South West London and St George's NHS
Mental Health NHS Trust

Quality Account
2015/16

Part 1: Chief Executive's statement on the quality of our services

Contents

I am delighted to present our Quality Account for 2015/16.

This document provides an update on the progress we have made against our quality goals in 2015/16 and highlights some of the achievements our staff have made possible.

I am pleased to report that we have continued to meet the targets for several quality initiatives since we published our last Quality Account in June 2015. This is especially important at a time when The Centre for Mental Health Annual Report 2015 highlights that mental health services are working harder than ever to meet growing levels of demand. This demonstrates our ongoing commitment to achieving high standards of quality across the organisation. Whilst there is a tremendous amount of good working taking place we understand that there are areas for improvement which we continue to focus on.

Awareness of mental health is improving at a time when one in four of us may have a mental health condition at any one time, while half of the people with lifetime mental health problems experience the first symptoms before the age of fourteen. The cost of mental ill health to the economy, the NHS and society as a whole is £105 billion a year. These figures only reveal part of the story and there is a wealth of experience amongst those living with mental illness so we continue to seek and value engagement from those we support and care for.

The Trust remains committed to the provision of consistent, high-quality, safe services and aims to continually improve the treatment and care provided for service users, carers and staff. Part of our commitment to quality is the development of our five year quality strategy, which articulates three broad quality objectives; Safety, Clinical effectiveness and Patient experience. We have also ensured that these three themes align with the five high level national domains for improvement specified in The NHS Outcomes Framework 2015/16. Quality governance is embedded in all aspects of the Trust's activities and it remains everyone's responsibility to develop and improve services - seeking the evidence and knowledge available to do so.

The Trust has achieved an overall score of 73% with community patients saying they have had a good experience while using our mental health community services, according to the annual Community Mental Health Survey published by the Care Quality Commission on 21 October 2015.

The Trust was also voted best in London for overall patient experience, and also in the top 20 per cent in the country for

several areas that look at user experience including:

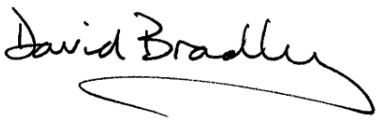
- Patients saying they definitely or to some extent agree that care takes into account their personal circumstance.
- Patients saying they had a formal review in the last year.
- Patients saying they are seen often enough for their needs with patients rating their experience at 72.7%.

Among our achievements this year has been our response to increased demand for our services. To meet demand we have redesigned our urgent care pathway and looked at innovative ways provide support in the community including the Crisis House and Cafés, Psychiatric Decision Unit and through Housing Discharge coordinators. We are proud of the new clinical admissions protocols for service users which include support for carers and relatives. We have also seen greater partnership working through the development of the Patient Quality Forum and through faith communities. We are also leading on a once in a lifetime £160m estate modernisation programme to build two new state of the art hospitals. These and a number of other quality initiatives will bring us to the fore of mental health services helping us to be an employer, service provider and partner of choice.

As well as reviewing the previous year, the Quality Account also looks ahead to our quality priorities for the next twelve months and summarises how we expect to manage and monitor them. Working with our patients and their carers, commissioners, partners and our staff we have agreed quality priorities that will strengthen the services and care provided for 2016/17. The initial themes were discussed at the Clinical Quality Reference Group and then developed into indicators using information provided by our clinical leads. The Quality Account was sent out to Clinical Commissioning Groups, Health Overview and Scrutiny Committees, Local Healthwatch, the Patient Quality Forum and sub-committees of the Trust Board for consultation prior to publication.

The Trust's sub-group to the Board, Quality Assurance and Safety Assurance Group, has signed off this Quality Account. To the best of my knowledge the information presented in this report is accurate.

Thank you to everyone who is helping keeping quality at the top of our agenda, and for your commitment to improving services by placing quality at the forefront.



David Bradley, Chief Executive

1.1 What is a Quality Account?

A Quality Account is an annual report detailing the quality of services that have been provided by an NHS healthcare provider, which is made available to the public.

It informs the public about the quality of services we deliver. In producing this report we are able to look back at the previous year and highlight where we are doing well and identify where we need to improve. The Quality Account also looks forward and details our priorities for improvement over the coming year.

1.2 Guidance on Quality Descriptors to help you when reading this document

Summary table with examples of quality areas

QUALITY DESCRIPTORS	DEFINITION	COMMENTS
1. Trust Quality Priorities	1.1 Given the multiple priorities in health and social services, the Trust agree quality improvement priorities with stakeholders	The priorities relate to: Safety / Patient Experience Clinical Effectiveness
2. CQUINS	2.1 Commissioning for Quality and Innovation (CQUIN)	These attract additional payments of 2.5% of overall annual income.
3. Key Performance Indicators	3.1 Provides performance measurements that define and measure progress.	Trust KPI examples include: Local audit, Peer Reviews, Carers being offered a care assessment, Care Planning, 7-Day follow up on discharged patients on a Care Programme Approach
4. National Clinical Audits	4.1 The National Clinical Audit Programme coordinated annual audits of specific conditions, assisting in benchmarking performance of providers to improving care.	These are monitored against delivery targets in the Corporate Clinical Audit programme and report to the NICE/Clinical Audit Group.
5. Local Audits against NICE Guidelines	5.1 In 2015/16 the Trust has undertaken 15 audits against NICE guidelines identifying areas for improvement.	National Institute for Health and Care (*formerly National Institute for Clinical Excellence (NICE)*) sets national standards of treatment and care.
6. CQC Requirement Notices	6.1 Issued by the CQC where visits and inspections identify when standards require improvement.	During 2015/2016, 6 Requirement Notices were issued in the areas of: Patient Safety, Dignity and Respect, Mental Capacity Act, Clinical Effectiveness. These Requirement Notices have all had actions taken and 5 are fully resolved
7. Core Indicators	Duty of Candour Staff Survey Friends and Family Test	Included in the supervision policies and added to the serious incident monitoring system (Ulysses)

1. A "traffic light" system of Red, Amber and Green rating shows where we have achieved compliance with agreed targets. These are:

Red	Target not met / Not Compliant
Amber	Target partially met / Partially Compliant
Green	Target met / Compliant

1.3 Introduction - about us

South West London and St George's Mental Health NHS Trust (SWLSTG) was formed in 1994. SWLSTG is the main provider of integrated mental health and social care services in south west London. The Trust serves just over one million people of all ages across the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth. In 2015/2016 the Trust's community services saw just over 19,000 individuals from approximately 23,300 referrals and had more than 390,000 contacts with service users (face to face or by telephone). In addition, 2,127 people were admitted into our inpatient units for more intensive treatment.

Our turnover in 2015/2016 was £163 million and we employed an average of 2,038 (whole time equivalent) staff from a variety of professional backgrounds including psychiatrists, psychologists, mental health nurses and allied health professionals.

We deliver a full range of services through 110 teams and are dedicated in our commitment to supporting some of the most vulnerable people in our community.

1.4 Our strategy and service development

Our mission statement has been developed and agreed with our key stakeholders to support:

"Making life better together"

Our vision is that:

We aspire to be a cost-effective centre of excellence; a place where patients choose to be treated; where clinicians want to train and work; our stakeholders want to work.

Supporting our mission statement and vision are our core overarching strategic objectives:

Our values:

The Board agreed the Trust values following wide consultation with service users, carers and staff. These values will set the standards for how we:

- plan and make decisions;
- deliver quality care;
- behave with each other and service users; and
- recruit, induct, appraise and develop our staff.

We want to build on our position as the provider of local, specialist and national services by maintaining high standards of care and delivering a programme of continuous improvements in quality.

We want to provide information that enables people to see why we are the best choice for providing mental healthcare and wider community care.

We recognise that we have to be safe, caring, effective and innovative. We will work collaboratively with service users, carers, GPs, local authorities and commissioners to deliver the best care we can and ensure that services meet service users and their families' needs holistically. We will do this together with different organisations including charities and other NHS organisations.

Quality underpins all the care and support we offer and we will ensure that the clinical care we deliver is evidence-based and meets quality standards.

Quality Strategy

The key principles that underpin the Quality Strategy are:

- **Quality:** continuous quality improvement.
- **Partnership:** to work in partnership with stakeholders to deliver clinical care.
- **Parity of esteem:** put mental health on a par with physical health.
- **Recovery:** to live a meaningful life, despite serious mental illness.
- **Seamless care:** people moving through care and treatment seamlessly.
- **Outcomes:** demonstrating quality of care through meaningful outcomes.

Our strategy - the model of care

At the heart of our clinical strategy is our ambition to provide the best possible clinical care and support to service users and carers in the communities we serve. Our approach to care and support is to put the service user at the centre and use recovery approaches to enable people to fulfil their potential, within and beyond their experience of mental illness and other chronic conditions.

The clinical strategy aligns with all our strategic aims by ensuring:

- **Improve quality and value:** the clinical care we deliver to service users, their families and carers is of high quality and makes effective use of resources.
- **Improve partnerships:** we will work in partnership with all our stakeholders to deliver care.
- **Improve co-production:** clinical care is delivered together with service users and carers making them the centre of decision making.
- **Improve recovery:** the clinical care we deliver is driven by the recovery principles, based on an individual's strengths.
- **Improve innovation:** our care will constantly improve and aim to achieve excellence in light of feedback and innovation.
- **Improve leadership and talent:** through education, research and innovation we will promote leadership to deliver high quality clinical care.

1.5 Our core services

During 2015/2016 the Trust provided inpatient and community mental health services under five management teams: Kingston and Richmond, Sutton and Merton, Wandsworth, CAMHS and Specialist Services.

Our services include:

- **Adults of working age mental health** – including single points of assessment operating or planned in each borough, Recovery and Support Teams, Early Intervention in Psychosis, Home Treatment Teams, Street Triage, Recovery College and Inpatient and Psychiatric Intensive Care Services.
- **Older people's mental health** – including Memory Assessment, Challenging Behaviour Services, Intensive Home Treatment, Community Mental Health teams and inpatient services.
- **Child and adolescent mental health** – including single points of access in each borough, a range of borough and sector based community services and specialist inpatient services.
- **Community mental health services for people with a dual diagnosis of learning disabilities and mental health** – community teams operating in Wandsworth, Merton and Sutton.
- **Drug and alcohol services** - community teams operating in wider partnerships in Richmond, Sutton and Merton.
- **Increasing Access to Psychological Therapies Services (IAPT)** – services in Wandsworth and Sutton.
- **Rehabilitation services** – either embedded in our adults of working age mental health services, or operating as specialist teams and wards in Wandsworth.

Services are provided to adults of working age, older people, adults with learning difficulties and autism and children. In addition, the Trust also provides a range of specialist regional and national services, including services for deaf people, those with eating disorders, community-based and inpatient-based treatment of severe, obsessive-compulsive disorder, body dysmorphic disorder, forensics services, eating disorders and deaf services for children, adolescents and adults and neuro psychiatry.

1.6 Who we work with

The Trust works closely with a range of commissioners and other health care partners in South West London:

- NHS England
- Five Clinical Commissioning Groups
- Five London Boroughs
- Five local Healthwatch
- Five Health and Wellbeing Boards and Health Overview and Scrutiny Committees
- Five GP federations
- Four acute trusts

1.7 Duty of Candour

The Duty of Candour has been included in our professional supervision policies.

The Trust is operating a standard of applying 'Being Open' principles to all incidents where possible. This is a well-established process within the Trust and, therefore, it has been a seamless transition to applying the Duty of Candour.

The sub-group of the Serious Incident Governance Group (SIGG), pre-SIGG and SIGG reviews all incidents that are reported as serious incidents on the Trust's electronic incident reporting system, Ulysses, and reviews the incident and the degree of harm.

Depending upon the nature of the incident, the Trust will ensure that contact is made with the patient or patient's relatives within 10 days as outlined in the Trust "Duty of Candour" information leaflet. In the case of incidents involving in-patients or community patients who would wish to meet with Trust staff, this will be done face-to-face, within 10 days. When a patient dies, it is not always possible for Trust staff to meet with relatives face-to-face within 10 days, although attempts will always be made to facilitate this. In the absence of a face to face meeting telephone contact will be made and relatives invited to meet with Trust staff at a time convenient to the family.

All serious incidents resulting in severe harm or death are responded to with a corporate response signed by the Chief Executive and families are invited to participate in the investigation process.

The Trust has improved the incident reporting system, Ulysses, to include a Duty of Candour tab and the last upgrade to the system in February 2016 saw this go live. This change supports staff in fulfilling their responsibilities and will enable the monitoring of Trust compliance with the Duty of Candour.

1.8 Raising concerns

As an organisation that provides care to vulnerable people, we take any concerns raised by our staff very seriously. We are committed to supporting any of our staff who are worried about areas of poor practice, attitudes or inappropriate behaviour within our organisation. We believe in encouraging openness and transparency in all we do. It is important that there are no negative consequences for individuals who act responsibly in highlighting issues that could put the people we care for at risk in any way.

We welcome that the Francis Review "Freedom to Speak Up" included a recommendation that all NHS Trusts must appoint a 'Guardian'. The Trust anticipates appointing a 'Freedom to Speak Up Guardian' in 2016. The Director of Nursing and Quality Standards currently holds this role. Following publication of the Francis Review – 'Freedom to Speak Up' - the Trust has engaged with the subsequent public consultations undertaken in 2015 to define the processes trusts will be expected to follow in implementing the recommendations, the process for which will be based upon guidance issued by the National Guardian and the national 'Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy for the NHS' which was published in April 2016.

The top concerns raised by our staff are:

We have had two whistleblowing incidents investigated under the 'Freedom to Speak Up' initiative. One incident was in regard to administering/recording medication within a community team and the actions have been added to the Trust-wide learning action plan where they are monitored for completion; the second incident was about the care and treatment within an acute ward (this resulted in a Service Level Review and the action plan was monitored at the Integrated Governance Group).

The Trust also plans to support the Trust 'Freedom to Speak Up Guardian' through the development of local guardians to ensure easy access for all staff across all of our sites.

If our staff feel concerned about any matter they can report it to:

- their line manager;
- their professional lead;
- a staff-side or union representative;
- any of our Executive Directors or members of our Trust Board.

1.9 NHS staff survey

In 2015, the Trust published its first 'Workforce Race Equality Standard' metrics and an action plan to address the issues highlighted within it which were agreed by the Board. To support our commitment to improving the experience of all our staff, the Trust has also appointed a full time Equality and Diversity lead, and in February 2016, the Board approved an ambitious Equality and Diversity Strategy, which will be overseen by a steering group, chaired by the Trust's Chair. The 2015 Staff Survey shows that the Trust has more work to do to address these issues, as illustrated by the following Key Findings:

- Key Finding 21: The percentage of staff believing the Trust provides equal opportunities for career progression/promotion - 75% (a decline from the 2014 survey of 79% and below the national average).

- Key Finding 26: The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months - 24% (the same as the 2014 survey and average when compared to the national average).

