Quality & Performance Committee

Paper title: Clinical Audit Annual Report 2018/19

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper title</td>
<td>Clinical Audit Annual Report 2018/19</td>
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<tr>
<td>Paper number</td>
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<tr>
<td>Paper author</td>
<td>David Jones, Clinical Effectiveness Manager</td>
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<tr>
<td>Lead director</td>
<td>Andy Mattin, Director of Nursing</td>
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<td>FOI status</td>
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This Annual Report updates on business relating to the Trust-wide Clinical Audit Programme and CNWL involvement in the National Clinical Audit and Patient Outcomes Programme (NCAPOP), including reporting progress on actions outstanding from the mid-year report, and the forward plan of Trust priority audits for 2019/20.

Highlights include:
- Results for the POMH-UK audit of Rapid Tranquilisation were better than the national average, particularly in terms of post-administration monitoring of mental and behavioural state and the revision of care plans to reflect patient preferences;
- Improved performance in most domains of the Sentinel Stroke National Audit Programme compared to previous quarters;
- Evidence of improvements in compliance with standards in the Trust-wide medicines programme, with many of the standards in the Controlled Drugs Audit, the Antimicrobial Audit and the Safe and Secure Handling of Medicines Audit being achieved at 100% compliance;
- Inclusion of key messages from the NCISH report on risk assessment in mental health settings in the Trust’s Clinical Risk Assessment and Safety Planning Policy, the Trust’s Zero Suicide Plan for all mental health wards and the Suicide Prevention Strategy, and currently planned for discussion at Operations Board in May.

Negatives include:
- A drop in performance in recording physical health parameters was observed in the POMH-UK Rapid Tranquilisation audit, and fewer patients receiving IM haloperidol had a baseline ECG completed than in the last iteration of the audit in 2016;
- Physical examinations were found not to be routine practice in some clinics in the POMH-UK audit on Prescribing Clozapine;
- Hand hygiene compliance in Diggory did not achieve the required standard in any quarter of 2018/19;
- Variances in practice in divisional management processes for NICE compliance monitoring have been identified, and these are being addressed under the leadership of the Clinical Effectiveness and Policies Group (CEPG).

Current developments include;
- the closing stages of the review of clinical policies;
- the continued conversion of the agenda of the CEPG to emphasise the wider clinical effectiveness agenda including policies, national audit recommendations and NICE compliance review via the newly-instituted central NICE compliance monitoring system;
- reviewing the use of the Optimum Meridian Audit Module, with consideration being given to other options on the market.

<table>
<thead>
<tr>
<th>Purpose (tick one only)</th>
<th>☐ For decision</th>
<th>☒ For discussion</th>
<th>☐ For information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation</td>
<td>To note the report.</td>
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<tr>
<td>Where this paper was previously discussed?</td>
<td>Shared with Divisions and relevant groups during development.</td>
<td></td>
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</tr>
<tr>
<td>This paper address the Trust objective (choose all that apply)</td>
<td>☒ Quality</td>
<td>☐ Workforce</td>
<td>☐ Finance and efficiency</td>
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<tr>
<td>Resource implications</td>
<td>There may be resource implications to acting upon the implementation of NICE guidance or recommendations from national or Trust-wide clinical audit and confidential enquiry activity.</td>
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<tr>
<td>Quality considerations</td>
<td>Participation in National Clinical audit programmes helps services benchmark and learn from peers</td>
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<tr>
<td>Risks associated with this report and mitigations (reference to the Board Assurance Framework)</td>
<td>Poor performance in clinical audits may signify poor care which is a risk to the Trust, as this may identify shortcomings in care provided by Trust systems, processes or staff. Completing the audit cycle and addressing any shortcomings identified and re-auditing mitigates this risk.</td>
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1.0 Purpose of the Report
The aim of this report is to report on the National and Trust wide clinical audit programme 2018/19, progress against outstanding actions from the midyear report 2018/19, and provide the forward plan for 2019/20. For the audits included in this report, information is given on performance, any recommendations being considered, and any actions already taken.

2.0 Update of clinical audit activity since the Midyear Report 2018/19
Reports for 11 audits have been received since the Midyear Report 2018/19. These are:

National audits
- National Confidential Inquiry into Suicide and Homicide (NCISH) – including Suicide by Children and Young People in England
- National Audit of Cardiac Rehabilitation
- POMH-UK: 16b Rapid tranquilisation
- POMH-UK: 18a Prescribing clozapine
- Sentinel Stroke National Audit Programme (SSNAP)
- National HIV audit (BHIVA) – Routine Monitoring and Assessment in Older Adults

Trust-wide audits
- Quarterly controlled drugs (CD) audit
- Quarterly antimicrobial audit
- Safe and secure handling of medicines
- Covert Administration of Medicines
- IPC – Hand Hygiene

The national and Trust-wide clinical audit projects being updated in this report are summarised in Appendix One. Participation remains strong in all mandatory national clinical audit projects. The Clinical Audit Plan for 2019/20 is in Appendix Two. The 2018/19 midyear report is provided as Appendix Three:

3.0 Key highlights and learning from completed audits
Highlights include:
- The reflecting of key messages from the NCISH report on risk assessment in mental health settings in the Trust’s Clinical Risk Assessment and Safety Planning Policy, the Trust’s Zero Suicide Ambition Plan, and the Suicide Prevention Strategy currently being finalised;
- Results for the POMH-UK audit of Rapid Tranquilisation were better than the national average, particularly in terms of post-administration monitoring of mental and behavioural state and the revision of care plans to reflect patient preferences;
- Improved performance in most domains of the Sentinel Stroke National Audit Programme compared to previous quarters;
- Evidence of improvements in compliance with standards in the Trust-wide medicines programme, with many of the standards in the Controlled Drugs Audit, the Antimicrobial Audit and the Safe and Secure Handling of Medicines Audit being achieved at 100% compliance.

Negatives from the reporting audits include:
A drop in performance in recording physical health parameters was observed in the POMH-UK Rapid Tranquilisation audit, and fewer patients receiving IM haloperidol were getting a baseline ECG than in the last iteration of the audit in 2016;

Physical examinations were found not to be routine practice in some clinics in the POMH-UK audit on Prescribing Clozapine;

Hand hygiene compliance in Diggory did not achieve the required standard in any quarter of 2018/19.

Recommendations are taken forward at Divisional level via appropriate fora, and practice monitored by further re-audit. Where specific activity has been noted, further information is provided in Appendix One.

4.0 Clinical Effectiveness and Policies Group – progress update

Over the last year, we have strengthened our corporate clinical effectiveness monitoring processes by extending the remit of what was Clinical Policies Group to include the wider clinical effectiveness agenda. The Clinical Effectiveness and Policies Group (as it is now called) critiques standards and process for the monitoring of NICE compliance, reviews and approves clinical policies, takes National Clinical Audit reports for discussion and action, and provides strategic direction for clinical effectiveness systems and processes across the Trust. The Trust Clinical Audit Policy is currently under review under its direction, and the Trust NICE Policy shall be reviewed in the coming year.

The Clinical Effectiveness and Policies Group (CEPG) continues to meet ten times a year to oversee delivery of the national clinical audit programme and approve local Trust-wide clinical policies not covered by specialist clinical committees elsewhere in the Trust.

A list of policies approved by CEPG in the last year follows:

**Policies published during 2018/19**

- Acupuncture Policy
- Administration of Electro-Convulsive Therapy (ECT) Policy
- Admission of Under 18s to an Adult Acute Psychiatric Ward Policy
- Consent to Care and Treatment Policy
- Deteriorating Patient – The Recognition and Management of the Deteriorating Patient Policy
- Substance Use in Mental Health Policy
- Handover for Inpatient Wards Policy
- Identification of Patients Policy
- Lower Limb and Leg Ulcer Management Policy
- Management of Dysphagia Policy
- Search Policy
- Smoke Free Policy
- Venepuncture Policy
- Clinical Risk Assessment Policy within Adult MH and Allied Specialities
- Use of Trust Phone Systems and Mobile Phones for Communicating (Calls and Texts) with Patients, their Families and Carers
- Failure to Attend Children’s Health Appointments Policy

In addition, a further 25 policies were extended to bring them in line with the Trust Policy on Policies for a standard five year review cycle for clinical policies.

5.0 Centralised system for monitoring NICE compliance – progress update

The central NICE compliance monitoring system has identified variations in the management of NICE compliance across the three divisions. This was reported to CEPG in April, where a decision was taken
to initiate work to standardise processes across the Trust. At the time of writing this report, the group was consulting with stakeholders to better understand areas where processes could be improved or standardised.

6.0 Optimum Meridian for clinical audit activity – progress update
The Trust continues to contract with IQVIA for Optimum Meridian Clinical Audit Module, and as this contract is due to expire in early 2020, discussions are being conducted both with IQVIA, and with potential alternative providers in the market. Its principal use has been the distribution of national audit tools across a large number of geographically diverse teams, allowing for secure and effective recording of information from which the Divisional Governance Teams are able to populate the National Audit portals, as well as providing a local dataset for targeted analysis where useful. A number of local audits have also been implemented on the software. The list of audits using the Optimum Meridian clinical audit module since the Midyear Report follows:

<table>
<thead>
<tr>
<th>Title</th>
<th>Division(s)/Dept(s)</th>
</tr>
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<tbody>
<tr>
<td>Improving Physical Health</td>
<td>G/J</td>
</tr>
<tr>
<td>CQC Key Lines of Enquiry (KLOE)</td>
<td>All</td>
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<tr>
<td>MH2 Audit Referral Process and Outcome of Triage</td>
<td>J</td>
</tr>
<tr>
<td>MH3 Mental Health Assessment Audit</td>
<td>J</td>
</tr>
<tr>
<td>MH4 Audit Care Plan Review</td>
<td>J</td>
</tr>
<tr>
<td>MH5 Transfer of Care</td>
<td>J</td>
</tr>
<tr>
<td>Care Plan Audit (Revised)</td>
<td>J</td>
</tr>
<tr>
<td>Controlled Drugs</td>
<td>Pharmacy (D/G/J)</td>
</tr>
<tr>
<td>NCAP EIP Spotlight Audit</td>
<td>All</td>
</tr>
<tr>
<td>NCAAD Psychological Therapies Spotlight Audit</td>
<td>All</td>
</tr>
<tr>
<td>Antimicrobials</td>
<td>Pharmacy (D/G/J)</td>
</tr>
<tr>
<td>Quality of Supervision Audit</td>
<td>J</td>
</tr>
<tr>
<td>Improving Access for People with Learning Disabilities</td>
<td>J</td>
</tr>
<tr>
<td>Royal College of Psychiatrists CQUIN Physical Health Audit</td>
<td>All</td>
</tr>
<tr>
<td>Hand Hygiene Audit</td>
<td>All/J</td>
</tr>
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</table>

7.0 Conclusion
The Clinical Audit programme for 2018/19 has been delivered and the plan for 2019/20 agreed.

David Jones, Clinical Effectiveness Manager, May 2019
## NATIONAL AUDITS – NHS ENGLAND QUALITY ACCOUNTS LIST 2018/19

<table>
<thead>
<tr>
<th>Project</th>
<th>Divisions</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NCEPOD Child Health Clinical Outcome Review Programme – Young People’s Mental Health</td>
<td>All</td>
<td>NCEPOD’s report, originally due to be published in April 2018, remains postponed, with a future launch date still to be confirmed. This is due to the report being held back for review by NHS England.</td>
</tr>
<tr>
<td>2. National Confidential Inquiry into Suicide and Homicide (NCISH) – including Suicide by Children and Young People in England</td>
<td>All</td>
<td>A topic-specific report from NCISH on risk assessment in Mental Health settings was published in October 2018. The key messages from this report are reflected in the interim Trust wide Clinical Risk Assessment and Safety Planning Policy. The Assessment of Clinical Risk in Mental Health Services 2018 Report findings are also reflected and referenced in the Trust’s Suicide Prevention Strategy and the Zero Suicide Ambition Plan for Mental Health Inpatient Wards, which are currently out for consultation.</td>
</tr>
<tr>
<td>3. Falls and Fragility Fractures Audit Programme (FFFAP) – National Audit of Inpatient Falls (NAIF)</td>
<td>All</td>
<td>The 2018 Organisational Audit data was submitted at the end of December 2018. From 1st January 2019, the Clinical Audit is becoming a continuous dataset, linked to completion of the National Hip Fracture Database by the acute trust managing the fracture. All inpatient wards could potentially need to contribute data to NAIF going forward. Systems are established to ensure CNWL contributes data as required, and these are overseen by the Trust Falls Board. Reporting mechanisms are yet to be outlined by the audit providers. A report is not anticipated until Spring 2020.</td>
</tr>
<tr>
<td>4. Learning Disability Mortality Review Programme (LeDeR – run by University of Bristol)</td>
<td>J</td>
<td>CNWL reported 19 cases to LeDeR in 2018/19. This project shall no longer be on the National Clinical Audit and Patient Outcomes Programme from April 2019.</td>
</tr>
<tr>
<td>5. National Audit of Cardiac</td>
<td>G</td>
<td>In response to the 2018 Report published in January 2019, the service is trying to increase uptake of cardiac rehabilitation with women by offering more home exercise programmes and exercise DVDs.</td>
</tr>
<tr>
<td><strong>Rehabilitation</strong></td>
<td><strong>Opinion on actions:</strong></td>
<td><strong>GREEN</strong></td>
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<tr>
<td><strong>To improve attendance rate, text message reminders for exercise classes have been introduced. The service is working closely with and meeting other services in a multidisciplinary team approach, to meet with the certification standards.</strong></td>
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<table>
<thead>
<tr>
<th><strong>6. National Audit of Care at the End of Life (NACEL)</strong></th>
<th><strong>All</strong></th>
<th><strong>Opinion on actions:</strong></th>
<th><strong>GREEN</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data collection was completed and submitted to the national audit by the deadline, and a full report is anticipated in Summer 2019, following review and approval for release by NHS England. Individual reports for each unit have been received and distributed to unit managers for comment, to ascertain whether any actions or improvements are needed. An update will be provided in the Clinical Audit Midyear Report 2019/20.</strong></td>
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| **7. National Audit of Intermediate Care** | **D / G** | **Data collection was completed and submitted to the national audit by the deadline, and reports were received in Q3. Both Hillingdon and Camden Services have drawn up local implementation action plans which will be monitored during 2019. An update will be provided in the Clinical Audit Midyear Report 2019/20.** | |

| **8. National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)** | **D / G** | **All relevant CNWL services signed up for the project, and continuous data collection is under way. Currently, only one of the three participating services has had eligible cases, submitting four since the audit commenced. The first report is not anticipated until March 2020.** | |

| **9. National Clinical Audit of Anxiety and Depression (NCAAD)** | **All** | **Data collection was completed and submitted to the national audit by the deadline, and a report is anticipated in Summer 2019, following review and approval for release by NHS England. An update will be provided in the Clinical Audit Midyear Report 2019/20.** | |

| **10. NCAAD Psychological Therapies Spotlight Audit** | **All** | **Data collection closed in January 2019, and a report is anticipated in the Summer of 2019, following review and approval for release by NHS England. An update will be provided in the Clinical Audit Midyear Report 2019/20.** | |

| **11. NCAP – EIP Spotlight Audit** | **All** | **Data collection closed at the end of November 2018. A final report is anticipated in June 2019, following review and approval for release by NHS England. An update will be provided in the Clinical Audit Midyear Report 2019/20.** | |

| **12. National Asthma and COPD Audit Programme (NACAP)** | **D / G** | **Data collection commenced in March 2019. Services in Milton Keynes and Camden are participating. The data collection period is scheduled to end in October 2020 and a report anticipated after that.** | |

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13. National Diabetes Audit – Diabetic Foot Care Audit  

D / G  

CNWL doesn’t contribute to this national audit in its own right, but provides data to partner acute secondary care trusts for inclusion in their submissions:  
- Hillingdon provides data for The Hillingdon Hospital NHS Trust submission;  
- Camden’s Podiatry service provides the data for UCLH, though a UCLH podiatrist gathers the data. The Mary Rankin Dialysis Unit may be submitting in the next financial year;  
- Milton Keynes Podiatry service shall be submitting data on behalf of Milton Keynes University Hospital NHS Trust from April 2019.  

Reports are reviewed on publication for actions which may require implementation within CNWL. The next annual report is anticipated shortly and this will be circulated to relevant services for comment. An update will be provided in the Clinical Audit Midyear Report 2019/20.

14. POMH-UK: 16b Rapid tranquilisation  

All  

Opinion on results:  
AMBER

The audit report was received and reviewed at Medicines Management Group in February 2019. Overall CNWL’s practice was better than the national picture, and in some areas was notably good, but in other areas there are some concerns; practice varied between wards.

