It will also investigate whether genomic analysis of patients with extreme forms of mental illness and personality disorder can lead to the identification of novel candidate genes that are relevant to more common forms of mental illness and personality traits. 10 service users have already taken part in the study.

Reducing restrictive practice

Following the CQC re-inspection in November 2016 they have issued five "Must" and two "Should" regulatory actions regarding reducing restrictive practice. The director of nursing and patient experience collates a bi-annual Trust-wide report to our Quality Matters Committee and Trust Board from each service detailing their progress against these actions.

Each service also has detailed CQC quality improvement plans to support this, and our High Secure, Forensic and Access and Urgent Care Services have set targets within their quality priority improvement plans against the quality priority 'to work collaboratively with service users to reduce restrictive practice'.

Some of the work being undertaken within the services includes:

West London Forensic Services

- Have reviewed the PMVA programme.
- Introduced Safewards and START programmes.
- Continue to work on collaborative risk assessments and can show evidence of increased collaboration in risk assessment and patient safety planning.
- Have begun measuring reducing prone restraint and reduction has already been noted.
- Have reviewed their seclusion practices.
- Have introduced a restorative justice programme.

Local and Specialist Services

- All acute inpatient wards had completed training on reducing restrictive practice
- Have introduced behavioural support plans.
- Have embedded reducing restrictive practice champions onwards.
- Have been successful in winning a research and evaluation bid (£20,000) to evaluate individual behavioural support plans.
- Hounslow and Hammersmith and Fulham mental health units have established 'reducing restrictive practice groups' attended by ward champions and led by the matrons. SMARG (seclusion management and review group) will be set up across each of the Local Services sites imminently.
- Specific PMVA training being developed for cognitive impairment and dementia services.

High Secure Services

- Have a two year CQUIN on reducing long term segregation underway with other high secure hospitals (Ashworth and Rampton).
- Have quality improvement projects underway to reduce long term seclusion and other restrictive practices.
- Have already seen a reduction in long term segregation in 2016/17.
- Have developed positive behaviour support plans with patients.
- Have introduced safety huddles.
- Expert by experience training within PMVA department.
- Introduced a barriers to change checklist and HOPES model to assist, assess and reduce long term seclusions.
- Introduced monitoring of prone restraint.

"Thanks to Dr Barrett and the team for all their help with care and treatment."

Annex 1: Stakeholders Feedback

Living well in Ealing

NHS Ealing Clinical Commissioning Group

NHS Ealing Clinical Commissioning Group

NHS Ealing Clinical Commissioning Group (CCG) has reviewed the West London Mental Health NHS Trust's Quality Account (QA) for the year 2016-17, 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 2016/17 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.

The Quality Account also demonstrates the continued progress for Local Services, based on last year's priorities and the plans for future development. The account demonstrates much of the work that has resulted from the CQC inspection in 2015, but does not fully incorporate the feedback provided following the CQC re-inspection in November 2016. However, we are pleased to report that an improvement plan in response to the latest CQC visit is underway, and we look forward to reviewing the progress of the plan in the months ahead.

This QA provides a clear rationale for the planned priorities alongside expected delivery dates. The priorities for quality improvements in 2017-18 are supported by commissioners.

Despite last year's improvements made by the Trust in the reporting and investigation of Serious Incidents, this momentum has not been maintained, and we remain disappointed that the reporting and investigation of Serious Incidents has not been given the priority expected and required, to ensure aligned learning throughout the organisation.

Commissioners are keen to continue working collaboratively to ensure that the priorities for 2017/18 are progressed at pace with the North West London transformation plans and Like Minded strategy. We hope that these priorities will include maintaining the culture of reporting incidents and improving the submission process of related reports, as well as further work in relation to the reporting and investigating of deaths, and progress with improving the physical health of patients.

One area which we strongly believe requires continued emphasis at all levels across the Trust is the distillation and sharing of learning gathered from incidents, patient feedback and soft intelligence. This will need to be supported by robust evidence of how the learning has been embedded and adopted across the Trust to improve patient care, safety and safeguarding.

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.

Dr Mohini Palmer
Chair, Ealing CCG

Tessa Sandall
Managing Director, Ealing CCG

Dr Serena Foo
Clinical Lead Mental Health

Ealing Health and Adult Social Services Standing Scrutiny Panel

London Borough of Ealing Health and Adult Social Services Standing Scrutiny Panel Response to West London Mental Health NHS Trust Quality Account

The Panel welcomes the opportunity to comment on the Trust's Quality Account for 2016/17.

West London Mental Health NHS Trust attended a Health and Adult Social Services Scrutiny Panel meeting in May 2016, along with Ealing CCG to inform members about the Like Minded Strategy aimed at improving mental health and wellbeing across North West London. The Panel was pleased to hear about the new services that had recently been introduced, such as the Specialist Community Eating Disorder Service, the Child and Adolescent Mental Health (CAMHS) Out of Hours Service, the 24/7 Single Point of Access, the recently opened crisis halfway house, and the work being undertaken to integrate mental healthcare into primary care.