The Trust will engage with staff to agree actions to address the issues highlighted within the Staff Survey, and has already commissioned and provided unconscious bias and recruitment training for all staff involved in the recruitment process.

Part 2a: Looking forward – priorities for improvement 2016/17

2a.1 How we decided our quality priorities for 2016/17?

The Trust commenced its consultation on the quality priorities for 2016/17 in February 2016 by seeking views on quality themes from each Clinical Commissioning Groups, SWLSTG staff, service users and carers. The Trust quality priorities were also tested with the Shadow Council of Governors.

2a.2 Our pledges

The themes identified within our Trust were:

- **Care in the Community Adult Autism – Fulfilling and Rewarding Lives**
- **Suicide Prevention – reduction in levels of suicide**
- **Prevention of Violence: Patient on Patient, Patient on Staff and Staff on Patient**
- **Refining and improving Trust inpatient discharge standards (Yr. 2)**

These themes were worked up into potential indicator ideas using information provided by the Trust clinical leads for Learning Disabilities, Safeguarding, Risk and Serious Incidents, and the Trust Commissioning for Quality and Innovation (CQUIN) Lead.

'Sign up to Safety' encompasses five key pledges as shown below and referred to in 2a.4

2a.3 Quality Account – Trust quality priorities for 2016/17

Based on Serious Incident data and linking with the Sign Up to Safety campaign. These priorities relate to all services provided by the Trust and therefore are relevant to all of our commissioners including NHS England and our Clinical Commissioning Groups as well as all of the Overview and Scrutiny committees which relate to our area.

Quality Domain	Link to Quality Strategy / Other priorities	Improvement priority	How progress will be monitored:	Indicators to be used:
Safety / Patient Experience	QS: Year on year reduction in avoidable harm. Sign up to safety pledge	**Priority 1: Reduce level of serious self-harm and suicide** Reduce levels of self-harm and suicide by reviewing current processes and policies following incidents of self-harm including feedback from service users and staff.	Quarterly report to Integrated Governance Group / Quality and Safety Assurance Committee	• Number and ratios of incidents of serious self-harm / low harm
Safety / Patient Experience	QS: Year on year reduction in avoidable harm. Sign up to safety pledge	**Priority 2: Reduce degree of Violence - Patient on Patient** Reduce degree of violence by reviewing current processes and policies following incidents of alleged violence - patient on patient - including feedback from service users and staff.	Quarterly report to Integrated Governance Group / Quality and Safety Assurance Committee	• Number and ratios of incidents of serious harm violence / low harm • Patient survey
Safety / Patient Experience	QS: Year on year reduction in avoidable harm. Sign up to safety pledge	**Priority 3: Reduce degree of Violence –Patient on Staff and Staff on patient'** Reduce degree of violence by reviewing current processes and policies following incidents of: alleged violence - patient on staff, alleged violence - staff on patient, including feedback from service users and staff.	Quarterly report to Integrated Governance Group / Quality and Safety Assurance Committee	• Number and ratios of incidents of serious harm violence / low harm • Patient survey / feedback / level of complaints
Clinical Effectiveness	Demonstrate delivery of recommendations arising from National Clinical Audit, and reports Improve access to health care for people with a Learning Disability.	**Priority 4:** Improving the identification of service users with mental health issues who have a diagnosis of autistic spectrum disorder within local mainstream services • Programme of work to be developed to improve the recording of service users who have a diagnosis of autistic spectrum disorder, • Develop training to staff to promote innovative methods of communication to improve service responsiveness • Promote service user and carer involvement by providing opportunities to attend 'Autism Awareness' Open days	Quarterly report to Integrated Governance Group / Quality and Safety Assurance Committee	• Audit of recording. • Training attendances and feedback • Attendance at Open days. • Patient survey / feedback
Clinical Effectiveness	**Coordinated Inpatient Discharge Planning**	Yr. 2 of 2 year QA priority **Priority 5:** Gaps identified by the year-end report will be used to inform the focus for Year 2 of this two year action plan to improve quality of coordinated discharge.	Quarterly report to Integrated Governance Group / Quality and Safety Assurance Committee	Discharge plan in place for inpatients

2a.4 Sign up to Safety

In 2014/15 NHS England launched a '**Sign up to Safety**' campaign.

'Sign up to Safety' is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. It encompasses five key pledges (see p16).

'Sign up to Safety' aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients.

'Sign up to Safety's' three-year objective is to reduce avoidable harm by 50% and save 6,000 lives across the NHS.

The Trust has developed a 'Sign up to Safety' Improvement Plan, which shows how we will aim to reduce harm for service users over the next three years with the focus on reducing the degree of serious self-harm and suicide and reducing the degree of violence. These have been identified as part of the Trust's priorities for the Quality Account for this year and next.

We want to further empower our operational front-line teams to deliver quality. We know that our frontline staff are key to improving the quality of care we provide.

2a.5 How the organisation is developing quality improvement capacity and capability to deliver care

The Trust continues to drive capacity and capability for quality improvement through a range of measures including strengthening local quality governance at team and directorate levels and by monitoring local improvements through conducting an annual cycle of quality improvement reviews and audits. Two of these quality improvement activities are the **15 Steps challenge visits** and the **peer review evaluations**. Both processes are unannounced and are complimentary to each other but are quite different in approach, style and time commitment.

The 15 Steps challenge is a national programme. The emphasis is on first impressions, rather than a detailed inspection into care plans and medical records and should take no more than 30 minutes to complete the visit with an additional 15 minutes allocated to complete the associated documentation and feedback to the ward/team. Executive Directors and Non-Executive Directors, senior staff and others not employed by the Trust (Hospital Managers, Commissioners, Health Watch volunteers, carer and service user representatives) participate in the 15 Step visits. A total of 42 15 Step challenge visits were

completed in inpatient areas and community teams during the period of review. Many of these visits were attended by Executive and Non-Executive Directors. The learning from these visits highlights examples of best practice as well as:

Inconsistency in:

Collaboration

- Some teams had little or no evidence of collaboration with service users, carers and families.

Well-led

- Staff photo boards need to show staff changes.

Environment

- Poor layout in some areas – needing improvement.
- Some areas in a poor state of repair.

Effectiveness

- Prescriptions delayed over 48 hours.

Where we excelled was in:

Care and Compassion

- Staff highly motivated to report safeguarding concerns and incidents.
- Staff showed respect to service users.
- Some areas had excellent information boards.
- Ward had an excellent Ward Clerk, who was very welcoming, and efficient administration.

Openness

- Managers were open and honest.

Peer review is a practice-focused process whereby health care professionals evaluate each other's clinical performance and is undertaken using a coaching and supportive approach. It is seen as a key indicator for quality assurance and measures the standards of the delivery of care in clinical services against Care Quality Commission fundamental standards. Peer reviewers are comprised of mainly clinical staff.

Care planning emerges as a theme for continued development within the Peer Review quality improvement programme with focus centred on achieving consistent provision of care plan and crisis plans to service users and evidence supporting involvement by service users and carers in care plans.

During quarters 1 and 3 (April-June 2015 and November 2015-January 2016), 96 Peer Reviews were completed across all directorates.

Areas of significant improvement include good examples of local leadership from ward and team managers, staff are recognised as caring and compassionate across many areas. The quality of service users and carer information has improved, particularly the ward and community team information packs.

Overall, the findings of the 15 Steps challenge visits and peer reviews are consistent with findings from other sources such as the Care Quality Commission and other inspection teams such as Healthwatch and findings from complaints. Both quality improvement activities continue to provide an important quality improvement monitoring function.

2a.6 Monitoring our progress

The Quality Safety Assurance Committee is the principal committee charged by our Trust Board to lead on quality. The Trust Board received a quarterly report on progress against the key corporate objectives and, in addition, a monthly update is also briefed by the Chair of the Quality and Safety Assurance Committee. The Quality and Safety Assurance Committee receives a quarterly report on progress in delivering the more detailed quality priorities. This Committee and the Integrated Governance Group will regularly review our progress against these priorities.

Each of our directorates has a Directorate Governance Group (DGG) that reports to the Integrated Governance Group and these groups will review all areas of quality in their own directorates. For 2016-17, each directorate has an annual business plan that includes the key quality priorities, which is used as the basis for the monitoring of delivery.

Part 2b: Statements related to quality: Statements of assurance from the Board

2b.1 Review of services

During 2015/16 South West London and St George's Mental Health NHS Trust provided core mental health NHS services under contract to five local Clinical Commissioning Groups (Kingston, Richmond, Sutton Merton and Wandsworth). Six other CCGs (Lambeth, Hounslow, Croydon, West London, Hammersmith and Fulham, Central London) are also signatories to this contract. During this period South West London and St George's Mental Health NHS Trust provided specialist and forensic mental health NHS services under contract to NHS England. South West London and St George's Mental Health NHS Trust provided other clinical services under contract to the London Boroughs of Merton, Sutton and Wandsworth.

South West London and St George's Mental Health NHS has reviewed all the data available to them on the quality of care in all of these NHS services. It reports regularly on the quality of care to Trust Board and through contract performance meetings with all its commissioners.

The income generated by the NHS services reviewed in 2015/16 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2015/16.

During 2015/16 Trust provided inpatient and community mental health services under five management teams: Kingston and Richmond, Sutton and Merton, Wandsworth, CAMHS and Specialist Services.

Our service areas include:

- Adults of working age mental health
- Older people's mental health
- Child and adolescent mental health
- Specialist mental health services (Adult and Child Eating Disorders; Deaf Adults and Children; Low and Medium Secure Forensic; Obsessive Compulsive Disorder / Body Dysmorphic Disorder; Specialist Child and adolescent mental health; Neuropsychiatry)
- Mental health services for people with learning disabilities
- Drug and alcohol services (Sutton & Merton)
- Improving Access to Psychological Therapies Services (IAPT - Merton, Wandsworth and Sutton)

South West London and St George's Mental Health NHS Trust sub-contracted East London Foundation Trust for acute mental health beds and Central North West London NHS Trust for female Psychiatric Intensive Care Unit beds. Beecholme Adult Care was sub-

contracted for Merton Step Down – as an interim arrangement whilst the tender was being run.

Community Drug Service for South London was sub-contracted by the Trust for substance misuse services in Wandsworth, Sutton and Merton.

Imagine Independence was sub-contracted by the Trust for IAPT / primary care services in Sutton Uplift.

South West London and St George's Mental Health NHS Trust was sub-contracted by Crime Reduction Initiatives (CRI) known as 'Change Grow Live' as from the 1 April 2016 for substance misuse services in Richmond.

2b.2 Participation in clinical audits

National clinical audit is designed to improve patient outcomes across a wide range of mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care. In mental health there are a number of audits run by the Royal College of Psychiatrists Prescribing Observatory for Mental Health (POMH) and the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

During 2015/16, two national clinical audits and one national confidential enquiry covered NHS services that South West London and St George's Mental Health NHS Trust provides.

During that period, South West London and St George's Mental Health NHS Trust participated in 100% of the national clinical audits and 100% of national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that South West London and St George's Mental Health NHS Trust participated in during 2015/16, for which data collection was completed are listed in table 1.

Table 1: Participation in National Clinical Audits

Participation in National Clinical Audits		
National Audit Topics that SWLSTG. was eligible to participate in	**SWLSTG Involvement**	**Cases submitted / Cases required**
POMH (UK) AUDIT *Topic 13b audit presents data on prescribing practice for ADHD conducted in 6 CAHMS settings*	Yes	5,654
Topic: 9c 'Antipsychotic prescribing in people with a learning disability' Supplementary audit		6,109
Early Intervention in Psychosis (EIP) audit	Yes	100
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Yes	Since 01/04/15 we have received 17 suicide questionnaires and 12 were returned. We have returned 2 homicide questionnaires. 2 Sudden Unexplained Death (SUD) questionnaires, remain outstanding at the point of publication.

The reports of 2 national clinical audits were reviewed by the provider in 2015/16 and South West London and St George's Mental Health NHS Trust intends to take the following actions to improve the quality of healthcare provided as outlined below.

National Clinical Audit - POMH (UK) AUDIT Topic: 13b audit presents data on prescribing practice for ADHD conducted in six CAHMS settings.

The Trust subscribes to membership of POMH-(UK) which supports the implementation of NICE guidelines to help clinical teams monitor and improve the quality of their mental health prescribing. POMH-UK audit reports were reviewed by the Drugs and Therapeutics Audit sub-group and the findings and recommendations circulated Trust-wide. Trusts were asked to include patients who had a diagnosis of ADHD in this audit.

Findings: Nationally

- Proportion of patients who receive physical health checks prior to initiation has remained high.
- Modest improvement in assessment of cardiovascular risk
- No improvements in physical health monitoring in patients on established treatment.

Findings: Locally

- Reduction in physical health checks prior to initiation from baseline audit (2013). This result was influenced by one team who documented this in four out of eight patients. The other four teams had 100% compliance.
- There was improvement in the assessment of cardiovascular risk from 56% to 74%. Results from two teams influenced this result. Other teams completed a Cardio Vascular assessment in all 10 patients, four of whom also had an ECG.
- There was continued poor assessment of substance misuse risk.
- There was a reduction in most measures of physical health monitoring of patients on established treatment – the exception being heart rate measurements.

Identified as a risk this has been added to the Trust Governance Risk Register and is being monitored through the Corporate Clinical Audit Programme. In development with Clinical Directors, action plans have been put in place to address areas of poor physical health and substance misuse assessments. Oversight and scrutiny of progress will be undertaken by the NICE and Clinical Audit group chaired by the Medical Director.

National Clinical Audit - Topic: 9c 'Antipsychotic prescribing in people with a learning disability' Supplementary audit

This supplementary audit report presents data on prescribing practice for people with a learning disability conducted in three community learning disability teams in SWLSTG.

Findings:

- There is variation in practice within and between teams at SWLSTG.
- Good level of documentation about rationale for prescribing and annual reviews.
- Below national average for documentation of cardio metabolic risk factors – weight, blood pressure, glucose and lipids.

This may reflect that prescribing is held by local General Practitioners and monitoring is being completed in primary health care settings. There was no evidence in records of communication from General Practitioners to the Learning Disabilities team or evidence of information from primary care records in the electronic patient record (RiO).

Action plans have been developed to address areas where performance falls

short of the standards. The Trust seeks assurance that the short fall of standards will be addressed though ongoing monitoring and has identified engagement with General Practitioners as a key area for development. Clinicians have since acquired access the GP electronic patient summary records improving the links between GP and mental health staff.

Early Intervention in Psychosis (EIP) audit

The Early Intervention in Psychosis (EIP) audit is a new national clinical audit commissioned by Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, and awarded to the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI).