Aspects of good practice in CNWL  
- A post-RT patient debrief was documented in ¾ of cases, which is an improvement in a patient focussed aspect of this restrictive practice.  
- There was an improvement in revising care plans after episodes RT to reflect the patients’ preferences and future wishes plus the teams’ management approach.  
- Patients’ mental and behavioural state after IM RT was routinely monitored and reviewed.  
- Recording of patients’ respiratory rate after IM RT remained high.  
- No IV medicines were administered.

Aspects of poorer practice in CNWL  
- Rates of recording of physical health parameters (with the exception of respiratory rate) were poorer, and all were lower than in our baseline audit.  
- Fewer patients receiving IM haloperidol had a baseline ECG than in the 2016 baseline audit.

Recommendations  
- Improve the recording of monitoring of physical health parameters, and patient refusals.  
- ECGs should be requested by inpatient doctors wherever possible prior to administering IM haloperidol.

Actions taken  
- These findings were reported to the Trustwide Restrictive Intervention Group, and then
to the Trustwide Medicines Optimisation Group.

- A monthly audit of all instances of rapid tranquilisation is in place in all divisions. The Restrictive Intervention Group regularly reviews all rapid tranquilisation audit data from each division on a monthly basis, this is ongoing and has been in place ever since the baseline POMH audit of 2016.
- Jameson has recently completed a deep-dive audit to further assess rapid tranquilisation practice. It concluded that the number of physical checks on patients post rapid tranquilisation was very low due to the number of recorded refusals from patients and/or patient was asleep during the intervals of monitoring. However, the observations for respiration were high at 93%, where only 2 cases were not documented to have completed a respiration check.

A further action relating to IM haloperidol for all wards to ensure that they have a functioning ECG machine is audited by the Medical Devices Team. This is a perennial challenge and requires ongoing assessment.

15. POMH-UK: 18a  
Prescribing clozapine

All  

Opinion on results:  
AMBER / GREEN

CNWL submitted data from all its clozapine clinics. Overall our practice was similar to the national picture, although practice varied a between clinics.

Aspects of good practice in CNWL
- 100% of patients had their blood pressure measured over the past year.
- All but one patient had their weight/BMI recorded during the past year.
- Physical examinations were routinely completed by most teams.

Aspects of poorer practice in CNWL
- Some patients (n=8, 13%) did not have the efficacy of clozapine reviewed or optimised by a senior clinician in the past year.
- Physical examinations do not seem to be routine practice in a few clinics.

Recommendations
- All clinics should monitor and record patients’ lipids and glycaemia control.
- All patients should have an annual physical examination at the Clozapine Clinic.
- All patients should be reviewed at least annually by a senior clinician to assess their response to clozapine and optimise its efficacy.
- CNWL prescribers and clozapine clinic staff should advise GPs to add clozapine to the
patients’ SCR for a full and safe understanding of prescribing.

- Work towards consistency in operational practices across the trusts clozapine clinics, overseen by the clozapine forum.

16. **POMH-UK: 7f Monitoring of patients prescribed lithium**

   | All | Data collection for this audit took place in Q4 2018/19 and a report is expected in July 2019. **An update will be provided in the Clinical Audit Midyear Report 2019/20.** |

17. **Sentinel Stroke National Audit Programme (SSNAP)**

   - **Domain**
   - **Results April 2018 to June 2018**
   - **Opinion on results in most recent local analysis:**
     - **AMBER / GREEN**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Results April 2018 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>2: Stroke Unit</td>
<td>E for both patient centred and team centred</td>
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<tr>
<td>5: Occupational Therapy</td>
<td>A for both patient centred and team centred</td>
</tr>
<tr>
<td>6: Physiotherapy</td>
<td>A for both patient centred and team centred</td>
</tr>
<tr>
<td>7: Speech &amp; Language Therapy</td>
<td>A for patient centred; B for team centred</td>
</tr>
<tr>
<td>8: Multidisciplinary Teamworking</td>
<td>C for patient centred; N/A for team centred</td>
</tr>
<tr>
<td>9: Standards by Discharge</td>
<td>A for both patient centred and team centred</td>
</tr>
<tr>
<td>10: Discharge Processes</td>
<td>C for both patient centred and team centred</td>
</tr>
<tr>
<td>Patient-centred SSNAP level (after adjustments)</td>
<td>B</td>
</tr>
<tr>
<td>Team-centred SSNAP level (after adjustments)</td>
<td>B</td>
</tr>
</tbody>
</table>

   The presentation of SSNAP data has been reconfigured since the Clinical Audit Midyear Report 2018/19. The most recently available current performance data covers the three months of Quarter 1 (April to June 2018). The arrows indicate direction of travel since the Clinical Audit Midyear Report 2018/19:

Other National audits

<table>
<thead>
<tr>
<th>Project</th>
<th>Divisions</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. National HIV audit (BHIVA) – Routine</td>
<td>D</td>
<td>A report was published by BHIVA in Autumn 2018. As a result, the service initiated a number of changes in line with the BHIVA recommendations:</td>
</tr>
</tbody>
</table>
## Monitoring and Assessment in Older Adults

### Opinion on actions: GREEN

- Initiating a QI project on recording bone health risk assessment, which the service has not done so well on historically;
- Streamlined management of those patients with cognition problems by creating a referral process via an expert MDT.
- The EPR proforma has been changed to ensure correct data is captured.
- Increased use of Summary Care Records to make sure the service had accurate comprehensive medication lists, initially on those attending our Treatment Assessment Clinic, and all patients receiving treatment for hepatitis C.
- Changes in the EPR system to better record vaccine status.
- Continue to use proformas where possible, however the slowness of EPR is a definite limiting factor.

A presentation benchmarking local performance with national results was presented to the department in May 2019.
### Project: 19. Quarterly controlled drugs (CD) audit

#### Divisions

<table>
<thead>
<tr>
<th>Division</th>
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<tbody>
<tr>
<td>Diggory: GREEN</td>
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<tr>
<td>Goodall: GREEN</td>
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<tr>
<td>Jameson: TBC</td>
</tr>
</tbody>
</table>

#### Update

**Diggory Division – Q4 key findings**
- Overall compliance with standard measured across Diggory in Q4 was 95.56%. This was an increase from the last quarter (93.65%).
- A total of 33 sites were audited across Diggory. Areas where 100% compliance was not achieved and action plans were developed:
  - HMP Woodhill House Units 1, 2B, 3, 6, CAU and Segregation
  - HMP Winchester Healthcare and ISMS C4
  - Campbell Centre Willow and Hazel Ward
  - TOPAS
  - HMP Coldingley
  - HMP/YOI Downview B and C Wing
  - Windsor Intermediate Care Unit
  - Heathrow IRC Colnbrook and Harmondsworth

**Goodall Division – Q4 key findings**
- Overall compliance with standards measured across Goodall in Q4 was 92.65%. This is comparable to Q3 (92.28%); [compliance in previous quarters were Q2 (89%) & Q1 (96%)].
- The CD categories with the lowest compliance were: errors in the CD book being appropriately

#### Actions

- Circulate results to Divisional Governance Leads and discussion at Divisional Board Meetings.
- Lead Pharmacists to ensure the report is circulated to individual teams who have participated in the audit for consideration and action
- Lead Pharmacists to circulate and follow up with services and site managers to address local areas of non-compliances identified. To also be presented at care quality meetings.
- Associate Chief Pharmacist to present results and outstanding actions from the audit at the Divisional Medicines Optimisation Group.
- To monitor all action plans submitted for non-compliance to ensure they are completed.
- Lead Pharmacist to discuss further with local pharmacy teams where the audit standard benchmark has not reach 75% to ensure there is a robust plan to raise the standard >85% or more within a month. If this is not possible to implement safety measures as soon as deemed possible.
amended and CD requisitions being appropriately entered into the CD record book.

**Actions**
- To monitor all action plans submitted for non-compliance to ensure they are completed.
- Borough Lead Pharmacists to circulate and follow up with ward and site managers to address local areas of non-compliances identified. To also be presented at borough or service line Quality Governance meetings.
- Circulate results to Divisional Governance Leads and discussion at Divisional Governance Board Meetings.
- Associate Chief Pharmacist to present results and outstanding actions from the audit at the next Divisional Medicines Optimisation Group in June 2019.

**Jameson Division – Q4 key findings**
The report is in preparation.

<table>
<thead>
<tr>
<th>20. Quarterly antimicrobial audit</th>
<th>Opinion on results:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health:</strong> GREEN</td>
<td>This audit is used to monitor antimicrobial prescribing trends and quality indicators in order to guide training and development of healthcare staff and to optimise prescribing practice. Headline results in the most recent quarter were:</td>
</tr>
<tr>
<td><strong>Community:</strong> GREEN</td>
<td>Mental Health Q4:</td>
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<tr>
<td><strong>Offender Care:</strong> AMBER / GREEN</td>
<td>- Overall compliance with the standards is good across Mental Health Services bedded units.</td>
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<td>- Full compliance was achieved for allergy status across all sites and most areas had good compliance with treatment choice.</td>
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<td>- Main area for improvement is documentation of the indication on the prescription chart.</td>
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<td><strong>Actions are:</strong></td>
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<td></td>
<td>- Q4 antimicrobial prescribing audit results should be presented at respective Quality Governance meetings and at ward level to medical staff &amp; wider MDT</td>
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<td>- To be shared at divisional IPC and IPCC</td>
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<td></td>
<td>- Action plans to be completed for all non-compliant areas &amp; submitted to respective Pharmacy Team Leader and Associate Chief Pharmacist</td>
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<td></td>
<td>- To monitor all action plans submitted for non-compliance to ensure they are completed.</td>
</tr>
<tr>
<td></td>
<td><strong>Community Services Q4:</strong></td>
</tr>
<tr>
<td></td>
<td>- Overall compliance with the standards is good across Community Health Services bedded units.</td>
</tr>
<tr>
<td></td>
<td>- Full compliance was achieved for, course length and allergy status across all sites.</td>
</tr>
<tr>
<td></td>
<td>- Main area for improvement was documentation of the indication on the prescription chart.</td>
</tr>
</tbody>
</table>
### 21. Safe and secure handling of medicines

**Q2 D; Q4 J**

**Opinion on results:**

- **Diggory:** AMBER / GREEN

The Care Quality Commission (CQC) requires NHS trusts to keep patients, visitors and staff safe by having systems in place to ensure that medicines are handled safely and securely.

In Jameson, the audit is in data collection phase. An update will be provided in the Clinical Audit Midyear Report 2019/20.

An annual safe and secure handling of medicines audit was carried out across Diggory and the vast majority of standards showed 100% compliance. Areas of non-compliance included:

#### Safe storage of medicines
- Medication storage areas were not tidy and not well organised
- Not all medication was stored in a locked cupboard

#### Room Temperature Monitoring
- Room temperatures in clinic rooms were not monitoring on every day a clinic was taking place.

#### Expiry Checks

---

Actions are:

- Q4 antimicrobial prescribing audit results should be presented at respective Quality Governance meetings and at ward level to medical staff & wider MDT
- To be shared at divisional IPC and IPCC
- Action plans to be completed for all non-compliant areas & submitted to respective Pharmacy Team Leader and Associate Chief Pharmacist
- To monitor all action plans submitted for non-compliance to ensure they are completed.

**Offender Care Q4:**

- With the exception of Heathrow IRC, all prisons were 100% compliant with all standards. Heathrow IRC compliance was at around 86% for all measures.

Actions are:

- Circulate report to all Pharmacists, Prescribers, and Divisional Medical Directors to discuss at respective quality and governance meetings. Also present findings of the audit to each divisional IPC subgroup and IPC Committee.

Progress against all actions will be monitored by the antimicrobial pharmacist and the Antimicrobial Stewardship Group.
- Expired medication and medical gas cylinders were found with in use stock
- Medicines expiry check list not in place.

Action plans have been developed for all areas of non-compliance and shared with individual teams.

| 22. FP10 prescriptions | All (Q2 D; Q3 J; Q4 G) | FP10 prescriptions are prescriptions written by a doctor which can be taken to any community pharmacy for dispensing. The prescription is then sent to the prescription pricing authority for pricing. The trust (CNWL) is charged with the cost of the medicines and a dispensing fee. As part of the CNWL medicines optimisation programme, the operational effectiveness of the procedure is reviewed through audits on annual basis. This is to ensure any risks associated with prescriptions are identified and managed.

In Diggory, the audit was conducted but no report was written. The findings were distributed within the Division.

In Jameson and Goodall, the report is currently being written and an update will be provided in the Clinical Audit Midyear Report 2019/20. |

| 23. Compliance with the Valproate Patient Safety Alert | All | This will be conducted in Q1 2019/20. An update will be provided in the Clinical Audit Midyear Report 2019/20. |

| 24. Covert Administration of Medicines | All | Data collection was conducted during Q2 and into Q3. The audit showed that there has been a marked improvement in adherence to the Covert Administration of Medicines Policy, and an improvement in majority of the standards compared to the 2016 audit. Recommendations include:
- to standardise recording of all information relating to covert administration;
- to standardise pharmacy recording of information on how to administer medicines covertly;
- to re-audit covert administration of medicines in two years’ time. |

| 25. High Dose Antipsychotics Therapy | All | This will be conducted in Q2 2019/20. An update will be provided in the Clinical Audit Midyear Report 2019/20. |

| 26. Prescribing of Benzodiazepines | All | This audit is in the report writing phase. An update will be provided in the Clinical Audit Midyear Report 2019/20. |
### 27. IPC – Hand Hygiene

<table>
<thead>
<tr>
<th>Divisions</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diggory: AMBER</td>
<td>Quarterly audits are conducted at divisional level of hand hygiene standards. The results for 2018/19 are presented below by division.</td>
</tr>
<tr>
<td>Goodall: GREEN</td>
<td></td>
</tr>
<tr>
<td>Jameson: AMBER</td>
<td></td>
</tr>
</tbody>
</table>

#### Diggory
- **Hand hygiene**
  - Q1: 93%
  - Q2: 89%
  - Q3: 93%
  - Q4: 91%

#### Goodall
- **Hand hygiene**
  - Q1: 97%
  - Q2: 98%
  - Q3: 97%
  - Q4: 97%

#### Jameson
- **Hand hygiene**
  - Q1: 97%
  - Q2: 89%
  - Q3: 99%
  - Q4: 97%

Percentages in Diggory are known to be affected on occasion by services not returning audit data, which then impacts on the calculations. The Diggory IPC team also carry out a number of initiatives to promote hand hygiene compliance throughout the year. These include:

- An additional hand hygiene audit alongside the annual environmental audits.
- Education sessions to staff, the public and service users.
- Alongside our Goodall & Jameson colleagues, support for World Hand Hygiene Day – this is promoted every year. This year included a Clinical Message of the Week and poster.

Whilst the IPC team promote and advise best practice, there is also a requirement for services and service leads to take ownership and ensure that staff carry out hand hygiene procedures correctly.
Appendix Two – TRUSTWIDE PRIORITY CLINICAL AUDIT PLAN FOR 2019/20

• NATIONAL AUDITS – NHS ENGLAND QUALITY ACCOUNTS LIST 2019/20

<table>
<thead>
<tr>
<th>Project</th>
<th>Divisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP) – National Audit of Inpatient Falls (NAIF)</td>
<td>G</td>
</tr>
<tr>
<td>Mental Health Care Pathway – CYP Urgent and Emergency Mental Health Care and Intensive Community Support – awaiting confirmation of 2019/20 NHSE funding</td>
<td>D / G</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review Programme – National Confidential Inquiry into Suicide and Homicide (NCISH) – including Suicide by Children and Young People in England</td>
<td>All</td>
</tr>
<tr>
<td>National Asthma and COPD Audit Programme (NACAP) – including Pulmonary Rehabilitation Audit</td>
<td>D / G</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
<td>G</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL)</td>
<td>All</td>
</tr>
<tr>
<td>National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)</td>
<td>D / G</td>
</tr>
<tr>
<td>National Clinical Audit of Anxiety and Depression (NCAAD)</td>
<td>All</td>
</tr>
<tr>
<td>NCAAD Psychological Therapies Spotlight Audit (Response to 2019 report)</td>
<td>All</td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis</td>
<td>All</td>
</tr>
<tr>
<td>NCAP – EIP Spotlight Audit (Response to 2019 report)</td>
<td>All</td>
</tr>
<tr>
<td>National Diabetes Audit – Diabetic Foot Care Audit (NB: Involvement dependent on acute trust requests. Response to 2019 report)</td>
<td>D / G</td>
</tr>
<tr>
<td>POMH-UK: 19a Prescribing for depression in adult mental health</td>
<td>All</td>
</tr>
<tr>
<td>POMH-UK: 17b Use of depot/LA antipsychotic injections for relapse prevention</td>
<td>All</td>
</tr>
<tr>
<td>POMH-UK: 6d Assessment of the side effects of depot antipsychotics (Response to 2019 report – DID NOT PARTICIPATE)</td>
<td>All</td>
</tr>
<tr>
<td>POMH-UK: 7f Monitoring of patients prescribed lithium (Response to 2019 report)</td>
<td>All</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>D / G</td>
</tr>
<tr>
<td>UK Parkinson’s Audit</td>
<td>D / G</td>
</tr>
</tbody>
</table>

• OTHER NATIONAL AUDITS WITH CNWL PARTICIPATION

<table>
<thead>
<tr>
<th>Project</th>
<th>Divisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>National HIV audit (BHIVA) (2019 topic tbc)</td>
<td>D</td>
</tr>
<tr>
<td>British Association for Sexual Health and HIV (BASHH) Annual Audit (2019 topic tbc)</td>
<td>D</td>
</tr>
</tbody>
</table>

• TRUSTWIDE AUDITS

Central Pharmacy Team – AUDIT PLAN FOR 2019/20 – TO BE CONFIRMED

<table>
<thead>
<tr>
<th>Project</th>
<th>Divisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPC – Hand Hygiene</td>
<td>All</td>
</tr>
</tbody>
</table>
Appendix Three – Clinical Audit Midyear Report 2018/19

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>28th November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper title</td>
<td>Clinical Audit Midyear Report 2018/19</td>
</tr>
<tr>
<td>Paper number</td>
<td></td>
</tr>
<tr>
<td>Paper author</td>
<td>David Jones, Clinical Effectiveness Manager</td>
</tr>
<tr>
<td>Lead director</td>
<td>Andy Mattin, Director of Nursing</td>
</tr>
<tr>
<td>FOI status</td>
<td>For publication</td>
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Paper summary

The Clinical Audit Programme reports biannually from now on, with the midyear report in November and annual report in May, to allow time for scheduled national audits to be completed and evaluated. This midyear report updates on business relating to the Trustwide Clinical Audit Programme and CNWL involvement in the National Clinical Audit and Patient Outcomes Programme (NCAPOP), including reporting progress on actions outstanding from the 2017/18 Annual Report.

