

*We care
to make the
difference*

Quality

Account

2013/2014

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Part 1: Statement on quality from the Chief Executive, Steve Shrubbs

Welcome to our Quality Account for 2013-14. Here you can read about the work we have been doing to improve patient safety, clinical effectiveness and the experiences of people using our services. In these pages you can see where we are doing well, where we need to improve, and crucially, what we are learning from both to ensure that improvement is a continuous process.

To help us with our drive for improvement, we have established a quality strategy to guide us through the next five years. The strategy is based on three principles: service users at the heart of all we do, with care personalised to best meet patients' needs; a focus on measurable clinical outcomes; and staff empowered to innovate and drive forward service improvements.

Supporting this over-arching strategy, every team has a small number of key local priorities, informed by national priorities, performance indicators, the learning from regular audits of our services, and, perhaps most important of all, feedback from service users and carers – including complaints.

This year we gained final approval to build a new Broadmoor Hospital which will consist of ten new wards alongside the existing Paddock wards. Once completed in 2017, the hospital will be able to accommodate 210 male patients and provide an additional 24 spare beds.

The Department of Health has also approved the redevelopment of a new medium secure 80-bed unit at St Bernard's in Ealing. Work has started on both projects and together they will result in significant improvements in patient safety, clinical effectiveness and patient experience.

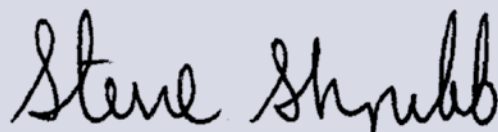
This year, as a trust we responded swiftly to the Francis report, and have an action plan in place to address its recommendations. The Francis report has had an enormous impact across the NHS, and one of its central findings is the importance of ensuring we do hear patients and carers. Who, after all, is better placed to tell us how we are achieving our goals and where we need to do better? Openness and honest engagement with patients and staff are key to improving quality.

You can read in this Quality Account about some of the things we are doing to ensure that we do have that two way dialogue, such as the roll out across the trust of the Meridian system, which uses electronic tablets to capture real time patient experience. Initiatives like our reporter programme and our 'back to the floor' scheme ensure that managers hear the voices of our front-line staff. All of these projects are designed to help us improve the experiences of people using our services.

Quality is everybody's business, and you can also read here about the work we are doing with partner organisations in our local services for example where, through a joint approach, we are seeing results, including planned reductions to inpatient bed capacity, the redesign of community mental health teams into assessment and recovery teams and plans for a 'recovery house' in each borough as an alternative to hospital admission.

This is the second Quality Account since I joined the Trust, and I continue to be impressed by the sheer dedication and commitment that I see among my colleagues to delivering high quality care. But I know too that quality isn't a one-off box ticking exercise; it is a continuous process, something that we have to deliver every day. It is the central, over-riding criteria for our work.

To the best of my knowledge the information contained in this Quality Account is accurate.



Steve Shrubbs
Chief Executive

Part 2: Priorities for improvement

Looking back - Our quality priorities 2013/14:

what were they, how did we do?

High secure services clinical service unit (Broadmoor)

Patient experience

Improving the management of Patient Transitions

Why did we focus on this?	Transitions are high risk periods with a potential loss of knowledge occurring at these points. They can also represent periods of increased anxiety for patients.
What did we aim to do?	To speed up the assessment and transfer process as well as to increase transparency of decision making to patients. Patients would be assessed in seven working days of referral and decision communicated to ward and patient.
What did we expect to achieve?	Safe transfer of patients between wards and improve patient experience by providing prompt feedback to patients.
How did we plan to monitor and report?	Via the inter ward referrals and transfers (IRT) meeting.
How well did we do?	The system was broadly welcomed and well governed via IRT. However, we learned that the simple model of rapid assessment and feedback was not always clinically appropriate, e.g. if there was no bed available this caused anxiety to patients in some cases.
What next?	We plan to continue next year but with an improved assessment and feedback loop. Patients would be assessed when there was a bed available and feedback would continue to be provided promptly.

Ensuring service users are treated with the highest levels of dignity, compassion and respect

Why did we focus on this?	This was selected as many themes from complaints were identified as staff attitude. Dignity, compassion and respect are key standards for the Trust and improving privacy and dignity standards are essential.
What did we aim to do?	Identify any areas for improvement via a patient survey on all wards based on See, Think, Act.
What did we expect to achieve?	To improve the patient experience via the survey and improvement from baseline.
How did we plan to monitor and report?	This was discussed and reviewed at focus groups.
How well did we do?	In the High Secure services patient satisfaction survey, 59 patients (30%) completed the questionnaire which is based on the department of health 'See Think Act booklet'. The questionnaire uses a 4 point Likert scale (0-3) (0= not at all like this ward: 1= a little like this ward: 2= quite a lot like this ward: 3=just like this ward. In relation to the statement 'staffs treat us with dignity and respect' – the average score was 2. In relation to the statement 'staffs treat us with compassion' the average score was 2. Further work is being carried out to develop patient satisfaction measures, and to continue to improve patient experience.
What next?	Better use of meridian with changes to questions and get real-time feedback.

What else have we done to support patient experience?

Patient groups and engagement	<p>The patient forum continued to be well attended with good representation from wards and senior managers. There has been positive feedback when issues were raised and addressed.</p> <p>A patient and carer governance group was introduced on 31 March 2014 with terms of reference agreed.</p> <p>Diversity focus groups have been set up with programmes planned for 12 months. This has included a Burns night, black history month and St Patrick's day.</p>
150th Anniversary Celebrations	<p>Celebrations continue for the 150th anniversary and have included; a terrace party, wellness day, promoting recovery, souvenirs for staff and patients and patients supported to design a flag.</p>
Improve staff and patient engagement	<p>Continue with the staff and patient joint choir set up.</p> <p>Continue staff and patient away days on wards following excellent feedback.</p>
Improve meal times	<p>Improved dining experience.</p>

Patient safety

Improving the dissemination of learning and best practice

Why did we focus on this?	<p>Learning lessons from significant events to promote positive patient safety.</p>
What did we aim to do?	<p>Hold in-house workshops and share relevant lessons for staff.</p>
What did we expect to achieve?	<p>Better appreciation and understanding of risk. Shared learning from vignettes which highlights the incident, recommendations from investigation and lessons to learn and implement.</p>
How did we plan to monitor and report?	<p>Monitored attendance at workshops. Learning lessons shared with clinical improvement groups. Directorate self audits reported back to safety and safeguarding meetings.</p>
How well did we do?	<p>Themes reviewed and audits of engagement and observation records.</p> <p>Good participation and feedback from workshops.</p>
What next?	<p>Further events planned to share lessons learnt, including relevant lessons from other parts of the Trust.</p>

What else have we done to improve patient safety?

Night-time confinement review	<p>A patient presented his experience of night time confinement to the trust board with very positive views.</p>
Improving safety	<p>Geese theatre company held workshops for a week with participation from both staff and patients. Very well supported, focussed on the safe disclosure concerns.</p> <p>Ligature audits continued to be carried out on all wards</p> <p>Joint working with Frimley Park Hospital set up to make shared care safer.</p>

Clinical effectiveness

Improving Physical Healthcare

Why did we focus on this?	To ensure the patients under our care receive optimal care and treatment for both mental health and physical health conditions.
What did we aim to do?	Ensure patients are provided with equivalent physical healthcare as in the community. Ensure physical healthcare needs are included in the Care Programme Approach (CPA) care plan.
What did we expect to achieve?	Ensure 90% of Quality Outcome Framework (QOF) standards are achieved.
How did we plan to monitor and report?	QOF standards reported to the board and Commissioning for Quality and Innovation (CQUINs) to the commissioners.
How well did we do?	Targets achieved for QOF and CPA. Prescribing nurse practitioner in post.
What next?	Maintain focus and standards for improving physical healthcare.

What else have we done to support clinical effectiveness?

Research	Increased involvement in research. Forensic research and development (FRED) group set up with terms of reference agreed. Increased higher profile conferences at Broadmoor. Increase involvement in pharmacology trials. Optimise treatment and generate revenue for reinvestment in research. Psychotherapy review completed and implemented with funds reinvested in Newbury Therapy Service.
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Local services clinical service unit

Includes the Boroughs of Ealing, Hammersmith & Fulham and Hounslow Clinical effectiveness

Improving Physical Healthcare

Why did we focus on this?	National data continues to indicate reduced life expectancy for people with severe and enduring mental illness. Internal audits have demonstrated areas for improvement. It is seen as a priority area for service user and carers.
What did we aim to do?	<ol style="list-style-type: none">1. Improve the prescribing for children and young people who have physical condition as well as a mental health problem2. Review physical healthcare facilities at community sites.3. Improve the management of diabetes amongst inpatients
What did we expect to achieve?	<ol style="list-style-type: none">1. Agree and implement new protocols2. Agree what is required and survey all sites.3. Agree and implement good practice guidelines
How did we plan to monitor and report?	<ol style="list-style-type: none">1. Monitor implementation of new protocols2. Identify where improvement is required3. Conduct repeat audit on physical healthcare
How well did we do?	<ol style="list-style-type: none">1. Protocols are now operational2. Some delay in getting this work underway but is now being addressed3. Good practice guidelines were agreed, disseminated and implemented
What next?	<ol style="list-style-type: none">1. We plan to audit the protocols2. We need to complete the survey of all sites and provide any equipment that is still needed.3. Need to complete re-audit of physical health care of inpatients

Patient experience

Improving the management of Patient Transitions

Why did we focus on this?	Periods of transition are recognised as a time of increased risk for service users and need to be managed as effectively as possible.
What did we aim to do?	Identify and disseminate good practice and learn from when things had gone wrong.
What did we expect to achieve?	Improvements and greater consistency in transitional management across the clinical service unit.
How did we plan to monitor and report?	Review of incident reviews and current transition protocols.
How well did we do?	We conducted a comprehensive review of all current protocols and reviewed all incident reviews over the year for failings in transition management. This has helped us produce revised staff guidance which will be incorporated into local CPA protocols.
What next?	Over the coming year we will audit practice against the revised protocols.

Patient experience

Ensuring service users are treated with the highest levels of dignity, compassion and respect

Why did we focus on this?	Compassionate and respectful care must be at the centre of everything that we do to support the recovery of service users. Staff attitude is a common theme behind some of the complaints that we receive.
What did we aim to do?	Move from a model of service user involvement to a model of co-production.
What did we expect to achieve?	Improve quality through four co-production projects.
How did we plan to monitor and report?	By establishing co-production work groups which would provide written progress reports.
How well did we do?	Two of the four projects are now well established; these are examining how the need for control and restraint and seclusion can be eliminated and how the service involvement structure can be improved. The project on real advance directives produced an abridged joint crisis plan, but this needs further work to be fully implemented. The project on shared decision making around medication has completed a literature review and now needs to develop tools to support service users and staff in the process.
What next?	All 4 projects will be continued until the work is completed.

What else have we done to support patient experience

"Being described as an asset to the trust really changed how I felt about being involved" – service user 2014.

A user led conference was held in April 2013 called "From service users to co-producers" where staff, service users and carers voted that the future of user involvement at the trust must be co-produced.

A further conference took place attended by over 80 people including the trust chairman and CEO as well as representatives from external stakeholders, service users and carers. The event concluded with a vote – It was agreed that the future model for user involvement would be an independent social enterprise utilising the best of what already exists. An independent report "Where to Next" was published.

Subsequently four co-produced workshops were held 'Our voice, Our Choice, & Three Very Important Workshops'.

The first three included: 'vision & values', 'key deliverables' and 'governance & structure'. The fourth workshop included a formal presentation by Accession. All these workshops were attended by at least 30 people.

Patient safety

Improving the dissemination of learning and best practice

Why did we focus on this?	Learning from the transition experience of young people between CAMHS and Adult services was raised in user involvement groups as a priority area. This is also a key area identified by mental health professionals at national level.
What did we aim to do?	Hold a patient centred “bottom up” staff learning event to develop a lifespan approach to the mental health needs of the local communities we serve with a particular focus on CAMHS- AMHS transition with an emphasis on early intervention, recovery, and evidence-based treatments
What did we expect to achieve?	<ol style="list-style-type: none"> to learn from the lived experience of young people and carers who had experienced transition to include the user/carer’s views and opinions in shaping the CAMHS AMHS transition protocol To harness the experience of adult service users to provide peer support to young people experiencing transition
How did we plan to monitor and report?	Views collated from the transition event and findings from a recent baseline audit will be used to revise the current transition protocol, This will be audited for adherence/ compliance. Service User /Carer feedback on transition will continue to be collated and actions followed through.
How well did we do?	<p>A successful Transition event was held with good representation from CAMHS and adult service users and carers and staff. The event helped to disseminate good practice to ensure that young people have a seamless transition experience.</p> <p>The event helped to consolidate the CAMHS-AMHS professional and user/carer links and the commitment needed to take this agenda forward</p>
What next?	<p>Views collated from the transition event and findings from the baseline audit will be used to revise the current transition protocol which will be subjected to a audit in the next year</p> <p>A group co facilitated by user/carers looking at transitions will continue to meet to take forward ideas from the transition event including development of a transition pack and leaflets</p>

Improve the dissemination of learning from serious incidents

Why did we focus on this?	Learning from serious incidents is a key component to improving patient safety.
What did we aim to do?	Ensure that lessons learnt from incidents are disseminated across all three boroughs.
What did we expect to achieve?	We aimed to devise a simple template which could be used to summarise incidents and lessons learnt so that pertinent information could be quickly disseminated to all relevant staff.
How did we plan to monitor and report?	We planned to monitor the content and use of the completed templates and check that they were disseminated via appropriate governance groups.
How well did we do?	The template was devised and is now used routinely following all serious incident reviews. Completed templates are used to inform staff of incidents and positive feedback has been received from staff.
What next?	We will continue to use the template and are now planning to introduce a similar format for the dissemination of complaints.

What else have we done to support patient safety

Actions taken:

1. Serious incidents are now routinely disseminated to all clinical services
2. The serious incident vignettes are discussed at the Trust and LS incident review group, SMTs, borough governance and team meetings. Random checks are undertaken to ensure vignettes are disseminated to clinical teams.
3. Complaint vignettes have recently been designed and are being trialled, they are currently discussed at LS service user and carer forum and cascaded to clinical teams
4. Grade 1 and 2 review process have undergone a focussed period to ensure compliance with timeframes this included:
 - LS IRG have agreed that panel members must be agreed within 48 – 72 hours
 - LS IRG have agreed that the completed report is sent to the respective Head of Service and Clinical lead for review and population of the action plan within 48 hours
 - Executive Director agreement for additional administration support with all reviews, five administration staff have been trained to date. The next phase is to roll out additional training programmes once the CSU administration review has been completed
 - Escalate all overdue reports to the commissioner and respective Heads of Services
 - Submission timeframes are monitored weekly, monthly and quarterly

At the time of writing this LS are 100% compliant with submissions

5. Learning from incidents and complaints is now included within local services monthly and quarterly governance paper
6. Two thematic reviews on learning from serious incidents were completed during quarter 2 and 3
7. Annual learning lessons booklet is draft form and will be on the IRG April 2014 agenda for sign off
8. Annual learning lessons conference, date to be confirmed at April 2014 IRG

Specialist & forensic clinical service unit

Patient experience

Improving the management of Patient Transitions

What did we aim to do?	We aimed to develop clear differential service specifications for the in-patient forensic pathway and consult with commissioners to develop agreed costing and commissioning plans for the 2014/2015 contract round.
What did we expect to achieve?	We expected to:- <ul style="list-style-type: none">• Baseline existing ward specifications• Begin to engage specialised commissioners in developing future re-specifications and costings• Complete staff engagement about future specifications• Embed new specifications and costing into 2014/15 contract negotiations• Successfully complete 2014/15 contracting round and implement new specification and costing model
How did we plan to monitor and report?	This was monitored through the senior management team.
How well did we do?	We have: <ul style="list-style-type: none">• Completed baseline ward specifications which will inform how we set up the new services.
What next?	<ul style="list-style-type: none">• Embed ward specification work into existing care pathway development work stream during 2014/15• Continue to engage with NHSE London on developing commissioning profile for London secure services during 2014/15• Embed costing work into national NHSE work stream aligning secure costs.

Improving the Management of Patient Transitions

What did we aim to do?	We aimed to provide evidence based psychological interventions in forensic services by:- <ul style="list-style-type: none">• Improving access on admission wards by facilitating groups addressing core skills on the wards• Reviewing the group content in line with the evidence base and avoiding duplication of core content• Ensuring speedier access to specialist groups• Reviewing the use of available resources e.g. medical staff to co facilitate• Reviewing the use of individual psychological interventions
What did we expect to achieve?	We expected to: <ul style="list-style-type: none">• Review the existing group programme and available resources• Identify high demand groups and develop a revised timetable to meet the high demand• Develop a specific programme for admission wards• Review the use of individual psychological interventions
How did we plan to monitor and report?	This was monitored through the psychological, rehabilitative and recovery interventions clinical governance group
How well did we do?	<ul style="list-style-type: none">• We undertook a review of the existing group programme, identified the high demand groups and those groups now run more frequently• We have developed and implemented a specific group programme for admission wards which will inform how we set up the new services• We undertook a review of individual interventions
What next?	We aim to review the psychology provision across the service to improve consistency across and increase the number of interventions offered.

Improving the Management of Patient Transitions

What did we aim to do?	We aimed to improve our practice around delayed discharges.
What did we expect to achieve?	We expected to establish a monthly meeting to review delayed discharges in the service to ensure peer review and shared learning which would lead to reduction in number of delayed discharges.
How did we plan to measure & monitor?	Delayed discharges would be monitored through the scorecards in directorate management and clinical governance and senior management team meetings.
How well did we do?	<ul style="list-style-type: none"> We established the meeting and delayed discharges were reduced from 22 in April 2013 to 13 in March 2014.
What next?	We will continue to review all delayed discharges on a monthly basis.

Ensuring Service Users are treated with highest levels of dignity, compassion and respect

What did we aim to do?	Pilot systemic / family engagement project.
What did we expect to achieve?	<p>We planned to convene initial social network meetings (known as 'welcome meetings' in the adolescent service) which would take place soon after admission and involve inviting significant people in the service-user's life – family, carers, professional network – to meet with the multi disciplinary team.</p> <p>This initial meeting would allow sharing of information about the service and addressing any family's anxieties. There would be an emphasis on establishing constructive relationships with the service users and their families and the service and carers.</p> <p>As part of the 12-week care pathway assessment we planned to write a systemic that could be entered onto RIO. The map could include family members and friends, professional network, affiliations in the community.</p>
How did we plan to measure & monitor?	We planned to evaluate the pilot project at quarterly intervals via the clinical service unit carer development group with a formal report at month twelve to the senior management team.
How well did we do?	Social network meetings and systemic interventions were introduced to the pilot wards. Findings, including participant feedback, reported to Executive Director and Service Director in September 2013.
What next?	We have reviewed our carer involvement strategy which we will implement from 2014/15.