Early intervention in psychosis services are specialist community services providing care and treatment to people who are experiencing their first episode of psychosis, and for those who are at high risk of developing psychosis. The EIP audit will help to establish the extent to which these services comply with a framework of NICE standards of care, NICE quality standard for psychosis and schizophrenia in adults (QS80), which put particular emphasis on early access, physical health, family intervention and supported employment programmes.

The results of the audit will provide a national overview of the EIP services' quality of care in England relative to those standards. In addition, the audit will enable participating services to identify their strengths as well as the areas of improvement they have to work towards. The report is expected to be published in July 2016.

Participation in local audits

The reports of 12 local clinical audits were reviewed by the provider in 2015/16 and South West London and St George's Mental Health NHS Trust intends to take the following actions to improve the quality of healthcare provided.

A review of audit was undertaken and, as a result, the Medical Director as chair of the NICE and Clinical Audit, has engaged Clinical Directors and Audit Leads in a programme that will build on the existing audit process. The Integrated Governance Group approved the programme in February 2015 and the Quality and Safety Assurance Committee ratified the programme in April 2015. All approved audits are registered on the electronic systems, which allows tracking and provides evidence and ability to assurance the audit programme.

The local clinical audits on the Corporate Clinical Audit Programme included in addition to the national audits noted above a full range of audit activity developed and ratified by the Compliance

and Clinical Practice Standards Group with consideration of Care Quality Commission concerns, national audit requirements and learning from serious incidents, complaints and claims. Some 120 local audits were registered for the 2015/16 period of review. The Trust conducted the following 12 local clinical audits during 2014/15 to determine the degree of practice compliance against local and national policy standards:

- Mental Health Act / consent and capacity
- Rapid tranquillisation
- Medicines code (including controlled drugs)
- Physical health; inpatient and community standards
- Care planning; inpatient and community standards
- Observation and intensive engagement practice
- Quality of risk assessments (inpatient and community)
- Searching of environment, property and person policy
- Information governance data quality
- Ligature audit
- Safeguarding adults – Lampard Report audit of recommendations
- Safeguarding children – Lampard Report audit of recommendations

Medicines Code Audit: NHS Trusts are required to establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner and that procedures are followed by Trust staff as required by the Trust Medicines Code (TWC20). The safe and secure handling of medicines must be monitored as outlined by the responsibilities of the controlled drugs accountable officer and for Care Quality Commission submissions and aims to ensure that risks are identified and managed.

The overall rating on safe and secure handling of medicines for all directorates and the Trust has stayed at amber for the third consecutive year, with at least one standard within the topic scoring between 75% and 99%. The Trust remains as an amber rating.

Table 2: During 2015-2016 the trust completed local audits against the following NICE guidelines

Local audits completed against the NICE guidelines Title	NICE Policy number	Compliance
Eating disorders (CG9)	CG9	Good
Dementia (CG42)	CG42	Partial
Psychosis and schizophrenia in adults: prevention and management NICE guidelines	CG178	Partial
Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care.	CG185	Partial
Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes	NG5	Partial
Psychosis and schizophrenia in adults	QS80	Partial
Personality disorders: borderline and antisocial	QS88	Partial

Safeguarding Adults at Risk Audit Tool 2015-2016

The Trust undertakes an annual audit of arrangements to safeguard and promote the wellbeing of adults at risk.

The Safeguarding Adults at Risk Audit Tool has been developed by the London Chairs of Safeguarding Adults Boards (SABs) network and NHS England London. It reflects statutory guidance and best practice. It also provides evidence for the Trust to draw together relevant information for its own assurance.

The aim of this audit tool is to provide the Trust with a consistent framework to assess monitor and/or improve their Safeguarding Adults arrangements in the five boroughs in which it provides services. In turn this supports the Safeguarding Adult Boards (SABs) in ensuring effective safeguarding practice across the five boroughs.

2b.3 Participation in clinical research

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by South West London and St George Mental Health Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was at least 350.

Research & Development – Quality Account 2015-16

Over the last 2 years, the Research and Development department has made tremendous progress in reconfiguring its operational infrastructure by devising an integrated and collaborative strategy, which envisions its development with key stakeholders over the period 2015-20. This short/medium-term plan responds to an overriding need to re-establish research and development at the heart of core Trust business, and to drive improvements in patient care not only within the Trust, but also the wider NHS. One core component of the department's infrastructural development is to enhance its technology and communications platform to remain abreast of the latest innovations initiated by national government and external regulatory agencies. The most notable examples are:

- The **EDGE** (Enhanced Data GSM Environment) data migration was implemented by the Clinical Research Network: South London (CRN: SL) as a local portfolio management system (LPMS) for member trusts to streamline local and national management and governance processes in the adoption and initiation of portfolio (national multi-centre) research. This now enables faster set-up and recruitment timeframes, consistent and reliable lines of communication between research sites and fewer anomalies in research data collection for researchers. The administrative costs for this will be borne by the CRN, which provides the Trust with ensure maximum efficiency using minimal cost and outlay.

- The **UK-CRIS** (Clinical Record Interactive Search) Steering group was convened to oversee and coordinate the implementation of the CRIS, which will drive research by providing researchers with access to a wide range of de-identified data from the Trust's electronic clinical records system. The UK-CRIS is being rolled out to 10 mental health trusts in the UK to run queries across all participating sites, while at the same time enabling the Trust to maintain jurisdiction over its own

data. The steering group is chaired by the Research and Development Director and retains oversight of all key stages of implementation, with representation from the Information Governance, IM&T and Research and Development departments, service users and the Caldicott Guardian. The estimated date of completion is mid-May and will give Trust researchers access to a potential pool of research data from over 2 million people.

- The **Health Research Authority (HRA) approval process** has entered its final stages of implementation and will simplify the approvals pathway for health research. The HRA will now assume responsibility for many of the key processes in the review and approval of research formerly conducted by the National Research Ethics Service (NRES) and Trust Research & Development Offices, effectively making it a quicker and more efficient 'one-stop' process.

In sum, the Research Management and Governance (RM&G) operational model is being superseded by a more robust prototype and will reduce the administrative burden on the department to ensure greater financial and operational sustainability.

The department has also continued to work conscientiously towards fostering closer relationships with the Trust's service user and carer body. Following on from its 'Moving Forward Together' workshops over the last two years, a research drop-in event is now planned for the end of March, which will provide an open forum for all stakeholders – service users, carers, staff, researchers – to talk openly about research and ask questions about the Trust's portfolio.

The Research and Development department's renewed commitment to quality, value, leadership, co-production and recovery has already yielded fruit, as demonstrated by the two successful National Institute for Health Research (NIHR) research grants (SinQUE and ENRICH) totalling £2.3 million led by Professor Gill Mezey and Dr Steve Gillard. The Clinical Trials Coordinator, Dr Philip Woodgate, has also submitted a small grant application to the Wellcome Trust for an innovative study looking at the use of biographical films to help dementia patients (in conjunction with MyLifeFilms).

Participation in clinical research

The number of patients receiving NHS services provides or sub-contracted by South West London and St Georges Mental Healthcare Trust in 2015/2016 that

were recruited during that period to participate in research approved by a research ethics committee was at least 350.

The Trust's current research portfolio can be broken down as follows. There are **48** ongoing studies in total, of which:

- **10** are educational projects (Master's level or higher);
- **33** are national multicentre (i.e. portfolio) studies;
- **1** is a commercially funded pharmaceutical study;
- **4** are either pilot, locally generated and/or non-commercially funded collaborative study.

There are currently **14** members of staff who are involved in portfolio research across mental health, of which:

- 7 are clinical;
- 5 are allied health professionals or non-clinical; and
- at least one study has a Pharmacy representative named as local collaborator.

This snapshot includes the sub-specialties of old age psychiatry, forensic psychiatry, neuropsychiatry, perinatal psychiatry, occupational therapy, eating disorders, learning disability, child and adolescent psychiatry, obsessive-compulsive disorder and liaison psychiatry.

The department has transformed itself to emerge as a revitalised, more efficient entity with stronger foundations for research delivery in the modern NHS. The pace and progression of development over the last two-three years bodes extremely well for the next five years and with the continued commitment of all multidisciplinary stakeholders, will undoubtedly lead to even greater achievements within the Trust's corporate level and service improvement agendas, underpinned by clinical effectiveness and a robust business and operational model.

2b.4 Commissioning for quality and innovation

A proportion of South West London and St George's Mental Health NHS Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between South West London and St George's Mental Health NHS Trust and our local commissioners and NHS England for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period are included in Part 3 with CQUIN priorities are detailed in the table on pages 41-45.

2b.5 Statements from the Care Quality Commission

South West London and St George's Mental Health NHS Trust is required to register with the Care Quality Commission and its current registration status is fully registered without conditions.

The Care Quality Commission has not taken enforcement action against South West London and St George's Mental Health NHS Trust during 2015/16.

Previous Care Quality Commission Pilot Inspection outcomes

Following a pilot inspection in March 2014 by the Chief Inspector of Hospitals (CiH) issued three compliance actions to the Trust in June 2014. The Trust had completed all agreed actions against these requirements with appropriate assurance so these were formally lifted by the Care Quality Commission in May 2015.

Care Quality Commission Focused Inspections

In May 2015 the Care Quality Commission undertook focused inspections of core services for wards for older people with mental health problems at Tolworth Hospital and Springfield University Hospital. They also undertook focused inspection of acute wards for adults of working age and psychiatric intensive care units at Tolworth Hospital, Springfield University Hospital and Queen Mary's Hospital. The Care Quality Commission issued five Requirement Notices (formerly known as Compliance Actions) that related to a breach of 4 HSCA Regulations.

In October 2015 the Care Quality Commission undertook a focused inspection on Avalon Ward, a specialist eating disorder service, in which a further Requirement Notice was issued to the Trust following publication of the inspection report in April 2016.

Care Quality Commission Requirement Notices 2015/16

a) The care and treatment of service users was not always appropriate or did not meet their needs and reflect their preferences. On Lilacs ward not all patients were aware of their care plans. Care plans did not address all of the patients' needs and did not reflect their preferences. Many patients were not involved with the development of care plans. This was a breach of **Regulation 9 (1)(a)(b)(c)(3)(a)(b).**

For ease of identification, care plans are distributed on yellow paper. The distribution of care plans for inpatients is significantly higher than community. The Trust wide

position at the end of December 2015 is 66%, lower than the target expected of 95%. Focus continues with teams to ensure the care plan is at the centre of all decision-making, a focus on recovery goals, risk assessment and service user involvement. The implementation of RiO Lite eases the navigation of the care record for the user. Although significant progress has been made, it is recognised that further work is required. An audit was undertaken in February 2016 and the findings from the audit identified required actions. and recorded on the corporate risk register, risk number 570. The action remains amber rated.

b) Patients were not always treated with dignity and respect. The layout of both wards for older people meant that the wards did not comply with guidance on same sex accommodation and compromised patients' privacy and dignity. This was a breach of **Regulation 10(2)(a).**

The immediate concerns raised were addressed. The action is green rated.

c) Staff on Lilacs ward lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a risk that they did not recognise when a patient was unable to give consent to care and/or treatment and did not understand their legal responsibilities. This was a breach of **Regulation 11 HSCA (RA).**

Application of the Mental Capacity Act (MCA) has been a challenge across the Trust. A new e-learning package was implemented to enable flexible access to training. In addition, face-to-face training has been provided to 46% of all inpatient staff and 20% of community staff. Training compliance overall is 90%. Mental Capacity Act leads are in place in each directorate to support development and queries. An improved consent and capacity electronic assessment and decision template has been implemented. Ongoing monitoring has been assisted by the introduction of automated fields in the electronic patient record, RiO. Although improvement has been made, the action is ongoing and the Board appraised in April 2016 of further actions to be undertaken. The action remains amber rated.

d) On Lilacs ward, patient risk assessments and management plans were not always updated following risk incidents. Staff had not always followed risk management plans. Ligature risk assessment and management was inconsistent and staff did not always recognise risks or know how to manage risks safely. This was a breach of **Regulation 12 (1)(2)(a)(b)(g).**

This was addressed by implementing quarterly audits and risk assessment training. The annual ligature audit has been completed and templates aligned for consistency. The corporate risk register captures risks under numbers 189, 551, 599 and 573. The action is green rated.

e) On Lavender ward some patients were administered 'as required' medicines every night. The reasons why patients required these medicines was not consistently recorded. Acute adult patients received care and treatment on the older people's wards when this was not always clinically appropriate. This posed a clear risk of harm to older patients. This was a breach of **Regulation 12 (1)(2)(a)(b)(g).**

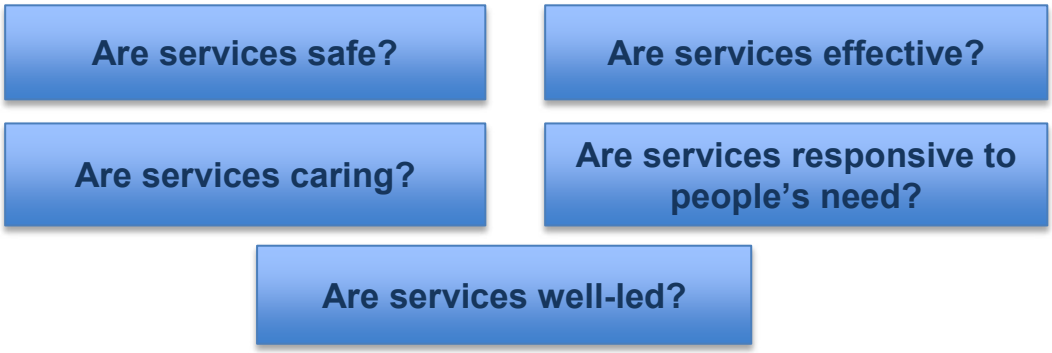
The Trust PRN medication is audited monthly and reported to the Board by exception. Revised guidance has been implemented to manage clinically appropriate and not clinically appropriate patients. The corporate risk register captures risks under numbers 189, 551, 599 and 573. The action is green rated.

Requirement Notice issued following Focused Inspection to Avalon Ward (October 2015)

f) Not all staff had received appropriate training to enable them to carry out the duties they were employed to perform. Significant numbers of staff had not completed required training in basic life support techniques, medicines management and fire safety awareness or had not updated this training when needed. This was a breach of **Regulation 18(2)(a)**.

2015/16 Care Quality Commission – Chief Inspector of Hospitals Inspection

The Trust was inspected by the Chief Inspector of Hospital's inspection team from the Care Quality Commission on the 14th to the 18th March 2016. They conducted 57 inspections during the week-long visit and reviewed five key areas of work provided by the Trust, asking:



The expectation is that areas of improvement will be required. The full report is expected to be published in the summer 2016 and is awaited. Once published, it will be accessible for review on the Care Quality Commission website.

However, early feedback to Executives from the Lead Inspectors at the end of the inspection and subsequently on the 4th May 2016 provided details highlighted a number of areas. The Care Quality Commission Inspectors noted the strength of work in the Acute in-patients services, CAMHS community services and LD community services. Care Quality Commission reinforced that staff were caring and that the Trust is well-led with the skills required to make any changes needed.