Positives from the reporting audits include:

- The Trust was rated as ‘top performing’ for Timely Access in the Early Intervention in Psychosis Audit;
- Camden Community Health Services achieved all eight standards relating to its commissioned services in the National COPD Audit Programme;
- Performance in Milton Keynes for the UK Parkinson’s Audit was better than the national average in many standards, and where improvements were required many of these have been undertaken, particularly in relation to equipment procurement and improving written patient information.

Negatives from the reporting audits include:

- Room for improvement was noted in many aspects of the National Clinical Audit of Psychosis, including in physical health monitoring and intervention, medication adherence, and access to psychological therapies;
- Documentation relating to the prescription of sodium valproate for bipolar disorder was found to be poor;
- There were drops in performance in two domains of the Sentinel Stroke National Audit Programme between July 2017 and March 2018.

Current developments include the expansion of use of the Optimum Meridian audit module for both local and national audits, and the creation of a Clinical Effectiveness Business Administrator role, to support the clinical effectiveness workstream, and related activity such as clinical networks, NICE compliance, and CQUIN monitoring.

The report also includes an update from the Clinical Effectiveness and Policies Group. The QPC is asked to give guidance on the preferred frequency of reports from the Clinical Effectiveness and Policies Group.

Purpose (tick one only)

☐ For decision
☒ For discussion
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>To note the report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where was this paper previously discussed?</td>
<td>Shared with Divisions and relevant groups during development.</td>
</tr>
<tr>
<td>Resource implications</td>
<td>N/A</td>
</tr>
<tr>
<td>Quality considerations</td>
<td>Participation in National Clinical audit programmes helps services benchmark and learn from peers</td>
</tr>
<tr>
<td>Risks</td>
<td>CQC regulatory compliance on risk assessment linked to care plans.</td>
</tr>
</tbody>
</table>
2.0 Purpose of the Report
The aim of this report is to provide a progress update on the National and Trust wide clinical audit programme 2018/19, and progress against outstanding actions from the Annual Report 2017/18. For the audits included in this report, information is given on performance, any recommendations being considered, and any actions already taken.

2.0 Update of clinical audit activity since the Annual Report 2017/18
Reports for 11 audits have been received since the Annual Report 2017/18. These are:

National audits
- National Confidential Inquiry into Suicide and Homicide (NCISH) – including Suicide by Children and Young People in England
- National Clinical Audit of Psychosis
- POMH-UK: 15b Prescribing valproate for bipolar disorder
- Sentinel Stroke National Audit Programme (SSNAP)
- UK Parkinson’s Audit
- British Association for Sexual Health and HIV (BASHH) Annual Audit – HIV Partner Notification Re-audit

Trustwide audits
- Quarterly controlled drugs (CD) audit
- Quarterly antimicrobial audit (Community Services and Offender Care)
- Safe and secure handling of medicines (Goodall)
- FP10 prescriptions (Diggory)
- IPC – Hand Hygiene

The national and trustwide clinical audit projects being updated in this report are summarised in Appendix One. Participation remains strong in all mandatory national clinical audit projects.

3.0 Key highlights and learning from completed audits
Highlights include:
- The Trust was rated as ‘top performing’ for Timely Access in the Early Intervention in Psychosis Audit;
- Camden Community Health Services achieved all eight standards relating to its commissioned services in the National COPD Audit Programme;
- Performance in Milton Keynes for the UK Parkinson’s Audit was better than the national average in many standards, and where improvements were required many of these have been undertaken, particularly in relation to equipment procurement and improving written patient information.

Negatives from the reporting audits include:
- Room for improvement was noted in many aspects of the National Clinical Audit of Psychosis, including in physical health monitoring and intervention, medication adherence, and access to psychological therapies;
• Documentation relating to the prescription of sodium valproate for bipolar disorder was found to be poor;
• There were drops in performance in two domains of the Sentinel Stroke National Audit Programme between July 2017 and March 2018.

4.0 Creation of the Clinical Effectiveness and Policies Group.
From June 2018, the former Clinical Policies Group had a remit expansion, and is now the Clinical Effectiveness and Policies Group. Whilst the approval of clinical policies remains its principal function for the time being, it is expected that as the backlog of policies is addressed, more opportunities will emerge to discuss the wider clinical effectiveness agenda. Clinical Effectiveness is now a fixed agenda item, and updates have been provided on national audits, NICE compliance, and updates from national confidential enquiries. From November 2018, the meeting shall be clinically chaired, and in 2019 it is expected that medical representation shall be increased to reflect the multidisciplinary agenda of the Group.

Policies recently approved and uploaded include the Search Policy, the Consent to Care and Treatment Policy, and the Lower Limb and Leg Ulcer Management Policy. As part of the AIMS Accreditation process for Inpatient Mental Health Units, a number of policies are being extended pending a review.

The creation of a Clinical Effectiveness Business Administrator role has been implemented from October 2018. This role is to support the clinical effectiveness workstream, and related activity such as clinical networks, NICE compliance, and CQUIN monitoring. It will also provide secretarial support to a number of related committees and groups, including the Clinical Effectiveness and Policies Group.

It is proposed that the Clinical Effectiveness and Policies Group makes a short report to the Quality and Performance Committee (QPC) on a quarterly basis, two reports as part of the Clinical Audit Annual and Midyear reporting cycle in May and November, and brief update reports in February and September. The QPC is asked to give guidance on the preferred frequency of reports from the Clinical Effectiveness and Policies Group.

5.0 Towards a centralised system for monitoring NICE compliance
The Trust has for several years pitched the monitoring of NICE compliance at Divisional level, and all three Divisions have long-standing mechanisms for reviewing NICE guidance and recording the compliance or otherwise of its services with that guidance. This information is reported on quarterly via each Division’s Quality Governance Report. However, there is an increasing awareness that corporate intelligence on NICE compliance is required, and this has been in development for several months. As there are differences in the systems employed at Divisional level, work will be undertaken to strengthen communication links between the Quality Team and the Divisions, such that updates to compliance status are notified centrally. It is anticipated that the database will be sufficiently developed to run reports by the end of 2018/19.

6.0 Use of Optimum Meridian for clinical audit activity.
The Trust has contracted use of the Clinical Audit module of Optimum Meridian following a successful pilot phase. Since the pilot, several audits have been developed using the software. It has been particularly useful for distributing tools for national clinical audits to a widely-dispersed group of clinical services, and enables the Trust to hold a local dataset for internal review and analysis in advance of receipt of the official national clinical audit report, which can often take six months or longer to be published. The list of audits using the Optimum Meridian clinical audit module is on the following page:
<table>
<thead>
<tr>
<th>Title</th>
<th>Division(s)/Dept(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Physical Health</td>
<td>G/J</td>
</tr>
<tr>
<td>CQC Key Lines of Enquiry (KLOE)</td>
<td>All</td>
</tr>
<tr>
<td>MH2 Audit Referral Process and Outcome of Triage</td>
<td>J</td>
</tr>
<tr>
<td>MH3 Mental Health Assessment Audit</td>
<td>J</td>
</tr>
<tr>
<td>MH4 Audit Care Plan Review</td>
<td>J</td>
</tr>
<tr>
<td>MH5 Transfer of Care</td>
<td>J</td>
</tr>
<tr>
<td>Care Plan Audit (Revised)</td>
<td>J</td>
</tr>
<tr>
<td>Controlled Drugs</td>
<td>Pharmacy (D/G/J)</td>
</tr>
<tr>
<td>NCAP EIP Spotlight Audit</td>
<td>All</td>
</tr>
<tr>
<td>NCAAD Psychological Therapies Spotlight Audit</td>
<td>All</td>
</tr>
<tr>
<td>Antimicrobials</td>
<td>Pharmacy (D/G/J)</td>
</tr>
<tr>
<td>Quality of Supervision Audit</td>
<td>J</td>
</tr>
<tr>
<td>Improving Access for People with Learning Disabilities</td>
<td>J</td>
</tr>
</tbody>
</table>

7.0 Conclusion
The Clinical Audit programme for 2018/19 remains on track.

David Jones, Clinical Effectiveness Manager, November 2018
### NATIONAL AUDITS – NHS ENGLAND QUALITY ACCOUNTS LIST 2018/19

<table>
<thead>
<tr>
<th>Project</th>
<th>Divisions</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. NCEPOD Child Health Clinical Outcome Review Programme – Chronic Neurodisability</td>
<td>D / G</td>
<td>NCEPOD published its report in March 2018 and following assessment by the Community Paediatrics Teams for relevance and any required actions, it was determined that the Teams are compliant with all but two recommendations. Partial compliance was declared for recommendations relating to coding for children with a neurodisabling condition, and regarding transition from children’s to adult’s services, as the pathway is currently being finalised.</td>
</tr>
<tr>
<td>29. NCEPOD Child Health Clinical Outcome Review Programme – Young People’s Mental Health</td>
<td>All</td>
<td>NCEPOD’s report, originally due to be published in April 2018, remains postponed, with a future launch date still to be confirmed.</td>
</tr>
<tr>
<td>30. National Confidential Inquiry into Suicide and Homicide (NCISH) – including Suicide by Children and Young People in England</td>
<td>All</td>
<td>The NCISH Annual Report was published in October 2018. The findings are to be reviewed by the Safety Team and presented at the Mortality Review Group. In addition, a topic-specific report from NCISH on risk assessment in MH settings was also published in October 2018. The key messages from this report will be reflected in the revised Trustwide Clinical Risk Assessment and Risk Management Policy and guidance, which is currently under review. The policy will be launched at the same time as the implementation of SystmOne in London, currently anticipated to be early 2019.</td>
</tr>
<tr>
<td>31. Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database</td>
<td>D / G</td>
<td>Contributions to the Fracture Liaison Service Database are made by acute trusts with such a service – CNWL does not fall into this category. However, there is a theoretical requirement that some data may need to be contributed by CNWL, as and when requested by the participating trusts. No such request has been made in recent months. <strong>It is recommended that this audit be removed from the CNWL Clinical Audit Programme, with future data requests being met on a case-by-case basis.</strong></td>
</tr>
<tr>
<td>32. Falls and Fragility Fractures Audit</td>
<td>All</td>
<td>The 2018 Organisational Audit is due for completion at the end of December 2018. From 1st January 2019, the Clinical Audit is becoming a continuous dataset, linked to completion of the National Hip <strong>...</strong></td>
</tr>
<tr>
<td>Programme (FFFAP) – National Audit of Inpatient Falls (NAIF)</td>
<td>Fracture Database by the acute trust managing the fracture. All inpatient wards could potentially need to contribute data to NAIF going forward. Systems are being established to ensure CNWL contributes data as required. Reporting mechanisms are yet to be outlined by the audit providers.</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>33. Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database – Physiotherapy Hip Fracture Sprint Audit</td>
<td>A national report was published in February 2018 and was circulated to relevant services. No local response to the recommendations has been made, and the recommendations were mapped to NICE guidance CG124 and shall be tracked through Divisional NICE compliance monitoring.</td>
<td></td>
</tr>
<tr>
<td>34. Learning Disability Mortality Review Programme (LeDeR – run by University of Bristol)</td>
<td>CNWL reported 2 cases to LeDeR between July and September 2018. No serious concerns were identified. The Learning Disabilities Service adapted an existing CNWL deaths reporting &amp; reviewing process when LeDeR processes were formalised and these continue to be followed. Safeguarding Trackers are being used where alerts are raised, and the tracker is reviewed monthly at Care Quality Meetings. All teams are encouraged to use full range of ICD 10 Diagnosis on JADE and in all clinical correspondence. In non-specialist services (e.g. adult mental health), Learning Disability Champions are briefed to spot-check use of “Disability” flagging system on electronic records.</td>
<td></td>
</tr>
<tr>
<td>35. National Audit of Cardiac Rehabilitation</td>
<td>The report for 2018 is due in January 2019. Data continues to be submitted by the Community Cardiac Team in Hillingdon. An update will be provided in the Clinical Audit Annual Report 2018/19.</td>
<td></td>
</tr>
<tr>
<td>36. National Audit of Care at the End of Life (NACEL)</td>
<td>Data collection was completed and submitted to the national audit by the deadline, and a report is anticipated in May 2019.</td>
<td></td>
</tr>
<tr>
<td>37. National Audit of Intermediate Care</td>
<td>Data collection was completed and submitted to the national audit by the deadline, and a report is anticipated in January 2019. An update will be provided in the Clinical Audit Annual Report 2018/19.</td>
<td></td>
</tr>
<tr>
<td>38. National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)</td>
<td>All relevant CNWL services signed up for the project, and continuous data collection is under way. The first report is not anticipated until March 2020.</td>
<td></td>
</tr>
<tr>
<td>39. National Clinical Audit of Anxiety and Depression (NCAAD)</td>
<td>All</td>
<td>Data collection was completed and submitted to the national audit by the deadline, and a report is anticipated in early 2019. <strong>An update will be provided in the Clinical Audit Annual Report 2018/19.</strong></td>
</tr>
<tr>
<td>40. NCAAD Psychological Therapies Spotlight Audit</td>
<td>All</td>
<td>The sample has been submitted to the national audit providers, and a plan for implementation of the audit within CNWL is being drawn up. Data collection closes in January 2019, with a report anticipated in the Summer of 2019.</td>
</tr>
</tbody>
</table>
| 41. National Clinical Audit of Psychosis | All | Opinion on results: **RED**  
The final report was published in June 2018. Principal areas for improvement were:  
- Provision of written information for service users is lower than expected in all areas, save Goodall inpatients.  
- Investigation of medication adherence in community patients not in remission, and investigation of alcohol or substance misuse for all patients not in remission, shows considerable room for improvement.  
- The data suggests the Trust is not offering clozapine to all those who are eligible, which is a diversion from NICE guidance. In community, this is offered to only just over half of those eligible.  
- Both the offering of cognitive behavioural therapy for psychosis (CBTp: CNWL 17%, National 26%. All CBT: CNWL 27%, National 36%) and the offering of family intervention where appropriate (CNWL 9%, National 12%), are very low for community service users. This triangulates with CQC feedback and suggests an urgent need for specific action in this area.  
Findings have been presented to Operations Board and QPC in separate reports, and actions are integrated into a larger programme of work steered by the Physical Health Steering Group. A monthly report on physical health is now instituted and is taken to QPC. Actions relating to aspects other than physical health, such as access to psychological therapies, medicines, and recovery, have also been addressed. |
| 42. NCAP – EIP Spotlight Audit | All | Data collection has commenced, and closes at the end of November 2018. A final report is anticipated in June 2019. |
| 43. Early Intervention in Psychosis Audit | All | Opinion on results: **AMBER**  
The final reports for each of the four Early Intervention Services in CNWL were published in May 2018 by the Royal College of Psychiatrists and reported in the Clinical Audit Annual Report 2017/18. The reports were further reviewed by the respective services and the Physical Health Steering Group, with an additional focus on the ‘domains of care’, for which the four EIP Teams achieved the same results:  
- Timely access – top performing (level 4)  
- Effective treatment – needs improvement (level 2)  
- Well-managed service – greatest need for improvement (level 1) |
### 44. National COPD Audit Programme – including Pulmonary Rehabilitation Audit – NOW NACAP (National Asthma and COPD Audit Programme)

<table>
<thead>
<tr>
<th>Opinion on results (Diggory):</th>
<th>Opinion on results (Goodall):</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMBER</td>
<td>GREEN</td>
</tr>
</tbody>
</table>

Reports were published in April 2018. MK has indicated that on current staffing levels, the recommendation to enrol a referred patient onto a pulmonary rehabilitation programme within 90 days will not be achievable, and the current performance is 126 days. Similarly, this lack of time precludes achievement of the recommendation for a practice walk to be part of exercise testing.