Ensuring Service Users are treated with highest levels of dignity, compassion and respect

What did we aim to do?	Engage service users in their care pathway.
What did we expect to achieve?	<ol style="list-style-type: none"> 1. We planned to continue to embed the recovery approach into all clinical Areas (except gender identify clinic) by:- <ul style="list-style-type: none"> • Providing recovery training • Provide training on STAR • Integrating recovery tools into other processes e.g. care programme approach (CPA) process, care plans, clinical team meetings, seclusion reviews, psychological interventions • Evaluating the pilot of peer review workers 2. We also planned to ensure that Meridian (the patient experience system) was used in all clinical areas with specific questions for different client groups. 3. We planned for Skype facilities to be piloted in 2 areas to facilitate family contact.
How did we plan to measure & monitor?	This was monitored through directorate management & clinical governance, nursing governance and security steering group meetings.
How well did we do?	<ol style="list-style-type: none"> 1. We have: <ul style="list-style-type: none"> • Delivered recovery training and STAR training • Audited the use of recovery tools into other processes e.g. CPA process, care plans, clinical team meetings, seclusion reviews, psychological interventions 2. Meridian is now in use in all clinical areas with questions specific to the service. 3. The Skype protocol was devised but because of security considerations this has not been implemented.
What next?	We plan to embed the Meridian system across all clinical areas. The agendas for CIGs have been reviewed to ensure feedback is discussed and action plans agreed. This will be monitored through directorate management and clinical governance meetings.

Patient safety

Improving the dissemination of learning and best practice

What did we aim to do?	We aimed to review the incident and error reporting systems (serious untoward incidents [SUIs] and near misses) to improve shared learning across the clinical service unit.
What did we expect to achieve?	We expected to: <ul style="list-style-type: none">• Conduct a thematic review of all incidents & effectiveness of action plans in 12/13• Review the terms of reference for the clinical service unit suicide prevention and incident monitoring group• To ensure that action plans are routinely sent to clinical improvement group meetings• Clinical service unit wide learning lessons event to be held to review developments in the year
How did we plan to measure & monitor?	This was monitored through the clinical service unit's incident reporting group.
How well did we do?	<ul style="list-style-type: none">• We conducted a thematic review of all incidents & effectiveness of action plans in 12/13• We reviewed the terms of reference for the clinical service unit suicide prevention and incident monitoring group To ensure that action plans to be routinely sent to clinical improvement group meetings• We undertook an audit of clinical improvement group meetings and identified that a large piece of work needed to be completed to standardise the meetings and improve effectiveness
What next?	We will agree a new agenda for clinical improvement group meetings and the governance team will issue a quarterly bulletin for discussion at clinical improvement group meetings.

What else have we done to support patient safety

We reviewed the Clinical Improvement Group agenda and agreed a forensic service wide agenda which will improve the consistency of the meetings across the service but also ensure that key issues are addressed in the meetings including the patient safety and ligature audits.

Clinical effectiveness

Improving Physical Healthcare

What did we aim to do?	<p>We aimed to:</p> <ul style="list-style-type: none">• Provide high quality evidence based care for long term conditions• Review service users physical health needs within the care programme approach (CPA) process• Ensure that all service users who were eligible could access national screening programmes
What did we expect to achieve?	<p>We expected to:</p> <ul style="list-style-type: none">• Achieve at least 90% of maximum quality & outcomes framework (QOF) score for long term conditions• 95% of CPA meetings to receive a completed health proforma• Have a call/re call system in place for cervical cytology, breast screening, bowel cancer and Triple A programmes
How did we plan to measure & monitor?	<p>This was monitored through the clinical service unit's physical healthcare group</p>
How well did we do?	<p>We achieved:</p> <ul style="list-style-type: none">• 90% of maximum QOF score for long term conditions• Completed health proforma was forwarded to 95% care programme approach (CPA) meetings• A call/re-call system in place for cervical cytology, breast screening, bowel cancer, Triple A programmes is now in place
What next?	<p>As part of the trustwide quality priority for 2014/15 we are aiming to improve the detection and management of long term physical health.</p>

Looking forward – our quality priorities for 2014/15: What they will be and how we will know if we have achieved them?

The trust continues to implement the quality strategy 2013 - 2018 which provides an over arching framework of how we deliver of services.

For 2014/15 the trust has agreed on seven quality priorities which will support the quality strategy and improve patient safety, patient experience, care and treatment provided.

In order to select the quality priorities for 2014/15 the trust held meetings with service users, carers and staff, consulted with commissioners as well as asking the clinical service units for their priorities.

Initially a full list of potential priorities were drawn up looking at the:

- NHS outcomes framework
- Care quality commission and Monitor compliance regimes
- Internal intelligence referring to risk registers, incident analysis, complaints, PALS (patient advice & liaison service), SIRIs (serious incidents requiring investigation),
- Actions from the Francis report on the care at Mid Staffs NHS Foundation Trust
- Key performance indicators
- Service user and carer feedback.

Priorities were identified from central governance teams, clinical service units and from patient, carer and staff meetings.

The feedback from all these groups was cross referenced and where ever possible the service user and carer key priorities were selected.

Governance arrangements for the quality priorities have been agreed and will be reviewed bi monthly by the patients' safety and safeguarding group, the physical healthcare group, the clinical effectiveness and compliance group and the service user and carer group. The quality assurance committee will review progress on the quarterly milestones and report to the board via the Chairs report.

(Internal reporting structures can be found in Annex 5).

Patient safety

Priority	Key milestones Q1	Key milestones Q2	Key milestones Q3	Key milestones Q4	Evidence
<p>S1. Improving medicines safety by ensuring consistency of medication error reporting and aim to reduce the number of medication errors in 2015/16 Applicable to inpatients and community</p>	<p>Report on medication errors via IR1 for each ward as baseline. Identify themes</p>	<p>Report on medication errors via IR1 for each ward and validated by manager. Identify themes</p>	<p>Report on medication errors via IR1 for each ward and validated by manager. Identify themes</p>	<p>Report on medication errors via IR1 for each ward and validated by manager. Analyse themes and compare with last year</p>	<p>Medication error reports validated by ward managers Themes reviewed</p>
<p>S2. Reducing physical assaults on service users and staff Applicable to inpatients</p>	<p>Violence reduction strategy Reports with trend analysis for assaults on staff, patients, staff sickness, Riddor*, Meridian** - 'do you feel safe'</p>	<p>Reports show improved trend analysis for assaults on staff, patients, staff sickness, Riddor*, Meridian** - 'do you feel safe'</p>	<p>Reports show improved trend analysis for assaults on staff, patients, staff sickness, Riddor*, Meridian** - 'do you feel safe'</p>	<p>10% reduction for assaults on staff and patients and staff sickness rates due to assaults. Meridian** reports - 85% score Improved staff survey</p>	<p>10% reduction in assaults 85% Meridian** score 'do you feel safe'</p>

*Riddor. Reporting status of staff who have been off sick more than 7 days due to a work related incident

**Meridian. Realtime patient experience feedback system

Clinical effectiveness and compliance

Priority	Key milestones Q1	Key milestones Q2	Key milestones Q3	Key milestones Q4	Evidence
C1. Improve the detection and management of long term physical conditions Part 1 applicable to inpatients and community Part 2 applicable to community patients	Screening process agreed for Diabetes, COPD, CHD, Hyper tension Baseline ICD10 report	50% secondary coding reported via RiO and audit	70% secondary coding reported via RiO and audit	90% ICD10 coding via RiO and audit	90% ICD10 secondary coding recorded on RiO
	Process for recording physical healthcare on RiO documents and circulated to Clin Gov Grps and Physical HC Grps	100% of patients with a physical healthcare ICD10 code have physical healthcare plan recorded on RiO/ clinical record	100% of patients with a physical healthcare ICD10 code have physical healthcare plan recorded on RiO/ clinical record	100% of patients with a physical healthcare ICD10 code have physical healthcare plan recorded on RiO/ clinical record	All patients with a physical healthcare ICD10 code have care details in care plan
C2. In light of the NHS constitution – we propose that every patient receiving care through West London Mental Health Trust should be offered the chance to participate in any part of research. Applicable to inpatients and community	Question set up on RiO and baseline report for Q1 from RiO and ConCERT-D	10% increase in patients being offered chance to participate in any part of research	10% increase in patients being offered chance to participate in any part of research	10% increase in patients being offered chance to participate in any part of research	Reports from RiO show an incremental increase in patients being offered to take part in research
C3. To support patients with a mental health condition to stop smoking Applicable to inpatients and community	Smoking status of all patients recorded on RiO or clinical record	100% of patients who wish to stop smoking are offered support	100% of patients who wish to stop smoking are offered support	100% of patients who wish to stop smoking are offered support	100% of patients who wish to stop smoking are offered support via RiO

Patient experience

Priority	Key milestones Q1	Key milestones Q2	Key milestones Q3	Key milestones Q4	Evidence
<p>E1. Improved clinical supervision improves lessons learnt from incidents, complaints, improves team working, patient experience and safety</p> <p>Applicable to inpatients and community</p>	<p>Baseline report from Exchange on all supervision sessions across all 3 CSUs</p> <p>Audit of quality</p>	<p>5% increase in supervision recorded on Exchange from Q1</p>	<p>10% increase in supervision recorded on Exchange from Q2</p>	<p>10% increase in supervision recorded from Q3</p> <p>Audit report for quality of supervision</p> <p>30% improvement expected from Q1</p>	<p>85% of supervision recorded on Exchange</p> <p>30% improvement in quality</p>
<p>E2. To improve the service user experience of engagement and communication with staff.</p> <p>Applicable to inpatients and community</p>	<p>80% of patients or their representative attend CPA</p> <p>80% of Care Coordinators attend CPA</p> <p>60% of patients invited to present their outcome or WRAP at CPA meetings</p> <p>Patients invited to chair CPA meetings</p> <p>Baseline report from Meridian 'Staff treat me with kindness & compassion</p>	<p>85% of patients or their representative attend CPA</p> <p>85% of Care Coordinators attend CPA</p> <p>75% of patients invited to present their outcome or WRAP at CPA meetings</p> <p>Increase in patients to chair CPA meetings</p> <p>5% improvement from Q1</p> <p>Meridian report 'Staff treat me with kindness & compassion</p>	<p>90% of patients or their representative attend CPA</p> <p>90% of Care Coordinators attend CPA</p> <p>90% of patients invited to present their outcome or WRAP at CPA meetings</p> <p>Increase in patients to chair CPA meetings</p> <p>5% improvement from Q2</p> <p>Meridian report 'Staff treat me with kindness & compassion</p>	<p>95% of patients or their representative attend CPA</p> <p>95% of Care Coordinators attend CPA</p> <p>95% of patients invited to present their outcome or WRAP at CPA meetings</p> <p>Increase in patients to chair CPA meetings</p> <p>5% improvement from Q3</p> <p>Meridian report 'Staff treat me with kindness & compassion</p>	<p>RiO confirms 95% attendance at CPA Meetings</p> <p>95% patients invited to present outcome or WRAP</p> <p>Continued increase in patients chairing their CPA meeting</p> <p>5% quarterly improvement from Meridian report 'Staff treat me with kindness and compassion</p>

Statements of assurance from the Board

Review of services

During 2013/14 West London Mental Health NHS Trust provided and / or sub-contracted 17 relevant health services.

West London Mental Health NHS Trust has reviewed all the data available to them on the quality of care in 17 of these NHS services.

The income generated by the NHS services reviewed in 2013/14 represents 100% of the total income generated from the provision of NHS services by West London Mental Health Trust for 2013/14.

Participation in clinical audits

During 2013/14, 3 national clinical audits and 1 national confidential enquiries covered relevant health services that West London Mental Health Trust provides.

During 2013/14 West London Mental Health Trust 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 West London Mental Health Trust was eligible to participate in during 2013-14 are as follows:

National Clinical Audits	<ul style="list-style-type: none">• Prescribing Observatory Mental Health-UK (POMH-UK): Prescribing in mental health services• National Audit of Schizophrenia (NAS)• National Audit of Psychological Therapies
National Confidential Enquiries	<ul style="list-style-type: none">• The National Confidential Inquiry into Suicide and Homicide for People with Mental Health Illness (NCISH)

The national clinical audits and national confidential enquiries that West London Mental Health NHS Trust participated in during 2013/2014 are as follows:

National Confidential Enquiries:

The National Confidential Inquiry into Suicide and Homicide for People with Mental Health Illness (NCISH)

National Clinical Audits

- Prescribing Observatory Mental Health-UK (POMH-UK): Prescribing in mental health services:
 - Topic 13a – Prescribing for ADHD (attention deficit hyperactivity disorder)
 - Topic 7d – Monitoring of patients prescribed Lithium
 - Topic 4b – Prescribing of anti-dementia drugs
 - Topic 10c – Use of antipsychotic medicine in CAMHs (child & adolescent mental health services)
- National Audit of Schizophrenia (NAS)
- National Audit of Psychological Therapies

The national clinical audits and national confidential inquiries that West London Mental Health NHS Trust participated in, and for which data collection was completed during 2013/14, 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 Topic 13a – Prescribing for ADHD	172	100%
POMH-UK Topic 7d – Monitoring of patients prescribed Lithium	105	100%
POMH-UK Topic 4b – Prescribing of anti-dementia drugs	200	100%
POMH-UK Topic 10c – Use of antipsychotic medicine in CAMHS	22	100%
National Audit of Schizophrenia	Audit of practice – 79 Patient – 34 Carer – 20	79% 34% 20%
National Audit of Psychological Therapies	Case record audit – 2,254 Therapist questionnaires – 77 Service user questionnaire – 267	100% 67% 38%
Name of National Confidential Inquiry	Number Submitted	%
The Confidential Inquiry into Suicide and Homicide by People with Mental Illness (CISH)	29	78%

The reports of **6 national clinical audits** were reviewed by the provider in 2013/14 and West London Mental Health NHS Trust intends to take the following actions to improve the quality of healthcare provided:

1. POMH-UK Topic 13a – Prescribing for ADHD (attention deficit hyperactivity disorder) in children, adolescents and adults

Data collection: April 2013

Report: September 2013

Lead: Dr Meenal Sohani

Re-audit: POMH to confirm date

A clinical records based audit of ADHD prescribing practice was conducted. A questionnaire/audit tool was sent to the Trust with instructions that copies should be made available to allow clinical teams to audit all current patients with a clinical diagnosis of ADHD, whether or not they were currently prescribed ADHD medication.

Audit standard

Initiating drug treatment for ADHD

1. Before starting drug treatment, children, adolescents and adults with ADHD should have a full pre-treatment assessment, including the following:
 - a. Heart rate and blood pressure (recorded as a centile in children)
 - b. Height and weight (recorded on a growth chart in children)
 - c. Cardiovascular risk
 - d. Substance misuse risk
2. Weight, heart rate and blood pressure measured within 3 months of starting treatment

Maintenance treatment

3. In all patients, ADHD treatment should be reviewed at least annually, using standardised rating scales
4. Height and weight should be measured every 6 months in children and young people, and recorded on a growth chart
5. Weight should be recorded every 6 months in adults
6. Heart rate and blood pressure should be measured every 3 months (recorded as a centile in children)

There was good adherence by CAMHS to the audit standards regarding measurement of baseline height, weight, blood pressure and pulse before starting treatment for ADHD performing well above the national average. However, these measures were often not documented on growth and centile charts in those 16 years of age or younger. This may, at least in part, be due to the lack of easy availability of these charts in some services. Adult service fared less well overall.

Action to be taken:

- Improve recording of height, weight, blood pressure and pulse in CAMHS.
- Adult services to ensure they work toward compliance with the standards in relation to baseline measures, early-on treatment monitoring and the monitoring of longer-term treatment.

2. POMH-UK Topic 7d – Monitoring of patients prescribed Lithium

Data collection: July 2013

Report: October 2013

Lead: Clinical Leads

Re-audit: POMH to confirm date

The trust has now participated in clinical audits for this quality improvement programme in 2008, 2010, 2011 and 2013.

Audit standards

1: The following tests/measures should be completed before initiating treatment with lithium (NICE CG38, recommendation 1.6.2.7):

- a) Renal function tests; urea and electrolytes (U&Es) including creatinine (or e-GFR or creatinine clearance)
- b) Thyroid function tests (TFTs)
- c) Weight or BMI or waist circumference

2: The following tests/measures should be conducted during maintenance treatment (NICE CG38, recommendation 1.6.2.10):

- a) Serum lithium level every 3 months
- b) U&Es including creatinine (or e-GFR or creatinine clearance), and TFTs every 6 months
- c) Weight or BMI or waist circumference during the last year

Since 2008, the Trust has performed relatively well in relation to assessment of patient before the initiation of lithium treatment, in terms of checking renal and thyroid function. The patients audited for this standard had been receiving lithium for a year or less.

Although practice was generally at, or above, the average for the national sample (714 in 2013), 15 failed to meet the standard in the Trust in that not all the patients had all the required assessments and tests. The clinical team section of the POMH-UK report shows heterogeneity across clinical teams regarding pre-treatment assessment, but there are only relatively few patients in each team.

Monitoring practice has been steady in the trust, but does not achieve the improvement from 2010-2011 that is consistently shown in the national sample. The clinical team section of the POMH-UK report shows heterogeneity across clinical teams with regard to monitoring, but there are only relatively few patients in each team.

This audit included the re-audit of the completion of Lithium Monitoring Record Books - National Patient Safety Agency (NPSA) Alert - Inpatient and Community Services.

Action to be taken:

- Improve the completion of necessary assessments and tests required.
- Improve monitoring of those patients prescribe Lithium via the Lithium register

3. POMH-UK Topic 4b – Prescribing anti-dementia drugs

Data collection: November 2013

Report: April / May 2014

Lead: Dr Sujoy Mukherjee

Re-audit: POMH to confirm date

Improvement noted from the baseline audit.

Audit standards

1. The clinical indications (target symptoms) for antipsychotic treatment should be clearly documented in the clinical records.
2. Before prescribing antipsychotic medication for BPSD (behavioural and psychological symptoms in dementia), likely factors that may generate, aggravate or improve such behaviours should be considered.
3. The potential risks and benefits of antipsychotic medication should be considered and documented by the clinical team, prior to initiation.
4. The potential risks and benefits of antipsychotic medication should be discussed with the patient and/or carer(s), prior to initiation.
5. 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:
 - a) therapeutic response and
 - b) possible adverse effects.

Although this a 're-audit', the data in this iteration cannot be directly compared with baseline and therefore baseline data was not included in the report. This is because:

- the baseline data were collected over five years ago,
- the NICE guidelines on the prescribing of an anti-dementia drug have changed which has led to the modification of the audit tool
- the eligibility criteria for inclusion in the audit were changed

Trust Performance

The trust performed well in comparison to the national average having the lowest proportion of patients prescribed an antipsychotic for dementia, however showed a slight decrease in the clear documented indication for antipsychotic treatment

4. POMH-UK Topic 10c – Use of antipsychotic medicine in CAMHS

Data collection: February 2014

Report Due: August 2014

Lead: Dr Meenal Sohani

Re-audit: POMH to confirm date

This is the third cycle of audit of this topic run by POMH-UK.

Audit standards

1. For all children and adolescents prescribed antipsychotic medication the indication(s) for treatment with antipsychotic(s) should be documented in the clinical records.
2. For all children and adolescents prescribed antipsychotic medication, the side effects of antipsychotics should be reviewed at least once every six months.