In sharing their feedback, the inspectors used words such as exemplary, beacon, exceptional and said the Trust had much to be proud of. They said that they met "very caring and committed staff wherever they went", that "the Trust culture was open" and that "the Trust should be proud of the dedication and commitment staff show in caring for patients". It was clear from the feedback that one area of focus for improvement is in adult community services.

More specifically the inspectors said:

- there were excellent examples of multi-disciplinary working;
- the Trust work in the community around equality and diversity was innovative and effective;
- bed pressures are a risk but the way this is managed is very good;
- the Trust has a good culture and staff are committed, motivated and caring;
- morale was positive and staff demonstrated the good work taking place.

By the very nature of inspections, the Trust can expect areas of learning to be identified, and will use this information to continue to improve services.

The Care Quality Commission confirmed that all previous requirement notices (except Avalon) were reviewed as part of the inspection. It is anticipated that the Trust will receive a number of new requirement notices. We were pleased that no enforcement actions were received.

The Care Quality Commission Lead Inspector expects to host the Quality Summit towards the end of July once the report has been published in advance.

2b.6 Data quality 2015/16

The Trust has unified data collection processes to ensure that almost all clinical information is recorded on electronic clinical record (RiO) or IAPTus for CAMHS Tier 2 and 3. As a consequence the information can be more easily monitored for accuracy and audited for quality, helping to ensure that the information is current, comparable and meets clinical standards.

Trust performance measures are based on information that is recorded within the electronic clinical record, with no need for additional data entry or local spreadsheets. Therefore, the quality of information is directly linked with the quality of the clinical record and the provision of care and support.

South West London and St George's Mental Health NHS Trust will be taking the following actions to improve data quality:

- The Trust is now able to configure a large proportion of RiO (the Trust's main electronic clinical record) to meet the local needs of clinicians as well as the business needs of the Trust. This means that data recording screens can be simplified and streamlined to support an improvement in data quality.
- The Trust will continue to benchmark against other trusts the quality of data submitted as part of the Mental Health Services Data Set (MHSDS). The reports issued by the Health and Social Care Information Centre (HSCIC) will be scrutinised to identify both areas of good practice and concern in relation to data quality.
- Data quality is reported by teams and individual clinicians and levels of performance against targets are reviewed at monthly Directorate Performance Review (DPR) meetings and reported to the Board.
- The "My dashboard" tool provides all staff with an easy to use personal dashboard which supports the management of data quality throughout the organisation. Each clinician is able to see how the quality of their data supports the provision of an accurate and reliable clinical record.
- A clinical audit on data quality is completed annually to check that the information is accurate. The Trust can easily check the information contained in an individual data field, but it is more difficult to ascertain the quality of the record or whether the necessary information is contained in free text fields

- The Trust receives additional assurance via external audit on specific performance areas. Grant Thornton audited seven day follow up and face-to-face gate keeping in 2015/16; similar audits are planned for 2016/17.

NHS number and general medical practice code validity 2015/16

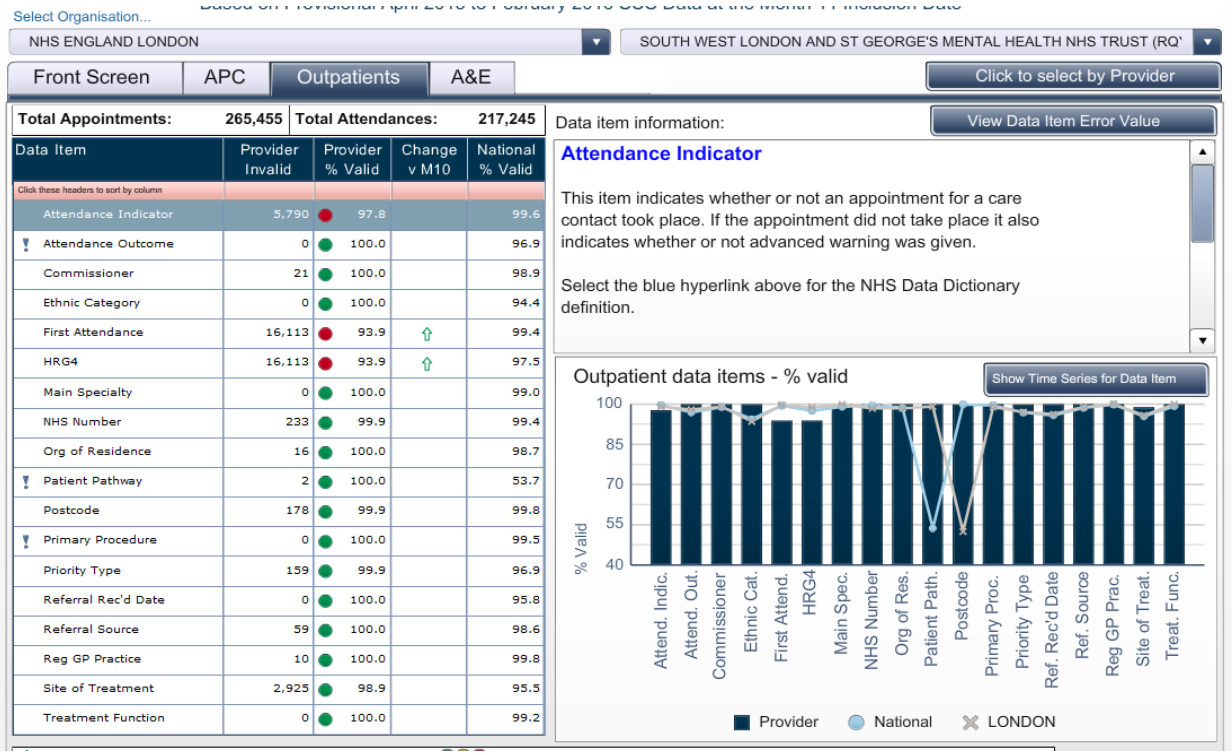
South West London and St George's Mental Health NHS Trust submitted records to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data, which included the patient's valid NHS number, was 99.2% for admitted patient care and 99.4% for outpatient care.

General Medical Practice Code Validity

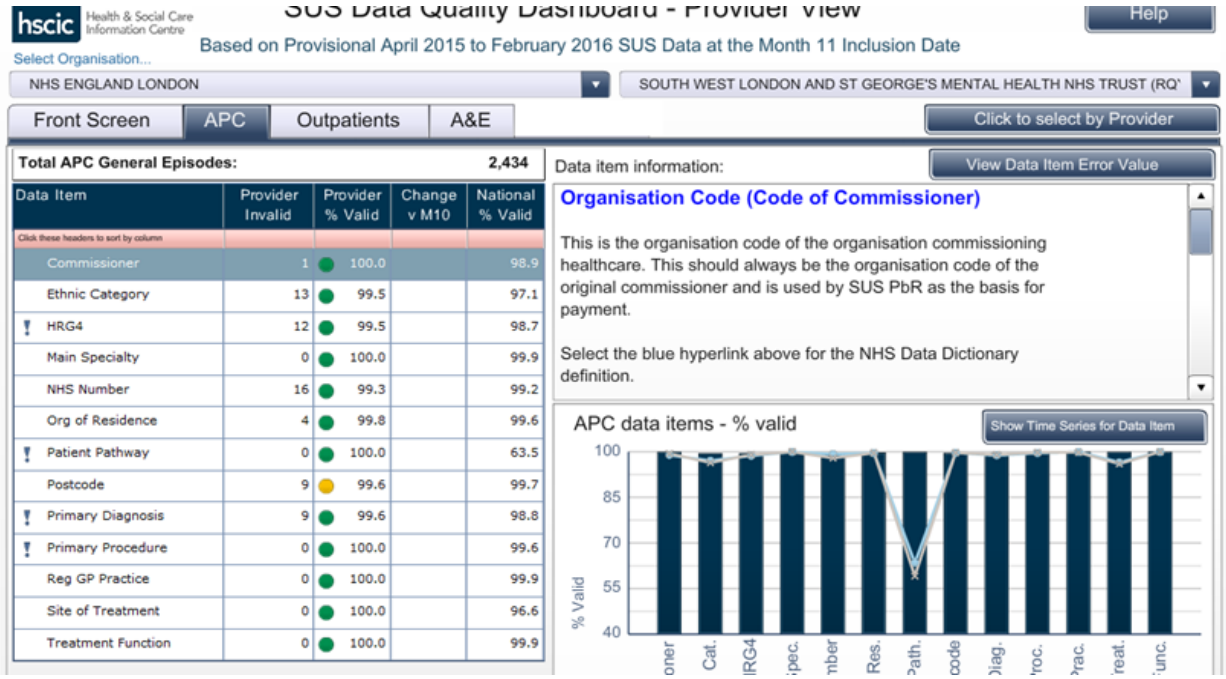
The Trust recorded compliance of 100% of submitted records contained a valid GP code for both outpatients and inpatients compared with a national average of 99.8% & 99.9% respectively.

Table 3: Data Quality

Data Quality: Admitted Patient Care APC (Inpatient)



Data Quality: Outpatients



Information governance toolkit attainment levels 2015/16

South West London and St George's Mental Health NHS Trust Information Governance Assessment Report score overall score for 2015/16 was graded Level 2 Compliant with a "satisfactory" annotation. With 33 requirements at Level 2 and 12 at Level 3 an overall score of 75% is an improvement on the 2014/15 submission.

Information governance personal data loss 2015/16

Personal data loss risk was managed by the Trust's Information Governance Group, this Group has been reconstituted to form The Data Protection and Information Governance Group (DPIGG) that meets quarterly, Chaired by the Caldicott Guardian or the Senior Information Risk Officer (SIRO) This group, as part of their remit, reviews data breaches. During the financial year 2015/16 serious incidents requiring investigation at level 2 or more numbered nil. Serious confidentiality incidents numbered one, this did not need reporting and has been addressed and remedied.

Clinical coding error rate 2015/16

South West London and St George's Mental Health NHS Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

The Trust has continued to focus on the coverage of clinical coding for both primary and secondary diagnosis for inpatient episodes of care. During the financial period 2015/2016, the Trust was audited for the accuracy of primary and secondary diagnosis. The Trust scored 100% in primary diagnosis and 84.48% in secondary diagnosis. The Trust figure for recording of primary diagnosis was 99.6%, against a national average of 98.8%.

On the quality of clinical coding, in 2015/2016 the Trust was audited for the accuracy of clinical codes for inpatient episodes. The Trust scored 100% accuracy for primary diagnosis and over 84.48% for secondary diagnosis on a random sample of 50 records. This was translated to Level 3 in the respective annual Information Governance Toolkit, which is the highest possible score in this category for that particular requirement.

Part 3: Our care quality achievements in 2015/16

This section of the Trust's Quality Account provides information on the quality of services provided in 2015/16 and reports on our progress against the 2015/16 Quality Account priorities.

3.1 Review of Quality Account priorities 2015/16

Last year the Trust identified the following priorities in its Quality Account. These were:

- Coordinated inpatient discharge planning (year one of a two year priority)
- Service responsiveness and web consultations
- Physical health – physical health handbook, diabetes and obesity, food and nutrition (year 2 of a two year indicator commenced in 2014/15)
- Learning Disabilities (LD) (year 2 of a two year indicator commenced in 2014/15).

A proportion of the Trust's income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the Trust and Commissioners for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework (CQUIN). The seven CQUIN areas (and measures) for 2015/16 were:

- Carers and Families – Triangle of Care (2 Year CQUIN)
- Mental Health Tariff – Care Packages and Programme of Audit
- Medicines and Physical Health Reconciliation at CPA Review and Discharge and Medicines Compliance in the Community (2 Year CQUIN)
- CAMHS – 'You're Welcome'
- Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) – Cardio Metabolic Assessments and Communication with GPs (Summaries of Care)
- Mental Health Safety Thermometer

Overview of Trust performance with 2015/16 Quality Account priorities

Indicator	Target	Year-end performance 2015/16
Clinical Effectiveness		
Priority 1: Coordinated Inpatient Discharge Planning (Year one of a two year quality account priority)	**Indicator 1** **Discharge Standards** • To refine and improve Trust inpatient discharge standards to ensure standardisation and learning from best practice across Trust wards	**Achieved –** The discharge standards were updated. Audits undertaken in Q2 and Q4 demonstrated improvements in discharge documentation on the Trust Electronic Care Record (ECR)
	Indicator 2 **Ward Information Packs** • To develop and implement a comprehensive discharge support and information element in ward packs for Adult Acute wards to facilitate discharge	**Achieved –** Information regarding the discharge process and support available, for adult acute wards, was produced and is included in the ward information pack
	Indicator 3 **Task Management System** • Publicise and engage staff with the Discharges Task List and Task Management System on My Dashboards. Refine processes and systems to ensure staff are able to make best use of the systems available.	**Achieved –** The Task Management System has been publicised and promoted using various communications and events. Process has been reviewed and refined.
Priority 2: Learning Disabilities	**Indicator 1** **Resource Development** • Build databases and online resources to support staff and service users and ensure best practice learning. This will include Hospital Passports for people with Learning Disabilities going into hospital.	**Achieved –** Database now available for staff on Trust Intranet containing online resources. Hospital Passport updated and renamed Health Care Passport.
	Indicator 2 **Training and Engagement with staff, family and friends**	**Achieved –** Two sessions for Learning Disabilities Champions

	• With a focus on ASD, events and engagement activities will take place for staff, CFF and service users, including a targeted Trust-wide LD Awareness Week.	and ward managers took place on 17 September and a Learning Disabilities Awareness Week during December with an ASD specific event on 16 December. A Learning Disabilities e-learning training packages has been developed and was re-launched in Q3.
Patient Safety		
Priority 3: Physical Health (Diabetes, Observations of Vital Signs and Falls)	**Indicator 1** **Physical Health Handbook** • This indicator will focus on co-producing a physical health handbook for inpatient service users.	**Achieved –** The handbook has been developed, reviewed and refined throughout 2015/16. The final version has been designed, printed, distributed and promoted to relevant teams.
	Indicator 2 **Diabetes** • Following the development of the diabetes e-learning package in 2014/15, the Trust will roll out the package amongst appropriate Trust clinical staff (target group to include staff RN and doctors CT1&2).	**Achieved –** The roll out of the training continued throughout the year. The number of appropriate staff to have completed the training steadily increased with a total of 272 staff members having completed the training at the end of Q4.
	Indicator 3 **Obesity, food and nutrition** • The indicator will focus on refining the obesity pathway, educating staff and updating the methods for supporting patients with dietary plans.	**Achieved –** The Trust's Obesity Pathway was updated in Q1 and awareness sessions ran throughout Q2 and Q3. An audit conducted in Q4 demonstrated improvements in the recording of interventions for people with identified obesity.