For Camden, 8 of 10 standards were achieved. For the 2 not achieved, the service is not commissioned to provide these services. A business case had been put to CCG in 2016 but was not funded. This is to be considered again.

This audit has now changed to become NACAP (National Asthma and COPD Audit Programme) and relevant CNWL services have registered to participate.

### 45. National Diabetes Audit – Diabetic Foot Care Audit

<table>
<thead>
<tr>
<th>Opinion on actions:</th>
<th>Overall assessment – needs improvement (level 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GREEN</td>
<td></td>
</tr>
</tbody>
</table>

A review of the Third Annual Report by Camden Podiatry Services demonstrated the effective management of diabetes patients, including pathways into the local acute trust and access to specialist care within 24 hours, for what is a more complex caseload than the national average. In Hillingdon, an action plan has been formulated and is in the process of being implemented. Purchase of an infrared thermometer has allowed for assessment at high risk clinics by CNWL skilled technicians.

It should be noted that CNWL doesn’t contribute to this national audit in its own right, but provides data to partner acute secondary care trusts for inclusion in their submissions.

### 46. POMH-UK: 15b Prescribing valproate for bipolar disorder

<table>
<thead>
<tr>
<th>Opinion on actions:</th>
<th>Overall assessment – needs improvement (level 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RED</td>
<td></td>
</tr>
</tbody>
</table>

Six clinical teams submitted a total of 325 cases to the national audit. A report was circulated to the Medicines Management Group in July 2018. Overall, CNWL’s practice was similar to the national picture, but this was below the recommended (NICE) standards.

1. Documentation of monitoring of physical health parameters was incomplete and notably lower than average national practice throughout.
Opinion on actions:

AMBER

2. Four out of six women newly prescribed valproate had no documented discussion around contraception.
3. There was poor documentation of advice given to women of childbearing age about the potential risks of the use of valproate in pregnancy, and contraception advice.

Recommendations

- Improve documentation of monitoring of physical health parameters throughout treatment.
- Fully implement the MHRA recommendations regarding the safe use of valproate in women of child bearing potential, including documentation of provision of advice to women of childbearing age about the potential risks of the use of valproate in pregnancy, and contraception advice (as part of the ongoing programme of work via the Safety Team, this practice is now better supported by the templates in the clinical systems).
- All patients should be offered written medicines information, preferably prior to commencing treatment; women of childbearing potential should be offered the MHRA approved Patient Guide and Card as part of the Pregnancy Prevention Programme.

These recommendations now rest with the Divisions in order to formulate action plans for local implementation.

47. POMH-UK: 16b Rapid tranquilisation

All

This audit report was due to be published in September 2018, but is still awaited from the audit providers. Once received, this will be taken to the Medicines Management Group for local interpretation and analysis. It is expected to be received from POMH-UK in November 2018. An update will be provided in the Clinical Audit Annual Report 2018/19.

48. POMH-UK: 6d Assessment of the side effects of depot antipsychotics

All

Data collection for this audit has been put back by POMH-UK to Autumn 2018. A report is due in 2019. However, it has been decided by CNWL to not participate in this audit.

49. POMH-UK: 18a Prescribing clozapine

All

Data collection for this audit took place in June and July 2018 and a report is anticipated in January 2019. An update will be provided in the Clinical Audit Annual Report 2018/19.

50. Sentinel Stroke National Audit Programme (SSNAP)

D / G

Opinion on results in most recent local analysis:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Results December 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>2: Stroke Unit</td>
<td>E for both patient centred and team centred</td>
</tr>
<tr>
<td>AMBER</td>
<td>5: Occupational Therapy</td>
</tr>
<tr>
<td>AMBER</td>
<td>6: Physiotherapy</td>
</tr>
<tr>
<td>AMBER</td>
<td>7: Speech &amp; Language Therapy</td>
</tr>
<tr>
<td>AMBER</td>
<td>8: Multidisciplinary Teamworking</td>
</tr>
<tr>
<td>AMBER</td>
<td>9: Standards by Discharge</td>
</tr>
<tr>
<td>AMBER</td>
<td>10: Discharge Processes</td>
</tr>
<tr>
<td>AMBER</td>
<td>Patient-centred SSNAP level (after adjustments)</td>
</tr>
<tr>
<td>AMBER</td>
<td>Team-centred SSNAP level (after adjustments)</td>
</tr>
</tbody>
</table>

The SSNAP data is monitored at Unit level by the Clinical Lead, who also receives detailed local analysis, enabling targeted actions and implementation of change where indicated.

### 51. UK Parkinson’s Audit

D / G

**Opinion on actions (Diggory):**

GREEN

**Opinion on actions (Goodall):**

AMBER / GREEN

Individual service reports have been received in April 2018 and a National report was published in May 2018.

In Milton Keynes, the local service is better than the national average for neurology services, in assessing the following areas: monitoring sitting and standing blood pressures, cognitive status, mood, communication issues and sleep. MK scored higher than average for referring to multidisciplinary services, education and signposting to other services including Parkinson’s UK and benefits advice. MK also scored higher than average on completing motor and ADL assessments. For advance care planning, MK asked 40% of people about power of attorney, compared to 15.3% nationally, and discussed end of life issues with 30% of patients compared to 8.1% nationally. For other domains not mentioned, MK scored the same as other services. (e.g. mood, on/off fluctuations, hygiene, problems with eating and drinking.)

The main observed weakness in MK was not routinely weighing patients (20% compared to 64.8% nationally) and linked to this, not assessing fracture and osteoporosis risk. (40% compared to 61.8%). There was evidence that MK assessed bowel function in 90% of patients, but only enquired about bladder function in 60% of patients, compared to 84.8% nationally. There was written evidence that MK asked 55% of patients if they had problems with saliva control. This can be an early indicator of swallowing difficulty. Since this audit, MK has obtained key equipment, improved written patient information and is currently modifying documentation templates to include all
domains of Parkinson’s assessment.

In Hillingdon, a Parkinson’s Education and Exercise programme called ‘Get Up and Go’ is being promoted, and screening for osteoporosis is being introduced alongside education for patients on bone health. A self-management course, following on from ‘Get Up and Go’ and running bi-monthly, is also being developed. Multidisciplinary team meetings have been established within the team. Advanced care planning with regards to end of life care requirements is being developed.

### Other National audits

<table>
<thead>
<tr>
<th>Project</th>
<th>Divisions</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>52. National HIV audit (BHIVA) – Routine Monitoring and Assessment in Older Adults</td>
<td>D</td>
<td>Data collection was in Summer 2018. A report is anticipated in Autumn 2018. <strong>An update will be provided in the Clinical Audit Annual Report 2018/19.</strong></td>
</tr>
<tr>
<td>53. British Association for Sexual Health and HIV (BASHH) Annual Audit – HIV Partner Notification Re-audit</td>
<td>D</td>
<td>This report was published in April 2018. Following the audit (and other service needs) the service now has dedicated HIV health advisors who have taken on the role of HIV PN within our service, which they now do in addition to partner notification for other STIs diagnosed in our patient cohort.</td>
</tr>
</tbody>
</table>

### TRUSTWIDE AUDITS

**Central Pharmacy Team**

<table>
<thead>
<tr>
<th>Project</th>
<th>Divisions</th>
<th>Update</th>
</tr>
</thead>
</table>
| 54. Quarterly controlled drugs (CD) audit | Opinion on results: Diggory: N/A | **Diggory Division – Q1 key findings**  
Due to unforeseen circumstances, Q1 was not completed.  
**Goodall Division – Q1 key findings**  
- Overall compliance with standards measured across Goodall in Q1 was 96% (17/18 Q4: 91% Q3:...
| Goodall: AMBER / GREEN | 88%; Q2: 95%; Q1: 95%).  
   - The CD category with the lowest compliance was related to ‘Receipt and records of Controlled Drugs’ being correct (80%);  
   - The lowest scoring question was ‘Errors in the CD record book being appropriately amended’ (60%). This standard has had low compliance across the previous four quarters.  
   **Actions**  
   - Circulate results to Divisional Governance Leads and discussion at Divisional Governance Board Meetings.  
   - Borough Lead Pharmacists to ensure the report is circulated to individual teams who have participated in the audit for consideration and action  
   - Borough Lead Pharmacists to circulate and follow up with ward and site managers to address local areas of non-compliances identified. To also be presented at borough or service line Quality Governance meetings.  
   - Associate Chief Pharmacist to present results and outstanding actions from the audit at the next Divisional Medicines Optimisation Group in October 2018.  
   - To monitor all action plans submitted for non-compliance to ensure they are completed.  
   **Jameson Division – Q1 key findings**  
   Overall level of compliance was 85%, this is a decrease from the previous two quarters.  
   - Q4 - 2017/18 was 92%  
   - Q3 - 2017/18 was 91%  
   There was consistent non-compliance with record keeping requirements relating to ordering and receipt of CD in record books.  
   **Actions in Q1:**  
   - Circulate results to Divisional Governance Leads and Divisional Directors of Nursing for consideration  
   - Borough Lead Pharmacists to follow up with ward and site managers to address local areas of non-compliances identified.  
   Q2 results for Diggory (including Dental Clinics), Goodall, and Jameson are anticipated later in Q3. **An update will be provided in the Clinical Audit Annual Report 2018/19.** |

| Jameson: AMBER / RED | 88%; Q2: 95%; Q1: 95%).  
   - The CD category with the lowest compliance was related to ‘Receipt and records of Controlled Drugs’ being correct (80%);  
   - The lowest scoring question was ‘Errors in the CD record book being appropriately amended’ (60%). This standard has had low compliance across the previous four quarters.  
   **Actions**  
   - Circulate results to Divisional Governance Leads and discussion at Divisional Governance Board Meetings.  
   - Borough Lead Pharmacists to ensure the report is circulated to individual teams who have participated in the audit for consideration and action  
   - Borough Lead Pharmacists to circulate and follow up with ward and site managers to address local areas of non-compliances identified. To also be presented at borough or service line Quality Governance meetings.  
   - Associate Chief Pharmacist to present results and outstanding actions from the audit at the next Divisional Medicines Optimisation Group in October 2018.  
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   - Q4 - 2017/18 was 92%  
   - Q3 - 2017/18 was 91%  
   There was consistent non-compliance with record keeping requirements relating to ordering and receipt of CD in record books.  
   **Actions in Q1:**  
   - Circulate results to Divisional Governance Leads and Divisional Directors of Nursing for consideration  
   - Borough Lead Pharmacists to follow up with ward and site managers to address local areas of non-compliances identified.  
   Q2 results for Diggory (including Dental Clinics), Goodall, and Jameson are anticipated later in Q3. **An update will be provided in the Clinical Audit Annual Report 2018/19.** |

| 55. Quarterly antimicrobial audit | Opinion on results:  
   This audit is used to monitor antimicrobial prescribing trends and quality indicators in order to guide training and development of healthcare staff and to optimise prescribing practice. Headline results in the most recent quarter were: |
Community Services Q2:
- CHS as a whole has demonstrated good compliance with the majority of the audit standards this quarter, however there is still significant room for improvement. Areas for improvement include documentation in the patient medical record and on the prescription chart.
- Compliance with the appropriate antimicrobial treatment choice audit standard for CHS as a whole this quarter was 100% (n=15) and has improved since Q1 2018/19 when compliance was 90% (n=31).
- Compliance with the appropriate antimicrobial course length audit standard for CHS as a whole this quarter was 93% (n=15) which has improved since Q1 2018/19 when compliance was 81% (n=31).
- Compliance with the allergy status standard this quarter was 100% and consistent with the previous quarter.

Actions are:
Antimicrobial pharmacist to attend local Medicines Management Group meetings to raise awareness of the following:
- Importance of documentation on prescription charts and in patient medical records when prescribing and antimicrobial
- The correct process of prescribing antimicrobials and importance of using antimicrobial guidelines
- Issues identified in quarterly audits and consumption reports.

Offender Care Q2:
- Offender care as a whole has demonstrated good compliance with all audit standards this quarter, however there is still some room for improvement. Areas for improvement include:
  - Appropriate antimicrobial treatment choice – Compliance for offender care overall was 89% (n=133) this is consistent with Q2 2018-19 when compliance was 90% (n=139). The main sites requiring improvement are HMP Winchester, HMP Highdown and HMP Coldingley.
  - Appropriate course length – Compliance for offender care overall was 84% (n=133) this has decreased since the previous quarter (Q1 2018-19 91% (n=139)).
- Overall compliance with the allergy status and documentation audit standards was above 90% indicating excellent compliance.

Actions in addition to those applying to Community Services are:
- Develop process to use Sytem1 reports to collect audit data and reduce data collection burden for Offender care pharmacy team.
- Formulate antimicrobial prescription templates for Sytem1 and implement across all offender
The Care Quality Commission (CQC) requires NHS trusts to keep patients, visitors and staff safe by having systems in place to ensure that medicines are handled safely and securely. In Goodall, overall compliance ranged from 93.3% to 99% Average across all services is 95.9%.

Key areas for improvement:
- More robust systems required for checking expiry dates to ensure all emergency medicines are in date.
- Ensuring fridge temperature is monitored on all days that the clinic is open.
- Ensuring there are adequate safe and secure storage arrangements for storing medicines
- Areas where medicines are consistently stored at higher than 25°C, should be discussed at local QG meetings and added to risk registers where appropriate.
- Further clarification on community health services sites that require emergency oxygen is required.

The Diggory and Jameson reports will be ready later in the year. An update will be provided in the Clinical Audit Annual Report 2018/19.

FP10 prescriptions are prescriptions written by a doctor which can be taken to any community pharmacy for dispensing. The prescription is then sent to the prescription pricing authority for pricing. The trust (CNWL) is charged with the cost of the medicine and a dispensing fee. As part of the CNWL medicines optimisation programme, the operational effectiveness of the procedure is reviewed through audits on annual basis. This is to ensure any risks associated with prescriptions are identified and managed.

The Diggory shall be available later in Q3. An update will be provided in the Clinical Audit Annual Report 2018/19.

This will be conducted in early 2019 (Q4). An update will be provided in the Clinical Audit Annual Report 2018/19.
<p>| | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>59. Covert Administration of Medicines</td>
<td>All</td>
<td>Data collection was conducted during Q2 and into Q3 and a report date is to be confirmed. An update will be provided in the Clinical Audit Annual Report 2018/19.</td>
<td></td>
</tr>
<tr>
<td>60. High Dose Antipsychotics Therapy for MH Rehab Services</td>
<td>All</td>
<td>This audit has been put back to Q4. An update will be provided in the Clinical Audit Annual Report 2018/19.</td>
<td></td>
</tr>
<tr>
<td>61. Prescribing of Benzodiazepines</td>
<td>All</td>
<td>This audit is scheduled for Q3. An update will be provided in the Clinical Audit Annual Report 2018/19.</td>
<td></td>
</tr>
</tbody>
</table>

### Others

<table>
<thead>
<tr>
<th>Project</th>
<th>Divisions</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>62. IPC – Hand Hygiene</td>
<td>Opinion on results:</td>
<td>Quarterly audits are conducted at divisional level of hand hygiene standards. The results for Q1 &amp; 2 are presented below by division</td>
</tr>
<tr>
<td>Diggory: AMBER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goodall: GREEN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jameson: AMBER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatients</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td>Community</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>63. IG – Care Records Annual</td>
<td>N/A</td>
<td>This audit shall not take place in 2018/19 as part of the formal Trust programme, as it is not</td>
</tr>
<tr>
<td>Audit</td>
<td>required for the IG Toolkit 2019 submission. Local targeted audits are advised to be conducted where documentation is thought to be a specific concern.</td>
<td></td>
</tr>
</tbody>
</table>
Overview

Trust wide reporting trends

A total of 5,083 incidents were reported during Q4, 2018/19. This shows a decrease of 1% when compared to Q3 2018/19 and continues to reflect a positive reporting culture across the Trust.

Annual reporting trends remain consistent with common cause variation to July 2018. Following this greater variation in reporting is present as shown by the statistically significant changes shown in August, October and December 2018 and January 2019. This is primarily due to effects of quality improvement projects, introductions of new services and changes in national reporting guidelines.