The trust performed particularly well in the last re-audit regarding compliance with recording and reviewing use of medication. It was noted however, that monitoring of prolactin levels was lower than the national average.

Action taken prior to re-audit:

- Increased recording regarding monitoring of prolactin levels
- Documented side effect assessments of body weight, blood glucose, plasma lipids and raised plasma prolactin in the six months (either a recorded result or test measurement, or some reference to screening or other relevant observation made) in patients who have been prescribed antipsychotic medication for over three months implemented
- Action plan monitored through governance processes on the Wells Unit and Child & Adolescent Mental Health Services

The trust is currently participating in the third cycle of audit which will report in August 2014.

5. National Audit of Schizophrenia – Royal College of Psychiatrist's Centre for Quality Improvement (CQI)

Data collection: August 2013

Trust Report: June 2014

National Report: Nov/Dec 2014

Lead: Professor Thomas Barnes Re-audit: TBC

The Trust participated in the second phase of the National Audit of Schizophrenia which commenced in August 2013 and will be reported in June 2014.

Audit standards

The standards set for this audit are based on the NICE Guideline (2009). Thus, the services offered to them, prescribing practice, psychological interventions offered and the quality of monitoring of physical health for these service users.

Trust performance:

Awaiting report.

6. National Audit of Psychological Therapies – Royal College of Psychiatrist's Centre for Quality Improvement (CQI)

Data collection: Between April 2012 & January 2013

Report Due: November 2013

Lead: Dr Rod Holland

Re-audit: TBC

The National Audit of Psychological Therapies (NAPT) aims to evaluate and improve the quality of treatment and care received by people with anxiety and depression in England and Wales. A baseline audit was carried out in 2010 and published in November 2011. This report is based on findings from the second round of the audit, which collected data 18 to 24 months after the baseline to determine whether performance had improved

Audit standards

The ten NAPT audit standards map onto the four domains of quality, as follows:

- Access – Standards 1-3
- Appropriateness – Standards 4-6
- Acceptability – Standards 7-8
- Outcomes - Standards 9-10

The standards were mainly the same at baseline to allow for comparison, but there have been some minor changes following feedback and recommendations from the first round. The results show that our services are improving in terms of the number of people accessing the service and collecting outcome measures. Whilst the audit has shown improvements in service quality against agreed standards of care, there are still improvements required regarding improving access for older people with anxiety, shortening waiting times, number of sessions provided, and skills and training of the workforce.

Action to be taken:

Obtain feedback from Rod Holland/Dominic Glover.

The reports of 14 local clinical audits were reviewed by the provider in 2013/14 and West London Mental Health Trust intends to take the following actions to improve the quality of healthcare provided described in table below:

Audit	Lead	Actions & Audit Frequency	Standards	Areas
Patient Safety	Medical Director	Review tool Assurance actions Monthly audit	Review of records	All services
Incidents & management of deliberate self harm	Director of Nursing & Patient Experience	Re audit physical treatment options & PRN medication Bi annually Audit Local and High secure services	NICE guidance CG16	London Forensic
Observational Audit of Engagement and Observation Practice Trust-wide	Director of Nursing & Patient Experience	Engagement & Observation info to all patients with copy of their engagement & observation care plan Annual	Standards as per Enhanced Engagement and Observation Policy O1	Trustwide
Safe guarding Adults Policy – experience and knowledge of clinicians	Director of Safe guarding	More joint training Identify chair for strategy meetings Safeguarding adults sub committee to review audit methodology for assurance Adhoc	Update baseline from CQC visit 2012	Trustwide safe guarding adults
NICE Infection Control	Director of Nursing & Patient Experience + Infection Control Lead	Actions not yet available Annual	NICE Clinical Guideline 139	Trustwide
Hand Hygiene	Director of Nursing & Patient Experience + Infection Control Lead	Local services staff to carry tittles and ensure supply available Progress monitored via CSU & Trustwide ICPEG meetings Monthly	10 standards	Trustwide
Self assessment checklist: eliminating mixed sex accommodation	Director of Nursing & Patient Experience	Lillie & Meridian to become single sex wards in 2014 Jubilee ward will be split into 2 distinct areas Each area has their own action plans to implement Annual	Single sex accommodation checklist	Trustwide
Observation of MEWs implementation	Director of Primary Care	MEWs fully implemented Adhoc	MEWs observation chart	Trustwide

Audit	Lead	Actions & Audit Frequency	Standards	Areas
NICE guideline 29 pressure ulcer	Director of Primary Care	Report not yet available Adhoc	NICE guideline 29 pressure ulcer	Trustwide
Copying letters to patients	Medical Director	Standard template for all correspondence to be developed. All letters copied to patients as per C19 policy Annual	Standards from C19 Copying Letters to Patients policy	Trustwide
NICE guideline 45	Consultant	Awaiting action plan from Amrit Sachar 2 yearly	Psychiatric care plans in maternity notes	Local Services
Clinical Coding	Medical Director	Clinical coding is quality priority for 2014/15 Annual	Primary & secondary ICD10 coding	Trustwide
NICE guideline 28	CAMHs Consultant	Children & YP to discuss issues in private CAMHs generic assessment tool to be used MFQ to be used in practice Risk assessments updated every 6 months on RiO Parental mental health to be discussed in assessment 2 yearly	Depression in Children & Young People	CAMHs
NICE guideline 170	CAMHs Consultant	Physical exam when assessing - Autism Clinics have a checklist of signs and symptoms NDT have allocated morning of physical exam - Autism Bi Annual	Guideline 170	CAMHs

What Baker Tilly, 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.

Safeguarding Adults

The results from the audit produced an amber/green status.

The summary concluded that the board could take reasonable assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied, and effective.

However, there were nine recommendations:

There were five medium recommendations and four low recommendations.

These will all be completed by March 2014.

Complaints

The results from the audit produced an amber/red status.

The summary concluded that whilst the board could take some assurance that the controls upon which the organisation relies to manage this risk are suitable designed; consistently applied, and effective, action needed to be taken to ensure this risk is managed.

There were eleven recommendations from this audit:

There were eight medium recommendations and three low recommendations.

All recommendations have been completed with evidence provided to Baker Tilly in December 2013 and further evidence for full assurance in April 2014 – they have confirmed that no further follow up from the Trust is required.

Rolling Care Quality Commission Review – Outcome 14

At the time of the audit the conclusion was that the trust had not fully implemented the three recommendations raised by the Care Quality Commission to demonstrate compliance with Outcome 14. However, there was progress made against each of the three recommendations.

1. Updating the whistle blowing policy
2. Implementation of the updated whistle blowing policy
3. Implementation of the trust workforce and organisational development policy

There was one medium recommendation from this audit.

An action plan was developed and has now been implemented.

The care quality commission have re assessed Outcome 14 and the trust is now fully compliant.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by West London Healthcare Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 827.

The trust continues to be committed to the research and development agenda; recognising that research can act as a driver for improving the quality of care and the patient experience as well as attracting and retaining good quality staff.

During 2013/14 827 patients were recruited into research studies; 328 to funded studies and 499 to unfunded and student studies. The number of patients recruited into commercial studies was 39.

The number of active studies within the trust for this period was 98; 66 of those were funded studies. Of the 98 live projects 48 of these were given research and development approval since April 2014; 22 funded 26 unfunded.

The trust continues to encourage its staff to become involved in research either by recruiting patients to studies or leading on their own research.

Studies within the cognitive impairment clinical research domain continue to lead the way however much effort has been made to encourage and further develop research in mood and psychosis, CAMHS and forensic which has seen the recent appointment of a senior lecturer in forensic clinical psychology.

There are a number of key projects starting within the trust this year; PREVENT, looking at identifying risk factors in mid-life for dementia and the TOMORROW study a global study seeking to prevent Alzheimer's dementia on the basis of a genetic biomarker. People thought to be at high risk enter the trial and may receive Pioglitazone to slow the progression of the disease. West London Mental Health Trust is the lead centre in the UK and targeted to recruit 500 participants of the 6,000 needed globally.

The trust has invested in the development of DemReg a dementia registry where patients with cognitive impairment and their carers have consented to be contacted when appropriate research becomes available that they can participate in. We are also involved in the implementation of D-CRIS within the trust. D-CRIS: the Dementia Care Record Interactive Search which allows us to carry out research using information from patients clinical records without revealing their personal details to researchers. D-CRIS is safe and secure and can make a real and positive difference to future treatments and care. Although it was initially developed to look at patients with dementia it can be used across all disease areas. This is a national project that is taking place in five trusts across the country; West London was picked because of its strong track record in dementia research.

West London Mental Health Trust has played a central role in its Comprehensive Local Research Network, through the involvement and leadership of its R&D Director; this will continue in 2014 - 15 as the network makes its transition to the Local Clinical Research Network which will contain all disease areas including mental health and dementia. The trust is also linked to Imperial College where it has funded a number of clinical academics in dementia and mood and psychosis and is a core member of Imperial College Health Partners which brings together academic and clinical experts with the aim of delivering improved mental health outcomes.

In 2011/12 researchers and academics linked to the Trust published 112 articles. 2012/13 this increased to 130 and 2013/14 saw the publication 69 peer reviewed publications with a further 8 in press.

Goals agreed with commissioners – CQUIN (Commissioning for Quality and Innovation)

A proportion of West London Mental Health NHS Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between the West London Mental Health NHS Trust 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 2013/14 and for the following 12 month period are available online at:

<http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/openTKFile.php?id=3275>

Local services

The following CQUIN targets were set for Local Services for 2013/14.

Local services CSU	Q1	Q2	Q3	Q4
Ealing, Hammersmith & Fulham and Hounslow				
1. Physical healthcare				
Mental health & physical health coding	Met	Met	Partially met	Partially met
Patient with long term conditions have check with GP	Met	Met	Partially met	Partially met
CPA review outcome or care plan to GP	Met	Met	Partially met	Partially met
Outcome of assessments to GP in 2 weeks	Not met	Met	Partially met	Partially met
Stop smoking advice to service users	Met	Met	Met	Partially met
Smoking status recorded	Met	Met	Met	Partially met
Smoking cessation advisory programme	Met	Met	Met	Met
System to record info on smoking status & referrals	Met	Met	Partially met	Partially met
CPA review outcome or care plan to GP	Met	Met	Met	Met
2. PbR				
Patients clustered by 2nd appt or 2nd OBN	Met	Met	Met	Met
PbR caseload with valid cluster	Met	Met	Met	Met
PbR caseload with valid cluster and accurate	Met	Met	Met	Met
DH clustering algorithm	N/A	N/A	N/A	N/A
Audit for cluster accuracy by diagnosis	Met	Met	Met	Met
3. Safe discharge				
Safer discharge protocol	Met	Met	Met	Met

Local services CSU	Q1	Q2	Q3	Q4
Ealing, Hammersmith & Fulham and Hounslow				
4. NHS Safety Thermometer Pressure ulcers, falls, urinary tract infection	Met	Met	Met	Met
5. Dementia Register to GPs twice a year	Met	Met	Met	Met
Trust and primary care to develop cluster 18	Met	Met	Met	Met
Audit of antipsychotics	Met	Met	Met	Met
Real time surveys to assess lack of advice	Met	Met	Not met	Met
6. A&E Frequent Attenders Reduction in A&E attenders specified cohort	Met	Met	Met	Met

Only Q1 confirmed with clinical commissioning group to date.

High secure services

The following CQUIN targets were set for High Secure Services for 2013/14

High secure services	Q1	Q2	Q3	Q4
Optimising pathways High Secure	Met	Met	Met	Met
Optimising pathways High Secure collaborative	Met	Met	Met	Met
Improving physical healthcare & well being of patients	Met	Met	Met	Met
Improving physical healthcare outcomes Broadmoor specific	Met	Met	Met	Met
Achieving a health community / Anti-Bullying Strategy in high secure hospital. Broadmoor specific	Met	Met	Met	Met

Confirmed with commissioners

Specialist and forensic clinical service unit

The following CQUIN targets were set for Specialist and Forensic Service for 2013/14

Specialist and forensic service CSU	Q1	Q2	Q3	Q4
Optimising Length of Stay	Met	Met	Met	Met
Improving physical healthcare	Met	Met	Met	Met
Provision of literacy, numeracy and IT	Met	Met	Met	Met
Clinical dashboard	Met	Met	Met	Met
Building on 12/13 CQUIN, develop work plan & key actions	Met	Met	Met	Met

Commissioners have not confirmed CQUIN performance for Q4

Care Quality Commission registration

West London Mental Health NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without conditions'.

The Care Quality Commission has taken enforcement action against West London Mental Health Trust during 2013/14

The CQC did take out one enforcement action against West London Mental Health Trust during 2013/14, and declared non compliance with two outcomes during a visit to the Limes in August 2013.

West London Mental Health Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

During 2013/14 the Care Quality Commission (CQC) made a total of five unannounced visits to the trust in year to assess compliance with the outcomes of the 'Essential Standards of Quality and Safety'

In May the CQC visited Lakeside and declared full compliance with the six outcomes assessed.

In June they visited High Secure Services and declared full compliance with the six outcomes assessed.

In October the CQC visited Ealing sites and declared full compliance with the seven outcomes assessed which included outcome 14, which had required action from a previous visit.

Outcome 07: Safeguarding people who use services from abuse

The CQC judged that the Limes was not meeting this standard and that this has a moderate impact on service users. The CQC felt that service users were not fully protected from risk of abuse because trust staff was not always able to take reasonable steps to ensure staff always responded appropriately to any allegation of abuse.

Outcome 16:- Assessing and monitoring the quality of service

The CQC judged that the trust did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others and this had a moderate impact on people who use the service.

Outcome 21:- Records

The CQC judged that people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained and that this had a minor impact on people who use the service.

The trust took immediate action as a result of the visit and a recovery plan was implemented. The plan was submitted to the CQC and monitored via the trust governance process and the trust board.

In December 2013 the CQC undertook another unannounced visit to the Limes to assess the progress the trust had made. They found that improvements had been made to ensure that people were safeguarded against the risk of abuse. Improvements had also been made to assess and monitor the quality of the service and to ensure that records were fit for purpose, and the trust was declared fully compliant.

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. CPA 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.

	2013/14				2012/13			
	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
WLMHT	**97.71%	96.0%	95.5%	95.15%	96.6%	96.9%	95.4%	97.8%
National Average	*n/a	96.7%	97.5%	97.45%	97.3%	97.6%	97.3%	97.5%
Highest Nationally	*n/a	100%	100%	100%	100%	100%	100%	100%
Lowest Nationally	*n/a	77.2%	90.75%	94.15%	93.6%	92.5%	89.8%	94.9%
WLMHT Annual Outturn	**96.34%				96.6%			
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

West London Mental Health Trust 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 West London Mental Health Trust during the reporting periods.

West London Mental Health Trust has taken the following actions to improve this percentage, and so the quality of its services by:

- Further investigation and refinement of the key performance indicator (KPI) definition in order ascertain classes of patients who should be included or excluded.
- Monitoring compliance 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 (see annex 5).

1 2012 Quality Account Amendment Regulations - <http://www.legislation.gov.uk/uksi/2012/3081/contents/made>

**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 they are treated effectively and promptly in the most appropriate settings of care.

	2013/14				2012/13			
	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
WLMHT	**97.52%	99.4%	99.4%	99.42%	95.9%	95.3%	97.6%	96.4%
England Average	*n/a	98.6%	98.7%	97.68%	98.6%	98.4%	98.0%	97.8%
England Highest Performer	*n/a	100%	100%	100%	100%	100%	100%	100%
England Lowest Performer	*n/a	85.5%	89.8%	74.50%	84.9%	90.7%	84.4%	83.0%
WLMHT Annual Outturn	**98.39%				96.3%			
Target	95%				95%			

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

West London Mental Health Trust 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 West London Mental Health Trust during the reporting periods. Compliance is monitored routinely via the trusts 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 trusts governance framework (see annex 5).

West London Mental Health Trust intends to take the following actions to improve this percentage compliance, and so the quality of its services by:

- Embedding consistent admission protocols across all trust sites where the same care specialities are delivered.
- Continue to monitor and report routinely to all relevant areas across the trust

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.

	2013/14	2012/13
0 to 14 years	0%	0%
15 years or over	8.1%	8.1%
Target	<10%	<10%

West London Mental Health Trust considers that this data is as described for the following reasons: the West London Mental Health Trust 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 specialist and forensic

services. No comparable national benchmarking has been available.

West London Mental Trust has taken steps to improve its discharge and care planning process following discharge from in-patient to community services to minimise readmissions.

4. Staff recommendation of the trust as a place to work or receive treatment

Measure	WLMHT Performance 2013	WLMHT Performance 2012	National Average for MH Trusts	Highest MH Trust Score	Lowest MH Trust Score
Staff recommendation of the Trust as a place to work or receive treatment	3.47/5	3.46/ 5	3.55/ 5	4.04/ 5	3.05/5

Data source: http://nhsstaffsurveys.com/cms/uploads/Individual%20Trust%20reports%202012/NHS_staff_survey_2012_RKL_sum.pdf

West London Mental Health Trust considers that this data is as described for the following reasons. The data is taken from the national NHS survey 2013 and is considered a reliable data source.

A major initiative is being undertaken by WLMHT to improve staff engagement. This includes a number of enablers and related actions to improve this percentage score, and so the quality of its services by:

- Being clear and consistent about our vision and strategy so that staff understand what the trust is aiming to achieve and how their role contributes.
- Engaging managers and empowering them 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 – achieving culture change starts with the leadership of the organisation.

- Promoting and improving staff health and wellbeing within the workplace.
- A number of initiatives are being undertaken by West London Mental Health Trust to improve staff engagement and motivation. These include:
 - Monthly listening events held by the chief executive and other senior members of staff where concerns and questions are received. Giving staff 'a voice' so they are listened to and know that their options count and enabling them to express concerns openly.
 - Trustwide learning lessons conferences look at specific incidents and how we can improve the way we share learning. The conference also covers positive examples showcasing good practice is shared.
 - Staff members were recruited as reporters to interview colleagues and report back to the board with their findings resulting in an action plan and a number of projects to address concerns raised.

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.

This survey is used to gain a better understanding of what service users think about their care and treatment provided by West London Mental Health Trust. 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	National Average			
	2013	2012	Highest	Lowest
Did this person listen carefully to you?	8.7	8.7	9.2	8.2
Did this person take your views into account?	8.3	8.2	8.9	7.9
Did you have trust and confidence in this person?	7.9	8.3	8.7	7.5
Did this person treat you with respect and dignity?	8.9	9.0	9.5	8.6
Were you given enough time to discuss your condition and treatment?	8.2	8.3	8.8	7.4
Overall, how would you rate the care you have received from NHS Mental Health Services in the last 12 months?	7.0	6.8	7.4	6.2

Data source: <http://www.cqc.org.uk/survey/mentalhealth/RKL> Scores are based on marks out of 10

The data for this report has been extracted from the Care Quality Commission patient survey report 2013 and correlates to the data supplied by Quality Health who undertook the survey on behalf of West London Mental Health Trust.