In September 2016, the Trust attended the Panel to discuss progress in delivering quality improvements since the Care Quality Commission Inspection in June 2015 which rated the Trust as 'requires improvement'. The Trust outlined the key actions which had been taken and informed the Panel of the main challenges that it was facing such as the variation in the quality of the Trust's estates, staffing issues, and major transformation programmes. In conclusion, the Panel said that they were frustrated to see concerns that had been raised several times still being highlighted as issues for the Trust. However the actions that had been taken and those due to take place were encouraging. The Panel noted that the Trust was re-inspected in November 2016, and that the CQC stated that they were able to see many areas of improvement however, there was more to do and the changes needed to be embedded and sustained. The Panel is pleased to see that the Trust's quality priorities for 2017/18 support the CQC quality improvement plan.

The Panel had the opportunity to visit the Trust at its St Bernard's site in December 2016. A number of Trust staff showed Panel members around the psychiatric wards and seclusion rooms, the Single Point of Access Service, and the Crisis and Assessment Team (CAT). Panel members were particularly interested to hear how a centralised single hub of access closely located to the CAT had significantly improved access to help for members of the public. The visit to the St Bernard's site also gave Panel members an insight to the challenges faced by the Trust due to the quality of its estate.

The Panel commends the Trust for its work on identifying learning from complaints and PALSs, and the annual result of the Friends and Family Test which show that 61% of responders would be extremely likely to recommend the Trust's services to friends and family. We would however like to see the Trust improving performance on resolving complaints within the timeframe agreed.

As highlighted in your Quality Account, the Panel is also concerned to see that the Trust continues to struggle with levels of bullying and discrimination and the increase in reports of staff physical violence is as you say a very serious issue. We hope that the Trust will find ways of addressing these issues and improving the staff experience urgently.

The Panel looks forward to continuing to work with West London Mental Health NHS Trust in 2017/18 and has included an update on the Like Minded Strategy and Children and Adolescent Mental Health Services in its work programme.

NHS England Specialised Commissioning (London Region)

NHS England Specialised Commissioning (London Region) welcome the opportunity to review and provide feedback for Promoting Hope and Wellbeing Together WLMHT Quality Account Report 2016/17.

We found the report to be a candid review of quality within the Trust that outlines both the achievements within West London Forensic Services and High Secure Services to date, whilst acknowledging the challenges ahead.

We look forward to continuing our positive working relationship in improving the quality of services provided to patients.

Healthwatch Central West London

HEALTHWATCH CENTRAL WEST LONDON RESPONSE TO WEST LONDON MENTAL HEALTH NHS Trust'S QUALITY ACCOUNTS 2016 - 17

We welcome the opportunity to comment on West London Mental Health NHS Trust's (WLMHT) Quality Accounts (QA), and on the quality of the services delivered locally to meet the health needs of local residents.

Healthwatch Central West London appreciates our working relationship with West London Mental Health NHS Trust. We acknowledge the work of the Trust in aiming to improve the quality of services for service users.

Comments on the 2016 - 17 Quality Accounts (QA)

Our members welcome the Trust's continued efforts to improve its services, through the quality improvement programme. In the section outlining the different steps taken towards a culture of continuous improvement it would be useful to highlight how each of the different initiatives will have an impact on the different services offered by WLMHT. Our members would like to see this included in the reporting of progress made through these initiatives in 2017-18 QA.

Our members commend WLMHT on the reduction of restrictive practices and anticipate reporting in 2017-18 will show continuing improvement.

We note that the 'looking back' section states that care plans remain a priority for the Trust in 2017-18, which is welcomed by our members. However, this intention is not reflected in the section outlining the 7 quality priorities for 2017-19. In particular, our members want to see targets set for collaboratively producing care plans with patients / service users to ensure this gains momentum and is reported on in the QA for 2017-18.

Patient & Staff Safety

Our members note that WLMHT has focused on increasing incident reporting throughout 2016-17 and our members are pleased to see that some actions have been taken to improve this. The issue of safety for both patients and staff has been highlighted as a key concern by our members. We note that the changes reported over the last year have led to an increased reporting internally by 30%, however our members would like to understand what further actions and changes will be made to move WLMHT out of being one of the lowest reporting Trusts in the UK.

Complaints

Our members note that the number of complaints has decreased; however, they also note that the decrease has been small (3%) and does not reverse the increase of 23% reported in 2015-16. We also note that only 58% of these were closed in time, which is less than in 2015-16 (62%). From the QA it is not clear what systematic steps the Trust has taken and will be taking to improve on the trends described or the time taken to resolve complaints and in this there is no improvement on last year.

OTHER COMMENTS

Working with voluntary and community groups
The QA does not provide any reference to working with external partners such as the voluntary and community sector organisations. Whilst it is essential to prioritise engagement with and participation of service users it is important to recognise how the third sector can assist in recovery.

Primary Care Plus

Primary Care Plus acts as a liaison with GPs and WLMHT following discharge from secondary care. Our members inform us that it works well in Ealing but in Hammersmith & Fulham there has been a turnover in staff and both GPs and patients have indicated that there seems to be minimal continuity of care.