Trustwide - Reporting Trends
96% of all incidents across the Trust were reported as resulting in no harm or low harm, indicating a positive reporting culture. This is an increase when compared with Q3. 3% of all incidents were rated as moderate and this has decreased when compared against 2018/19.

**External Context**

National benchmarking against our peer group shows the Trust is the third highest reporter of incidents during 2018/19 when compared with other similar organisations in London and there is no evidence of potential under-reporting. The Trust has improved from reporting 41 Incidents per 1000 bed days (Apr 17- Sep 17) to 43 incidents per 1000 bed days (Apr 18- Sep 18). During the last financial year the Trust has maintained a consistent number of submissions to the National Reporting and Learning System each month. The Safety Team continues to work with divisional governance teams and services to maintain and improve on the Trusts current position.

**Internal Context**

Internal benchmarking indicates that Mental Health services continue to have the highest rate of incidents per 1,000 patients seen; this is typical of a large inpatient based service where care is provided 24 hours a day and is in keeping with previous year. For MH services, during Q4 2018/19 there were 66 incidents per 1000 patients seen in comparison to 75 in Q3 2018/19. Reporting in boroughs has varied with no outliers; Harrow, Hillingdon, Westminster and Milton Keynes showing a decrease in the number of incidents reported per 1000 patients seen during Q4. Brent and Kensington and Chelsea saw a small increase when compared against Q3. An increase was observed in Mental Health services from 2017/18 (998 per 1000 patients seen) to 2018/19 (1021.28 per 1000 patients seen).

For community health services, during Q4 2018/19 there were 19 incidents per 1000 patients seen in comparison to 23 in Q3 2018/19. Milton Keynes, Hillingdon and CIS all saw increases in reporting when compared to Q3. However, increases in the number of patients seen in Q4 resulted in a decrease in incidents per 1000 patients from Q3 to Q4. A small increase was observed in Community services from 2017/18 (276.32 per 1000 patients seen) to 2018/19 (296.91 per 1000 patients seen).

Specialist services all saw significant increases in reporting within the quarter; CAMHS (Q3 83/ Q4 99 per 1000 patients seen), Eating Disorders (Q3 89/ Q4 143 per 1000 patients seen), and Learning Disability services (Q3 115/ Q4 144 per 1000 patients seen). This increase was also observed year on year for specialist services.

**Top 5 Incident Categories – Analysis, Learning and Actions Underway**

<table>
<thead>
<tr>
<th>Top 5 Incident Categories 2017/18</th>
<th>Top 5 Incident Categories 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Distressed Behaviour (including attempt to abscond)</td>
<td>1. Distressed Behaviour (including attempt to abscond)</td>
</tr>
<tr>
<td>2. Assault / Physical Violence</td>
<td>2. Assault / Physical Violence</td>
</tr>
<tr>
<td>3. Pressure Ulcer / Moisture Lesion</td>
<td>3. Pressure Ulcer / Moisture Lesion</td>
</tr>
<tr>
<td>4. Slips, Trips and Falls</td>
<td>4. Self Harm (including Refusal of Medication)</td>
</tr>
<tr>
<td>5. Medication - Administration or Supply from a Clinical Area/ Patient Home</td>
<td>5. Medication - Administration or Supply from a Clinical Area/ Patient Home</td>
</tr>
</tbody>
</table>
Distressed Behaviour and Assault/Physical Violence

Trust-wide, distressed behaviour (including attempts to abscond) is the most frequently reported category of incident reported during 2018/19. There were a total of 611 incidents in Q4; this is an increase of 11% when compared against Q3.

The second most prevalent type of incident reported Trust-wide in 2018/19, relates to assault and physical violence. A total of 480 incidents were reported in Q4; this is a decrease of 10% when compared with Q3 2018/19.

**Distressed Behaviour and Assault / Physical Violence – Key Learning and Actions Underway**

There has been a 3% decrease in the number of physical assault and distressed behaviour related incidents in 2018/19 when compared to 2017/18. The incidents largely occur within mental health services. There was a significant drop in reporting across both categories in August and September 2018 (Q2); as well as in February 2019 (Q4) this could be partly attributed to an
increase in use of temporary staff during this peak annual leave period who may not be as familiar with incident reporting as substantive staff.

To support the Trust’s Violence Reduction Strategy from April 2019, the disruptive behaviour category has been relabelled as distressed behaviour to more accurately reflect the event that is being reported. The previous category often covered a range of indents and lacked detail regarding types of behaviours displayed. The addition of further questions have allowed for more defined reporting and data analysis and identification of potential areas of improvement. The supplementary questions that have been added to the Datix Incident Report form are based on the Dynamic Assessment of Situation Aggression (DASA) scale categories, it is hoped that this descriptive reporting will assist identifying which behaviours staff are able to de-escalate and which behaviours lead to the use of restraint and/or rapid tranquilisation to further support the Violence Reduction Strategy.

Restrictive Interventions

The Trust’s initial aim was to reduce the use of prone restraint by 50%; this was achieved in July 2017. The Trust is now working towards an aspirational aim to end the use of all prone restraint, with a particular emphasis placed upon learning from those prone restraints which are identified as being avoidable. The Trust continues to strive to reduce all restraint across all wards. The most recent national benchmarking (2017/18) showed that for all restraints, CNWL were on the cusp of being placed in the best 25% of providers. It is anticipated that as our work to reduce incidents of violence develops, we will see further improvements in this area.

Violence Reduction Strategy

The Violence Reduction Strategy was approved at the Restrictive Interventions Group in July 2018 and was ratified at the Operations Board in August 2018. The Strategy underpins the work required to engage and support each ward to develop a range interventions using Quality Improvement (QI) methodology. Each Borough is responsible for the implementation of their individualised QI strategy and progress is monitored through Care Quality Meetings who have clinical oversight. Violence reduction has been identified as a Quality Priority for the Trust and due to the need for spread of this work, it is being supported as a Central Quality Improvement.
Programme. A high level plan for the three year period has been developed, and the 10 teams who are the highest reporters of violence have been selected. These ward teams will join the QI Practicum where a full package of training in QI methodology will support the improvement work.

Pressure Ulcers

The third most prevalent type of incident reported Trust-wide in 2018/19, relates to Pressure Ulcers. Q4 2018/19 saw a marked increase in the number of pressure ulcers and moisture lesions reported trust-wide in comparison to the previous 3 quarters 2018/19. This was expected following the introduction of the revised NHS Improvement standardised guidance that was implemented across CNWL in November 2018. This included additional reporting categories for example Medical Devices related pressure ulcers and moisture lesions. The communication to all staff regarding these changes (e.g. via the bulletin, clinical messages of the week and Pressure Ulcer Board) and training led directly to a shift in reporting. The SPC chart limits have been amended accordingly to reflect this change. Within the last quarter, the number of pressure ulcer related incidents reported remains within the limits and therefore shows common cause variation.

Pressure Ulcers – Key Learning and Actions Underway

The Trust Pressure Ulcer Board continues to oversee the provision of evidence based training (in relation to the assessment, management and prevention of pressure ulcers/moisture lesions) and development in line with national guidance for all staff. Lessons learned through the revised initial management report process continue to be shared within the Pressure Ulcer Board ensuring that areas identified as requiring improvement are addressed to support care for similar patients. Specific training is in place across the divisions to ensure that staff are aware of the differentiation between moisture lesions and pressure ulcers and how to categorise accurately. Community Health practitioners are also focusing on providing skin care regime advice to all patients currently receiving nursing care for continence issues but have no other nursing needs and to their formal and informal carers. Staff are supported to understand that the SSKIN bundle needs to be updated regularly to reflect skin checks. Additionally, training is underway to ensure that all relevant staff are aware of the impact of medical devices on pressure ulcer development with focused training for therapists.
Self-Harm (including Refusal of Medication)

Trust-wide, self harm is the fourth most frequently reported category of incident reported during Q4 2018/19. There were a total of 367 incidents; this is an increase of 8% when compared against Q3.

There has been an observed shift in incidents since October 2018. This is partially attributable to the opening of Lavender Walk (CAMHS tier 4 service), where deliberate self harm is a feature of presentations by young people with acute mental health problems.

Self-Harm – Key Learning and Actions Underway

Incidents relating to self-harm remains the fourth most reported type of incident in Q4, this is in keeping with Q3. A total of 367 incidents were reported during this period. There was an increase in reporting, from 340 incidents in Q3 to 367 incidents in Q4. As shown in March 2019, an astronomical data point was observed; this is mainly due to a significant increase in the number
of incidents reported by the Eating Disorders Service, particularly in March 2019. The Eating Disorder Service reported 5 incidents in February and 38 in March 2019; the incidents in March largely involved 2 patients who refused their prescribed diet and required naso-gastric feeding as a result.

However, there was also an increase in the number of self-harm incidents reported in March that were not related to the refusal of medication. During March, 4 teams had increased reporting relating to cutting and ligatures incidents. HMP Winchester (n=20), 8 incidents were related to one distressed patient with episodes of cutting. There is ongoing work in place in relation to strengthening care pathways within the Offender Care Service. Others occurred in Lavender Walk - Adolescent Unit (n=17) mainly related to 3 distressed patients and were due to a combination of cutting and ligature related incidents. On Willow Ward – a female acute mental health ward (n=15) - the incidents related to 2 patients and a combination of cutting and ligature incidents. Vincent Square Eating Disorder Service, (n=13) 9 incidents were in relation to one patient who was distressed and refused her prescribed diet in addition to banging her head against the wall. Overall, there has been a shift in reporting since October 2018, this was partly due to the opening of Lavender Walk and the acuity and presentations of their patient group. Robust Clinical Risk Assessments and Safety Plans were in place for each of these patients.

Clinical Risk Assessment and Safety Planning

We recognise that reducing means and access to means of self-harm and suicide is critical and that this supports our wards in providing an environment that is safe and therapeutic. Annual ligature risk assessments of all inpatient mental health wards are undertaken in CNWL. This is supported by the Policy for the Identification and Management of Ligature Suspension Points. Ward based action plans are developed detailing the agreed actions. This accompanied by a local management plan which lists all ligature points and how they will be managed by staff. All staff are supported in managing this risk via an education and instruction package. Governance of this important work stream is overseen by a Ligature Risk Control Team and Group which reports to the Trust-wide Health and Safety Group. Environmental risk assessments of all wards as a minimum are completed annually.

A Clinical Risk Assessment and Safety Planning Task & Finish Group has been established to support the ongoing work to embed the Clinical Risk Assessment and Safety Planning Policy, this policy was revised in Q4 2018/19 in line with the implementation of SystmOne, recent national guidance and evidence based practice. The group also provides a forum to support the dissemination and embedding of shared learning from incidents via internal clinical risk/safety alerts and Clinical Messages of the Week. The zero suicide activities for all mental health wards relies on accurate risk assessment and safety planning as well as the safe management of the environment.

CNWL’s Suicide Prevention Strategy is in the process of being ratified and reflects the actions the Trust is committed to implementing to prevent suicide and self-harm in high priority and vulnerable groups. Additionally work is underway to develop the Safety and Self-Harm and Suicide Prevention e learning package and competency framework. This will be available for all mental health practitioners in Q2 2019/20 via the Learning and Development Zone.
Reporting of medication related incidents across the Trust during Q4 has fallen compared with Q3, however, it remains fairly consistent compared with the previous quarters and last year. The decrease in Q4 is mainly attributed to decreases in incidents reported in Harrow, Brent, CIS, Hillingdon Community and Rehabilitation services. 99.8% of all medication incidents in Q4 were rated as either no or low harm; and <1% were reported as moderate harm (n=1). There were no severe harm incidents. This is comparable with data from the previous quarters in 2018/19. 55% of Q4 medication incidents were attributable to CNWL staff and key themes in Q4 included omission/missed dose/missing medication/omitted medicine (24%); Controlled drugs related (21%); Wrong/unclear dose/strength (11%) and Medication not transferred when patient moves wards/hospital or discharged (8%). There was one incident relating to medication this quarter that was reported on STEIS relating to clozapine blood monitoring.

Throughout 2018/19, the number of medication incidents reported across the Trust remained high with a total of 1927 reported on Datix. This remains consistent with 2017/18 (n=1937). Medication incidents were amongst the top five most commonly reported Datix incident categories each quarter across all CNWL services. Whilst reporting levels fluctuated on a monthly basis, consistent reporting across all boroughs/ service lines is indicative of a good reporting culture and increases the opportunity to learn.

**Medication – Key Learning and Actions Underway**

Lessons have been learnt from serious incidents involving lithium, for example, shared care agreements have been reviewed in Milton Keynes so that patients can be treated and monitored by the CNWL team where the expertise lies as opposed to primary care.

A review of clozapine related incidents in 2018 (n=72) identified that the majority were due to issues with the Jade appointment list (JAL) system used to identify patients requiring their clozapine to be dispensed. These issues arose due to last minute changes to the list and omissions. Additionally, monitoring, follow up and advice incidents centred on communication issues, i.e patient's blood results were available but not communicated to ZTAS or the pharmacy.
team. The clozapine clinic forum has representatives from London and MK clozapine clinics with aims including to standardise practice and governance arrangements.

The revised MHRA valproate risk acknowledgement form has been uploaded to SystmOne and a Quick Ref Guide for healthcare professionals has been developed with reference to CNWL contraceptive services so that Mental Health clinicians can refer for advice. An audit of compliance to the MHRA requirements is due in Q3 2019-20 to ensure practice is embedded and that patients are reviewed by a specialist at least annually.

### Slips, Trips and Falls

Q4 2018/19 showed a slight decrease of 5% was noted when compared against Q3 18/19. The main types of falls continue to be those where the patient has fallen whilst walking or mobilising or where there have been found unable how to recall how they fell. In Inpatient settings falls most frequently take place in the bedroom. Peak times for falling in inpatient setting are afternoons and in community teams it is morning. Most falls in inpatients continue to be unwitnessed.

The revised Falls Policy and associated guidance including a streamlined risk assessment tool is now embedded in practice. The Falls Board reviews internal falls data themes and trends and reviews related guidance. The Falls Board is going to oversee a Trust-wide falls reduction programme over the next 3 years (starting in October 19). This programme will use the QI methodology to ensure that we properly understand what needs to be done, and that the various changes we make actually do lead to the expected improvements. In the first year, the programme will help the 10 wards with the highest level of need to make the improvements that are most important to them, and in future years we will promote improvements in falls reduction practises across all of CNWL's services.

### Patient Centred Leave

Ensuring that patients are safe from harm whilst on leave and return on time from the ward remains a clinical priority. The Patient Centred Leave Steering Group is well established and continues to provide oversight in relation to supporting ward teams across mental health services. They are developing a variety of initiatives using quality improvement methodology that are underpinned by working alongside patients to understand why patients leave the ward directly or fail to return from leave as planned. The group’s membership includes senior practitioners from each borough and aims to reduce failure to return to the ward by 50% and reduce absconding to below 10 per year by March 2019. Phase One projects across all Boroughs have been finished and are currently being evaluated. Phase Two is going to focus on the use of escorted leave across the acute units and aim to reduce the number of patients who abscond whilst on short periods of escorted leave. The impact of this work is that in 2018/19 saw a 20% overall reduction in the number of patients who failed to return from leave and an 11% decrease in the number of patients who go directly AWOL from the wards/units across the Trust.

We know that as a result of engaging with patients about their leave that one of the main reasons why patients decline to come back to the ward is not being able to smoke. Ward staff have learnt that during admission patients tend not to have the finances to buy the e-cigarettes. An agreement has been reached for each ward to have access to e-cigarettes for patients on admission as part of the stop smoking initiative. Inpatient units are working with the smoking cessation groups to develop uptake, monitoring and further guidance for staff around e-
cigarettes. The impact of the increase in availability of e-cigarettes is being monitored and will be reported in Q1, 2019/20.

We are also seeing summer peaks in patients not returning to the wards on time; this was noted in September and October 2018 and is in keeping with previous years. Work is underway to explore whether more effective temperature control of ward environments and access to outside space during summer may prevent further spikes in people choosing to go AWOL directly from the wards during the warmer months.

Summary

When compared with the previous financial year the most obvious change has been the increase in reporting of self-harm incidents which is now the fourth most reported incident category. This has been primarily due to the introduction of new acute services and the acuity of their patient group. The Trust continues to support with the management of these incidents via annual ligature risk assessments of all inpatient mental health wards, development of action and local management plans and staff learning and development. Furthermore, the updated Clinical Risk Assessment and Safety Planning Policy supports staff to develop robust and comprehensive risk assessment and safety plans in conjunction to the work in place to support the safe management of the environment. In addition, changes to national guidance has resulted in a significant increase in the reporting of Pressure Ulcers and this is expected to continue going forward as staff are now reporting moisture lesions and medical device related pressure ulcers. Specific training is in place across the divisions to ensure that staff are aware of the differentiation between moisture lesions and pressure ulcers and how to categorise accurately.