West London Mental Health Trust has taken the following actions to improve this percentage, and so the quality of its services by:

- Completing a review of current service user/carer involvement via an external agency to improve communication and feedback mechanisms.
- Ensuring that service user's families and others close to them are as involved as the service user

wants them to be in decisions about their care and treatment.

- Conducting bespoke surveys within the services using technology to report back real time information, to enable us to support and improve service user experiences.
- Out of hours arrangements have been reviewed to ensure service users and carers can contact West London Mental Health Trust when required.
- 24 x 7 crisis line established.
- Listening Event held to develop a realistic and achievable action plan.

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.

Indicator	Performance	2013-14 Q3/Q4	2013-14 Q1/Q2	2012-13 Q3/Q4	2012-13 Q1/Q2
Severe harm/death	WLMHT	(12)*	(16)*	1.2% (12)	1.9% (19)
	National Average	n/a**	n/a**	1.3% (1485)	1.6% (1747)
	Highest MHT	n/a**	n/a**	2.5% (170)	9.4% (334)
	Lowest MHT	n/a**	n/a**	0% (0)	0% (0)

Data source: <http://www.nrls.nhs.uk/resources/?entryid45=135195>

* 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.

West London Mental Health Trust 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
- Data has been verified by them up to and including 31 March 2013
- The national average and highest and lowest mental health trust was provided by the NRLS in their six monthly feedback reports

West London Mental Health Trust 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
- Holding regular learning lesson events
- Improving system processes for quality checking and timeliness of reported date.

This has resulted in a sustainable improvement in our reporting rate and number of days taken to report incidents to the NRLS.

At the date of publication no reports for 2013/14 were available from the NRLS, hence incidents reported above have been taken from internal systems.

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 discharge. 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 2013/14 we reduced our delayed discharges from 6.4% to 5.5%, remaining well within the target of 7.5%.

The table below shows our performance over the last three years:

	2013/14*	2012/13*	2011/12	Target
% Delayed Transfers of care	5.75%	6.4%	9.8%	< 7.5%

Source : manually collected from wards

*This is not a true comparison as from 2012/13 we have included both High Secure and Specialist and Forensic services to provide and trust wide position. 2011/12 percentage relates to Acute Services.

Quality Indicators – Other indicators

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.

More than ever before we, as a Trust, are focused on providing better and more accessible information to our staff who are encouraged to access relevant information and tools to monitor and improve practices.

West London Mental Health NHS Trust will be taking the following actions to improve data quality:

- data quality managers will ensure data is complete and correct by working closely with clinicians to improve data recording processes and effective use of our clinical systems
- there will be continued use of automated data quality reports to monitor data quality, and for staff to identify and resolve specific data quality issues
- there will be further development and roll out

of data quality dashboards identifying areas that need attention and correction

- there will be focus on Payment by Results (PbR) cluster information and use
- there will be ongoing 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'

NHS Number and General Medical Practice Code Validity

West London Mental Health Trust submitted records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics. The percentage of records in the published data:

which included the patient's valid NHS Number was:

- 99.3% for admitted patient care;
- 99.8% for outpatient care; and
- N/A for accident and emergency care.

which included the patient's valid General Practitioner Registration Code was:

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

Information Governance Toolkit

West London Mental Health NHS Trust's Information Governance Assessment report overall score for 2013/14 was 71% and was graded "green".

Staff Engagement

The trust has identified improving staff engagement as one of its key priorities and has established a staff engagement committee which sits as a formal sub committee of the board, monitoring the progress and impact of the staff engagement action plan.

Over the course of the last year the trust has taken forward an innovative staff reporter initiative which involved the recruitment of 30 staff reporters from all areas of the organisation. Each reporter interviewed 10 members of staff and the results of the interviews were fed directly back to the board. In response to this feedback a staff engagement action plan has been developed in close consultation with the staff reporters. The action plan includes the following six key work programmes and each programme is led by an executive director and staff reporter.

Programme 1 - Developing an effective and enabling culture and behaviours

Programme 2 - Making the quality of patient care control our decision making

Programme 3 - Developing and communicating an effective vision for the organisation

Programme 4 - Improving our management of change

Programme 5 - Improving our leadership and management competencies

Programme 6 - Getting our structures right and investing in our infrastructure

Through this action plan we have developed a number of initiatives including:-

- The launch of a talent management framework
- Implementation of a new leadership development programme; jointly designed with reporters
- Launch of a full programme of listening events across the organisation led by the chief executive
- Launch of a befriender scheme for staff experiencing difficulties at work
- Launch of back to the floor programme in high and medium secure services
- Review of the Whistleblowing policy with clear guidance for staff on raising concerns
- Review of our change management policy and process
- Launch of an early intervention scheme for managing staff sickness

The trust will now be undertaking a 'temperature check' to gain a clearer understanding of whether the interventions are improving staff satisfaction. This will involve the reporters running focus groups as well as the distribution of a short questionnaire.

It is recognised however that it will take time to change the culture of the organisation and for the impact of this work to be fully represented positively by the results of the staff survey.

Information Governance

The Trust achieved level 2 out of 3 levels.

Clinical Coding Error Rate

West London Mental Health Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Part 3: Other Information

Review of Quality Performance

Message from the Medical Director Dr Nick Broughton

2013/14 has undoubtedly been another challenging year for the trust as a consequence of the considerable financial pressures we, along with the wider NHS, have faced. Despite this challenging financial climate I have been very encouraged by the trust's ability to maintain and indeed improve the quality of its services and at the same time improve efficiency.

The year has seen a number of significant developments in relation to the three domains of quality, namely patient safety, patient experience and clinical effectiveness. The trust has responded promptly to the recommendations and implications of the Francis, Keogh and Berwick reports which undoubtedly will have a profound and positive impact on the quality of services delivered by the NHS during the years ahead. Detailed action plans have been developed, the implementation of which is now well advanced.

The trust in particular is committed to ensuring that it is able to respond positively to feedback from all its service users to improve service user experience. This commitment has been evidenced by the effective roll out of the Meridian system across the trust which uses electronic tablets to capture real time patient experience. In addition quality notice boards have now been introduced to provide a standardised means of providing regular feedback to our service users and their carers regarding the quality of our services.

The year has seen a significant reorganisation in the trust's approach to delivering integrated governance. As medical director I am now responsible for quality governance and have developed a corporate governance team led by a highly experienced director of governance. The trust's integrated performance report has undergone an extensive revision in order

to provide the board with greater assurance regarding all aspects of the trust's performance including, most importantly, the quality of our clinical services.

The Care Quality Commission's inspection of the Limes Unit in the summer of 2013 highlighted the importance of the trust being able to identify early, services where there may be concerns regarding incident reporting and as a result, patient safety. As part of the comprehensive response to such concerns a patient safety heat map has now been developed which provides senior managers across the organisation with comprehensive information regarding the safety of all inpatient services.

In addition to improving the quality of existing services the trust has continued to develop new services which better meet the needs of the service users we serve. With this in mind I have been particularly encouraged by the development of our liaison psychiatry services which are now well established in all our local acute hospitals. On going funding for such services has now been agreed and undoubtedly they will play a key role in improving the care provided to service users with both physical and mental health problems across the boroughs of Ealing, Hounslow and Hammersmith & Fulham.

Research and development (R&D) remain a priority for the Trust. The last year has seen the continued successful implementation of our first R&D Strategy with an increasing number of service users being offered the opportunity to participate in research. More however, can, and indeed should be done to ensure all patients are offered an opportunity to be involved in research. For this reason we are pleased to have identified a specific quality priority regarding R&D for 2014/15.

The trust has remained an active member of the North West London Academic Health Science Network and continues to play a major role in developing the network's mental health programme. We are therefore extremely pleased that one of the trust's consultants, Professor Thomas Barnes, is now chairing the network's mental health clinical advisory group and helping to lead work which will improve the treatment provided to service users suffering from schizophrenia across North West London.

The trust's commitment to develop innovative models of care which provide better clinical outcomes for our service users is also reflected in the role we have played along with colleagues from primary care, the acute sector and community trusts in developing models of integrated service delivery. We are proud of the fact that North West London was identified as a pioneer site for whole systems integrated care during the last year and that we have been able to play a key role in the development of integrated models of care delivery.

As an organisation we are committed to ensuring that we recruit and retain staff of the highest quality and in addition continue to develop our staff in order that they can fulfil their potential and provide the best possible care to our service users. Our commitment has been reflected in the fact that a significant number of our senior leaders have obtained places on courses run by the NHS leadership programme including the prestigious Nye Bevan and Mary Seacole courses. It is essential also that our staff are able to provide care in high quality and safe physical environments. For this reason the trust was

extremely pleased to secure funding from the department of health (DH) to both redevelop Broadmoor Hospital and build a new medium secure unit on the St Bernard's site. Together these projects will constitute one of the largest capital projects ongoing in the NHS and will result in two of the finest secure psychiatric hospitals anywhere in the world.

Despite all the achievements of the last year much more can, and indeed will be done, to improve the quality of our services. Central to this are the trust's quality priorities which have been developed following extensive consultation, and the ongoing implementation of our quality strategy. The continuous improvement of the quality of our services will remain the trust's overarching priority.

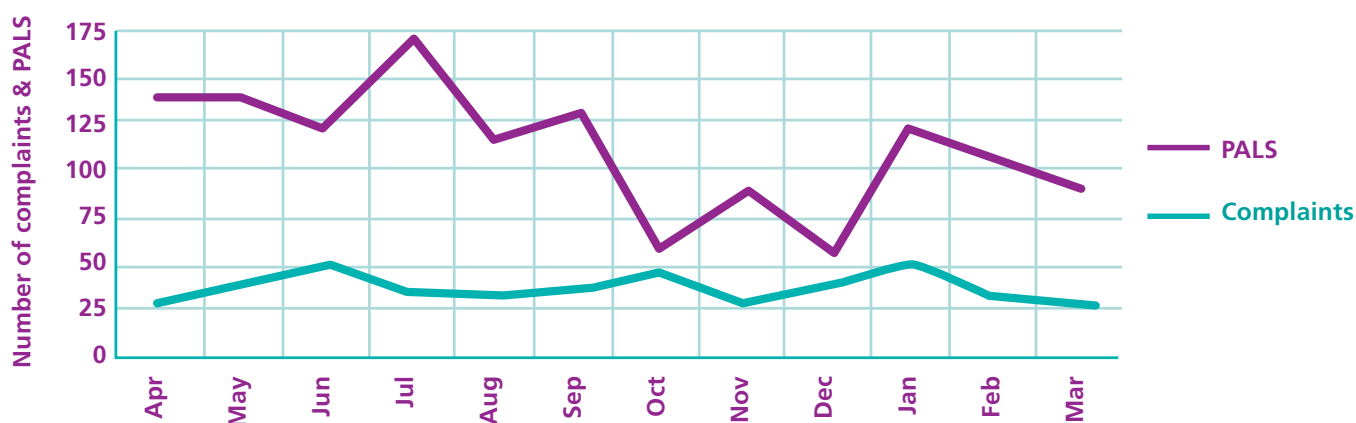
What service users, carers and the public say - key messages and actions taken during 2013/14

During the reporting period 1st April 2013 to 31st March 2014 we received and registered a total of 444 complaints. This is substantially higher on the previous years with an increase of 45% when compared to the 307 complaints registered in 2012/13, and 199 in 2011/12. Further analysis will be carried out to identify the services and key factors contributing to the rise in complaints.

The Trust continues to provide a dedicated PALS Officer to work with the individual service user, carers, families and the wider 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 by our patients, service users, families and wider public. The graph below shows the comparison between complaints and PALS throughout the year.

Trust-wide complaints & PALS 2013/14



Our Local Services CSU received 160 complaints, Specialist and Forensic Services CSU received 121, High Secure Services CSU received 156 and Estates & Corporate Services CSU received 7 complaints. This is relatively higher in comparison with previous years, although as the service structures are different, an exact comparison is difficult.

We consider it essential to respond to and seek to resolve complaints in a timely and effective way. We are pleased that 87% of complaints received during the year were resolved within the timeframe agreed with the complainants which compares favourably with our performance in 2012/13 (89%).

Our aim is to investigate the 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 trusts and national data.

The table below illustrates the Department of Health themes to which complaints are allocated and a trend analysis between each quarter of the year.

Complaint Themes	Q1 13/14	Trend	Q2 13/14	Trend	Q3 13/14	Trend	Q4 13/14	Trend	TOTAL
Admission discharge and transfer arrangements	4	m	1	n	1	@	2	m	8
Aids & Appliances	2	n	0	n	1	m	0	n	9
All aspects of care and treatment	47	m	35	n	38	m	40	m	160
Appointments	8	m	8	@	6	n	11	m	33
Communication written and oral	7	m	7	@	6	n	6	@	26
Complaints handling	1	m	0	n	0	@	0	@	1
Consent to treatment	1	m	2	m	0	n	0	@	3
Failure to follow agreed procedures	5	m	7	m	5	n	10	m	27
Hotel Services	0	m	2	m	6	m	3	n	11
Length of waiting time for response/to be seen	2	m	0	n	0	@	1	m	3
Other category	6	@	6	@	6	@	8	m	26
Patient status & discrimination	0	n	0	@	1	m	0	n	1
Personal Records	5	m	1	n	0	n	0	@	6
Policy & commercial decisions	0	@	1	m	0	n	0	@	1
Privacy and dignity	6	m	2	n	1	n	2	m	11
Property and expenses	3	n	9	m	6	n	8	m	26
Staff attitude	23	n	15	n	34	m	19	n	91
Transport	0	@	1	n	0	n	0	@	1
Total number of complaints	120	m	103	n	111	m	110	n	444

Most of the complaints made about our services fall into 3 categories:

- **All aspects of care and treatment**

- which includes treatment, medication, assessment, ward moves, home visits, detention, diagnosis, seclusion, progress of treatment / care pathway, treatment of physical ailments and general aspects of inpatient & community care.

- **Staff attitude**

- which includes staff mannerisms, rudeness, being shouted at and feeling ignored.

- **Appointments (inpatient & outpatient)**

- which includes cancellation of appointments, length of delay on waiting time for appointments, referral delays.

In terms of learning from complaints and sharing good practice, the following outcomes have been achieved:

Messages from complaints	Action taken as a result of complaints received
Improve care & treatment	All leave and transfers to another ward are clearly documented and the decision clearly communicated to the patients by nursing and medical staff.
Improve catering	<p>Dietary needs and food portion servings was raised with the Catering department and the portions have now been changed.</p> <p>All patient meals are now checked prior to serving so that a replacement or substitute meal can be ordered in time if needed.</p> <p>A copy of the daily meals summary sheet for both lunch and tea meals is sent to all wards with the food trolley to ensure food delivered is what was ordered.</p>
Changing culture to improve staff attitude	<p>Reflective practice sessions held during Team Meetings for all staff.</p> <p>Mediation meetings for staff and patients have been established to improve therapeutic relationships.</p> <p>All Trust staff have been reminded to display a professional attitude towards patients, relatives and carers throughout any contact.</p>
Improve Communication	<p>A clear explanation is provided to all patients about any clinical decision to remove risk items from bedrooms.</p> <p>Information will be available on the role of the assessment team and their functions so service users know what to expect.</p> <p>Mental capacity information leaflet is available for patients and carers.</p> <p>Staff reminded to be more careful when discussing client matters or diary issues at the reception desk as these can be overheard in the waiting area.</p> <p>Versions of Demographics forms, Change of Details forms and Travel forms are being created in large print.</p> <p>A change in diagnosis from previous treatment spell is being communicated by the medical teams and explained to the service user to prevent any misunderstanding and ambiguity and also to improve service user experience of using our services.</p> <p>All staff have been reminded about sensitivity as to what is included in letters to patients as letters may appear hostile and critical to patients.</p>
Better processes & procedures	<p>All staff have been reminded that patient records are to be kept in locked storage when not in use.</p> <p>All staff reminded to be more vigilant of any defective or suspicious mail and inform senior management accordingly. All related incidents are recorded in the control room sheets.</p> <p>A new procedure was introduced to ensure waiting list does not build up and service users are allocated to new staff in a timely way.</p> <p>Patients are allocated a Primary and Associate Nurse whose responsibility is to ensure Care Plans are written collaboratively and that the patient has participated and has a copy. This is audited weekly.</p> <p>All patients' property is to be kept in the patient bank for safe keeping or family/carers are to remove the property from the ward. If a patient wants to retain the valuable property a Patient Disclaimer of Responsibility form will be completed.</p> <p>The 'Patients Post' procedure has been amended to ensure clear time limits on how soon after mail arrives on the ward it should be handed out and when the post leaves the ward.</p> <p>A review is being carried out to look into improved protocol/process between inpatient units to support joint working, quicker access and transfer of patients services.</p>

We have worked on reporting the PALS themes this year and have broken down the themes into the top five in the table below:

PALS THEMES	High Secure	Local	Specialist and Forensic	Estates & Corporate	Total
Any other issue (issues relating to other trusts & signposting, parking, noise levels on ward)	10	231	277	68	586
Any aspect of care & treatment (lack of treatment/neglect, support, visiting, CPA issues, detention, diagnosis, assessment, ward moves, consent to treatment, leave, medication, quality of care, referral & request for 2nd opinion)	6	142	107	10	267
Access to services (referral difficulties, access when in crisis & appointments/waiting times)	0	22	103	12	137
Complaints handling (complaints procedure, direction to advocates, dissatisfaction with outcome of complaint)	1	33	13	8	55
Staff Attitude (not listened to, rudeness, alleged bullying, alleged abuse)	7	24	16	1	48
Medical and other Records	7	17	8	8	40

The vast amount of the PALS concerns this year were regarding the appointment delay/waiting times and referrals at the Gender Identity Clinic. PALS have been working closely with the clinic and the service users to ensure that communication regarding the delays are communicated effectively and efficiently. A voicemail service is now in place at the clinic to address the feedback received about service users not being able to make contact with the clinic due to one telephone line.

The Trust received a total of 113 compliments during 2013/14 which is a significant increase from previous years of 34 in 2012/13 and 41 in 2011-12. We are pleased with the increase of compliments logged this year which has been the highest received to date. See below a few examples of the positive feedback received:

"I would like to express my greatest appreciation of a care coordinator's sincere efforts to try and

help my son to recover from what I believe to be a deep depressive state."

"My wife is a patient in one of the wards within the Orchard Unit. I was invited to a meeting in the grounds at St Bernards, involving the day to day of running the hospital and care of the patients at the Orchard Unit. I was a bit apprehensive of going to the meeting but I was glad I took time to go as I was very happy with what I saw and heard from Managers and staff who I listened for more than an hour and half. I was amazed to hear people discuss the day to day running of the unit. I thought the people were very professional and caring for those concerned including patients as well as staff. It has opened my eyes to see the dedication of people who no doubt don't earn tremendous amounts of money and dedicate themselves to their duties. I can put my head on my pillow at

night and put myself at ease knowing that my wife is getting the best of care day and night. Thank you for everything.”

“Thank you doctor and all staff on Wells Unit for your care and hospitality and love you display during and after my son was with you. He never stops talking about the staff who looked after him and he is very happy to be home.”