Patient Experience		
Priority 4: Service Responsiveness and Web Consultations	**Indicator 1** **Trust Standards** • Update and refine Trust standards and procedures for responsiveness in Trust teams, to include: - Expected time frames for returning calls when service users contact community teams - Appropriate methods of communication	**Achieved –** The Trust Standards were updated in collaboration with community staff, patients, carers, friends and family members. This included the different time frames for returning calls within working hours and out of hours procedures, and appropriate methods of communication including letters and email.
	Indicator 2 **Web Consultations** • Co-produce, pilot and implement web consultations for service users, and for clinicians and GPs	**Achieved –** Skype for business has now been implemented on all staff laptops and PCs. The Trust went live in December 2015 enabling all teams to be able to communicate with patients, virtually, as appropriate, agreed by clinician and the patient. A relaunch is planned for 2016/17 to promote the use of web consultations further.

Overview of Trust performance with 2015/16 CQUIN priorities

CQUIN	Indicator	Year-end performance
Carer and Families – Triangle of Care	Co-produce a comprehensive Carer, Family and Friend* Identification, Information Provision, Support and Involvement Protocol	**Achieved –** The Carer, Family and Friend (CFF) Identification, Information Provision, Support and Involvement Protocol was coproduced and includes training guides, ECR recording guides, process

		flowchart and feedback and evaluation tool.
	Develop and implement a Carer Family Friend Triangle of Care involvement and service satisfaction monitoring process and tool.	**Achieved –** A CFF ToC involvement and service satisfaction monitoring process tool was developed piloted, refined and implemented.
	Demonstrate improvement against the current KPI for assessments being offered for eligible carers of CPA service users in Kingston, Richmond and Merton (Sutton and Wandsworth are exempt from this indicator as they are not integrated into the service): - 60% to have been achieved by the end of Q4	**Achieved –** 74.3% of identified carers of CPA service users in Kingston Richmond and Merton were offered a carer assessment at the end of Q4.
Safety Thermometer (Patient Safety)	Collect and submit monthly Safety Thermometer screening data for Self-harm, Violence and Aggression, Psychological Safety, medication omissions, and restraints for inpatient wards	**Achieved –** The Trust successfully collected and submitted monthly safety thermometer screening data for all 22 inpatient wards.
	Establish Safety Thermometer Webtool	**Achieved –** Safety Thermometer Webtool has been establish and utilised.
Improving Physical Healthcare – Cardio Metabolic Assessment and Treatment	**Cardio Metabolic Assessment** for patients with psychoses, including Schizophrenia Demonstrate, through the National Data Collection Exercise, full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with psychoses, including schizophrenia. The results recorded in the patient's notes/care plan/discharge documentation as appropriate, together with a record of associated interventions according to NICE guidelines or onward referral to another clinician for assessment, diagnosis, and treatment e.g. smoking cessation programme, lifestyle advice and medication review. The following cardio metabolic parameters (as per the 'Lester tool' and the cardiovascular outcome framework) are assessed:	**Partial Achievement –** The National Data Collection Exercise was completed in Q3 and an Audit report demonstrating EIS results was produced. In total the Trust achieved 43% for inpatient services and 38.75% for EIS. Systematic feedback of CMA data for clinicians was reviewed including the National Audit of Schizophrenia Report on the Trust ECR. Guidance is now available on the Trust Intranet on how to access CMA

	• Smoking status • Lifestyle (including exercise, diet, alcohol and drugs) • Body Mass Index • Blood pressure • Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate) • Blood lipids	performance.
	Summaries of Care Completion of a local audit of communication with patents' GPs, demonstrating that, for 90% of patients audited, an up-to-date summary of care has been shared with the GP, which meets the standards of the Academy of Royal Colleges and includes: a) NHS number b) ICD codes for all primary and secondary mental and physical health diagnoses c) Medications prescribed and monitoring requirements, d) Physical health conditions and ongoing monitoring and treatment needs e) Recovery focussed healthy lifestyle plans	**Achieved –** The Trust achieved 94.8% against the 90% target.
Mental Health Tariff – Care Packages and Programme of Audit	Provide training to 90% of pilot staff on how to share care packages effectively with service users and carers	**Achieved –** Training was provided to a total of 54 (90%) pilot staff
	Develop a Patient Reported Experience Measure (PREM) which can be used with service users and carers to demonstrate sharing of care packages with focus on recovery, personalisation and choice	**Achieved –** A PREM was developed in Q1 and utilised in both phase 1 and phase 2 to gather feedback from service users.
	Develop Care Packages information for service users – leaflets and editable letters	**Achieved –** Care Packages information, including editable letters and leaflets, were developed in Q1 and piloted in both phase1 and phase 2. Care Packages information has been revised based on service user feedback and final copies have been implemented.
	Review the new Trust ECR functionality and	**Achieved –**

	provide recommendations for configuration to support care packages, care planning and recording activities	The ECR functionality was reviewed throughout the pilot and configuration change requests recommended based on staff feedback including care planning and diary activities.
	Develop plan for further implementation of care packages Trust wide	**Achieved –** A plan was developed for further implementation of care packages Trust wide including the potential to combine care packages training with care planning and clustering training.
Medicines and Physical Health Reconciliation at CPA review and discharge and medicines compliance in the community	Implement process for contacting service users 5 days after inpatient discharge to ensure medicines compliance and that the service user has all the necessary details required and understands all the information.	**Achieved –** A total of 15 service users were interviewed and their feedback collated and recommendations provided.
	Develop Standard Operating Policy	**Achieved –** A Standard Operating Policy was developed in Q2 based on audit findings from Q1.
	Produce Assistance Tool and supporting materials for staff, to provide them with the necessary skills to carry out the Medicines and Physical Health Reconciliation	**Achieved –** An assistance tool was produced in Q2 along with guidance for staff on how to utilise the tool.
	Provide training sessions to clinical staff across the Trust in Medicines and Physical Health Reconciliation at CPA review and discharge	**Achieved –** In total 233 care coordinators completed the Medicines and Physical Health Reconciliation Training facilitated by the Trust pharmacy.
CAMHS You're Welcome	Self-assessment against the 'You're Welcome' Quality Criteria for Young People Friendly Health Services	**Achieved –** The self –assessment against the 'You're Welcome' Quality Criteria was completed in May 2015.
	Develop and produce publicity and information materials (posters, flyers, screen saver,	**Achieved –** Information and publicity

	information sheets etc.)	materials were developed and coproduced in Q2 and are available in a variety of languages and formats
	90% of all appropriate CAMHS staff to have completed 'You're Welcome' training package	**Achieved –** 92% of all appropriate CAMHS staff completed the 'You're Welcome' training package by the end of Q2.
	'You're Welcome' event	**Achieved –** The 'You're Welcome' Launch Event was held in Wimbledon in December 2015 and included workshops for young people and for teachers.
	Audit of 17 year old service users to establish potential commissioning gaps when these service users make the transition to Adult services	**Achieved –** An audit tool was developed by the Trust 'You're Welcome' Steering Group and an audit conducted in Q3 to establish potential gaps in the Trust Transition Procedure.
	Co-produce a system/process to ensure that young people are regularly involved in monitoring and evaluating patient experience.	**Achieved –** A process was co-produced with young service users to ensure young people are regularly involved in monitoring and evaluating patient experience in Q3 and implemented in Q4.
	Refresh Trust transition procedure (from CAMHS to Adult mental health services)	**Achieved –** The Trust Transition Procedure was refreshed.

3.2 Looking back - progress against the core quality indicators 2015/16

The table on the following pages details the Trust's performance against the core set of indicators for 2015/16. All Trusts are required to report against these indicators using a standardised statement set out in the Quality Account regulations. Some of the indicators are not relevant to all Trusts, and we have therefore only included indicators that are relevant to the services that the Trust provides.

Data has been sourced from both the Health and Social Centre Information Centre (HSCIC) and from the Trust internal data warehouse system.

Indicator	April 15 – Jan 16	April 15 – Feb 16	Apr 15 – Mar-16	National Average	Other Trusts – Highest	Other Trusts – Lowest
13. The data made available to the Trust by the Health and Social Care Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	96.0%	96.0%	95.8%	97.2%	100%	80%

Comments:
South West London & St George's MH NHS Trust considers that this data is as described for the following reasons.

Year to date the Trust is compliant with the Monitor target of 95%. The Trust performance is just below national benchmark recorded for quarter four on HSCIC 2015/16 community team report.

The Trust closely scrutinises performance on seven day follow ups which can be either face to face or by telephone, and the Trust has robust monitoring systems in place to ensure target compliance is maintained.

The trust has taken the following actions to improve this percentage and so the quality of its services, by;

Ensuring that systems and regular reviews are completed. This is measured on the Trust Performance Report. This is an important aspect of recovery management of which the Trust seeks ongoing improvement. In addition performance across the organisation is subject to scrutiny at the monthly Directorate Performance Review Meeting which is chaired by the Chief Operating Officer for the Trust. Directors are held to account and actions agreed to maintain and improve on current achievements.

Indicator	April 15 – Jan 16	April 15 – Feb 16	Apr 15 – Mar 16	National Average	Highest	Lowest
17. The data made available to the Trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	99%	99%	99%	98.2%	100%	84.3%

Comments:
South West London & St George's MH NHS Trust considers that this data is as described for the following reasons.

The Trust's Crisis and Home Treatment Teams have performed well against the Monitor Gatekeeping target of 95%. YTD position was 99% just above national benchmark.

It is important to note that where Mental Health Act Assessments have taken place with section 12 doctors and Approved Mental Health Professionals (AMHP) this is the equivalent of a gate-keeping assessment.

The trust has taken the following actions to improve this percentage and so the quality of its services, by;

Ensuring that this key indicator is subject to monthly scrutiny at the monthly Directorate Performance Review.

Indicator		Feb-16	Mar-16	National Average	Other Trusts – Highest	Other Trusts – Lowest
19. The data made available to the Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged:- (i) 0 to 15; and (ii) 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	% patients aged 0 to 15	0%	0%	No England Benchmark recorded *To note:* 7.81% Greater London LA's	6.53% (Mental Health provider only)	0% (Mental Health provider only)
	% patients aged 16 or over	5%	5%	11.45%	14.18% (Mental Health provider only)	0% (Mental Health provider only)

Comments:
South West London & St George's MH NHS Trust considers that this data is as described for the following reasons.

We have ensured that records of re-admission are maintained accurately.

The trust has taken the following actions to improve this percentage and so the quality of its services, by;

Ongoing monitoring of patients re-admitted within 28 days of discharge.

Indicator	2015 - 2016	National Average	Other Trusts – Highest	Other Trusts – Lowest
21. The data made available to the Trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	2015/16 Q1: 62% 2015/16 Q2: 64% 2015/16 Q4: 64% **2015/16 Average: 63%**	Data to be published 26th May 2016	Data to be published 26th May 2016	Data to be published 26th May 2016

Comments:

South West London & St George's MH NHS Trust considers that this data is as described for the following reasons.

The Staff Friends and Family Test is undertaken on behalf of the Trust by *Picker Europe* in line with NHS England guidance. All staff employed by the Trust are offered the opportunity to complete the Test, which is supported by an internal communications campaign.

(The Staff Friends and Family Test is not undertaken in Q3 as the National Staff Survey takes place during that time)

The trust has taken the following actions to improve this percentage and so the quality of its services, by;

Evidence shows that staff who feel engaged and valued within their workplace provide better quality care. The Trust's Staff Friends and Family test scores have shown a slight improvement over 2015/16, which is also reflected in the annual Listening into Action (LiA) Pulse check results for the Trust. Through LiA, the Trust will engage with staff to identify the key issues arising from their experience of working in the Trust and support local directorates to collaboratively agree actions to address these. This work will also be monitored within Directorate Performance Reviews.

On a Trust wide basis, LiA will oversee and co-ordinate actions and initiatives designed to improve the experience and retention of all our staff, and to enable staff to implement changes that directly impact the experience of our patients and quality of care. This work will take place in parallel with the Trust's Quality Improvement work, which will also improve the quality of care provided.

Indicator	2015 - 2016	National Average	Other Trusts – Highest	Other Trusts – Lowest
22. The data made available to the Trust by the Health and Social Care Information Centre with regard to 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.	73%	68.90%	74%	62%

Comments:
South West London & St George's MH NHS Trust considers that this data is as described for the following reasons.

The results of the CQC Community Mental Health Survey have been discussed at a corporate level in:

- Chief Inspector of Hospital (CIH) preparation days for community teams
- Service user experience group
- Integrated Governance Group
- Leadership conference
- Quality and Safety Assurance Committee (Sub-Committee of the Board)

The trust has taken the following actions to improve this percentage and so the quality of its services, by;

Disseminating results across the organisation and respective boroughs are working to improve the experience of care. Service user experience is central to the outcomes of the Community Transformation Programme and a refreshed service user experience action plan is currently being developed through the Service User Experience Group.

Indicator				
25. The data made available to the Trust by the Health and Social Care Information Centre with regard to the number and, where available, 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				
NRLS Data	SWLSTG **April 15 –Sept 15**	Ave for Mental Health Trusts **April 15 –Sept 15**	Highest Trust % (all regions) **April 15 –Sept 15**	Lowest Trust % (all regions) **April 15 – Sept 15**
Reported Incidents per 1000 bed days	36.56	38.62	80.78	6.46
Percentage of Incidents resulting in Severe Harm	0.60%	0.30%	2.5%	0.10%
Percentage of Incidents reported as deaths	0.30%	0.70%	3.2%	0.0%

NRLS Data	SWLSTG **April 15 –Sept 15**	Ave for Mental Health Trusts **April 15 –Sept 15**	Highest Trust % (LONDON regions) **April 15 –Sept 15**	Lowest Trust % (LONDON regions) **April 15 – Sept 15**
Reported Incidents per 1000 bed days	36.56	31.15	53.76	6.46
Percentage of Incidents resulting in Severe Harm	0.60%	0.40%	0.9%	0.1%
Percentage of Incidents reported as deaths	0.30%	0.60%	2.2%	0.2%

Comments:
South West London & St George's MH NHS Trust considers that this data is as described for the following reasons.

- Reporting of incidents in the Trust has improved
- The Trust has routinely uploaded Patient Safety Incidents to the NRLS as required
- Reporting is continuously encouraged in both community teams and inpatient wards

The trust has taken the following actions to improve this percentage and so the quality of its services, by;

The Trust has established Patient Safety Incidents as a Key Performance Indicator. In 2015/16 this target was reviewed and increased to encourage more reporting with the aim to be within the top 25% of reporting Trusts. The Trust continues to work with the provider Ulysses Safeguard to maintain and update the system in line with national requirements. Staff are continuously encouraged to report incidents and try to ensure staff feel supported in doing so through de-brief sessions, training and updated policy.