Key themes such as Violence and Aggression have been identified as a quality priority for the Trust and the focus will be to reduce incidents of physical assault involving staff and service users by 30%. The Violence Reduction Strategy and associated QI programme will continue to support this work. A high level plan for the three year period has been developed, and the 10 teams who are the highest reporters of violence have been selected. These ward teams will join the QI Practicum where a full package of training in QI methodology will support the improvement work in these areas. Work continues to support safe patient leave from the wards underpinned by best practice and national guidance. Incidents related to slips, trips and falls continue to be an area of focus and has now been identified as Trust quality priority for the coming year. A QI programme is in place to support this work to reduce these incidents to minimise risk of harm for our vulnerable patients. Medication related errors remain within the top five most frequently reported type of incident. This is in keeping with previous reporting years. The Pharmacy Team remain focused on the analysis of key themes and trends and dissemination of shared learning through a range of communications.

To conclude, for each of the key themes identified following analysis of incidents across 2018/19, established working groups are in place to support improvement in these areas. Progress will reported at the end of Q1 2019/20.

Ashtami Bharathan
Patient Safety Manager
Learning from Deaths Annual Report 2018/19

1. Introduction

In March 2017 the National Quality Board published guidance for Trusts on Learning from Deaths. CNWL subsequently developed and published its Responding to and Learning from Deaths

The Trust policy sets out the arrangements to ensure that we not only learn from deaths which are identified and investigated as serious incidents but also outlines the systems in place to support learning for those cases which do not require this higher level of investigation.

2. External Context

2.1 Care Quality Commission

The CQC set out the findings from their original review in December 2016, when they published Learning, candour and accountability. From September 2017, the CQC began assessing NHS Trusts’ implementation of national guidance on learning from deaths. This formed part of their new well-led inspection. As part of our Well Led review the CQC requested a range of information on the work undertaken by our Mortality Review Group. No issues were identified, evidenced by the CQC not identifying any ‘Must Do or Should Do’ actions for this area of work.

In March 2019, the CQC published their report “Learning from Deaths, a review of the first year of NHS Trusts implementing the national guidance”. This report identified variation in how Trusts were implementing the guidance and also highlighted that the guidance is better suited to Acute Trusts rather than Mental Health and Community Trusts.

The report identified a range of factors that enable good practice including:

- Values and behaviours that encourage engagement with families and carers
- Clear and consistent leadership
- A positive, open and learning culture
- Staff with resources, training and support
- Positive working relationships with other organisations

The recent CQC inspection of CNWL provides assurance that our arrangements in these areas are robust but in order to provide further assurance and support continuous
improvement, the Mortality Review Group are considering what steps can be taken to enhance its arrangements to support the application of these themes in practice.

2.2 Royal College Psychiatrists Mortality Review Guidance

In December 2018 the Royal College of Psychiatrists published a Care Review Tool. Based on the Structured Judgement Review methodology which was originally developed by the Royal College of Physicians, the tool is suitable for supporting mortality reviews for patients who were under the care of Mental Health Trusts and can be adapted for use by joint Mental Health and Community Providers. The Mortality Review Group considered the tool and recommended a number of changes to our existing review process based on the screening tool which it uses. Furthermore, a pilot is now being undertaken to consider whether the full screening tool can be adapted and used within the Trust. This pilot is due to report back to the Mortality Review Group in quarter 2.

2.3 The Learning Disability Mortality Review Programme (LeDeR) Annual Report 2018

The Learning Disabilities Mortality Review (LeDeR) programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme by the University of Bristol commenced in June 2015, initially for three years. The contract has since been extended until the end of May 2020. All deaths of patients being cared for by CNWL and with a learning disability diagnosis are referred to this programme which then oversees their review.

The aims of the LeDeR programme are to:


The LeDeR programme supports the review of deaths of people with learning disabilities (aged four years and over) using a standardised review process. The team based at the university also provides support to local areas to take forward any lessons learned in the reviews to make improvements to service provision. The LeDeR programme also collates and shares anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

The LeDeR Annual Report for 2018 was published in early 2019. It is detailed report and includes information about the deaths of people with learning disabilities notified to the programme from 1 July 2016 – 31 December 2018. It places a particular focus is on deaths for which a review was completed during the calendar year 1 January – 31 December 2018.

The report makes 12 recommendations, the can be found in appendix 1. The majority of these recommendations are at a national level however a key piece of learning, where actions were relevant to CNWL related to the rationale for Do Not Attempt
Cardiopulmonary Resuscitation (DNACPR) orders being made. The report found that the rationale for a number of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were cases documented as Learning Disability and Down Syndrome.

In response, Professor Stephen Powis, Medical Director for NHS England NHS Improvement issued a letter to all Trusts and CCG’s reminding and recirculating relevant guidance for staff. In response to this letter, it was cascaded within the Trust via the Medical Director to all Doctors for their attention.

3. Learning in CNWL

3.1 Mortality Reviews

The Mortality Review Group places a strong emphasis on the value and importance of learning from all deaths. There is however, a particular emphasis placed on the systems and arrangements that we have in place for those who are considered vulnerable.

In recognition of this, our systems are set up to ensure that all deaths of patients who are under the care of our learning disability and mental health services are reported and reviewed in detail. This system is aligned to our incident reporting system and integrated with our serious incident reporting and investigation processes.

During the 2018/19 reporting period a total of 353 deaths were recorded by Mental Health services with 18 deaths reported by the Learning Disability Service. All of these cases have been subject to a CESDI review and investigated, where required the deaths was reported as a serious incident and investigated under this policy. The Annual Report for Serious Incidents provides more detail on these cases.

During 2018/19 there were 9 cases which were identified as a CESDI grade 2 with 0 cases identified as CESDI Grade 3 (please see appendix 2 for the definitions use for the CESDI Grading System). All CESDI Grade 2 cases where the care provided may have contributed to the patient’s death are subject to investigation under the Serious Incident Policy and follow the process for Duty of Candour. Where these investigations have been completed the learning has been included within the thematic analysis within the Annual Report for Serious Incidents. All serious incident investigation reports are reviewed by the relevant Division(s). Where wider learning opportunities are identified these are also then discussed at the Mortality Review Group.

3.2 Learning and Actions Taken

During 2018/19 the following key learning and actions have been undertaken across the Trust:

- A review of deaths reported by Learning Disability Services during 2017/18 was completed by the Clinical Director for Learning Disability Services; this was presented at the Trust Mortality Review Group in June 2018 and highlighted both areas of good practice and opportunities to improve in information sharing and physical healthcare
A further review of the 18 cases reported during 2018/19 is scheduled to be presented to the Mortality Review Group in August 2019. This will also provide an update on the outcome of work completed during 2018/19

The Trust held a Bereavement Conference which was attended by multi-professional staff across all Divisions and was co-created by bereaved relatives

Subsequently, the Trust developed its Compassionate Care after Death Policy which has now been implemented across the Trust

Our case note reviews for Community Physical Health Services continue to be completed each quarter and we have extended the sample size completed to increase the opportunity for learning

A Quality Improvement Project within a Community Mental Health Team was undertaken, this has supported improvements in this locality whilst also providing learning for wider changes and improvements

Based on the above and alongside the launch of SystmOne - our new Clinical System, the Trust has reviewed and implemented a revised Clinical Risk Assessment and Safety Planning Policy taking into account feedback from service users and carers who were involved in the above project

We have partnered with the Zero Suicide Alliance, developed our Suicide Prevention Strategy and also finalised our plan for Zero Suicides on Inpatient Wards

In line with this plan, our policy for the Identification and Management of Ligature Suspension Points on Inpatient Wards was completed

All inpatient areas have copies of their ligature risk assessment and local management plan with monitoring of Estates work being undertaken by the Corporate Health and Safety Group

A new Task and Finish Group to oversee both risk assessment and suicide preventions has been established and will also be used to ensure that ongoing system wide changes are considered and made where required

Our Strategy for Physical Health in Mental Health has been agreed with work streams and leads set up

4. Mortality Reporting

4.1 Trust wide

During 2018/19 a total of 3,108 patients who were under the care of CNWL services passed away. Whilst there have been instances which have required further investigation it is important to note that the majority of people who die whilst under the care of an NHS service experience good care. Reporting details of deaths which required further investigation are included within the Trust’s Serious Incident Annual Report.

Graph 1 provides an overview of all deaths recorded across the Trust’s services since April 2017. The graph reflects the Trust’s Mental Health, Specialist and Community Health Services and includes both inpatients and outpatients who at the time of their death were open to a CNWL service.
During the 2018/19 reporting period there were no astronomical data points noted when considered at a Trust level. This is in contrast with the same reporting period last year which highlighted an increase in deaths across the Trust reported during the winter months of 2017/18. National data for England and Wales has previously shown that more people die during this seasonal period. The Trust will compare its data against the national picture once the national data is made available.

It is important to note that during 2018/2019 of all deaths reported within the Trust, 91% occurred whilst people were under the care of our Community Health and Primary Care Services. The majority of these deaths were expected and are not as a result of a direct patient safety incident e.g. deaths which follow palliative care.

### 4.2 Community Health Services

During 2018/19 a total of 2,837 patients who were under the care of CNWL Community Health Services passed away. Graph 2 provides an overview of all deaths recorded across these services since April 2017.
Deaths which occur within Community Health Services where there are no concerns regarding care and treatment do not require reporting on the Trust’s Incident reporting system. However, the Trust has an auditing system which reviews a random sample of cases on a monthly basis which are then rated using the CESDI framework. During 2018/19 15% of the deaths reported by Community Health Services were reviewed using the CESDI framework. No significant concerns were identified via this review process, where specific learning was identified following a review this is fed back to relevant clinicians.

4.3 Mental Health and Specialist Services

During 2018/19 a total of 371 patients who were under the care of CNWL Mental Health Services passed away. Graph 3 provides an overview of all deaths recorded across the Trust’s Mental Health and Learning Disability Services since April 2017

Graph 3 – Overview of deaths reported by Mental Health and Learning Disability Services

Unlike the Trust wide and Community Health Services, reporting across Mental Health Services is showing special cause variation, with higher than normal reporting during December 2018, January 2019 and March 2019. Analysis of these months shows increased levels of reporting by Older Adult Mental Health Services and Memory Services across the Trust. Analysis of the CESDI reviews of these cases has not identified any common themes or issues around the care provided. Whilst there is no clear evidence suggesting an issue, further consideration is being given as to whether the Trust could place a stronger emphasis on the availability of seasonal vaccinations to patients in these services leading up to winter 2019.

As previously highlighted, the Trust is fully engaged in the Learning Disabilities Mortality Review (LeDeR) programme. During 2018/19 there were 18 deaths of patients who were under the care of the Trust’s Learning Disability Services, all these cases have been referred for review by the LeDeR programme and the Trust is awaiting feedback on the findings of the reviews. Once available the Clinical Director will report back to the Mortality Review Group.
5. Next Steps

The Mortality Review Group continues to review in detail all deaths where it is identified that the care we provided may have contributed to the outcome with the overarching aim to facilitate learning and improvement.

Our key areas of focus for improvement continue to be physical health in mental health and learning disability services and suicide prevention:

- Via the suicide prevention strategy and zero suicide on inpatient wards, the Trust has clear plans to support improvement in this area
- The Physical Health Steering Group also continues to support improvements in this area and will oversee the new Trust wide Quality Priority to support the management of the deteriorating patient.

Jack Pooler
Head of Safety
# Key recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Details</th>
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<tbody>
<tr>
<td>1</td>
<td>Consider designating national leads within NHS England and local authority social care to continue active centralised oversight of the LaDoR programme.</td>
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<tr>
<td>2</td>
<td>NHS England to support Clinical Commissioning Groups to ensure the timely completion of mortality reviews to the recognised standard.</td>
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<tr>
<td>3</td>
<td>There should be a clear national statement that describes, and references to relevant legislation, the differences in terminology between education, health and social care so that ‘learning disability’ has a common understanding across each of the sectors and between children’s and adults’ services.</td>
</tr>
<tr>
<td>4</td>
<td>Clinical Commissioning Groups and local LaDoR steering groups to use local population demographic data to compare trends within the population of people with learning disabilities. They should be able to evidence whether the number of deaths of people from Black, Asian and Minority Ethnic groups notified to LaDoR are representative of that area and use the findings to take appropriate action.</td>
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<td>5</td>
<td>The Department of Health and Social Care and NHS England to support national mortality review programmes to work with ‘Ask, Listen, Do’ and jointly develop and share guidelines that provide a routine opportunity for any family to raise any concerns about their relative’s death.</td>
</tr>
<tr>
<td>6</td>
<td>The Department of Health and Social Care, working with a range of agencies and people with learning disabilities and their families, to prioritise programmes of work to address key themes emerging from the LaDoR programme as potentially avoidable causes of death. The recommended priorities for 2019 include: i) recognising deteriorating health or early signs of illness in people with learning disabilities and ii) minimising the risks of pneumonia and aspiration pneumonia.</td>
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<td>7</td>
<td>Guidance continues to be needed on care-coordination and information sharing in relation to people with learning disabilities, at individual and strategic levels.</td>
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<td>8</td>
<td>Shortfalls in adherence to the statutory guidance in the Special Educational Needs and Disability Code of Practice in relation to identifying and sharing information about people with learning disabilities approaching transition, transition planning and care coordination must be addressed.</td>
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<tr>
<td>9</td>
<td>The Royal College of Paediatrics and Child Health to be asked to identify and publish case examples of best practice and effective, active transition planning and implementation for people with learning disabilities as they move from children’s to adults’ health services.</td>
</tr>
<tr>
<td>10</td>
<td>The Department of Health and Social Care, working with a range of agencies and the Royal Colleges to issue guidance for doctors that ‘learning disabilities’ should never be an acceptable rationale for a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, or to be described as the underlying or only cause of death on Part I of the Medical Certificate of Cause of Death.</td>
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<tr>
<td>11</td>
<td>Medical Examiners to be asked to raise and discuss with clinicians any instances of unconscious bias they or families identify as in recording ‘learning disabilities’ as the rationale for DNACPR orders or where it is described as the cause of death.</td>
</tr>
<tr>
<td>12</td>
<td>The Care Quality Commission to be asked to identify and review DNACPR orders and Treatment Escalation Personal Plans relating to people with learning disabilities at inspection visits. Any issues identified should be raised with the provider for action and resolution.</td>
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### Appendix 2

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Grade 0</strong></td>
<td>Unavoidable death, no suboptimal care</td>
</tr>
<tr>
<td><strong>Grade 1</strong></td>
<td>Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome</td>
</tr>
<tr>
<td><strong>Grade 2</strong></td>
<td>Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)</td>
</tr>
<tr>
<td><strong>Grade 3</strong></td>
<td>Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)</td>
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</table>
Mental Health Law Compliance Report 2018/2019

Meeting date
Paper title Mental Health Law Compliance Report
Paper number
Paper author Anthony Beschizza, Head of Mental Health Law
Lead director Andy Mattin, Executive Director of Nursing & Quality
FOI status This paper cannot be published

Paper summary
This report highlights the Trust’s compliance regarding the responsibilities outlined for the Board in the Mental Health Act 1983 (MHA), and informs the Board of Directors of the actions being taken to mitigate against any areas of non-compliance, as well as outcomes. The Trust has performed well in MHA CQC visits, however areas for improvement are the recording of Section 132 rights, patient views and involvement in care plans and the recording of capacity assessments. Patients’ rights are of fundamental importance to the Trust, given that we are care for some of the most vulnerable people in society. A review of the auditing process is in progress, and plans are being developed to personalise patient care plans and provide 132 rights, using a Quality Improvement approach. The report identifies that CNWL has a rate of 0.4% rate of unlawful detentions, well below the national average of 4%. It reports that the Associate Hospital Managers review patient detentions and that there is a low rate of discharge following these. It notes that the CQC published a report on the rise in the use of the MHA to detain people in England and that the 4 broad themes had been already identified in our Mental Health Law Group, which oversees the use of compulsory powers in the Trust and MHA performance with Divisional leads. The report also informs the Board of any changes to MHA legislation, for example, the reduction in time for completion of Section 136 assessments, and the Trust’s implementation plan, as well as outcomes. It concludes with an update on MHA training which is now essential to role and supported by the development of e-learning. This report also sets out 4 clear objectives for the Mental Health Law Department and Mental Health Law Group for 2018/2019.

Purpose (tick one only)
☐ For decision
☒ For discussion
☐ For information

Recommendation
To discuss key points identified in the paper

Where was this paper previously discussed?

Resource implications
To support the essential to role training in the MHA an e-learning package has been purchased and this will need refreshing as legislation changes.

Quality considerations
Improved MHA Compliance in the areas of focus for the Board will result in better patient care and engagement, a better CQC rating.
1. Executive Summary

This report is the annual report for 2018/2019. This report highlights the Trust’s compliance in specific areas pertinent to the responsibilities outlined for the Board in the Mental Health Act 1983 (MHA), and informs the Board of Directors of the actions being taken to mitigate against any areas of non-compliance, as well as outcomes. The report also informs the Board of any changes to MHA legislation, and the Trust’s implementation plan, as well as outcomes.