“I am writing to thank you, and all your staff for their thoughtfulness and kindness shown to me and my family over the period my son was in Broadmoor. Can you please also extend all our thanks to reception, escorts, security, social

workers, work shops etc, as all staff throughout the hospital, where a part of making our lives for the past decade, so much easier.”

Data on complaints, compliments and PALS is collated and reported throughout the Trust and reported monthly to the Board, bi-monthly to the service user & carer experience sub-committee and quarterly to the Quality Assurance Committee. An annual complaints report is also published as part of our statutory requirements.

WLMHT complaints process is accessible to all, both within each CSU and the wider organisation.

Examples of key messages and action taken in response to incidents and serious incidents

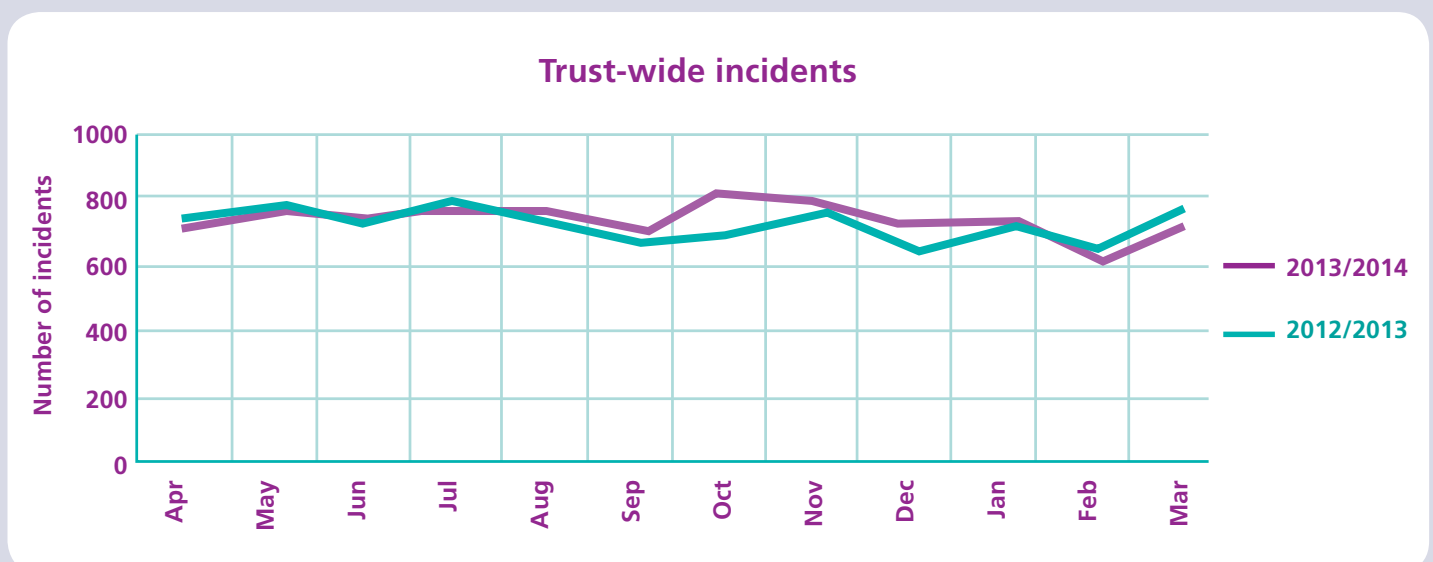
The Trust aims to provide patient care that is safe, effective and high quality for a diverse range of service users. Our priority is to reduce avoidable harm in line with the trust’s incident management policy.

A total of 8505 incidents of all types and severity were reported across the 3 CSUs and corporate services. This represents an increase of 1.3% (112) on the number of incidents recorded for 2012/13 (see table 1).

Table 1

Trust-wide Incidents					
	Q1	Q2	Q3	Q4	
2013/14 Incident Total	8505	2125	2160	2234	1986
2012/13 Incident Total	8393	2188	2124	2017	2064

Table 2



Of the 1986 incidents reported for Q4 29% (591) were reportable to the National Patient Safety Agency, as these incidents are classified as causing potential or actual harm to the patient.

WLMHT has continued taking steps to improve the rate and quality of its services by following up on the actions and recommendations from the review of the severe harm and death incidents, holding regular learning lesson events and improving system processes for the quality checking and timeliness of reported data.

This has resulted in a sustained improvement in our reporting rate and number of days taken to report incidents to the NRLS.

Also, following a review of the incident categories reported on to the NPSA earlier this year for the reporting period 12/13 it is evident that more Patient Safety incidents have been reported to the NPSA (see table 2), suggesting that the Trusts attempts to improve and promote a reporting culture have been successful.

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

Table 3

Highest Reported Incidents Trust-wide								
	Q1	Q1	Q2	Q2	Q3	Q3	Q4	Q4
	12/13	13/14	12/13	13/14	12/13	13/14	12/13	13/14
Verbal Assaults to staff	345	401	349	389	338	392	334	376
Security incidents	331	326	287	325	319	345	359	281
Self injury to patient	199	173	213	178	135	135	171	125
Physical assaults to staff	193	164	172	182	181	236	144	197
Personal accidents to patients	134	127	139	119	139	115	140	146

As shown on the table above, the number of physical and verbal assaults to staff have reduced for the first time in 12 months since the same period in 2012 after remaining consistent for verbal assaults throughout last year and from increasing steadily for assaults to staff.

Staff have been encouraged to report all types of physical and verbal assault, in order that care plans can be reviewed and risk assessments carried out to prevent these escalating.

Matrix of Top 12 Incidents by Category by Clinical Service Unit

Matrix of Top 12 Incidents by Category by Clinical Service Unit												
	HSS Q1	HSS Q2	HSS Q3	HSS Q4	Loc Q1	Loc Q2	Loc Q3	Loc Q4	S&F Q1	S&F Q2	S&F Q3	S&F Q4
Assault Non-Physical to STAFF	275	266	264	272	42	45	56	52	83	78	71	52
Assault Physical to PATIENT	23	21	13	16	51	75	89	53	21	22	24	38
Assault Physical to STAFF	69	59	82	78	70	87	112	76	23	36	39	43
Damage to Property	63	40	50	41	41	50	42	28	13	22	19	11
Death to Patient	0	1	0	0	38	40	39	48	4	1	3	1
Fire	5	5	4	4	26	19	17	15	17	10	15	11
Medication	32	33	41	29	60	35	44	35	10	21	17	15
Missing Persons	0	0	0	0	50	46	36	36	19	16	17	16
Personal Accident - PATIENT	34	14	30	19	70	83	62	93	23	22	24	34
Personal Accident - STAFF	31	16	15	22	15	11	11	7	12	10	9	13
Security	189	141	156	132	34	59	77	44	101	119	107	103
Self Injury - PATIENT	47	50	35	36	37	44	52	64	75	73	48	25
Categories	900	792	847	797	663	793	853	717	520	525	493	445

HSS – High Secure Services

Local – Local Services including Ealing, Hammersmith & Fulham & Hounslow

S&F – Specialist and Forensic in Medium and Low Secure, Gender Identity and the Cassel

Serious Incidents Trustwide

Serious incidents are Graded for Review into Grade 1 and Grade 2 depending on the severity.

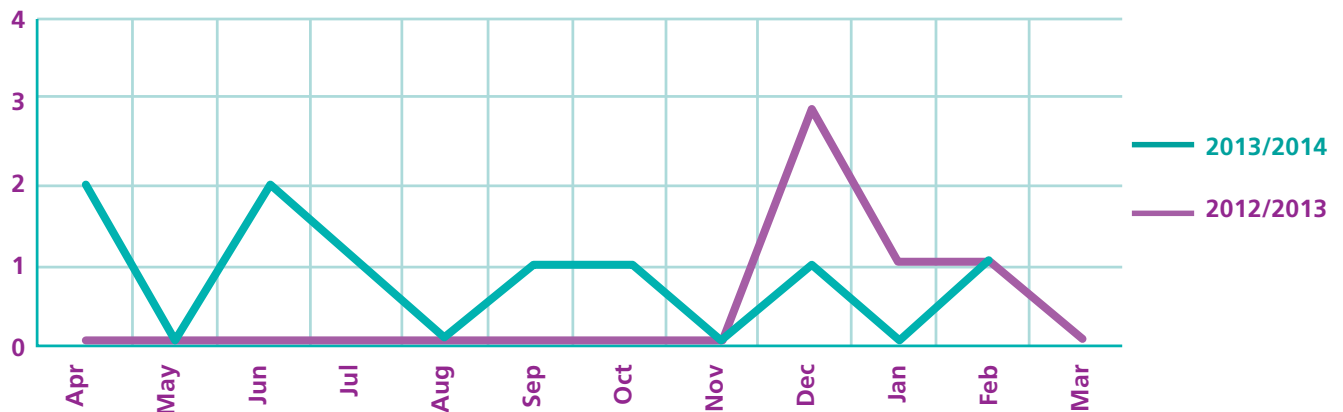
Grade 1 is SEVERE (major harm/loss) to be investigated within 45 working days

Grade 2 is CATASTROPHIC (significant harm/loss) to be investigated within 60 working days.

Table 2 below shows the number of Grade 2 serious incident reviews commissioned trust wide for 2013/14 to date in comparison with 2012/13.

Table 2

Grade 2 Reviews Commissioned Trust-Wide



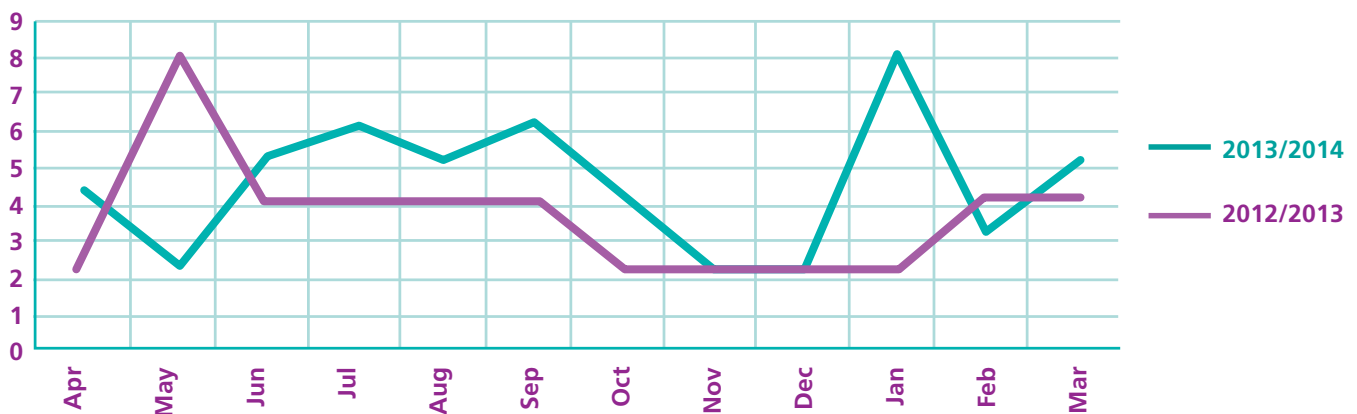
1 Grade 2 serious incident review was commissioned during quarter 4 2013/14 (Local Services, Hammersmith & Fulham, In-Patient being safeguarding vulnerable adult) in comparison with 2 Grade 2 reviews commissioned at the same point in 2012/13. There does not appear to be any trends

identified with regard to the commissioning of Grade 2 reviews.

Table 3 below shows the number of Grade 1 serious incident reviews commissioned trust wide for 2013/14 to date in comparison with 2012/13. This data includes any safeguarding adult or safeguarding children reviews.

Table 3

Grade 1 Reviews Commissioned Trust-Wide



16 Grade 1 reviews were commissioned in quarter 4 2013/14 in comparison with 10 Grade 1 reviews commissioned at the same point in 2012/13.

There does not appear to be any trends identified with regard to the commissioning of Grade 1 reviews.

Coroners Rule 43

The Trust has not received any rule 43 instructions from the coroner during the reporting period.

Health and Safety Executive (HSE)

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

Safeguarding Children & Vulnerable Adults

West London Mental Health NHS Trust maintains its commitment to the safeguarding of children and adults at risk. Safeguarding is considered an essential component of all its services and we understand that safeguarding underpins quality and improves service-user and carer experience.

The last year has seen many gains despite significant challenges for safeguarding and these are summarised below:

Safeguarding Governance and Quality Assurance:

In the last year, we have focussed on bedding in the mechanisms that were established the previous year to improve our awareness of safeguarding. The Trust Board now receives information monthly in the integrated performance report about how safeguarding functions are being discharged.

In addition, we report safeguarding quality and performance data to the Patient Safety And Safeguarding Committee every two months after which the information is cascaded through service governance structures. The report includes a detailed breakdown on referral activity across the different localities, wards and teams. The report has now also includes a quarterly report on numbers of adult service-users with dependants. We now know that about a third of our adult service users have dependents and this knowledge will allow us to work closely with these families to ensure they are safe.

We have also started collecting information on children and young people who may have caring responsibilities. This is a sensitive set of information to collect accurately and during 2014-15 we will work to improve the quality of this information.

We have continued to strengthen our partnership-working arrangements through active membership of all the Local Safeguarding Boards for Adults and Children and all their subgroups. Safeguarding Adult Partnership Boards are expected to become statutory when the new Social Care Bill is confirmed. We will be reporting our quality and performance data on safeguarding to the adult boards, as we already do for children's boards, during the coming year to aid the establishment and strengthening of their quality improvement sub-groups.

The Trust also reports on safeguarding quality and performance data directly to commissioners via their Clinical Quality Groups. This supports our endeavours to maintain transparency about how we safeguard service-users and their families.

We said we would improve our intranet pages last year and a newly designed safeguarding page that brings together information on safeguarding adults and safeguarding children has been introduced. The range of information and links to other agency information has been strengthened and the pages are more visible to all our staff.

Summary: Safeguarding Quality and Performance Data

Trustwide Performance - February 2013 - January 2014					
Target / Measure	Ealing	H&F	Hounslow	Specialist & Forensic	High Secure Services
Safeguarding Children Activity					
Number of referrals to Children's Social Care	Inpatient	Inpatient	Inpatient	0	0
	12	6	13		
	Community	Community	Community		
	17	10	4		
	CAMHS	CAMHS	CAMHS		
	8	10	14		
Number of child protection case conferences for new referrals attended by provider	0	0	3	0	0
Number of child visits made	63	60	68	75	96
Number of children admitted to Adult Wards	4 Admissions 1 x 3 days 1 x 2 days 1 x 0 days 1 x 4 days	4 Admissions 1 x 0 Days 1 x 2 days 2 x 1 day	4 Admissions 3 x 0 days 1 x 8 days	N/A	N/A
Number of allegations referred to LADO. (Safeguarding Children)	2	0	0	0	0
% Number of users of the service who are known TO BE parents / carers of children	Inpatient 0.72%	Inpatient 0.72%	Inpatient 1.20%	Inpatient 0.48%	Manual Audit Being Conducted
	Community 5.98%	Community 11.48%	Community 8.37%	Community 0.48%	
% Number of users of the service who are known NOT to be parents / carers of children	Inpatient 0.24%	Inpatient 0.72%	Inpatient 1.67%	Inpatient 0%	
	Community 0.72%	Community 5.26%	Community 1.91%	Community 0.24%	
% Number of users of the service where their status as parents or carers of children is unknown	0.48%	0.24%	0%	0%	
	Community 15.31%	Community 5.50%	Community 35.89%	Community 0.96%	
New Young Carers data %	Inpatient 0%	Inpatient 0%	Inpatient 0%	Inpatient 0%	N/A
	Community 18-21 - 0.24%	Community 0%	Community 18-21 - 0.24%	Community 0%	
Safe Guarding Adult Activity					
Number of Safeguarding Adult Referrals	Inpatient	Inpatient	Inpatient	Inpatient	Inpatient
	58	19	5	25	60
	Community	Community	Community	Cassel	
	63	45	43	0	N/A
CHANNEL Referrals	0	1	0	0	0
Governance and HR Functions					
Number of Incidents - where there is a safeguarding Child element	2	0	9	3	3
Number of Incidents - where there is a safeguarding Adult Element (including Serious Incidents as a subgroup)	42	16	13	9	16
	Serious Incidents 6	Serious Incidents 2	Serious Incidents 1	Serious Incidents 0	Serious Incidents 1
Active Domestic Homicide Review (DHRs)	2	2	0	0	0
% of CRB checks that are in date (In date = checked in last 3 years)	90%				

Safeguarding Children:

We completed self-assessment audits of our compliance with the requirements of Section 11 of the Children's Act for the Local Safeguarding Boards (LSCB's) of the Boroughs of Ealing and Hammersmith and Fulham. (A section 11 Audit was done for Hounslow in 2012-13). These audits were positively received and are supported by an action plan continuously monitored via the Trust Safeguarding Child Governance Group.

We have reviewed our safeguarding children training programme in detail and a new training strategy for safeguarding children is in the final stages of preparation to help us deliver training more efficiently.

During 2014 we will be hosting a conference focussed on domestic violence with a range of expert external speakers to raise awareness of this important issue.

There were no new serious case reviews during the last year. However, we will be participating in multi-agency learning events over the coming year focussing on cases shared with partner agencies in different boroughs. These events are intended to improve how we learn from each other through analysis of complex cases and help us improve quality in our own services.

As part of our learning from a previous serious case review in Ealing, we assisted the Local Authority in Ealing to develop 'Guidance for the Management of Children and Young People at Risk of Suicide'. The guidance has been accepted by both the Hammersmith and Fulham (Tri-Borough) and Ealing LSCB's. We will be rolling out co-produced training programmes with our Local Authority colleagues in these boroughs for all partner agencies. The guidance has also been presented to other LSCB's in Greater London where they have been well received.

Safeguarding adults

In the last year, we revised our safeguarding adults policy which was ratified in October 2013 after extended consultation.

We have reviewed safeguarding adult training and improved the training package to recognise the learning from serious cases nationally and to reflect the statutory changes anticipated in the coming year.

In May 2013 we hosted the Trust's Annual Safeguarding Conference. The conference focussed on safeguarding adults in mental health settings

and we were pleased to welcome external expert speakers addressing the issues emanating from the Francis Enquiry and the enquiry into events at Winterbourne View. We had very positive feedback from delegates reflecting the value of expert learning for our practitioners.

Resourcing the PREVENT training agenda has been a challenge. We have however included reference to the issues of vulnerability to radicalisation in our safeguarding adult training. The Trust made a referral under the Channel Protocol, for support for individuals vulnerable to radicalisation, during the last year, which reflects positively on our staff awareness. At the time we were the first London mental health trust to have used the protocol.

We conducted a comprehensive internal audit of safeguarding adults in collaboration with Baker Tilly during 2013. The audit rated our safeguarding adult functionality as 'Amber-green' and made a number of recommendations in relation to safeguarding adult staff resource, further development of training and audit activity. All the actions identified have been completed and reported to our local boards.

In August, the CQC inspected The Limes – an inpatient unit in the community for service-users with enduring difficulties that are unable to live in the community. The inspection resulted in a notice of non-compliance with Outcome 7 – Safeguarding people who use services from abuse. The Trust responded with a comprehensive plan of action and we worked with our Local Authority partners and the CCG's to address the issues raised. Following a service review and training support, a re-inspection by the CQC a month later declared the Trust compliant with its responsibilities.