3.3 Compliments 2015/16

The Trust has received and reviewed over 1,300 compliments over the past year via letters, emails, cards and Real Time Feedback kiosks, tablets and online on the Trust's wards. Examples include the following:

- *'I feel that you have listened to me and that is all I wanted'*
- *'Thank you so much for helping me. I know I was asking for a lot of information, you haven't made me feel as though I am keeping you from other work'*
- *'thanks – that's brilliant service'*
- *'many thanks for picking this up immediately after our conversation and to all who have subsequently helped to resolve this'*
- *'to say I am grateful to you both is to grossly understate my appreciation of your assistance with my request.'*
- *'thank you most kindly for your invaluable help on this matter I am extremely grateful to you'*
- *'I appreciate you listening and talking to me today'*
- *'I would like to thank you and everyone involved for your robust investigation and response to our complaint'.*
- *'Thank you for your reply and being so helpful in this matter'*

Merton Home Treatment Team

"'A big thanks to the Home Treatment Team for their so supportive [sic]. I will forever be grateful for this lovely team 'cos their support kept me alive and looking forward for the positive side of life. Thank you all'

Lilacs Ward

'Thank you for being so wonderful. Hearing your voice and laugh at the start of all your shifts was like pure sunshine, always making me smile. You've always had the natural ability to bring me out of my shell, you never had to try. You've given me confidence to hold a conversation without being self-conscious or feeling as though my opinions aren't valid. I've loved every minute of the time I've spent around you, talking and laughing. Thank you for listening to me when I needed to talk. thank you for the hugs filled with warmth and love. I've never forgot what you've done for me.'

Wandsworth Home Treatment Team

'I just want thank you so much for encouraging and helping me. Little things make things easier and care has touched my heart. I feel much better.'

Jupiter Ward

'I have been on the ward for approximately 5 weeks. I have found my time on the ward to be quite relaxed, the atmosphere on the ward is mostly peaceful, when patients are having difficulties coping the staff are always first on hand to assist with any incidence that occurs, which alleviates tension and undue pressures to other patients. The staff have excellent communication skills, they are flexible but also firm when needed. It's very friendly atmosphere I have to say that Jupiter ward has to be the best ward within Springfield. I have no critical things to say of my observations other than well done to all staff members for an excellent caring role each of play in turning Jupiter ward into the best ward for patients to come and find respite and inner strength and peace, care is what all of us patients want a warm smile a caring nature a kind heart a firm hand when urgently needed in a crisis is what makes us all safe…..'

Kingston Older People's Community Mental Health Team

'May I commend the service provided by the Psychiatry Department at Tolworth Hospital, my wife (patient name) being the patient, accompanied by myself as carer…….the level of care was both professional and sympathetic to the needs of my wife. My wife has been recently discharged from the service and on leaving was given positive advice to carry her forward.'

3.4 Safeguarding

Safeguarding – Adults and Children

The learning from the safeguarding adult element of the Quality Accounts in 2013/14 and 2014/15 helped the Trust develop practise in line with the requirements of the Local Government Association national programme 'Making Safeguarding Personal' (MSP) and Care Act Statutory Guidance (DH 2014).

Making Safeguarding Personal

Making Safeguarding Personal guidance promoted a shift in culture and practice in safeguarding practices. It asked for services to engage the adult at risk of abuse in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. In 2015/16 the Trust Safeguarding Lead and the Sutton and Merton Service User Reference Group initiated Making Safeguarding Personal co-production meetings to make safeguarding services more personal, responsive and effective for the people who use Trust services and their carers. This project formed the template for the application of Making Safeguarding Personal principles Trust-wide.

The Making Safeguarding Personal Group met monthly, and meetings were chaired by Sutton 1 in 4 Network under the Sutton User Involvement and Co-production Framework and the Trust Service User and Carer Involvement policy.

The Making Safeguarding Personal Group formulated a number of recommendations for safeguarding service delivery, including the development of publicity materials, staff training, and the education of service users and carers about safeguarding. This included developing a programme for service users and carers within the Recovery College.

There were also recommendations about the prevention of abuse and neglect, and seeking service user representation at Safeguarding Adult Board meetings. The Trust's Safeguarding Adults Quality and Compliance Group (SAQG) oversees the co-produced Making Safeguarding Personal Group action plan development and implementation.

The Patient Quality Forum will receive reports on progress of Making Safeguarding Personal action plan to provide additional service user-led scrutiny of our progress.

Looking back - safeguarding vulnerable children 2015/16

During 2015/16, the Trust further developed the quarterly data provided to the 5 Local Safeguarding Children's Boards. Key developments for 2015/16 are outlined below:

- **Improved attendance at and contributions to Child Protection conferences, reviews and core group meetings.**

  The Trust requested from all LSCBs that non-attendance, without an apology and a report being submitted, following an invitation to attend was to be reported to the trust Named Nurse for Safeguarding Children. This would be followed up directly with the team and practitioner concerned.

- **Further develop safeguarding children data to include improved electronic access to the number of children across the Trust who are subject to a Child Protection Plan.**

  As part of the CAMHS Transformation, the Trust moved from the RiO electronic records system to the IAPTus system. This delayed the migration of this added detail which was being developed for 2015.

- **Develop, with partners, a more consistent understanding of safeguarding and risk issues across the partner agencies. Improve communication by better understanding of the role of agencies and the language used by agencies**

  One of the significant findings from the national reviews of SCRs, was the level of parental mental illness. This was in the region of 65% of all SCRs and although not a causal factor it was an important risk factor. The Trust developed and jointly facilitated multi-agency training on the Impact of Parental Mental Illness on Children. This was been positively received in the 3 boroughs where it continues to be delivered and the feedback has been that this has supported multi-agency staff to better understand mental health, referral and escalation processes and the implications of the Mental Health Act.

- **Improve the understanding of emotional and psychological well-being among children and young people. Contribute to multi-agency school based awareness raising of emotional and psychological well-being.**
  This was a challenge that was primarily developed in Wandsworth where the majority of the Trust acute services are based. This is an area that the Trust would like to develop further in Sutton with Children's Social Care and other agencies, particularly education.

- **Contribute to the development of regular multi-agency audits and shared learning.**
  The Trust contributed to multi-agency audits across the 5 LSCBs. This included focus on parents who are known to mental health services and have responsibility for children. Given the Trust commitment to these multi-agency audits, the scope of the Trust single agency audits was less developed. The Trust agreed that it would share learning from audits in other boroughs with each LSCB audit/QA group.

- From October 2015, the Trust provided details of reporting regarding female genital mutilation (FGM).

- The Safeguarding Children's policy was reviewed, amended and ratified in February 2016. The policy has included details of managing child sexual exploitation (CSE) and FGM.

The Trust has reviewed access to Safeguarding Children Mandatory Level 3 training and is in discussions with an external organisation to provide this training.

Challenges and priorities for 2016/17

1. Ongoing and improved Trust attendance at local multi agency safeguarding children training and learning events.
2. Further develop training on the impacts of parental mental health on children across all 5 LSCBs.
3. Develop a multi-agency task and finish group to develop a shared multi agency risk assessment matrix.

3.5 Looking Back – service improvements

Urgent Care Pathway - like many trusts across the country, the Trust has seen a significant increase in pressure for inpatient beds. We have had to both expand the number of local beds and purchase beds externally to ensure patients can access inpatient services when required, but are planning a range of preventative services within an Urgent Care Pathway that will better support people in the community and thus reduce the demand on inpatient beds. We hope to develop these proposals in 2016/2017 in partnership with our Clinical Commissioning Groups and third sector partners:

- **Psychiatric Decision Unit** – a 24/7 unit where people with mental health needs in crisis can be safely assessed and supported over a 24-hour period as to whether they actually need an inpatient bed, or can agree what support they require in the community.
- **Out-of-hours services** – we have reviewed our current out-of-hours services to ensure a better coordinated response to crisis and emergencies.
- **Crisis House** – we hope to develop a crisis house as a valid community based alternative to admission.
- **Crisis Cafes** – we hope to work with Clinical Commissioning Groups and third sector partners to develop crisis cafes where people can access enhanced support from peers or services in the evenings and weekends.

Street Triage schemes in Wandsworth and Richmond – Psychiatric nurses have been working with police to better identify and manage mental health presentations in the community. This joint working has helped to reduce inappropriate referrals to Section 136 suite by 30% in Wandsworth and Richmond. Following Clinical Commissioning Groups agreement, we hope to roll out similar schemes in Kingston and Sutton in 2016/2017.

Sutton Uplift – the Trust and Imagine created a successful partnership to win the tender to provide Improving Access to Psychological Therapies and Mental Wellbeing services in Sutton.

Sutton Inspire – the Trust has been successful in the tender to provide drug and alcohol services in Sutton within a wider partnership with Cranston Project and Community Drug Services for South London.

Kingston and Richmond Assessment Service – Adult Community Mental Health referrals have been remodelled in Kingston and Richmond and all referrals now go to a single point of access. This

has had the positive effect of much reduced waiting times for patients being seen. This system already operates in Sutton and Merton, and we hope to roll this out in Wandsworth in 2016/2017.

3.6 Recruitment and retention

Like all NHS Trusts we have experienced difficulties in recruiting and retaining some of our staff which has resulted in high dependency on agency staff, particularly for nurses. We have reviewed our recruitment processes, and have worked very hard to make the Trust more attractive for potential applicants, reduce bureaucracy and time taken to recruit staff and reduced overall vacancy rates from 22% to 18% over the last 6 months of 2015/2016.

As a result, in January 2016 the Trust launched a major recruitment campaign to target difficult to recruit staff groups including:

- Community Nurse Practitioners Band 6
- Home Treatment Team Band 6
- Inpatient Registered Mental Health Nurses Band 5
- Bank Registered Mental Health Nurses Band 5
- Community Team Leader Band 7

As part of the campaign, the Trust has completely redesigned the nurse recruitment process. We now hold assessment centres three times per week and all candidates are contacted within one week of application.

The Trust has also successfully trained 14 nursing and HR staff in the use of Thomas International Personal Profile Assessment which are psychometric evaluations to assist the recruitment of quality staff. This will support and encourage a workforce that supports our Trust ethos and values. The recruitment team will be using this tool as an ongoing component of our selection process.

The Trust has also contracted OMNI Recruitment to assess our service and make recommendations on making our internal recruitment service more commercial.

3.7 Looking back - evaluation of current practice against the findings of the Francis Inquiry and Winterbourne Review 2015/16

Following the publication of the Mid-Staffordshire NHS Foundation Trust Public Inquiry in 2013, the Trust conducted a baseline evaluation determining the current practice at South West London and St George's Mental Health NHS Trust against the recommendations from the Winterbourne View Report and the Francis Inquiry and from the findings developed an action plan to address areas of concern.

Actions:

1. Develop a plan to maximise nurse's experience and professional development by rotating staff between different areas.
2. Develop a Continuing Professional Development portfolio for registered nurses to complete as evidence towards their NMC annual registration. Pending guidance from the Nursing and Midwifery Council (NMC).
3. A cultural barometer framework has been drafted based on the Department of Health's interpretation of the Chief Nursing officer six C's for Mental Health Nurses. A plan to pilot this will be developed.

Progress against actions one and two of the three actions has been encouraging leading to the development and strengthening of nurse training, development and support. The third action, the development of a cultural barometer framework focussing on strengthening and improving transparent measures of the cultural health of front-line nursing workplaces and teams, has been delayed, due to the identified provider not having capacity to deliver the Collective Leadership programme as previously planned.

The Board has commissioned an alternative provider to deliver this, the plans for which will be confirmed in due course.

The learning from both these important reports was recognised in the Trust. In particular, learning from Winterbourne View was used to inform actions and developments, overseen by the Trust's Quality and Safety Assurance Committee.

The Trust's Adult Safeguarding policy has been revised in light of the Care Act 2014, 'Making Safeguarding Personal' guidance and the new Pan-London policy and procedures.

The Trust's Monthly Learning Forum ensures that appropriate structures and support processes are in place to help develop the Trust as a learning

organisation, as well as encouraging open and transparent practices.

The Trust's Monthly Learning Forum aims to:

- identify learning through the review of data and information from patient experience, claims, inquests, serious incidents and safeguarding adult reviews;
- promote and maintain quality improvement in safety, clinical effectiveness and patient experience.
- receive assurance from directorates of learning through completion of actions/recommendations and monitor for completeness by exception.

For example:

How to escalate clinical risk (safeguarding)

Following the learning identified in a Serious Case Review, it is recommended that directorates map their local risk escalation processes.

For example - risk may be escalated from CPA, safeguarding or multi-disciplinary meeting to a Care Pathway meeting, and if needed, then escalated to a Virtual Risk Team meeting; with further escalation to a Multi-agency Risk Panels (e.g. VARMM, MARAC, CMARAP etc.) if risk remains.

In February 2015, the Secretary of State for Health published an independent report – "Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile" written by Kate Lampard. The report summarises the findings of the NHS Savile investigations into allegations of abuse by Savile at a number of NHS hospital sites, and identifies themes and lessons to be drawn by the NHS as a whole.

The Trust's progress against the recommendations within the report are monitored, audited and updated and are included in the Corporate Clinical Audit Programme for monitoring.

During 2015/16 the Ulysses Electronic Incident Report system was further developed to generate better reports to show how many incidents have been reported, where they happened, who was affected and how they were managed. The management of all cases can now be overseen centrally and be more easily subjected to audit, to make sure policy and good practice is being followed. This means that when abuse or neglect does occur, the Trust can assure itself that all actions required were taken in a timely way.

- Total number of Safeguarding Adults incidents reported in 2015 - 2016: 675
- Number of Safeguarding Adult Reviews (Formerly Serious Case Review): 1


South West London and St.George's
NHS
JOSEPH MUKUBA
STAFF NURSE
KEITH DESMOND
South West London & St George's
NHS
KEITH DESMOND

3.8 Complaints 2015/16

We take all our complaints very seriously and consider them to be a valuable feedback mechanism. Listening carefully to the concerns, we endeavour to everything possible to resolve them and respond to complainants. We aim to learn from what has happened and make demonstrable improvements to the service where appropriate.

During 2015/16 the Trust continued to embed the Patient Experience Team that was established in 2013/14. This marked a change in the way complaints were handled in that the team is managerially separate to the directorates and work in a corporate context, investigations are independent to the clinical services where care is provided, the team are able to challenge information received during the course of the investigation and reach conclusions that are objective and impartial. This is not a replacement to an externally independent investigation from outside the Trust but represents a positive non-partisan approach. Clinical advice is also sought by the team about practice and learning issues from a clinician within the team.

The Patient Experience Team continues with its quality review structure in place to ensure that complaint responses cover all points raised, are clinically appropriate and resolves the complaint as far as possible.

Communication with complainants during the complaints process has been a key feature this year as has led to the introduction of a local performance indicator within the Patient Experience Team to contact or attempt to contact complainants within 7 days in at least 75% of cases and that this be monitored. The indicator was in response to service user feedback at the Service User Experience Group who wanted assurance that contact was being made. This is in addition to the Trust's 2 other Key Performance Indicators:

- 75% of written responses sent to the complainant within 25 working days; and
- 75% of all complaints acknowledged with 3 days.