- In the last year, the Trust has performed well in MHA CQC visits, and staff are reported to be providing excellent care to patients

- Areas for improvement were the recording of Section 132 rights and evidence of assessments of the patients’ capacity to consent to treatment being completed by the treating clinician in a small number of cases, as well as a lack of evidence of patient views and involvement in care plans. Patients’ rights are of fundamental importance to the Trust, given that we care for some of the most vulnerable people in society. Auditing of section 132 rights has been ongoing for two years, and improvement lacks consistency in a number of areas across the Trust. A review of the auditing process is in progress, and plans are being developed to personalise patient care plans and provide 132 rights, using a Quality Improvement approach

- Unlawful detention in CNWL remains well below the national average, and systems continue to be monitored and improved to keep this figure low.

- Associate Hospital Managers carry out a key function on behalf of the Board and regularly review patient detentions, exercising their power to discharge where the criteria for detention is no longer met. Figures continue to show that the discharge rate is low. Appeal rates to Associate Hospital Managers are low. This does not appear to suggest an issue in relation to reading patients Section 132 rights as the number of applications to the First Tier Tribunal have consistently remained high. Primarily, this issue appears to be linked with legal aid funding. The Trust mitigates against this by keeping a list of solicitors who are willing to attend AHM hearings, pro bono, in order to ensure that patients are legally represented. However, this limits the choice of representation for patients. Consequently, the use of advocacy is promoted to ensure patient’s rights are upheld. The vast majority of hearings are renewal hearings, which must be automatically heard by the AHM’s every time a patient’s section is renewed by the Responsible Clinician.

- MHA Training has not had mandatory status historically; as a result staff have opted into face to face training sessions at a frequency which has been self-dictated. In light of recent changes in MHA Law, and parity with other Trusts,
MHA training has been given ‘essential to role’ status in 2018. To support effective learning the MHA Department has purchased an MHA e-learning package, and the Department continues to work with local teams to deliver face to face training in inpatient, community and rehabilitation sites across the Trust.

2. Introduction

The MHA is the main piece of legislation that covers the assessment, treatment, and rights of people with a mental disorder. It provides the Trust with the authority and power to treat such people who cannot be supported in less restrictive ways.

‘Hospital Managers’ are responsible for ensuring these powers are used lawfully. In England, NHS hospitals are managed by NHS Trusts, NHS Foundation Trusts and CCG’s. The Trusts themselves are defined as the Hospital Managers for the purposes of the MHA: the Hospital Managers in CNWL are the Board of Directors. Most of the decisions of the Hospital Managers are delegated and made by individuals e.g. Consultant Psychiatrists, Mental Health Law Officers, Nurses and Approved Mental Health Professionals from day to day. The Hospital Managers i.e. the Trust Board has the power to discharge patients from detention under Section 23 of the Act which is delegated to Associate Hospital Managers (AHM’s).

The Board has an overall responsibility for making sure that patients are:

1. Detained only as the Act allows
2. That their treatment and care accord fully with its provisions
3. That patients’ are fully informed of, and supported in, exercising their statutory rights

3. Unlawful Detention

The Trust has consistently fallen below the national average for unlawful detention. Patients are detained against their will in line with the MHA in the vast majority of cases. Under the provisions of the Mental Health Act, there are specific guidelines that must be followed when completing detention papers, in order to legally detain a person against their will for assessment/ and or treatment.

Approved Mental Health Professionals, Local Mental Health Law officers, and bleep holders (out of hours) and doctors scrutinise mental health act paperwork to ensure that patients are legally detained, and that there are no uncorrectable errors present. This is to maintain compliance with statute, avoid legal challenge and claims for compensation from solicitors, but most importantly to safeguard patients’ rights.

The national average rate of unlawful detentions as quoted by the CQC is 4%. In 2017/2018 CNWL had 1,851 admissions under the Mental Health Act 1983, of which there were 8 incidents of unlawful detention, which is generally as a result of human error, and represents a rate of 0.4%. CNWL falls well below the national average of unlawful detentions. The Trust continues to implement systems and processes to reduce the possibility of these incidents occurring, these include local training, and administrative systems, and prompts.
4. Trust wide MHA Compliance - CQC MHA Inspections

The Trust performed well in MHA CQC inspections, as fed back by the CQC during their annual inspections to our inpatient mental health wards. In 2017/2018, the CQC has visited 31 inpatient wards across Diggory, Goodall and Jameson Divisions. CQC feedback is that patients feel that staff are “friendly, kind, professional, caring, attentive, polite, respectful, and engagement is positive”. The CQC have also commented on the following:

- AMHP reports have been located on files, and MHA paperwork has been in order
- Safeguarding processes are robust, and staff have received appropriate training
- There was good evidence of close monitoring of physical health by the doctors and nurses on the ward
- Certificates of consent (T2&T3) were present in the records of qualifying patients. The records contained assessments of capacity to consent which had been completed on admission. This was reviewed on change of legal status or renewal
- Receipt and scrutiny of documents was carried out by the MHA administrator who also helped process applications and referrals to the Mental Health Tribunal and Hospital Managers
- Good advocacy provisions on the wards
- The detention paperwork was available to view and in good order, including the outline reports from the approved mental health professional
- There was good evidence of the MHA administrator on site discharging the obligations of the hospital managers, advising professionals of deadlines under the MHA and organising Mental Health Tribunals and hospital managers’ hearings
- Patients were actively involved in the running of the ward through a weekly community meeting that was chaired by an ex service user and was minuted

Areas for improvement were the recording of Section 132 rights and evidence of assessments of the patients’ capacity to consent to treatment being completed by the treating clinician in a small number of cases, as well as a lack of evidence of patient views and involvement in care plans and were out of date. Patients’ rights are of fundamental importance to the Trust, given that we care for some of the most vulnerable people in society. Auditing of section 132 rights has been ongoing for two years, and improvement lacks consistency in a number of areas across the Trust. A review of the auditing process is in progress, and plans are being developed to personalise patient care plans and provide 132 rights, using a Quality Improvement approach.

Between 16th January 2019 and 2nd April 2019, the CQC conduction an in depth inspection of services, as well as a well led inspection of the Trust. The feedback contained in the Well Led Evidence Appendix was extremely positive:

- The trust had clear structures and procedures for keeping scrutiny of the Mental Health Act (MHA) and Mental Capacity Act (MCA) at the forefront of practice. Policies were subject to review, and there was board level buy in to
the sub-groups that monitored the day-to-day functioning of MHA activity. Despite the size of the trust, the mental health law team had a presence on each inpatient site and also spent time in community settings. The director of nursing was the executive lead for mental health law and oversaw the work of the mental health law team. The trust head of mental health law was responsible for the strategic role out of any new or revised policy and the dissemination of information about new legislation.

- The mental health law office team, which comprised the mental health law officers on each site and the centrally based mental health law managers, met every month to review concerns and also to try and collate evidence of good practice. The mental health law office was overseen by the associate director of quality, safeguarding, safety and security who reported to the director of nursing. There were six designated localities which covered all of the sites of the trust and each locality had its own mental health law locality manager and mental health law officers. Mental health law team meetings informed the mental health law group, which reported to the trust board. The structure of the administration of deprivation of liberty safeguards (DoLS) under the MCA was different. This function was managed by the safeguarding and MCA leads, who reported to the head of social care.

- A yearly mental health law performance report and quarterly mental health law compliance reports were presented to the board by the mental health law group. These included analyses of trends over the past year, but also recorded incidents of unlawful detentions, unlawful treatment, and problems with MHA assessments. The rate of these incidents was compared to the national average and the evidence consistently showed that the trust was below the national average for incidents that breached the Act or the Code of Practice. The majority of breaches were first identified by the local mental health law office. All were discussed in team meetings and by the mental health law group and, where necessary, meetings were arranged with the relevant staff. Lessons learned were written up and disseminated across the trust.

- The mental health law office conducted a number of audits each year, particularly focussed on matters brought to its attention by CQC MHA review reports. Data was collected from the electronic records system by way of a business intelligence application.

- Through inspection and MHA reviews CQC had noted a possible over reliance on the use of section 62 while waiting for a second opinion appointed doctor (SOAD) to attend. The trust had developed a tracker for SOAD requests and at present there were 30 cases outstanding. Requests had been lodged with CQC for 28 of these cases. CTO patients had to wait the longest time, with one patient waiting 147 days for a SOAD to be identified.

There was one “should do” action for Acute wards for adults of working age and psychiatric intensive care units (PICU) in relation to the Mental Health Act 1983:
• The trust should make sure all responsible clinicians are aware of the need to make prompt requests for second opinion appointed doctors when required and that their use of section 62 of the Mental Health Act 1983 is monitored.

It is the view of the Mental Health Law Department that that there needs to be some triangulation between the two statements made by the CQC. Our audit which is highlighted in the well led reports, showing that we have some longs delays when waiting for a second opinion appointed doctor from the CQC, which will inevitably mean prolonged use of section 62.

The Trust has systems in place to remind the Responsible Clinicians of their responsibilities and trackers in place to highlight and monitor consent to treatment status, including Section 62, which includes an escalation process to senior management and Borough Directors.

There was one “should do” action for Community-based mental health services for adults of working age in relation to the Mental Health Act 1983:

• The trust should ensure that there are systems in place to check that staff explain patients’ rights to people subject to compulsory treatment orders (CTOs), in accordance with the Mental Health Act Code of Practice

The Trust has systems in place to reminder staff of the need to explain patients’ rights. Clinicians and managers are sent weekly reminders of outstanding actions relating to the Mental Health Act in order to ensure that rights are provided in a timely manner.

There was one “should do” action for people with learning disabilities of autism in relation to the Mental Health Act 1983:

• The trust should review how it records and monitors its training requirements relating to the Mental Health Act.

Date regarding Mental Health Act training is held with the Learning and Development Team. A compliance report is provided to the Mental Health Law Department on a monthly basis. This helps the department target specific areas of non-compliance.

5. Consent to Treatment

There were **432** Second Opinion Appointed Doctor (SOAD) requests to the CQC for the Trust in 2018/2019.

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of SOAD Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beatrice Place</td>
<td>3</td>
</tr>
<tr>
<td>Woodfield Road</td>
<td>10</td>
</tr>
<tr>
<td>Campbell Centre</td>
<td>8</td>
</tr>
<tr>
<td>Cherrywood</td>
<td>2</td>
</tr>
<tr>
<td>Rosedale Court</td>
<td>7</td>
</tr>
<tr>
<td>Roxbourne</td>
<td>7</td>
</tr>
</tbody>
</table>
In 2018/2019 the reasons for SOAD requests were as follows:

<table>
<thead>
<tr>
<th>Reason for SOAD Request</th>
<th>Number of SOAD Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in consent status</td>
<td>43</td>
</tr>
<tr>
<td>Change in medication</td>
<td>141</td>
</tr>
<tr>
<td>Expiry of time limited SOAD certificate</td>
<td>1</td>
</tr>
<tr>
<td>Expiry of 1 month CTT rule (CTO)</td>
<td>39</td>
</tr>
<tr>
<td>Expiry of 3 month CTT rule</td>
<td>190</td>
</tr>
<tr>
<td>ECT</td>
<td>10</td>
</tr>
<tr>
<td>CTO Revoked</td>
<td>2</td>
</tr>
<tr>
<td>Start of new course of treatment</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>432</strong></td>
</tr>
</tbody>
</table>

In 2018/2019 the outcomes of SOAD requests were as follows:

<table>
<thead>
<tr>
<th>Outcome of SOAD Request</th>
<th>Number of SOAD Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>No form issued</td>
<td>22</td>
</tr>
<tr>
<td>Medication significantly changed</td>
<td>8</td>
</tr>
<tr>
<td>Medication slightly changed</td>
<td>118</td>
</tr>
<tr>
<td>Treatment plan endorsed</td>
<td>284</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>432</strong></td>
</tr>
</tbody>
</table>

Following concerns raised by the CQC regarding prolonged use of Section 62 (urgent treatment powers), the Mental Health Law Department conducted a snapshot audit as of 25th February 2019, for all patients where consent to treatment rules under the MHA 1983 were applicable.

The audit highlighted that there were 30 relevant cases where by consent to treatment rules were applicable. Requests had been lodged with CQC for 28 of these cases. The audit highlighted significant delays with the CQC in sending out a SOAD. CTO patients had to wait the longest time, with one patient waiting 147 days for a SOAD to be identified. These delays, with the CQC, will inevitably mean prolonged use of section 62.
6. Associate Hospital Managers (AHM’s)

In England, NHS hospitals are managed by NHS Trusts, NHS Foundation Trusts and CCG’s. For these hospitals, the Trusts themselves are defined as the hospital managers for the purpose of the Act.

The Board of Central and North West London NHS Foundation Trust (the Trust) are the Hospital Managers for this purpose.

The Hospital Managers i.e. the Trust Board has the power to discharge patients from detention under Section 23 of the Act which is delegated to Associate Hospital Managers (AHM’s).

The AHM’s are a group of independent volunteers who are appointed and trained by the Trust as lay persons. AHM’s are not employees of the organisation, have no financial interest in it, and are independent of the management and clinical teams assessing and treating detained patients. They have the responsibility, on behalf of the Trust Board, to review a patient’s detention when requested or at other appropriate times in order to ensure that the terms of the MHA are applied correctly and that patients are not detained inappropriately.

A panel of three AHM’s carries out a review of a patient’s detention, which involves hearing the views of the patient, and evidence from the clinical team before arriving at a decision to uphold or discharge the detention.

An AHM Committee meets three times a year and is led by the Trust Chair, and also attended by the Director of Nursing and CEO. The Committee discusses AHM activity, as well as Trust wide issues arising from recent cases. A Sub Group of AHM’s, led by two Co Chairs, meets four times a year to discuss operational issues.

In 2018/2019, there were 323 hearings, and of those hearings 13 Patients were discharged. This shows that although AHM’s have the power to discharge patients from detention, this power is not often utilized, as the risk associated with relapse is often high and potential negative outcomes arising from this. Nevertheless, some patients find the option of having an independent review of their detention, and the opportunity to speak to a group of people outside of their clinical team therapeutic.

The number of appeals to AHM’s remains low. The vast majority of hearings are renewal hearings, which must be automatically heard by the AHM’s every time a patients section is renewed by the Responsible Clinician. This does not appear to suggest an issue in relation to reading patients Section 132 rights as the number of applications to the First Tier Tribunal have consistently remained high. Primarily, this issue appears to be linked with legal aid funding and the fact that some firms of solicitors will not represent patients at AHM hearings when they receive little or no remuneration. The Trust mitigates against this by keeping a list of solicitors who are willing to attend AHM hearings, pro bono, in order to ensure that patients are legally represented. However, this limits the choice of representation for patients. Consequently, the use of advocacy is promoted to ensure patient’s rights are upheld.
7. Review of the Mental Health Act

The review of the Mental Health Act final report was published on 6 December 2018 and makes a total of 154 recommendations.

The review recommends that a statement of fundamental purpose and principles should be articulated in the MHA’s opening section. This is in contrast to the current guiding principles which are contained in the Code of Practice and not in the Act itself. This is a welcomed recommendation which would provide the basis for all actions taken under the act, setting the standards against which decisions can be held to account and providing service users with clear expectations for their care and treatment.

The review proposes the following principles:

- Choice and autonomy: Ensuring service users’ views and choices are respected
- Least restriction: Ensuring the act’s powers are used in the least restrictive way
- Therapeutic benefit: Ensuring patients are supported to get better, so they can be discharged from the act
- The person as an individual: Ensuring patients are viewed and treated as rounded individuals

These four principles form the basis for the 154 recommendations set out by the review. The following section summarises those proposed actions.

On publication of the report, the government said it accepts two of the review’s recommendations to modernise the MHA:

- Those detained under the Act will be allowed to nominate a person of their choice to be involved in decisions about their care
- People will also be able to express their preferences for care and treatment and have these listed in statutory ‘advance choice’ documents

The Law Group will continue to receive reports and updates with regard to the MHA review.

8. MHA Training

Whilst MHA training did not receive mandatory status, agreement has been given for Mental Health Law Training to be given ‘essential to role (ETR) status’ in 2018. The Mental Health Law Department provides training across inpatient and community sites to staff, and to external Trusts as part of contractual duties performed under Service Level Agreements for MHA Administration Services rendered.

The Mental Health Law Department has recently purchased an E-Learning package which will form part of the ETR training programme, aimed at specific professional staff groups. The e-learning package will make training more accessible to staff, and introduce automated reminders to staff who are out of date with their training
compliance. The package is aimed at reaching more staff across the organisation, which will support existing face to face training on offer, and will support staff to acquire the skills and knowledge to meet the statutory requirements of MHA legislation as well as the requirements of the CQC.