Allegations involving Jimmy Saville

The Trust was named in the historical allegations relating to the late Jimmy Saville. During 2013, we participated in the external review commissioned by the Department of Health into the period when it managed Broadmoor Hospital. The publication of the report is expected during the early summer of 2014 and the Trust will implement any actions emanating from this review.

Key Development for 2014-15: The Integrated Safeguarding Strategy:

We have recognised that we need an integrated plan for the improvement of quality in safeguarding in the Trust. As a result, we developed a strategy that integrates our development plans for safeguarding children and safeguarding adults under common themes. The themes were identified from the various assessments that safeguarding underwent in the last year (Section 11 Audits, the SAAF's and the Baker-tilly Audit). The strategy is in keeping with 'Safeguarding Vulnerable People in the Reformed NHS - Accountability and Assurance Framework' – published during 2013.

1. **Organisational Intelligence:** The need for the organisation to have good knowledge of how well it is doing delivering its safeguarding functions across all services.
2. **Partnership working:** The Trust is a key stakeholder in numerous safeguarding boards. On-going participation in these boards and their subgroups is key to our ability to influence the quality of safeguarding in all agencies and allows us to experience challenge about our own performance.
3. **User and Carer Involvement:** Safeguarding is a sensitive and important issue for our service-users and carers. We started our programme of user and carer involvement in safeguarding by presenting a draft information leaflet on safeguarding for service-users and their carers to the Trust's Service User and

This document provides guidance about standards for safeguarding in the new NHS structure.

Our safeguarding strategy is aligned with the Trust Quality Strategy and supports the aims it sets out to deliver. The safeguarding strategy outlines a 3-year staged development plan to support implementation. The four key areas for development that have been identified in the safeguarding strategy are:

4. **Safeguarding Resource:** In order to deliver our goals of improved awareness, strengthened assurance processes, more collaborative user involvement and quality staff performance, safeguarding resource needs to be developed. This was supported by the outcome of the internal audit and allowed us to develop a business case for added safeguarding adults resource.
- Carer Forum. This revealed that much work is needed to engage our service users and we have agreed to convene a specific event on the issue early in the new year.

West London Transformation Board

The West London transformation board oversees the redesign of mental health services across local services. The board is jointly chaired by Dr Nick Broughton, the trust medical director, and Dr Annabel Crowe, GP mental health lead Hounslow clinical commissioning group (CCG).

The transformation board reports directly to the North West London Mental Health Programme Board. The transformation board embraces the principle of multi-organisational/stakeholder co-design and is divided into the following work-streams:

- Shifting Settings of Care
- Urgent Assessment & Care
- Child and Adolescent Mental Health Services (CAMHS)
- Cognitive Impairment and Dementia
- Learning Disability (Added Feb 2014)
- Perinatal (Added Feb 2014)

Significant progress has been made in a number of areas including local response to the Shifting Settings of Care priorities. This includes significant planned reductions to inpatient bed capacity, the redesign of community mental health teams into assessment and recovery teams, the design of recovery house provision as an alternative to hospital admission in each borough in partnership with the 3rd sector, and the safe discharge of service users from secondary to primary care. Mapping has commenced of out of borough placements and associated costs with a view to enabling repatriation back to local services where clinically appropriate. The development of primary care mental health teams in each borough, joint care record interface between physical and mental health, coupled with significant GP and primary care staff training delivered by West London Mental Health Trust senior clinicians have underpinned the shifting settings of care work.

The Urgent Assessment & Care work has led to design of access and care standards, coupled with associated paperwork for referral and

shared care, and a performance dashboard. A first cut of their urgent assessment and care performance dashboard offering a baseline of compliance against the access standards has been completed to inform planning. More recently the transformation board has discussed the model for a single point of access for assessment and support from secondary mental health services, with supporting telephony solution. This front door to local trust services will incorporate the 24/7 telephone support line and e-referral solutions implemented with the clinical commissioning groups in Hounslow & Ealing. The urgent assessment & care steering group is developing a business case to support the extension of daytime operation hours for urgent and emergency assessment and crisis home resolution towards 8 – 8pm, in line with GP Practice operating hours and peak need. This is being underpinned by significant trust investment in remote working through purchase of toughbooks/laptops for community based clinicians. In January 2014 West London Mental Health Trust published an assurance dashboard showing trust performance against the access standards. The new referral and safe discharge forms have now been worked up into RiO templates and are available for GPs to download from both West London Mental Health Trust's website and local GP extranets.

The Cognitive Impairment and dementia work stream is driven by an integrated project board chaired by the director of research and development (R&D) with membership from the clinical commissioning group (CCG), service user and carer, local authority, research and education. The board is working on developing a cognitive impairment and dementia (CID) service specification, incorporating the clinical pathway and model incorporating the inpatient complex health and dementia component.

The transformation board has identified the need to address issues associated with local access to and provision of mental health services for those with a learning disability. The outcome of, and lessons associated with the Winterbourne review, offers a

context to support progressing this work. The other contextual aspect is the updating of the green light for mental health self-assessment tool that will enable mental health trusts and specialist learning disability services to self-assess their current position and agree a joint action plan.

Scoping work been undertaken in the last year by West London Mental Health Trust in relation

Physical healthcare Initiatives

Physical health strategy

The physical health strategy continues to be implemented, with the development of a primary care service for forensic services at Ealing. The model for this service, is similar to Broadmoor, with recruitment of a GP and an additional nurse, to supplement the two nurses and nurse manager already present.

The strategy provides for a structured approach to case finding of long term conditions, and managing the physical consequences of antipsychotic medication. That approach is to link a physical health care programme approach (CPA) to the current mental health CPA – at the physical health CPA, each patient is offered a physical health examination, an ECG, and a full range of blood tests that are inclusive of, but more extensive than, NICE guidelines. This approach allows the cardiovascular and diabetic morbidity to be predicted, and has been the source of research papers and a quality award from a primary care conference. Identification of high risk patients (nationally defined in NICE guidance) allows the health centres at both Ealing and Broadmoor to target resources at the most at-risk individuals.

Both services are up and running. Both have been independently reviewed by external GPs, to assess the quality of care being provided, and clinical outcomes (based on the Quality and Outcome Framework – QOF) are at least as good as would be achieved in the community. One of the quality priorities for 2014/15 is to ensure that both mental health and physical health diagnosis codes (ICD10) are recorded onto the clinical information system.

MEWS

A structured approach to recording patient observations has been introduced, called MEWS – Modified Early Warning Score. This is an evidenced-based scoring system, of blood pressure, temperature,

to the need for perinatal services in the West London area. Further work is needed to develop a model, cost it and write a service specification to support commissioning. This work will be taken forward by the transformation board in partnership with public health, acute providers, patient representatives and the third sector.

pulse etc. that is used in the acute sector to identify patients who are likely to become unwell. This has now been introduced, and is included in mandatory training for all nurses – it is linked to Basic Life Support training, and is being rolled out across the Trust.

This is now embedded in normal practice, with staff using the new recording forms routinely. A trustwide audit shows full compliance.

Physical healthcare conference

Following a successful national conference on physical health care in secure environments last year a second conference is planned for May 14th to be chaired by the National Clinical Director of Mental Health, and we are waiting for confirmation that the Minister will be able to give the key note presentation.

Service specific

Local services: Older people's services have been transferred to Jubilee Ward, and the physical health care team at Ealing Forensic Services, are providing extra support to the ward through weekly medical supervision, and specialist nursing advice when required. Support has also been provided to The Limes, reviewing the care that has been provided in the past, and supporting the recruitment and appointment of a trust employed GP to continue to provide care.

The national commissioning for quality and innovation (CQUIN) on cardiovascular risk assessment will present challenges within local services, and will require some further development. The same CQUIN will also apply to medium and high secure forensic services, but it is of note, that this care has been provided for a number of years. The national CQUIN is, in part, based on the work done at West London Mental Health Trust in this area.

Finally succession planning is in progress, as the Director of Primary Care reduces his clinical commitment, and identifies clinicians to replace his role.

Pharmacy initiatives

Improving patient experience

The pharmacy team are working with service users on a number of co-production projects including shared decision making on medicines and eliminating the need for control and restraint.

Pharmacists continue to work closely with the recovery hub to develop and facilitate courses requested by service users and carers.

A pilot has been carried out in high secure services of a pharmacist drop in session for patients which has been utilised well and will be rolled out to other wards.

The trust pharmacy continues to subscribe to the Choice and Medication website, which provides detailed but easy to digest information about common mental health conditions and medications that are encountered in mental health and have developed a card with details of the website which is provided to all patients when discharged from an inpatient unit.

Local services pharmacists have participated in a number of patient and carers groups to provide information and education on medication and allow carers to ask questions about treatments.

Side effect standards have been developed and are being implemented across the trust.

Pharmacists have also been involved in smoking cessation- awareness sessions in inpatient settings.

Clinical effectiveness

The pharmacy team and medicines management group have developed a number of guidelines including smoking cessation guideline, FP10 use and cost effective prescribing, PRN prescribing and medication error reporting. They have also worked with the dietitians developing guidelines on the management of overweight and obesity. In addition they have also developed procedures on lithium treatment, clozapine prescribing and use of medicines in the crisis resolution home treatment teams.

The pharmacy department have developed pharmacy technician standards which will ensure consistent standards across the trust.

The trust ran a one day conference on medicines "Medicines in mental health conference – supporting choice and recovery" which was well attended by a variety of delegates including service users, carers, doctors, nurses, pharmacists and GPs.

The pharmacy continues to provide in house and external teaching on a number of medication related topics.

The pharmacy department continues to support all aspects of medication for clinical trials medication.

Patient safety

The pharmacists working in forensic have introduced a monthly joint pharmacy physical health care medication review with the primary care services to ensure all current physical health medication is regularly reviewed and does not interact with medicines used for mental health conditions.

The pharmacy department have developed a medicines safety audit which is currently being undertaken in all areas of the trust where medicines are used. This will ensure that medicines are being managed appropriately and safely within the trust.

Pharmacy have introduced red emergency trays to ensure second line emergency medicines are clearly accessible on the inpatient wards.

Pharmacy continue to carry out regular audits on controlled drugs management, and have audited oxygen supply and medicines reconciliation this year. Medication incidents are being themed by the consultant pharmacist to identify common issues which are then highlighted in learning lessons to increase awareness within the trust.

Pharmacy has also responded to and, where appropriate, taken action on alerts on medication.

The medicines management group have developed a lithium register to track all patients on lithium and highlight when their required blood tests are due. This has been implemented in both high secure services and specialist and forensic services and is being rolled out in local services.

Following an incident the medicines management group developed a poster highlighting the symptoms of Neuroleptic Malignant Syndrome (NMS) and actions if NMS is suspected.

Medication error reporting is a quality priority for 2014/15 as the trust has been identified nationally as a low reporter and this will help to validate that all errors are recorded and reported.

Medical revalidation

Revalidation of the medical profession is the statutory process by which licensed doctors are required through annual appraisal to demonstrate they are up-to-date and fit to practice thereby reassuring patients, public and employers that doctors are being scrutinised by their employer and the General Medical Council (GMC).

Board level oversight of the appraisal system and outputs sits with the Responsible Officer (RO). In 2013/14 the RO made 24 revalidation recommendations to the General Medical Council.

In 2013, the trust procured an electronic appraisal system to support doctors with

appraisal and revalidation. A completed medical appraisal rate of 82 % was achieved. The trust carried out internal and external quality assurance audits identifying good practice and areas for development. Updated appraisal training was provided to doctors and appraisers. An annual report was received by the quality assurance committee.

West London Mental Health Trust has embraced revalidation enthusiastically and is working with doctors to ensure it is one way to ensure high-quality care for patients.

Institute of Mental Health

Following a period of conceptual and project development activity during 2013, the business case for the Institute of Mental Health was formally approved at the end of November 2013. The Institute of Mental Health (IMH) represents a joint working between West London Mental Health Trust (WLMHT) and Buckinghamshire New University (BNU) as founding partners. Developed in close and synergistic collaboration with the Research and Development (R&D) department and resonating with the aspirations of the West London Mental Health Trust R&D strategy, the vision of the Institute of Mental Health is to bring together experts by experience, clinicians and academics to work together to support excellence in workforce design and transformation, inter-professional practice development, education and applied research. A fundamental focus of activity is to contribute to enhancing the trust's operating performance through the generation of a culture of quality improvement and advanced practice-focused and clinically applied scholarship.

A seminar series has been established with monthly seminars given by key opinion leaders within the areas of translational mental health research. These have been extremely well attended and more recently, over-subscribed. The reputation of the seminar series has been established quickly and attendees include staff from West London Mental Health Trust, Buckinghamshire New University and Imperial College London among others. The focus of the seminars are areas that exemplify the

translation of evidence into practice and consistent with the needs and profile of the trust. Thus, recent seminars have, for example, focused on:

- (i) psycho-education in forensic settings
- (ii) alcohol use and abuse
- (iii) perinatal mental health
- (iv) psychosocial interventions in psychosis
- (v) physical health care in mental health settings

Consistent with this approach, forthcoming seminars will examine evidenced-based translational issues of relevance such as:

- (i) neurocognitive assessment of traumatic head injury
- (ii) post-traumatic stress disorder
- (iii) the service-user perspective on care and service innovation
- (iv) dementia
- (v) R&D and
- (vi) knowledge transfer

Development of the three year business plan, an intrinsic component of the one year business plan, is currently ongoing with key stakeholders. This will focus around two fundamental issues: (i) capacity building and (ii) sustainability. Issues relevant to this include specific project development and facilitation, for example, recent success with a

collaborative for leadership in applied health research and care (CLAHRC) fellowship application with a West London Mental Health Trust service user. Other relevant activity includes a nursing technology fund (NTF) grant

application, development of a psychometrically robust staff well-being survey and identification of 'shop floor' prioritised research projects with R&D.

Initiatives and improvements in Local Services

Community Services

The main challenge for our community services in the past year was to increase productivity and quality so that cost improvements were achieved and service user experience improved. To meet these challenges assessment processes have been accelerated and, when required, transfer to treatment and recovery teams has happened earlier in care pathways. These changes have established a good foundation on which we can improve our out of hour responses in line with the strategic needs established across North West London.

We have also worked closely with our commissioners and primary care colleagues to support more service users to access specialist support directly from primary care. Primary Care Mental Health workers have been appointed in each borough to help identify service users whose needs can be met within primary care. Our early experience has been that many service users have welcomed this approach and our pleased to have the opportunity to have their mental and physical health needs addressed from the same setting. This programme of work, known as Shifting Setting of Care (SsoC) has been overseen by the joint Transformation Board.

There have been numerous examples of good partnership working between the trust and other organisations. Examples include our involvement with MARACs (Multiagency Risk Assessment Committees) to identify and respond to needs related to risk for service users who do not meet MAPPA thresholds. This approach has been exemplified as a good practice model and is now being rolled out to other London boroughs by the Metropolitan police. We have also been active in establishing partnerships with Safer Neighborhood services to support people challenged by issues related to their accommodation and local environment.

Over the year there have been some significant improvements in our community estate. In Ealing, we have moved out of Manor Gate and now base some of our Recovery services in the Grand Union Village

Health Centre. This provides a modern and less stigmatizing environment which supports integrated working. In Hounslow the East Recovery Team has moved into new modern central premises which provide an attractive and accessible team base.

Our new Cognitive Impairment and Dementia (CID) services are now in their second year of operation. Although it has presented capacity challenges we have welcomed the continued increase in the rate of referrals as the service has been working closely with primary care to increase the early diagnosis of dementia. Senior clinicians have continued to work closely with carers and primary care colleagues through Integrated Care Pathway groups and have run successful training sessions for GPs and practice nurses.

All our community services maintain the commitment to delivering recovery focused services. Specific examples of this include a new Employment Advice service initiative in Hammersmith and Fulham run in conjunction with The Richmond Fellowship, Hearing Voices Groups and Peer support workers being embedded in recovery teams.

Service User Telephone Service

This service was started in 2012 to provide 24/7 support, advice, information and signposting to service users and carers. The service is now highly valued by service users and the volume of calls has increased to its current level of more than 2500 per month. 36% of callers have reported that the service has prevented them from going to A&E or using emergency services. We are planning to expand the service further and it will be an integral part of our urgent assessment and care developments.

Service User and Carer Involvement

In April 2013 a Service User and Carer recovery conference was held. A number of priority areas for co-production were agreed. One area was eliminating the need for control and restraint and seclusion. A co-production group was established with service users and staff. This group went on to run 4 workshops, and identified 3 pioneer wards to establish the process. Members of the group have

joined in learning sets as part of ImROC programme enabling the group to be part of a national network of trusts involved in this process. Another priority was improving on current Service User Involvement Structures. In line with recommendations from an external review of involvement we established three further workshops to agree upon a structure for local services involvement. The outcome was a vote in favour of an independent service user organisation (currently known as The Voice) hosted by Accession.

Real-time service user feedback is now routinely collected through the Meridian system at community and inpatient sites. The number of responses has increased over the year. There is increasing evidence of feedback being used by staff to improve patient experience. We are currently introducing Quality Boards which display feedback and our responses to the feedback received.

Within CAMHS services there was a strong focus this year on involving the users of the service, in shaping the services they receive. The most significant achievements in co-production have been the work on an accessible, inviting and useful website for C&YP. They have influenced how we manage care transitions, how younger children can have their voice heard and improvements in the physical environments at all the CAMHS sites.

Inpatient Services

During the year there have been extensive changes across our inpatient units. The closure of the John Connolly unit on the Ealing site provided an opportunity to develop two new facilities. The Wolsey Wing was opened in a refurbished building. This provides high quality inpatient facilities for adult patients as well accommodation for the Ealing Crisis and Home Treatment Team and a dedicated suite for Section 136 and other emergency assessments. The environment has been enhanced with artwork by the acclaimed illustrator Quentin Blake. Jubilee ward is a specialist facility for older people with cognitive impairment and complex needs. It has improved the safety, privacy and dignity for some of the most vulnerable people that we care for. Specific new facilities include a hairdressing salon and dedicated Physical Health Care room.

Elsewhere in Hammersmith and Fulham the wards were reconfigured to create two separate single gender assessment wards, which have helped to create a calmer and more therapeutic environment for service users when they first come into hospital. Changes in Hounslow have included an improvement in the outside space for inpatients.

Our continued focus on improving all aspects of inpatient care has been reflected in positive comments from a number of CQC visits. In Hounslow all four wards went through the rigorous Royal College of Psychiatrists' eight-month AIMS (Accreditation for Inpatient Mental Health Services) assessment process which examined the staff, the therapies and the environment. The outcome was that all four wards were given the award, with three achieving the highest level – 'excellent'.

We have worked hard to ensure that we are always able to offer a bed when needed and that we do not need to admit service users in crisis to external providers. This has been achieved through excellent 3 borough collaboration and bed management.

CAMHS

Development of practice guidance for social workers in how to manage suicidality in young people in the community. This was achieved by senior leaders working collaboratively with colleagues in social care to identify needs of staff and to tailor the guidance so that care professionals can work more effectively to protect vulnerable children and keep them safe from suicide. The guidance is underpinned by staff training across health & social care framework.