Both have been achieved this year, save for March 2016, relating to the 25 working day indicator.

The Patient Experience Team continued to receive positive feedback this year, particularly around their listening skills. The Team was shortlisted for two national awards at the Patient Experience National Network Awards (PENNA) 2015 for 'Team of the Year' and 'Turning It Around When It Goes Wrong' The team was voted 'Finalist' in the first category and 'Runner Up' in the second category.

During the year we received 504 complaints, which is an increase from the previous year figure of 421. We continue to improve the quality of resolution and our responses to complainants and, of the 504 complaints received in the year, five cases were referred to the Ombudsman for independent review. Two cases remain open and three referrals (which were from one complainant) were not upheld by the Ombudsman which commented positively in their findings about the care that the patient received, the frequency of their reviews and the level of recording.

In terms of upheld complaint themes, communication remains a key theme and examples of experiences of poor communication expressed through complaints were reported to the Board in November 2015. It was reported that developing good customer service skills for staff was a response to this theme and includes the way front-line staff use their communication skills positively to engage with those whom they come into contact with. It explained that customer service training is being developed in the Trust to be rolled out on a continuing basis by the Training and Development department and introduces positive customer care behaviour principles.

Embedding a positive culture with staff and engaging with staff to ensure they feel valued and listened to and empowered to speak at these conversations is helping to embed a culture of openness and good communication. Good communication between and across staff groups can be translated into positive interactions in daily working life with front-line staff, patients, carers and families.

Listening in Action (LiA) is a programme which places staff at the centre of decision making in the Trust and empowers staff to make changes to the way they work to improve the quality of the care we provide. There has been a series of 'conversations' with staff led by the Chief Executive that look at our values and this was the subject of the Trust's Leadership Conference in January 2016 with a view to rolling out new values and behaviours.

After a review of the most common complaints there has been the development of 10 things that we will ask staff to commit to. This includes always returning calls, providing your name and title when asked, etc. This is currently being prepared by the Communications Team for roll out to staff.

A Complaints Annual Report will be prepared in accordance with Regulation 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulation 2009.

3.9 Serious incidents 2015/16

Serious incidents involving suicide is one of the most difficult situations we manage due to the impact on the families and community. We seek a collaborative approach and work closely in undertaking reviews and investigations. Throughout 2015/16 we have managed a number of serious incidents. There has been one incident investigated that did not meet the 60-day deadline. This was in part due to complexities of the case and requirement for an external review. The Trust continued the trend of meeting the KPI relating to the quality of reports submitted to Kingston Clinical Commissioning Group.

The Trust worked collaboratively with Kingston Clinical Commissioning Group in maintaining an open approach to managing incidents. From January 2016 the South East Commissioning Support Unit (SECSU) took over responsibility of managing the Serious Incident process, the Trust aims to continue to work openly and transparently.

April to March 2015/16 there have been 52 incidents added to STEIS, of which 3 incidents were de-escalated. The Trust has embraced the new National Framework and assesses each incident to add to STEIS. The Trust is not an outlier in the number of Serious Incidents reported in the year when compared to other mental health trusts.

The Trust has made significant improvement in incident reporting in terms of patient safety incidents reported to the National Reporting Learning System (NRLS). The Trust is currently an average reporter when benchmarked against the cluster and at the last publication of data (April – September 2015) the Trust reported 2,235 incidents which was 36.35 patient safety incidents per 1000 bed days. This was an increase on the previous period (October to March 2015) the Trust reported 27.34 patient safety incidents per 1000 bed days.

In 2015/16, South West London and St George's Mental Health NHS Trust continued to strive to embed learning across the Trust. A review on how learning is shared across the Trust was undertaken with staff requesting more up to date forums for doing this such as podcasts and video's rather than attending events. It was felt this method will capture a wider audience and further interaction is planned in the form of a chat room to share experiences. A number of risk alerts have been circulated including those received through cross-Trust learning.

Trust wide actions arising from incidents, safeguarding cases and complaints continue to be monitored by the Monthly Learning Group. The Trust structures ensure that local actions are monitored at

the Directorate Clinical Governance Groups.

The top 3 reported categories for 2015/16 were Suspected Suicide (9) and Attempted Suicide (9), Unexpected death (8).

There were 2 reported homicides in 2015/16.

There were no reported Never Events.

3.10 Real Time Feedback

The Trust in continued using Real Time Feedback (RTF) throughout 2015/16 and it has been accessed widely in both community and in-patient services. In Quarter 4 of 2015/16 there were 7,800 items of feedback received. Feedback comments are all triaged and comments flagged for action by the Patient Experience Team if they not already been addressed by the service area. As a result of this it has been reassuring to see the evidence when clinical areas are highly responsive while others have shown improvement over the year. Clinical and Service Directors, along with the Executive are provided with an update on trends and issues raised. Real time feedback supports the 'You Said - We Did' boards that display feedback from service-users providing wider awareness of what has been raised and what has changed as a result.

3.11 What else have we done?

- The Trust has met the contractual requirements under the Duty of Candour and implemented Regulation 20 effective from November 2014.
- Updated and reviewed all Trust-wide clinical policies taking into account the new National Framework and compliance with NICE guidance.
- Produced a quarterly report on themes and learning.
- Review incidents on a daily basis to provide support to staff and encourage a proactive approach to risk management.
- A review was undertaken following the Southern Healthcare Trust investigation that provided assurance to the Board that systems and process imbedded are sufficiently robust.

Part 4: How we developed our Quality Account

This is the sixth year that NHS trusts have reported formally on the quality of their services. Much of this report is set out to meet legal requirements. However, we also report on our priorities for improvement which have been agreed in partnership with clinicians, service users and carers.

Our aim has been to produce a true and fair representation of our services, including information that is meaningful, relevant and understandable to our service users, their carers and the public.

Throughout the year, we have had ongoing engagement with service users and carers across the Trust via our existing Patient Quality Forum. Each service informs their quality improvement activities by gathering service user and carer feedback from a variety of mechanisms: Patient Experience team (incorporating PALS), compliments and complaints, annual surveys, real-time surveys, service user and carer representation on Trust groups, focus groups and at special events.

We have continued to develop the use of the recovery approach with resources and trained peer mentors offering support and we have also engaged across the organisation with our staff and clinicians through the Listening into Action (LiA) programme and events.

The Trust is also grateful to our service users, carers, staff and stakeholders who commented and contributed to this document.

External assurances and comments

We provided a draft of this Quality Account to our five local Clinical Commissioning Groups, NHS England, five London Boroughs of Wandsworth, Sutton, Merton, Kingston and Richmond, all five local authority Health Overview and Scrutiny Committees and local Healthwatch groups and invited them to review the document and provide us with comments. In the time available we have responded to these comments, wherever possible by adding information or making appropriate amendments while producing our final document. The Trust is grateful to all of the above organisations for helping to verify the content and for their suggestions for improving this document.

The verbatim comments received from the above organisations are available in full further in this Quality Account. A downloadable version of our Quality Account is available on our website **http://www.swlstg.nhs.uk**.

Concluding comments

We very much hope that the information contained within this document is useful and meaningful, reinforcing the fact that providing high quality and safe services is our highest priority and at the heart of all that we do. *We welcome feedback from a variety of stakeholders and the final report will be influenced by responses to this initial draft.*

We would value your feedback on this document so we can improve next year's Quality Account. You can contact us via the details below. Alternatively, if you would like further information, a hard copy of this document, or have any questions, please contact us.

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South West London and St George's Mental Health NHS Trust
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Comments from Stakeholders

A summary of key changes made to this report as a result of comments provided by our stakeholders are listed as follow:

Healthwatch – Richmond upon Thames:

The Trust accepts that at the time that the draft Quality account was shared with our stakeholders that the layout required further work and this has been addressed in this final version. Additional evidence has also been provided to demonstrate the Targets achieved by the Trust (at the time of the consultation unfortunately this data was not all available).
Other changes in response to comments include:

- Trust data relating to Performance targets and CQUIN targets have since been added.
- Comparative data regarding the Community survey has also been added and is included as part of the statutory indicators reported.
- NRLS data report is reported on Page 50 and is also included as part of the statutory indicators this also reflects on the increase in incidents reported.
- Examples of lessons learnt from Serious incidents are highlighted on pages 58 and 61

Richmond upon Thames Scrutiny committee

As above the style and completeness of report has been addressed since the report was originally issued for stakeholder feedback.

- Comparative data for complaints is provided from the previous year, however benchmarking data with other Trusts has not been included due to the differences in Trust arrangements and configurations make it difficult to draw any significant conclusions.
- Public health: The Trust has signed up to the National CQUIN which is detailed in the report and can further note that it is developing plans to implement smoke free arrangements.

Healthwatch Wandsworth

As with other comments details in the original consultation draft have been added and layout improved

- The Safeguarding section has been moved to reflect the comments made.
- Section 1.9 was revised to reflect the comments made.
- Detailed information on Quality account priorities and CQUIN have been updated.
- The request for public reporting of progress against our priorities is accepted and the Trust is committed to reporting these in public documents.
- A section on real time feedback has been expanded upon in 3.10.

Clinical Commissioning Group Commissioner Quality Account Feedback (*Note: final version awaited)*

Merton (MCCG) took over from Kingston (KCCG) as the lead CCG for Mental Health Commissioning in South West London on the 1st October 2015. The CCG acts on behalf of Kingston, Sutton, Richmond and Wandsworth CCGs in this role. We thank the Trust for the opportunity to comment on the 2014/15 Quality Account and for seeking the views of the CCGs in its development. We have worked closely with the Trust during the year to seek assurance of the quality of the services it provides and have appreciated the open and frank discussions that we have been able to have at the CQRG and in other fora.

Merton, Kingston, Sutton, Richmond and Wandsworth have been involved in reviewing the content of this Quality Account, ensuring that it reflects accurately the quality, safety and effectiveness of services provided. It is noted that the Trust was also voted best in London for overall patient experience; this is a positive endorsement particularly in circumstances where demands on services are challenging. The CCG's are reassured that SWLStG has also consulted with patient and public groups, staff and statutory bodies and has taken into account their opinions. The report provides the requested breakdown of safety, patient experience and performance data by localities and against the patient safety and experience sections, contracting CCG's can confirm that the information provided is an accurate reflection of performance throughout 2015/16.

The Trust has responded to our challenges quickly and clearly when we have sought further clarification or have expressed concerns. During the past year we have monitored the further development and implementation of the Trust's Quality Strategy. The Trust was subject to a comprehensive and intensive inspection by the Chief Inspector of Hospital's inspection team from the Care Quality Commission on the 14th to the 18th March 2016 and while the verbal feedback was described as positive the Commissioners await the published report with interest. Feedback from the inspection team reflects Commissioner concern that an area requiring improvement is adult community services; the use of agency and/or temporary staff has been a focus of debate at the CQRG. We note that the Care Quality Commission Lead Inspector expects to host the Quality Summit toward the end of July once the report has been published and Commissioners welcome the invitation to participate.

The Commissioners are alert to the Trust's need to maintain improvement regarding physical health care checks and patients healthcare generally, from initiation of treatment and regular planned annual review or when physical healthcare needs change and interface with Primary Care.

Safeguarding practice is improving and Commissioners note that identification of safeguarding concerns and risk posed is understood and shared with partner agencies and communicated effectively by establishing clarity of approach and utilisation of a common language. Nevertheless; in a number of serious incidents recently reviewed safeguarding knowledge and practice by frontline staff requires development and note the documented Trust challenges and priorities for 2016/17 in this respect.

Commissioners support the Trust's commitment to improving the experience of all their staff and commend the Trust's appointment of a full time Equality and Diversity lead and notes that the Board approved an as Equality and Diversity Strategy, the implementation of which will be overseen by the Trust's Chair.

Commissioners commend the Trust quality priorities for 2016/17 as detailed:

- **Priority 1: Reduce level of serious self-harm and suicide**
- **Priority 2: Reduce degree of Violence – Patient on Patient**
- **Priority 3: Reduce degree of Violence – Patient on Staff / Staff on patient**
- **Priority 4: Improving the identification of service users with mental health issues who have a diagnosis of autistic spectrum disorder within local mainstream services**
- **Priority 5: Gaps identified by the year-end report will be used to inform the focus for Year 2 of this two year action plan to improve quality of coordinated discharge.**

The priorities identified are reflective of the five quality domains and Commissioners look forward to supporting and working with the Trust to achieve positive change, service development and improved patient, carer and staff experience. The priorities and performance illustrated within the account for this year and last year accurately reflect and support both national and local priorities. Merton, Kingston, Sutton, Richmond and Wandsworth Clinical Commissioning Groups are pleased to endorse and support the publication of this account.

healthwatch Sutton

Healthwatch Sutton has not carried out any pieces of work that relate directly to the services provided by South West London and St George's Mental Health NHS Trust in the year 2015/16. As such, we are unable with any certainty, to agree that the priorities identify reflect the needs of the people of Sutton.

However, Healthwatch Sutton has welcomed the opportunity to have a dialogue with senior Trust staff through the regular South West London Healthwatch meetings set up during 2015/16 that enable all five South West London Healthwatch organisations to share feedback and hear about changes at the Trust.

In addition, Healthwatch Sutton is in the process of carrying out two projects that could result in recommendations for changes or improvements to mental health services for Sutton residents. The first project is our investigation in to the experience of people with dementia and their carers. A report is expected in summer 2016. We have also produced a film showing young people's views about 'body image' and how this impacts on their general mental wellbeing. We are using the film to start conversations with a larger cohort of young people in Sutton with a view to developing some recommendations.

Healthwatch Sutton looks forward to working more closely with the Trust in coming year.

healthwatch Richmond upon Thames

Healthwatch Richmond welcomes the Quality Account (QA). The narrative is informative and gives a good overview of the Trust's drive towards improvement in quality. It is written in an accessible way. We welcome the Trust acknowledging that although there are many areas of good work, there are also areas that need to be targeted for improvement.

Unfortunately, the layout of the report requires the reader to compare and cross-reference sections to gain a full picture of the account. We also found that there is little supporting evidence within the body of the report to demonstrate what the Trust achieved against its targets.

It is very disappointing that at the time of being asked to comment on the QA, none of the vital data or evidence of performance in relation to the 2015- 2016 priority targets was available. As such, Healthwatch Richmond is unable to make an informed judgement on whether the Trust achieved the goals it set out to achieve or if the priorities going forward are relevant or based on failings in the previous year. Also, there was no information available to us regarding the Trust's performance against its CQUIN targets.

We acknowledge the Trust's honesty regarding the requirement notices and breach in regulations issued by the Care Quality Commission (CQC). The Trust is currently awaiting feedback from the last inspection by the Chief Inspector of Hospital's inspection team from the CQC.