Access to Urgent Care

Our members note that whilst some staff members are excellent, others display a lack of empathy both in A & E and with the Crisis Team. Whilst acknowledging that this could be due to temporary staff and an increasingly heavy workload, our members suggest that this is also a potential training requirement and urge the Trust to address this.

Claybrook Centre
Our members state that one the biggest complaints for the Claybrook Centre is the lack of continuity of staff, with patients seeing different doctors and being asked to repeat their symptoms many times, leading to a feeling that they are not being considered. The Trust should note that where patients see a regular psychiatrist, they express satisfaction with the system.

Hammersmith IAPT
Our members consider Hammersmith IAPT to be a first-class service in which staff are empathetic and responsive. However, our members also note that they have long waiting lists.

CONCLUSION
Our members welcome the commitment to continued improvement in quality of services. We look forward to continuing to work with West London Mental Health NHS Trust in improving the care and support of service users.

Contact:
Helen Mann
Programme Manager
Healthwatch Central West London
Phone: 020 8968 7049
Email: helen.mann@healthwatchcentralwestlondon.org.uk

Date: 19th May 2017

healthwatch Bracknell Forest

Comment West London Mental Health NHS Trust 2016-2017 Quality Account

Thank you for the opportunity to comment on your 2016-2017 Quality Account. Broadmoor Hospital is based within the Borough of Bracknell Forest and we are commenting in respect of the services at Broadmoor only.

Healthwatch Bracknell Forest, as the local voice of patients and carers is interested in patient experience and the care environment. It is difficult to directly review Broadmoor from the statistics presented in the quality account, however we take the opportunity to make the following comments.

We are pleased to read that you are improving your staffing packages with the aim to increase staff retention and that the new building works continue as planned and that patients have been involved in the internal decorations.

Staff recommendation of the Trust as a place to work and those reporting harassment, bullying or abuse from other staff has improved but we feel still requires improvement, which should lead to improved patient feedback.

We are also pleased to read that you will be proactive in monitoring physical health. Which we hope will lead to an increase in patient opportunities to improve their physical health. We are also pleased that the use of restrictive interventions including physical restraint, seclusion and long-term segregation continues to be a quality improvement.

We have been working with senior managers and members of the Trust to establish a protocol that enables patients to have a stronger voice about the health and care services they receive. We have been attending a number of meetings at the site which is helping us to identify trends, but this is limited and access to the patients to provide feedback is difficult which we hope will improve this year.

We look forward to continuing to work with West London Mental Health NHS Trust with the aim to improve patient engagement and experience together.

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: 

Tom Hayhoe
Chairman

Date: 28th Jun 2017

Signed: 

Dr José Romero-Urcelay
Medical Director

Date: 28.06.17

Annex 3: How our services are structured

Local and Specialist Services CSU

Liaison and long-term conditions
Gender Identity Clinic
Health / neuro psychology
IAPT
Homeward
Liaison psychiatry
Stop smoking services
Perinatal services

Access and urgent care
Assessment service
Crisis resolution teams (CRT)
Electro-convulsive therapy (ECT)
Inpatient assessment service
Inpatient recovery service
MH Act assessment service
Psychiatric intensive care unit (PICU)
Recovery houses
Service user telephone support line (SUTS)

Primary and planned mental healthcare
Cassel Hospital services
Clozapine clinics
Community recovery teams
Early intervention service
Eating disorder service
Placement & repatriation work
Primary care mental health service
Psychotherapy and personality disorder service
Rehabilitation service (Glyn & Mott)

Cognitive impairment and dementia (CID)
CID community services
CID inpatient services

CAMHS and developmental services
Adult neurodevelopmental services (in development)
CAMHS
CAMHS learning disabilities
CAMHS eating disorders service

Forensic Services CSU

West London Forensic Services
Men's services:

- Low secure, medium secure and rehabilitation

Women's services:

- Enhanced medium secure and low secure

Adolescent services:

- Community Forensic Services

High Secure Services (Broadmoor Hospital)
Mental illness services
Personality disorder services
Centralised group work services
Rehabilitation therapy services
Annual

Annex 4: Internal Governance Structure

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 2017 ("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 2017 subject to limited assurance consist of the following indicators:

- 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; and
- The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period indicator.

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 requirement 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 2016 and May 2017;
- papers relating to quality reported to the Board over the period April 2016 to May 2017;
- feedback from the NHS Ealing Clinical Commisioning Group (CCG) dated 9 June 2017;
- feedback from the London Borough of Ealing Health and Adult Social Services Standing Scrutiny Panel dated 30 May 2017;
- feedback from NHS England Specialised Commissioning (London Region) dated 2 June 2017
- feedback from Healthwatch Central West London dated 19 May 2017;
- the Trust's draft complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 13 June 2017;
- the latest national patient survey dated 8 September 2016;
- the 2016 national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 10 May 2017; and
- the annual governance statement dated 24 May 2017.

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 assure 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.

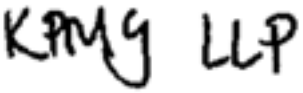
The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

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 to believe that, for the year ended 31 March 2017:

- 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
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15 June 2016

Promoting hope and wellbeing together

West London Mental Health NHS
NHS Trust

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