Development of a single point of access to the CAMHS pathway across health and social care. This has been made possible by joint working with partners, and agreement threshold criteria's across agencies. Patients now receive the right treatment the first time by the right person. The benefits for the system is more effective use of joint resources.

Successful bid for Children & Young Peoples (C&Y) Improved Access to Psychological Therapies (IAPT) has meant new funding from the NHS for CAMHS dedicated to developing improved access to psychological therapies for children and young people. The key central tenet of the Children & Young Peoples Improved Access to Psychological Therapies programme is to improve clinical outcomes for children with serious mental health conditions by delivering evidence-based treatment packages with outcomes-based clinical practices, and shaped by service users and their carers. Children and their families across all three boroughs will benefit.

Development centralised specialist pan-boroughs CAMH services for children & young people with eating disorders and Tourettes and Tic disorders made possible by clinical leaders, front-line staff and managers working creatively together to explore new service models. This has resulted in better quality services for patients whilst at same time improving

cost-effectiveness of services. Children and young people across West London boroughs received standardised evidence-based packages of care, delivered by staff who have built up specialist skills.

New mental health services for children with learning disability in Hounslow.

Made possible by excellent relationships across multi-agency partnership and effective collaboration with commissioners and commitment to joint working across health and care landscape, Benefits patients and their families in Hounslow who now receive the care they need. The service has developed its staff to achieve new skills-set required to improve the quality of services to patients with particular needs – PTSD, emerging personality problems, those in foster care or adopted, those with emerging gender dysphoria problems.

Overall a major achievement for the whole service is how senior leaders, managers, and clinical staff have continued to build on its effectiveness at working jointly, collaboratively, transparently and openly with it's partners and commissioners to keep the focus on children mental health, so that the central tenet of intervening early results in benefits for the communities in which our patients live, grow up in and contribute to.

IAPT

Our three IAPT services are constantly looking to develop new and innovative ways of working. This includes developing group programs to improve

access, as well as groups for specific disorders and people with long term physical conditions.

The Hounslow service is working with the CCG to pilot the "Big White Wall" which provides access to a supervised on line peer support network and a web based platform to enable remote access to face to face interventions. Earlier on in the year the Hammersmith & Fulham and Hounslow services piloted the use of "Buddy", a system designed to increase the efficiency and effectiveness of services. In the end it was decided not to proceed with this as the benefits were not clear from this pilot.

All the services have been working to improve access for minority ethnic groups. In Ealing work has been undertaken with Race on the Agenda (ROTA) to improve awareness and access from the Tamil community and the Hammersmith Service pioneered an innovative way to engage with the communities of the White City – where it was notoriously hard to meet the needs of this group.

All of the services deliver good recovery rates (close to 50% of those using the services), run evening clinics – and see more people than might be expected based on national guidelines.

Finally, the Hounslow IAPT service was put out to tender this year, and the trust was successful in being awarded a contract for a further 3 years, a testament to the good work which the existing team have been doing.

Aims Accreditation for Lakeside

AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. The Care Quality Commission (CQC) also uses the accreditation status of AIMS members as one of its sources of information for trust quality and risk profiles.

The focus of AIMS is on achieving timely and effective admission, safety, a positive ward environment, high quality facilities, therapies and activities.

Staff at Lakeside Mental Health Unit celebrated their accreditation for inpatient mental health services (AIMS), awarded by the Royal College of Psychiatrists in 2013.

These ratings followed a rigorous, eight-month long process of self-assessment, followed by a peer review of standards, including policies, protocols, and staffing.

Staff at Lakeside worked hard for this achievement. Sharing of information and ideas across the wards ensured that they had the very best opportunities when the final assessment was carried out. These standards continue to be maintained following the assessment.

Three wards, Finch, Kestrel and Kingfisher attained the highest level possible as 'excellent', and Grosvenor received a level 2 accreditation 'good.' This accreditation assures our staff, service users, carers, commissioners and regulators that the services we provide are very high quality.

Initiatives and improvements in Specialist and Forensic Services

Recovery and Involvement Workers

The West London Forensic Service has successfully developed and appointed to a number of Recovery and Involvement Worker roles within its secure mental health services. These posts are paid work roles for individuals with lived experience of secure mental health services. There is provision for four Recovery and Involvement Workers and all those in post have current or previous experience of being inpatients within the service. The roles were developed as part of the service's Recovery and Involvement Strategy and aim to promote a more recovery orientated ethos as well as provide a platform to develop specialist peer support worker roles.

The roles provide multiple benefits to the worker such as;

- supporting their personal recovery journey,
- boosting self-esteem and confidence and
- providing opportunities to develop skills likely to open up further opportunities within the job market.

The roles have proven invaluable in supporting other individuals within the service; providing a source of hope and inspiration to those experiencing mental health difficulties,

challenging negative attitudes and inspiring staff teams. Furthermore, these posts and post-holders are benefiting the whole organisation; influencing policy and strategy developments as well as contributing to positive changes in behaviours and culture more generally.

The post-holders all bring their personal strengths and lead on different recovery-orientated activities including;

- training for staff and patients,
- developing and editing patient newsletters and publications,
- ensuring patients voices are heard and acted upon
- recovery groups and mentoring peers in co-production and involvement activity.

The Recovery and Involvement Workers receive bespoke training, mentorship and supervision from an experienced Service User Consultant as well as staff members whose roles are dedicated to recovery.

It is hoped that these roles can continue to evolve and take on new roles and responsibilities, including more traditional peer support activities.

Opening of low secure rehabilitation ward

West London Forensic Services opened Tennyson Ward which is a low secure rehabilitation ward. This was as a result of increasing pressure on beds in low secure services and in order to avoid placing service users in private hospitals away from their homes.

It offers support to service users who require conditions of low security but are moving towards a discharge care pathway and require an active rehabilitation environment. The feedback from staff and service users has been very positive regarding the new service.

Case Example- RolloMay Improvement from service user feedback

The Approach: The Meridian iPad is made available at daily Plan of the Day meetings and each evening. Weekly discussions at the community meeting about the Meridian scores and feedback tend to focus on the lowest scored questions through which the community of staff

and patients try to reach a greater understanding of the issues. The Meridian feedback and community meeting minutes are then displayed on the ward Quality Notice Board. As part of the implementation process, the Ward Manager shares detailed information about the Meridian

system with the rest of the multidisciplinary team, who are actively engaged in the process. Meridian feedback is also discussed and progress reviewed via the ward Clinical Improvement Group.

Example of Feedback and Actions Taken:

The issue of staff respect was raised as a concern. Specifically, patients felt some of the nursing staff were very rude especially when they were responding to them. Patients were able to identify that it was not all the nursing staff and the names of the individuals were provided.

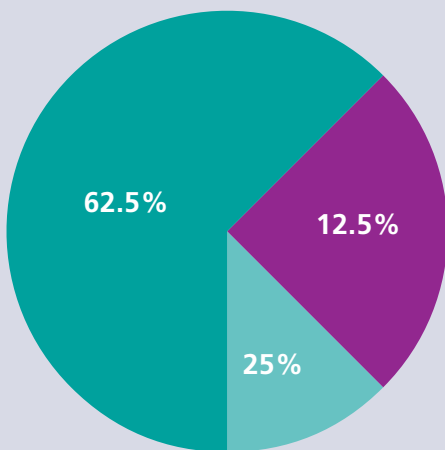
The issue of respect/lack of respect was discussed with staff. Some of the staff acknowledged that colleagues can, at times, come across as disrespectful to patients in their responses and staff agreed to supportively challenge colleagues

whenever they notice this. Staff reported that in some cases staff need to better support each other whenever they notice a colleague under pressure as this could be a precipitating factor. The staff group also discussed re-introducing the customer care training to support the development of staff’s communication/engagement skills. Currently this training is not provided, however, there are a number of trainings available that support communication and therapeutic engagement skills development as well as address attitudes and staff are being encouraged and supported to attend. Clinical supervision and reflective practice are also encouraged and uptake of monthly clinical supervision is monitored.

Meridian Question: “I feel staff are respectful of me”

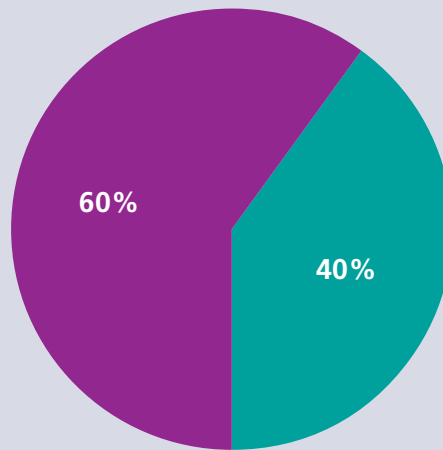
Results - September 2013

I feel staff are respectful of me (overall score: 56.25%)



Results - December 2013

I feel staff are respectful of me (overall score: 70%)



Scores as weighted

Yes definitely x 2,
 Yes x 1
 No x 0
 Don't know x 0
 Then totalled as a percentage

Comment: This example demonstrates an attempt by the ward community to use Meridian feedback to inform changes in behaviour aiming to improve patient experience on the ward. Although the data indicates some improvements, more work is required.

Initiatives and improvements in High Secure Services

Actions taken as a result of service user and carer feedback

- The Diversity Steering Group has been set up with organised focus groups inclusive of both the patient and staff groups. This has resulted in an increased plan of activities taking place during 2013/14, including black history events, Burns nights, etc.
- Patients requested the ‘Geese’ Theatre Company to undertake workshops in the hospital. This took place and provided positive feedback from both patients’ and staff.
- Patients wished to improve the dining experience in wards and a pilot has been set up on identified wards to improve the overall dining experience.
- Patients requested a football tournament with staff and patients. A tournament was organised which included patient and staff teams and

teams made up from both. Feedback from staff and patients suggested the tournament was very successful, therefore further tournaments will be organised for 2014.

- Patients wished to be actively involved in planning events to mark the 150th anniversary of the hospital. A number of patients were integral members of the 150th Anniversary steering group which organised all the events throughout the year.
- Patients wished for more activity at weekends. Out of hours and weekend events have been facilitated in the patient's Caffe.
- New patients' report for CPA has been developed and patients have been actively involved in developing the CPA process. This has included focus groups and workshops that have specifically looked at enhancing CPA reviews.
- Feedback from patients has continued to strongly influence various aspects of the design for the redevelopment of the new hospital. This has

included a recent opportunity for patients to feedback on bedroom design.

- The Carers' Forum has been held inside the secure perimeter of the hospital (at the carers' request) and different speakers have attended this quarterly meeting. A number of initiatives have been generated by the Carers' Forum including progressing a number of ideas about improving family contact (e.g. via DVD messages and possible use of a secure Skype type service.)
- Patients wished to have autonomy in developing their own recovery booklet (My Goals). The initiative has been successful and the booklet is now in print. On a recent visit to the hospital the High Secure Commissioners praised the nature of the booklets' development.
- A Recovery College has been established in collaboration with patients who continue to contribute to training programme content and delivery.

National Offender Management Service (NOMS) audit

The NOMS audit team carried out their annual review of security at Broadmoor Hospital from 27th – 31st January 2014 and returned an overall score of 97%.

The audit team are members of the Internal Audit and Assurance Department of Her Majesty's Prison Service.

The audit of security across the three High Secure Hospitals has been conducted by the National Offender Management Service, since it was agreed as part of the recommendations of the Tilt report (2000) and became a legislative requirement under the High Security Psychiatric Services Directions in their first iteration.

The use of an external audit team to carry out the audit process provides assurance to the Department of Health that proper rigour is applied in maintaining safety and security across the three hospitals and for the last few years Broadmoor Hospital has consistently maintained scores in the top 5th percentile.

The auditors scrutinise practice and documentation across the hospital against a number of baselines drawn directly from the directions themselves. The baselines of the audit are grouped into 4 main categories, or 'functions' as follows:

- **Searching, control of possessions and patient communications** – In this area Broadmoor scored 97% overall with minor non-compliances being found in the areas of rub-down searches, searching of vehicles & searching of mail.
- **Patient movement, risk assessment, escorting patients, visits and patients' shop** – In this area Broadmoor scored 100%, with no non-compliances.
- **Management of Intelligence** – In this area Broadmoor scored 88% overall with a non-compliance with regard to how the senior management team set intelligence objectives.
- **Perimeter Security** – In this area Broadmoor scored 96% with a minor non-compliance regarding the management of radios.

Immediate actions were taken following the audit to remedy those areas found to be non-compliant.

Meridian is the system implemented for recording and reporting real time patient experience

Comments added by service users on the Meridian system when asked

“Is there anything else you would like to tell us about?”

Broadmoor

- Nursing staff have a great tendency to not want to socialise with patients they would rather put their paperwork first
- Why are staff hardly ever in the day area
- Staff to encourage patients to fill in their own CPA progress report before their CPA
- Staff are very professional and very helpful
- More staff for safe ward would be good
- Things are not too bad 86 out of 100

Local Services Inpatients

- We need more activities on the ward
- I am happy on the ward. The environment is good
- I feel that staff are contributing to my recovery from severely depressed state. They are always handy if something needs to be done. They discuss daily plans in the morning and make sure our personal needs are met on time.
- Our concerns in regards to meals are not listened to
- Inconsistent rules
- Staff have always respected anything I need done or would like done

- Thank you for the great service Special thanks to the staff for supporting me

- I feel staff are respectful of me

Local Services Community

- I found the service extremely helpful
- I am very happy from help and support getting from doctor. He is really nice and lovely doctor best doctor in the world
- I would like my section 2 reinstated
- Satisfied with care.

Specialist & Forensic

- Most of the staff are friendly and caring
- I am very happy with my care I feel that I can talk to staff
- The ward feels safe and focuses on patient experience
- I think that the staff should show the patients more respect than they do at the moment

As well as the Meridian questions being reported, reviewed and actioned - these comments are now being reviewed and categorised into themes and will be reported and actioned where appropriate.

NHS Ealing Clinical Commissioning Group (CCG) have reviewed the West London Mental Health NHS Trust's Quality Account (QA) for the year 2013-14 with support from the Hounslow CCG, Hammersmith & Fulham CCG, North West London Commissioning Support Unit (CSU) quality, contracting and performance teams.

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. We believe that the Account represents a fair, robust, representative and balanced overview of the quality of care at the Trust. We have discussed the development of this Quality Account with The Trust over the year and have been able to contribute our views on consultation and content.

We would like to praise the trust on a very well written account. It is clearly set out and easy to follow. It clearly demonstrates the progress made on achievement of last year's priorities and the plans for future development. It provides a clear rationale for the coming priorities alongside expected delivery dates. The priorities for quality improvements in 2014-15 are fully supported by Ealing CCG.

We would like to take this opportunity to highlight the marked improvements we have seen in the reporting and investigation of Serious Incidents. The process and the quality of the investigations are notably better than 12 months ago and we are pleased with the progress we continue to see with dissemination of the learning across the organisation.

The CCG is also pleased to note that the Trust did receive positive feedback in the latest national patient experience survey in regards to medication. It scored above average for three out of five markers. The greater focus the Trust has put on involving patients in decision making through the implementation of last year's quality priorities and through the AIMS accreditation in Lakeside has no doubt contributed to this improvement.

The high level outcomes of the audits are a welcome inclusion in this year's quality account and provide the CCG and public an additional level of assurance. The Trust has a number of clinical audits included for review in next year's quality account. The CCG look forward to working with the trust and receiving the detailed reports on outcomes and actions at the regular Clinical Quality Group meetings throughout the year.

The CCG have worked closely with West London Mental Health Trust and Care Quality Commission across this year to ensure all standards are being met or where non-compliance has been identified the appropriate action is taken. The CCG is pleased with the CQC report of 3rd January 2014 which highlights the changes implemented to improve safeguarding service users and the changes implemented to assess and monitor the quality of the services. The CCG would like the Trust to ensure local leadership and governance structures continue to be strengthened. It is felt that while integrated governance structures can provide an overview, they often lack the detail needed for robust clinical governance processes.

The CCG's do think it would be helpful to include a borough breakdown of measures such as Delayed Transfers of Care (DTC) for in year's quality account. This is an area where there is variation due to local service provision and pathways of care. We will monitor and aim for improvements to be made through the local quality group this year.

Kathryn Magson
Managing Director

The CCG will continue to work collaboratively with you to help shape how we move the quality agenda forward both from a commissioner and provider perspective. Given the publication of the Francis Inquiry and subsequent Berwick, Keogh and Cavendish reports clearly our agendas will continue to evolve further as we embed the recommendations.

Ealing CCG hopes that West London Mental Health NHS Trust has found these comments helpful and we look forward to continuous improvements and productive collaborative working in 2014-15.

Mohini Palmer
Ealing CCG Chair

Healthwatch Central west London response to the West London Mental Health Trust quality accounts 2013-2014

Healthwatch CWL appreciates our working relationship with West London Mental health Trust (WLMHT). We acknowledge the good work of the Trust in ensuring and improving the quality of services for patients and in engaging a wide range of service users and the public for this purpose. We commend overall improvements from last year in various quality areas and have the following comments on progress on last year's priorities:

Priority – Improving physical healthcare.

We welcome the progress that has been made on this priority and note that the review and survey of physical healthcare facilities at WLMHT sites is ongoing, we would like to know what opportunities for patient involvement exist in this review/survey process?

Trust response: WLMHT will continue to ensure it's community sites meet the needs for physical healthcare. This process will be carried out by ensuring the rooms meet privacy standards and there is a recommended checklist of equipment that will be audited. The Trust does not intend to include service users in this process.

Priority – Ensuring service users are treated with the highest levels of dignity, compassion and respect.

We commend the work of the trust in this area and note that two co-production groups are now well established and that a successful service user conference was held in April 2013, will steps be taken to ensure all four co-production groups become well established? Will WLMHT publish a timescale to implement the recommendations of the service user conference held in April 2013?

Trust response: 4 co-production groups

- *Eliminating the need for Control & Restrain and Seclusion – ongoing group continues to meet bimonthly – next meeting June 2014*

- *Real advanced directives – there are no further timescales planned as it is being revisited via the above group as part of the tool kit to support reducing ward violence*
- *Shared decision making around medication – project continues with conference on 28 January 2015 to highlight the issues and launch further co-production work.*
- *Co-produce service user involvement – The West London Collaborative (WLC), an independent co-produced service user involvement organisation has been formed.*

Priority S2 – Reducing physical assaults on service users and staff.

We note that the Meridian system is highlighted as a key method of gathering evidence, however patient feedback to Healthwatch has highlighted problems with the Meridian system, I-Pads at particular sites not working, patients using I-Pads are sometimes supervised by staff making patients uncomfortable. Will work be done to improve the effectiveness of the Meridian system and make sure it is at all times anonymous?

Trust response: The use of the Meridian system will continue to be improved. There will be emphasis on reliable i-pads and network during 2014/15. The Trust will ensure that patients are comfortable to feedback via this system where the information is anonymous. Meridian will not be the only source of information to support reducing physical assaults on service users and staff. The number of incidents of assaults will also be reported on a monthly/quarterly basis along with staff sickness due to assaults.