Healthwatch Richmond is pleased to read that within the Community Mental Health Survey by the CQC in October 2015, the Trust was voted best in London for overall patient experience and in the top 20 per cent in the country, in several areas that look at user experience. We have noted that 73 per cent of community patients said they had a good experience while using the mental health community services, but it would have been beneficial to have the previous years data to make a valid comparison.

With mental health services under increasing public scrutiny and high demand, it is reassuring that SWL MHT has redesigned its urgent care pathway and looked at innovative ways of providing support in the community, including the Crisis House and Cafés, Psychiatric Decision Unit and Housing Discharge coordinators.

Healthwatch Richmond is pleased to read that the Trust is taking its *Duty of Candour* very seriously and supports staff to raise concerns. This is particularly welcome due to the vulnerability of some of those accessing the mental health services. The introduction of local guardians at all sites is also very reassuring. We look forward to learning about the success of this initiative.

Healthwatch Richmond is concerned there is little information regarding the serious incidents referred to in the report, despite the Trust stating it has made significant improvement in incident reporting. There is no data regarding patient safety incidents reported to the National Reporting Learning System (NRLS) or level of harm.

There is no comparative data to support the statement that there has been an improvement in incident reporting or to indicate if serious incidents have increased or decreased. There is also no information regarding any lesson learnt from such serious incidents.

We are pleased to see that, going forward, the Trust has pledged a zero tolerance approach to suicide, which is very reassuring considering in 2015-2016 they reported nine 'suspected' suicides and nine attempted suicides. To a

layperson, the term 'suspected suicide' may be confusing. Clearer narrative would resolve issues such as this.

We welcome the challenges and priorities going forward in relation to safeguarding vulnerable adults and children and look forward to reviewing the progress made. Again comparative data would have been beneficial, in order to make a calculated and informed judgment on progress.

We are pleased to see that the Trust has benchmarked itself and evaluated current practice against the findings of the Francis Inquiry and Winterbourne review. It is reassuring that a review was undertaken following the Southern Health NHS Trust investigation, which provided assurance to the Board that systems and processes embedded are sufficiently robust.

We are pleased to learn that the Patient Experience Team received positive feedback this year, particularly for their listening skills. They were shortlisted for two national awards at the Patient Experience National Network Awards (PENNA) 2015 - 'Team of the Year' and 'Turning It Around When It Goes Wrong'. The team was a finalist in the first category and runner up in the second. They are to be commended on this achievement, particularly because the Trust received 504 complaints during the year, compared to 421 in the preceding year. We recognise that this increase may be an indication that patients and carers feel more comfortable making complaints than previously.

Healthwatch Richmond conducted a survey of parents and schools about experience of CAMHS services in 2015 and made some recommendations for improvement. We were pleased that the Trust accepted these suggestions and made efforts to implement changes to take account of the views expressed.

Although the report on the last CQC inspection will be published later in the summer, we want to emphasise the importance of progressing with the range of service improvements outlined in the QA draft report. The provision of Mental Capacity Act training to staff is key to ensuring patient-centred care. The Trust recognises this has been a challenge and has introduced a new e- learning package in addition to face to face training for staff. We welcome MCA leads in place in each directorate to support development and achieve full compliance.

We look forward to reviewing the outcomes of the most recent CQC visit when the report is available. We do however wish to express our disappointment that we have been asked to comment on a draft from which vital information is missing.

Richmond upon Thames' Health Services Scrutiny Committee response to South West London and St George's NHS Trust Quality Accounts

Following on from the meeting held on Thursday 19th May 2016, to discuss South West London and St George's Quality Account, we welcome the opportunity to provide additional input, as the London Borough of Richmond upon Thames (hereinafter 'LBRuT') is determined to champion the interests of its residents by playing a full and positive role in ensuring that the people living and working in the LBRuT have access to the best possible healthcare and enjoy the best possible health.

Whilst we appreciate that the version provided is a draft and the final version is yet to be approved we have a number of points we wish to raise and a number of suggestions we wish to proffer. The panel noted that the style of the report made it difficult to read and understand and some sections in the report i.e. Sections 3.1 and 3.2 in particular were incomplete.

Generally, we were pleased to hear that progress has been made in many quality areas over the past year. The LBRuT particularly noted the Trust's accomplishments in the following areas in 2015/16:

- The Trusts received over 1300 compliments in the period; this is a number which should be commended.
- The Panel was pleased to learn that the Trust had received positive feedback from the Care Quality Commission (CQC) regarding its bed management.

We have a number of points we wish to raise and a number of suggestions we wish to see incorporated in the final version, as we believe that these will further highlight the hard work and commitment which has taken place to improve the quality of services at the South West London and St. George's Mental Health NHS Trust. These are as follows:

- The Trust received 504 complaints, a rise from 421 in 2014/2015. The Trust has not included any benchmarking figures to compare this figure to other Trusts; however this does seem to be a significant increase. We were pleased to note the support provided to care teams in terms of customer care and

communication to addressing main issues of misunderstandings and miscommunications to patients and their families.

- Trust received 6 CQC Requirement Notices during 2015/2016 in the areas of: Patient Safety, Dignity and Respect, Mental Capacity Act, and Clinical Effectiveness. This is a high number, as compared to some other Trusts. The Panel was encouraged to hear this was recognised by the Trust and that measures are in place to learn lessons and improve practice going forward, such as the reduction of self-harm and reducing violence on inpatient wards to keep staff and patients safe.
- During 2015/2016, the Trust participated in a self-assessment safe-guarding audit to review their compliance and appeared before a local Safeguarding Improvement Panel. There were some issues highlighted such as the training levels amongst staff were low. The panel were pleased to hear that that measures have been put in place to review the training needs analysis, provide training at different times and on different sites, and embed training in appraisal mechanisms.
- While the Trust is not an outlier in reporting 59 Serious Incidents, this is still a significantly high number. The Panel welcomed the initiatives taking place within the Trust to address this issue such as supporting staff to report incidents and with police action where necessary. We were pleased to learn that violence is not assumed as being an occupational hazard for staff and taken seriously with training, peer and management support and policies in place. We noted the aspirations of the trust to learn from these incidents and implement improvements from this learning, e.g., staff support and training.
- The panel noted actions to address the recent increase in suicides and work with commissioners to identify common causes or unique factors. The panel welcomed the work taking place to address ligature risks and address challenges of older buildings and support staff.
- The panel noted that there had been a fall in staff survey results, which may correlate with increasing pressure on beds. The panel noted challenges with recruitment and retention, and work to reduce numbers of agency staff.
- The panel would welcome further information on progress on Public Health initiatives such as smoking cessation, promoting physical activity, healthy diet and obesity and reducing excessive alcohol use. We noted that the Trust is not as yet "smoke free" and further work will be taking place on this over the next year. The panel welcomed the Trusts engagement in the national health and well-being CQUIN and hope this will provide a structure to take forward a wider public health approach for staff and patients in line with Simon Steven's

Five Year Forward review and new vision of the NHS. These issues are particularly relevant to mental health patients who are at high risk of engaging in unhealthy behaviours.

- We would also invite the trust to consider engaging in the London Healthy Workplace Charter.
- A greater focus on self-care and self-management in line with Richmond Council and Richmond CCG's Prevention Framework, Better Care Fund, and Better Care Closer to home strategy would be welcomed.
- The Outcomes Based Commissioning (OBC) framework captures in depth the perspective of Richmond patients. Integration between hospital and community services to provide a seamless service around the patient's need is a recurrent theme and we would welcome a commitment to work closely with partners to achieve this.

Conclusion

Our aim is to ensure that your Quality Account reflects the local priorities and concerns voiced by our constituents as our overall concern is for the best outcomes for our residents. Overall, we are happy with the QA, agree with your priorities and feel that it meets the objectives of a QA – to review performance over the previous year, identify areas for improvement, and publish that information, along with a commitment about how those improvements will be made and monitored over the next year.

We hope that our views and the suggestions offered are taken on board and acted upon. We wish to be kept informed of your progress throughout and thereafter.

London Borough of Richmond upon Thames Health Scrutiny Committee

healthwatch Wandsworth

Healthwatch Wandsworth is once again grateful for the opportunity to comment on this annual Quality Account.

We have had occasion in previous years to criticise the layout and general readability of the Trust's Quality Account and we regret having to say the same again this year. We appreciate that the content of the Account is to a great extent externally prescribed and that the presentation has to meet the scrutiny of the Trust's Auditors but we feel more could be done to make the document navigable and intelligible to the general lay reader. Section 1.9 headed "Guidance to help you when reading this document" does little to help in practice. if the opportunity has passed for this year, we would urge the Trust to consider what other ways there might be of publicising key aspects of its quality improvement programme.

For the committed reader the draft QA does include a wealth of information about the Trust's progress and successes, which testify to the commitment to quality improvement at senior corporate level as well as to the commendable efforts of individual staff teams. The draft QA also rightly includes a number of references to areas where further improvement is needed: for example, the finding from 15 Steps visits (p.18) that "some teams had little or no evidence of collaboration with service users, carers and families" is rather disturbing given the Trust's public commitment to and ongoing work on the Triangle of Care; and the brief description on p. 23 of priorities for improvement following the Trust's participation in the 2014 National Clinical Audit of Schizophrenia suggests that this particular action plan may deserve greater prominence. Clearly the process of quality improvement is an unending one and all concerned need every encouragement to keep the momentum going.

We are unable to comment on performance against the Quality Account priorities and CQUINs in 2015/6 as the detailed information on this has not yet been provided in the draft QA. We look forward to seeing this important element in the story once the final document is published.

We welcome the 5 Priorities for improvement to be set for 2016/7. The first three Priorities, relating to the reduction of self-harm and violence (including signing up to the NHS England safety pledge), are clear, measurable and challenging. If achieved, they are likely to make a significant contribution to the improvement of service quality. The process of trying to achieve them is likely to be beneficial in itself over time. Having set these priorities in the Quality Account a clear baseline position will presumably need to be established in each case together with a statement of the level of reduction considered realistically achievable in the short term, taking account of the NHS England objective of reducing avoidable harm by 50% over three years. The Trust will clearly be giving thought, as the monitoring and investigative work progresses, to the range of actions needed to promote and support the desired reductions and it will be useful to publish these in due course, along with the results of the monitoring. It would be reassuring to service users, carers and the general public to have some commitment to public reporting on progress, e.g. at quarterly or half-yearly intervals.

Priority 4 on identification of service users with a diagnosis of autistic spectrum disorder is in our view also of significant value, and we welcome the proposal to develop a work programme as well as training for staff. We would hope that service users and carers will be involved

in this development work, including through the proposed "Autism Awareness" Open Days.

We welcome Priority 5 which is to continue the work from the previous year on coordinated inpatient discharge planning. We look forward to seeing the results of the first year's effort and the direction of the further work once the final document is published. Improved handling of discharge from Community Mental Health Teams would also contribute greatly to the experience of service users moving back to Primary Care: we understand that there is work coming to fruition on a new protocol for this, although it is not mentioned in the draft QA.

One final comment: we were surprised to find so little reference in this draft quality Account to the Trust's ongoing system of Real Time Feedback from service users and carers (we found a reference on p.33 in relation to compliments, but not on p.58 where other sources of feedback are listed). It may be that this system is now taken for granted but we believe its role as an instrument of quality improvement deserves continuing attention.

Glossary

Abbreviation	Definition
ADHD	Attention Deficit Hyperactivity Disorder
BDD	Body Dysmorphic Disease
BME	Black and minority ethnic
CAMHS	Child and Adolescent Mental Health Services
CCGs	Clinical Commissioning Groups
CFF	Carers, Friends and Family
CPA	Care Programme Approach
CQC	Care Quality Commission
CQRG	Clinical Quality Commissioning Reference Group
CQUIN	Commission for Quality and Innovation
CRHT	Crisis Resolution and Home Treatment
EAP	Employee Assistance Programme
EIP	Early Intervention in Psychosis
HOSCs	Health Overview and Scrutiny Committees
HSCIC	Health and Social Care Information Centre
IAPT	Improving access to psychological therapies
KPIs	Key Performance Indicators
L(S)CLRN	London (South) Comprehensive Local Research Network
LSCB	London Safeguarding Children Board
MHSDS	Mental Health Services Data Set
NAPT	National Audit of Psychological Therapies
NAS	National Audit of Schizophrenia
NAS2	National Audit of Schizophrenia (second round)
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
OCD	Obsessive Compulsive Disorder
PALS	Patient Advice and Liaison Service
POMH	Prescribing Observatory for Mental Health
PPI	Patient and Public Involvement
PQF	Patient Quality Forum
RATE	Risk Assessment Training and Education
RiO	The Trust's electronic clinical and patient record system.
SIRO	Senior Information Risk Officer
STEIS	Strategic Executive Information System
SURG	Service User Reference Group
SUS	Secondary Uses Service
SWLSTG	South West London and St George's Mental Health NHS Trust

Annex – Statement of Director's responsibility in respect of the Quality Account

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendments Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has 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 Accounts present 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; and
- the Quality Account had been prepared in accordance with Department of Health guidance.

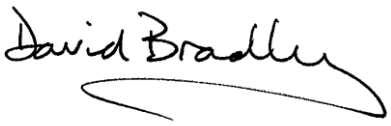
The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Date: 2nd June 2016
Chairman

Peter Molyneux

Date: 2nd June 2016
Chief Executive



David Bradley

Independent Auditors' Limited Assurance Report

Independent Auditor's Limited Assurance Report to the Directors of South West London and St George's Mental Health NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of South West London and St George's Mental Health NHS Trust's Quality Account for the year ended 31 March 2016 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following indicators:

- **Percentage of patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient care**
- **Percentage of admissions to acute wards gate kept by the Crisis Resolution Home Treatment Team (CRHT).**

We refer to these two indicators collectively as "the 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 criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2015 to May 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the following named stakeholders involved in the sign off of the Quality Account: Richmond Upon Thames Healthwatch, Richmond upon Thames' Health Services Scrutiny Committee, Wandsworth Healthwatch and Sutton Healthwatch.
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the Head of Internal Audit's annual opinion over the trust's control environment reported to the Audit Committee on 25 May 2016; and
- the draft annual governance statement 2015/16;

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 South West London and St George's Mental Health NHS Trust.

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

Assurance work performed

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

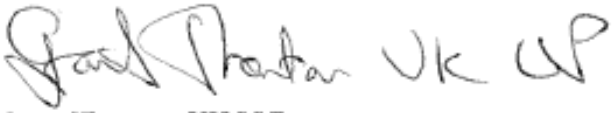
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by South West London and St George's Mental Health NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016

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



Grant Thornton UK LLP
Grant Thornton House

28 June 2016

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Quality Account
2015/16

Our values

 **Respectful**

 **Open**

 **Collaborative**

 **Compassionate**

 **Consistent**

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