Priority C3 – To support patients with a mental health condition to stop smoking.

Will support offered be entirely by WLMHT or will the trust facilitate support by external organisations such as public health commissioned services?

Trust response: WLMHT already employs smoking cessation advisors as well as training nursing staff at Level 1 & 2. We will also work with local providers so that smoking cessation advice is available to all patients and staff.

Priority E2 – To improve the service user experience on engagement and communication with staff.

We note that the priority sets ambitious targets of improving attendance at CPAs, will there also be an emphasis on increasing the level of co-production of care plans?

Trust response: Care Planning Standards Group initiated in December 2013.

This group builds on the work commenced in 2012/13 regarding recovery goals in care plans. The group is developing standards for care planning which will include clear indicators of service user and carer involvement. The care plans will be audited against these standards. The group is chaired by the Head of Nursing Education and includes service user representatives from two boroughs. This should be fully implemented by autumn / winter 2014

Patient experience & patient safety

We are concerned to see that the amount of complaints has risen considerably in the last year (an increase of 45%), does the trust have a view on whether this is caused by a deterioration in the quality of care or an increase in the willingness or ability of patients to complain? We are also concerned to see that the percentage of complaints dealt with stands at 87%, though this is a high figure we would hope the trust would commit to work towards 100% and would be keen to know what steps the trust can take to improve this figure? We note that the second highest category of complaints was staff attitude, this matches our findings from our 'Enter & View' visit to the WLMHT mental health unit at Charing Cross Hospital, we support the actions stated under 'changing culture to improve staff attitude'

but would suggest more measures to ensure staff communicate with patients in a respectful and calm manner. We commend the decrease in the amount of incidents over the past year (4%) and would be interested in hearing from the trust how they plan to improve patient safety further.

Healthwatch CWL would like to draw the trusts attentions to the 'Enter and View' report on the WLMHT mental health unit at Charing Cross, this report highlighted a number of key concerns about the quality of the service at Charing Cross. We invite WLMHT to respond to our report and work with us to address the concerns/recommendations included in the report.

Staff from Local Services have since met with Sam Wallace to review the report and have agreed further meetings to ensure the key concerns are addressed

The following are areas we would be interested in working with WLMHT over the coming year:

- Working with WLMHT in engaging with more patients, especially in addressing WLMHTs priority areas for 14/15.
- Healthwatch CWL would be very keen to work with WLMHT to address the key concerns/recommendations in our 'Enter & View' report on the WLMHT mental health unit at Charing Cross Hospital.

Mr Samuel Wallace
Borough Manager H&F
Healthwatch Central West London
Ph: 0208 964 1490
Email: sam.wallace@hestia.org

Healthwatch Hounslow's response to West

London Mental Health NHS Trust Quality

Account 2013-2014

Introduction

Healthwatch Hounslow wish to thank WLMHT for the opportunity to comment on the Trust's Quality Accounts (QA) for the year 2013-2014 and we welcome the opportunity to be involved the setting of future priorities.

It is to be noted that our comments below are only initial observations, as we are disappointed to have been given a very short turn around to respond to the QA and not the full 30 days expected and we hope that this will be addressed for future consultations and reports.

Quality Account

We would like to acknowledge WLMHT's commitment to improve their QA through a continuous learning process. We would put forward that the QA could be utilised more robustly as a tool for continuous improvement with clearly defined indicators which is currently lacking.

We were pleased to see WLMHT were proactive in their endeavour to involve patients in their review of quality and the increased focus on staff/patient relationships throughout. We would welcome seeing more information and results from the Pilot Family Engagement project and the sharing of any best practice that results from the project.

We laud the 4% decrease in complaints recorded, however would like to see more detail on the actions of the trust to achieve this, and we would seek more clarity and information on the nature of complaints, and timescale in complaint handling by the Trust.

We commend the Trust in their reduction of delayed discharges, but would have welcomed seeing further details and quantitative data to evidence this.

We applaud the Trust in their meeting their annual Quality Indicator targets and the work that has gone to achieve this.

We would like to see further assessment and impact measurement on the good practice guidelines the Trust produced on improving Physical Healthcare. We would also like to see more data on staff to patient ratios throughout the Trust following recommendations in the Francis Report, to which the Trust was an early responder.

We feel that more efforts are needed by WLMHT to make quality accounts more concise and understandable to the general public.

Healthwatch Hounslow looks forward to continuing our relationship and working with WLMHT.

Healthwatch Bracknell Forest Statement on West London Mental Health Trust Quality Account 2013/14

Healthwatch Bracknell Forest is at the early stages of engagement with the staff and patients of the high secure services clinical service unit (Broadmoor). We are currently assisting with PLACE assessments. In the coming year we will concentrate our work on the quality priorities concerning patient experience and physical health care. This will involve providing an outreach service to ensure Healthwatch is accessible to all.

We will be in a position, next year, to comment on how well we feel the trust has met these quality priorities.

Health and Wellbeing boards comments from the Health and Adult Social Services Standing Scrutiny Panel - Ealing Council

General

The Panel welcomes the Trust's efforts in improving patient safety, clinical effectiveness, and the customer experience. The Panel also congratulates the Trust on plans for physical infrastructural improvement such as the building of a new Broadmoor Hospital and redevelopment of St. Bernard's in Ealing (pg.3).

The establishment by the Trust of a Quality Strategy is considered to be of particular importance in providing the correct ethos for the Trust (pg.3)

Quality Priorities 2013/2014

"Dignity in Care" has to be important in the delivery of care service. The Panel notes that this was recognised by the Trust, and an attempt made via patient survey and focus group to identify areas for improvement. Although the Trust is to undertake further work to assess the viability and validity of results obtained, nonetheless it is felt that preliminary results should be disclosed and shared (pg. 4).

The Panel notes that protocols for improving physical healthcare are now operational although there was some delay in getting the work underway. The Panel would welcome the Trust sharing information as to the nature of the delays experienced and the work being undertaken to progress the work

(pg.7). Lesson learning as to the delays experienced would be of great value to stakeholders.

Quality Priorities 2014/2015

The Panel anticipates that the seven priorities developed by the Trust for 2014/2015 will have the actual effect of supporting the quality strategy, improve patient safety, patient experience, care and treatment. This is especially owing to the Trust having reviewed several far reaching and in-depth sources of information so as inform these priorities (pg.16). The Panel looks forward to receiving an update in due course as to the Trust's performance in respect of these priorities.

Statements of Assurance

The Panel is pleased that the Trust participated in a 100% of national clinical audits and 100%

national confidential enquiries for which it was eligible to participate. This demonstrates the Trusts pro-activeness in facilitating rigorous independent testing of its performance (pg.20).

Initiating Drug Treatment for ADHD

The Panel is concerned regarding the in-adequate documentation of growth and centile charts in those 16 years of age or younger. However the Panel is pleased that the Trust has taken action to address this problem in recording height, weight, blood pressure and pulse in CAHMS. We congratulate the Trust however on its performance regarding measurement of baseline height, weight, blood pressure and pulse before starting treatment for ADHD which was well above the national average (pg. 22).

Internal Audit

The Panel hopes that the nine recommendations for improving the safeguarding of Adults, and eleven recommendations for complaints will be acted upon by the Trust. (pg. 28)

Care Quality Commission

The Panel also hopes that the Trust will take remedial action to address Care Quality Commission concerns regarding Outcomes 7 (safeguarding people who use services from abuse, 16 (assessing and monitoring the quality of service), and 21 (records) (pg. 32).

Review of Quality Performance

The Panel welcomes the Trust's continued development of liaison psychiatry services in local acute hospitals so as to better meet the needs of users, and encourages the Trust's continued work in this regard (pg. 40).

The Panel also commends the work of the Trust in encouraging staff to become involved in research either by recruiting patients to studies or leading on their own research. This is considered crucial in ensuring that the Trust is always at the forefront of improved care service and performance. The Panel looks forward to continuing to work with the Trust in the forthcoming year.

Annex 2:

Statement of directors' responsibilities

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

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, 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

NB: sign and date in any colour ink except black

Date **26th June 2014**

Signed



Chair

Date **26th June 2014**

Signed



Chief Executive

Annex 3:

Our services

Local Services

High Secure Services Clinical Services Units: Inpatient services	Inpatient Services	Community Services	CAMHS	Specialist & Forensic Services Clinical Services Unit
<p>MENTAL ILLNESS Admissions Assertive Rehabilitation High Dependency Intensive Care</p> <p>PERSONALITY DISORDER Admissions Assertive Rehabilitation High Dependency Medium Dependency Day Care Services</p>	<p>EALING Clozapine Crisis Resolution Home Treatment Electroconvulsive Therapy Men assessment Older People Services Recovery Women assessment</p> <p>HOUNSLOW Assessment Recovery Crisis Resolution Home Treatment</p> <p>HAMMERSMITH & FULHAM Admission Crisis Resolution Home Treatment Older People Services Psychiatric Intensive Care Unit Recovery</p>	<p>EALING Assessment Cognitive Impairment & Dementia Early Intervention Service in Psychosis Eating Disorders Group Homes & Community Road IAPT Recovery Substance Misuse Accession Primary Care Mental Health Nurses Psychiatric Liaison SUTS Health Psychology</p> <p>HOUNSLOW Assertive Outreach Team Assessment Cognitive Impairment & Dementia Early Intervention Service in Psychosis Eating Disorders IAPT Psychiatric Liaison Primary Care Mental Health Workers</p> <p>HAMMERSMITH & FULHAM Assertive Outreach Team Assessment Cognitive Impairment & Dementia IAPT Peer Support Workers Recovery Employment Services Primary Care mental Health Nurses Health Psychology Psychiatric Liaison</p>	<p>EALING Tier 3 Adolescent Service Eating Disorder Service Family and Young Peoples Service Neurodevelopment Service Paediatric Liaison Service</p> <p>Tier2 ESCAN (Learning Disabilities) SAFE (Supportive Action for Families in Ealing) Other: TAMHS, Primary behaviour Service, LAC, YOS, Parenting</p> <p>HOUNSLOW Tier 3 Adolescent Team Children & Families Team Neurodevelopmental Team</p> <p>Tier 2 Early Intervention Service Looked After Children & SISP TAMHS</p> <p>HAMMERSMITH & FULHAM Tier 3 Tier 2 Tier 3 CAMHS Community Psychology Looked After Children Primary Mental Health Workers Psychotherapy in Schools Youth Offending Service</p>	<p>MEN'S SERVICES Low Secure & Rehabilitation Medium Secure</p> <p>WOMEN'S SERVICES Enhanced Medium Secure</p> <p>ADOLESCENT Community Secure</p> <p>COMMUNITY FORENSIC SERVICE</p> <p>GENDER IDENTITY CLINIC</p> <p>THE CASSEL (Therapeutic community) Residential & Outreach</p>

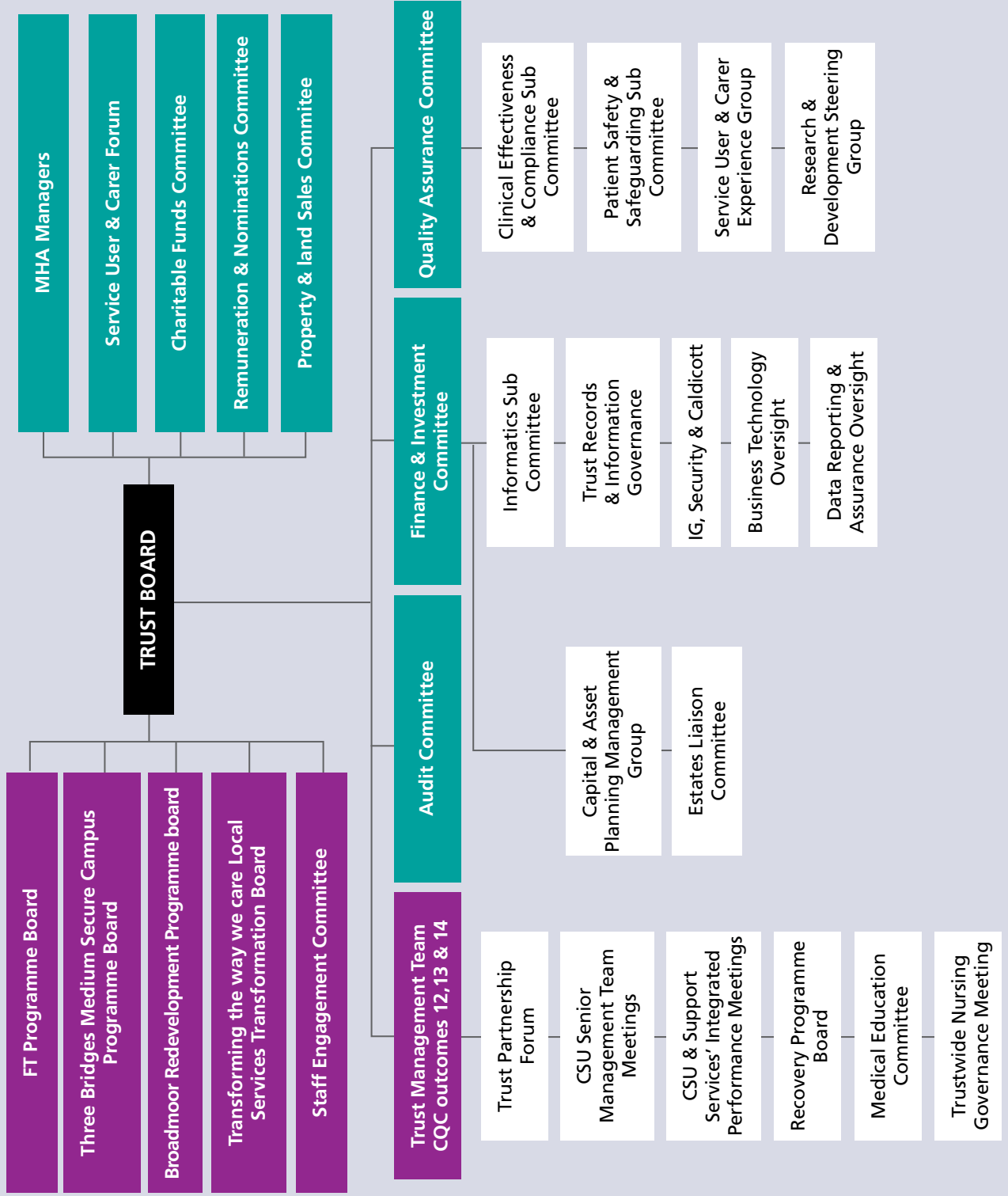
Annex 4:

Governance Structure

Key:

Chaired by Executive

Chaired by Non Executive



Annex 5:

Independent Auditors' Limited Assurance Report To The Directors Of West London Mental Health Nhs Trust On The Annual Quality Account

We are engaged by the Audit Commission to perform an independent assurance engagement in respect of West London Mental Health NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). 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 2014 subject to limited assurance consist of the following indicators:

- Number of delayed transfers of care (page 39 of the Quality Account)
- Percentage of admissions gatekept by the CRHT (page 35 of the Quality Account)

We refer to these two indicators collectively as "the specified indicators".

Respective responsibilities of Directors and auditors

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

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

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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

- the Quality Account is not prepared in all material respects in line with the information requirements prescribed in the Schedule referred to in Section four of the Regulations ("the Schedule");
- the Quality Account is not consistent in all material respects with the sources specified below; and
- the specified indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account have not been prepared in all material respects in accordance with Section 10c of the NHS (Quality Accounts) Amendment Regulations 2012 and the six dimensions of data quality set out in the NHS Quality Accounts - Auditor Guidance 2013/14 issued by the Audit Commission in February 2014 ("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 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners NHS Ealing Clinical Commissioning Group dated 17/06/2014;
- feedback from Local Healthwatch Central West London dated 17/06/2014 and Hounslow dated 15/05/2014;
- feedback from the Ealing Council Adult Social Services Standing Scrutiny Panel dated 02/05/2014;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 2012-13;
- the latest national patient survey dated 2013;
- the latest national staff survey dated 2013;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 15/04/2014;
- the annual governance statement dated 02/06/2014;
- Care Quality Commission quality and risk profiles dated March 2014; and
- Care Quality Commission Intelligent Monitoring Report dated March 2014

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 in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and West London Mental Health NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with the Guidance. Our limited assurance procedures included:

- reviewing the content of the Quality Account against the requirements of the Regulations;
- reviewing the Quality Account for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties ;
- considering significant judgements made by the management in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading 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 Schedule 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 Hospital NHS trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Account is not prepared in all material respects in line with the requirements of the Regulations and the prescribed information in the Schedule;
- the Quality Account is not consistent in all material respects with the sources specified above; and

- the specified indicators in the Quality Account subject to limited assurance have not been prepared in all material respects in accordance with Section 10c of the NHS (Quality Accounts) Amendment Regulations 2012 and the six dimensions of data quality set out in the Guidance.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Chartered Accountants
7 More London Riverside
London
SE1 2RT

30 June 2014

The maintenance and integrity of the West London Mental Health NHS Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Our external auditors PricewaterhouseCoopers LLP are required under the Audit Commission's 'NHS Quality Accounts Auditor Guidance 2013-14' to perform testing on two national indicators. A detailed definition and explanation of the criteria applied for the measurement of the indicators tested by PricewaterhouseCoopers LLP is included below.

Percentage of admissions to acute wards gatekept by the Crisis Resolution Home Treatment Team (CRHT)

The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Account:

- The indicator is expressed as proportion of inpatient admissions gatekept by the crisis resolution home treatment teams in the year ended 31 March 2014
- The indicator should be expressed as a percentage of all admissions to psychiatric inpatient wards;
- Patients recalled on Community Treatment Order should be excluded from the indicator;
- Patients transferred from another NHS hospital for psychiatric treatment should be excluded from the indicator;
- Internal transfers of service users between wards in the trust for psychiatry treatment should be excluded from the indicator;
- Patients on leave under Section 17 of the Mental Health Act should be excluded from the indicator;
- Planned admission for psychiatric care from specialist units such as eating disorder unit are excluded;
- An admission should be reported as gatekept by a crisis resolution team where they have assessed the service user before admission and if the crisis resolution team were involved in the decision-making process which resulted in an admission;
- Where the admission is from out of the trust

area and where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas, the admission should only be recorded as gatekept if the CR team assure themselves that gatekeeping was carried out.

- The indicator applies to patients aged 16-65 years and only when they have been admitted to an adult ward.

The reported indicator for 2013/14 is presented on page 35.

Number of delayed transfers of care

The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Account:

- The indicator (both numerator and denominator) only includes adults aged 18 and over;
- The numerator is the number of patients (non-acute and acute, aged 18 and over) reported in the SitRep figures whose transfer of care was delayed as at midnight on the last Thursday of each month, averaged over the reporting period.
- The denominator is the average number of occupied beds (in the quarter, open overnight);
- A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed; and
- A patient is ready for transfer when:
 - o A clinical decision has been made that the patient is ready for transfer;
 - o A multi-disciplinary team decision has been made that the patient is ready for transfer; and
 - o A decision has been made that the patient is safe to transfer.

The reported indicator for 2013/14 is presented on page 39.