The Learning and Development Department established a target audience of just under 1500 staff members where MHA training is applicable.

In setting up the essential to role training, it was established that the Trust would achieve 80% compliance by the end of year one. To date, the Trust has achieved a completion rate of 41%. The Trust is on target to meet the target of 80% compliance by year one.

Data regarding Mental Health Act training is held with the Learning and Development Team. A compliance report is provided to the Mental Health Law Department on a monthly basis. This helps the department target specific areas of non-compliance.

As of Monday 29th April 2019, individual staff members and their managers will be informed via email, of the need to complete the Mental Health Act E-Learning package. It is envisaged that this will help improve training compliance in this area.


<table>
<thead>
<tr>
<th>Objectives 2018/2019</th>
<th>Objective status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment of new AHM Lead</td>
<td>Complete – Sally Friend and Roy Flowers were appointed in April 2018</td>
</tr>
<tr>
<td>Development of annual training plan for AHMs</td>
<td>Complete - A annual training plan was agreed and developed by the AHM Sub Group, which focuses on 3 overarching themes; knowledge, skills and behaviours</td>
</tr>
<tr>
<td>Ensure SystmOne is compliant with the MHA 1983 and has the ability to improve compliance with key areas of the law (Section 132 rights, Mental Capacity Act 2005, Deprivation of Liberty Safeguards)</td>
<td>Complete - SystmOne is now operational</td>
</tr>
<tr>
<td>Mental Health Law Department to complete business case for team restructure</td>
<td>Complete - This was agreed by Andy Mattin</td>
</tr>
<tr>
<td>Mental Health Law Department to commence a Quality Improvement project to improve compliance with Section 132 rights</td>
<td>This is scheduled to commence in September 2019</td>
</tr>
<tr>
<td>The Mental Health Law Group to continue to develop a MHA analytical report which provides the Trust with a clear overview of the use of the Act</td>
<td>The Mental Health Law Group receives a quarterly analytical report which provides the Trust with a clear overview of the use of the Act</td>
</tr>
<tr>
<td>Ensure Mental Health Law Department staff continue to be compliant with</td>
<td>This is ongoing</td>
</tr>
</tbody>
</table>
10. Trust Wide Health Based Place of Safety (HBPoS) Group

The Trust wide HBPoS Group has been established following the 2017 HBPoS Task and Safety meetings which mapped each HBPoS against specified criteria.

The work of this group is to ensure consistent standards of practice across all HBPoS sites in CNWL and establish an expert group of staff maintaining legal literacy on the changes of the Policing and Crime Act, 2017 and the impact this has made to practice.

Of note in 2018/2019, the Group developed guidance for staff on the use of HBPoS for Under 18s.

The Group continues to set specific focused areas of work and is current developing guidance on the management of medicines for people brought into the HBPoS.

10. Objectives for 2019/2020

1. Ensure that the Trust is kept up to date with developments with the Mental Health Act review

2. Ensure the implementation of the new Liberty Protection Safeguards are monitored and reviewed by the Mental Health Law Group

3. Ensure Mental Health Law Department staff continue to be compliant with Statutory/Mandatory training

4. Mental Health Law Department to commence a Quality Improvement project to improve compliance with Section 132 rights

11. Conclusion

The Trust remains compliant with Mental Health Law Legislation as a whole, and areas for improvement are being monitored through the Mental Health Law Group. CQC inspectors are feeding back positively about the Trust’s MHA compliance, and areas for improvement including the recording of Section 132 rights and patient involvement in care plans, which are historically challenging areas. A new Quality Improvement methodology approach is being considered whilst existing actions and audits are reviewed. New changes in legislation to Section 136 of the MHA are being effectively managed, and systems are in place to implement the changes necessary for compliance. Whilst AHM hearings are changing, given the lack of solicitors at renewal hearings, they hold some therapeutic value for patients, and valuable insight to the Trust, particularly around delayed discharge. Unlawful detention remains low, which is evidence of robust systems to maintain MHA compliance.

12. The Board is asked to:
1. Note areas of good practice and improvement from MHA CQC visits, as well as proposed action
2. Note the objectives set for 2019/2020
### Paper summary

This report presents the views of patients and carers who used our services in 2018/19, based on Friends and Family Test (FFT) feedback and compliments, complaints and concerns received. It also presents highlights from our patient and carer involvement and engagement activities and sets out our plans for 2019/20. Key points to note are:

**Rates of feedback have increased**

Our FFT response rates rose from 2.6% to 3.1% and we are particularly pleased that mental health services response rates have improved.

**We have fewer complaints compared to last year**

We have a rate of 14.29 complaints per 1,000 staff, which is an improvement on the 31.45 we reported in 2017/18. According to Model Hospital we are performing better than many of our peers (who reported 25.15 per 1,00 staff) and slightly better than the national average of 15.54. We are seeing more concerns being raised and fewer formal complaints, which is positive.

**We respond promptly to complaints but the quality of our response varies**

We responded to 98% of complaints within the agreed timescales, compared to 96% in the previous year. Some services respond quickly, compassionately and effectively to concerns and complaints but others struggle with this. We are improving our training and guidance for staff to help address this. Across the Trust we need to improve the way we record outcomes, actions and lessons learnt from complaints on Datix.

**Our FFT feedback is largely positive and the same as 2017/18**

Most feedback through the FFT is positive and satisfaction rates remain high at 92%, the same as 2017/18. Satisfaction remains higher in community services (95%) than in mental health (87%) and this is consistent with the national trend. Compared to last year, satisfaction has improved in mental health services in Brent, Harrow, Kensington and Chelsea, as well as Learning Disability Services, Hillingdon Mental Health Services, CAMHS, Community Independence Service, Milton Keynes Mental Health, Milton Keynes Community Services, Addictions and Offender Care Services. A slight decline in satisfaction was seen in Westminster, Eating Disorder Services and Sexual Health Services.
**Most positive feedback was about staff**  
Staff were described as supportive, respectful, helpful, professional, understanding and caring, as one patient said: “Like sunshine in the dark.”

**Negative feedback often focused on access and communication, e.g.:**  
- Waiting times, booking systems, delays to care, treatment or follow up  
- Insufficient time being given to patients and families  
- Lack of adequate communication and information from staff around services, pathways and care plans, information getting lost or not passed on, patients not feeling informed in or fully involved in their care  
- Care co-ordinators not contacting patients regularly or not providing clear enough information about their role or what they offer. This is a theme that became more prominent in the last two quarters of the year.

**Patient and carer involvement activities have increased in 2018/19.**  
We have seen increased patient and carer involvement activities across the Trust. New guidance documents and training sessions have been co-produced by patients, carers and staff. These include guidance on i) good practice in service user involvement, ii) training in carer awareness, iii) guidance on how to involve people from overlooked groups and iv) involving service users and carers in Quality Improvement (QI). CNWL patients and carers have delivered national and international conference presentations showcasing our involvement work and our CNWL carers council designed and delivered a conference for 120 carers. Our aims for expanding involvement further are set out in the new patient and carer involvement strategy which was produced in partnership with patients, carers and staff.

<table>
<thead>
<tr>
<th>Purpose (tick one only)</th>
<th>☐ For decision</th>
<th>☒ For discussion</th>
<th>☐ For information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation</strong></td>
<td>The Board is asked to: discuss the report and actions underway.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Where this paper was previously discussed</strong></td>
<td>This report contains feedback that has been previously been discussed at Board, Divisional, borough and local meetings for quarters 1, 2 and 3. Only the quarter 4 data and annual summary is new information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resource implications</strong></td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Quality considerations</strong></td>
<td>Patient feedback is a key component of how we measure and improve quality across the Trust.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risks</strong></td>
<td>Complaints, FFT and national survey data are externally shared and benchmarked so poor performance can present a reputational risk.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Executive Summary

This report summarises feedback from patients, their families and carers on their experience of CNWL services in 2018/19. We have looked at responses to the Friends and Family Test (FFT) questions, including over 30,000 free text comments. We have analysed a further 4,835 concerns, compliments and complaints that came in through our Patient Feedback and Complaints Service (PFCS). We report on highlights from our 2018/19 patient and carer involvement activities and actions planned.

1. Our Friends and Family Test (FFT) response rate has increased from 2.6% to 3.1% this year
2. The number of compliments has increased from 2,490 to 3,131
3. The number of concerns has increased from 860 to 1,262 and the number of complaints has decreased from 582 to 442. This may indicate that we are getting better at resolving lower lever concerns promptly before they become complaints, an area of focus for us. We need to build on this in 2019/20.
4. We have a rate of 14.29 complaints per 1,000 staff, which is an improvement on 2017/18, better than our peers and slightly better than the national average
5. 43% of the complaints we received were upheld or partly upheld which is fewer than the previous year. Three complaints were investigated and closed by the Parliamentary and Health Service Ombudsman (PHSO), of which only one had been upheld.
6. The percentage of patients who would recommend our services in 2018/19 has remained the same as 2017/18 at 92%. This is line with the national picture.
7. Patients are more likely to recommend community services compared to mental health services and this is also in line with the national picture
8. Patients are most likely to be satisfied when they are treated promptly by caring staff, communicated with well and involved in decisions, from first contact through to discharge
9. We responded to 98% of complaints within the agreed timescales but the quality of our response varied
10. As a Trust we need to be much better at recording on Datix what action has been taken and what lessons have been learnt in response to complaints
11. We have seen a wide range of patient, carer and public involvement and engagement activities in 2018/19 and our new involvement strategy will make sure this expands further

Introduction

Nothing matters more than providing services that meet the needs of patients and families. This report summarises feedback from patients, their families and carers on their experience of CNWL services in 2018/19. We have looked at responses to the Friends and Family Test (FFT) questions, including over 30,000 free text comments. We have analysed a further 4,835 concerns, compliments and complaints that came in through our Patient Feedback and Complaints Service (PFCS). We also report on highlights from our 2018/19 patient and carer involvement activities and actions planned.

1. Are we are getting more or less feedback and what does this indicate?

1.1 Friends and Family Test (FFT) responses

The FFT question asks patients and carers ‘How likely are you to recommend our service to friends and family if they needed similar care or treatment?’ In 2018/19 we heard from 25,686 people through the FFT, compared to 16,407 people the year before. This is an increase of 56% and means that we are now hearing from 3.1% of our service users compared to 2.6% last year. FFT response rates are calculated using the total number of responses received and the number of unique patients seen within a service.

To help increase response rates, we worked with services to include the FFT question in existing surveys. The number of active surveys the Trust has which include the FFT question has increased to 43.
A small email pilot was conducted in community services to see if emailing patients after their appointment would improve response rates. Due to practical difficulties this pilot was inconclusive and will be repeated in another service. We remind teams of the importance of collecting FFT feedback from all service users. A new monthly newsletter has been developed which gives the FFT headlines for the Trust, an overview of who is using the system and examples of good practice.

To encourage greater inclusivity, we provide the FFT survey in multiple languages, in an easy read format and a version for children and young people. In 2018/19, the number of patients who completed our easy read FFT dropped to 1,243 from 1,498 in 2017/18. We have reviewed the easy read guidance with internal staff to make it more user-friendly and we will promote this option more in 2019/20. We also encourage people to provide FFT feedback online and this method is growing in popularity as we continue to promote it.

Figure 1: Friends and Family Test Response Rates 2018/19 by Borough, presented in a p chart

Looking at the above chart, the services in large green circles (Brent, Milton Keynes Mental Health, Offender Care and Rehabilitation Services) have achieved particularly positive response rates. The services highlighted in smaller red circles (Hillingdon Community and Hillingdon Mental Health) have the lowest response rates. Services that fall within the dotted line above are within the normal range. The grey line shows the average.

- Brent Services had the most improved FFT response rate from 4.6% to 7.4%, as well as a 4% increase in satisfaction
- Offender Care created patient involvement roles and this helped them achieve an increase of over 150% in FFT responses. Offender Care also saw the highest increase in satisfaction. Community Independent Service, Kensington and Chelsea, and Westminster also made good progress with response rates this year.
- The lowest response rates were found in Hillingdon Mental Health Services (1%) Hillingdon Community Services (1.5%) and Westminster (2%)
- Learning Disabilities saw a decrease in responses but a 7% increase in satisfaction
1.3 Compliments, concerns and complaints

In 2018/19, CNWL patients and carers:

- Gave 3,131 compliments, compared to 2,490 in the previous year
- Raised 1,262 concerns, compared to 860 in the previous year and made 442 complaints, compared to 582. We are encouraging staff to resolve issues locally and quickly before they become complaints.
- The highest rate of compliments was recorded by Learning Disability, Kensington and Chelsea and CIS and the lowest rate Hillingdon Community Health Services
- The Community Independence Service (CIS) reported the lowest rate of complaints at zero
- The highest rates of complaints were reported in Kensington and Chelsea
- We have a complaints rate of 14.29 per 1,000 staff. Our peers are at 25.15 and the national rate is 15.54. This means we currently have fewer complaints than our peers and are performing above the national average, which is also an improvement on 2017/18.

Figure 2: Written Complaints Rate per 1,000 staff from March 2016 to December 2018, taken from NHS Improvement’s Model Hospital Site
The above chart shows that Kensington and Chelsea had the highest rate of complaints per 1,000 patients. The percentages in the rising arc show the accumulative percentage of complaints. Looking at the chart we can see that Kensington and Chelsea complaints account for 25% of the overall complaints received by CNWL in 2018/19. By adding Harrow, we now have 37% of the complaints in the Trust, and so on. This means that three areas (Kensington and Chelsea, Harrow and Brent) accounted for almost half of CNWL complaints in 2018/19.

1.5 Parliamentary and Health Service Ombudsman (PHSO) complaints

The Parliamentary and Health Service Ombudsman (PHSO) is an impartial organisation that makes final decisions on complaints that have not been resolved in the UK by NHS, governments and other public organisations. The PHSO investigated and closed three CNWL complaints in 2018/19. One complaint was upheld, the remaining two were not upheld. The upheld complaint related to Harrow East CMHT and a patient’s personal budget and eligibility needs under the Care Act. CNWL had partly upheld this complaint and the Ombudsman upheld the complaint stating ‘although the patient did not always engage in the Care Act process the service had not fully utilised services such as an advocate / mediation in its attempts to complete the assessment’. Lessons have been learnt in response to this.

The Ombudsman also closed four cases relating to 2017/18 and none of these were upheld. Five other cases are still under investigation by the Ombudsman.
2. **What is the feedback about; is it indicating a growing issue?**

In 2018/19, 92% of people completing the FFT said that they would be likely or extremely likely to recommend CNWL services, which is the same as 2017/18.

When we look at the FFT comments in detail we can see that patients appreciate being seen promptly by skilled, experienced and compassionate staff. Where care is being provided on an ongoing basis, patients benefit from seeing consistent members of staff who understand their needs and history. For some services, particularly in community mental health teams, patients fed back on how unsettling it can be to have a constant change of care coordinator.

2.1 **Notable highlights**

- FFT satisfaction remains higher in Community Services than in Mental Health and this is consistent with the national trend
- The highest FFT satisfaction rates in Community Services are the Community Independence Service, Milton Keynes, Hillingdon and Camden Community Services
- The highest FFT satisfaction rates in Mental Health Services are in Addictions, Milton Keynes, Harrow and CAMHS
- The lowest FFT satisfaction rates are in Offender Care, Westminster, Kensington and Chelsea and Learning Disability Services
- The service that has seen the most positive change in satisfaction scores is Offender Care, where satisfaction rose to 79% compared to 71% last year

**Figure 4: Percentage of patients completing the FFT who would recommend the service, presented as a p-chart**

Most services fall within - or very close to - the dotted line above, meaning they are performing within the normal range. The services of interest are those outside of the normal range. Camden Community, CIS, Hillingdon Community and Milton Keynes (in the larger green circles) were above average, whilst Brent, Kensington and Chelsea, Offender Care and Westminster (in red) were outliers due to more negative responses.
3. How well are we responding to the feedback we get?

We encourage staff to look at their FFT scores and take action where needed, and in 2018/19, we held 12 monthly training webinars and 2 in-depth face-to-face training for staff members. The FFT features on the Diggory division preceptorship training, in which staff are shown real-life examples of how FFT feedback can directly lead to better patient outcomes. This is helping to embed FFT in local service culture.

In terms of formal complaints, we responded to 98% of formal complaints within the agreed timescale. This is an increase since 2017/18, where 96% were responded to on time.

Of the complaints we received, 43% were upheld or partly upheld, compared to 60% last year.

We have put in place stronger systems for acting on feedback, including earlier dialogue with services to help them tackle issues. In 2018/19 we held training sessions to help managers and staff respond promptly and positively to feedback and we will do more of this in the year ahead. We have changed the name of the Patient Support Service to the Patient Feedback and Complaints Service and updated our information and resources:

- We have provided new posters to be displayed in clinical areas, encouraging patients to give feedback and explaining how to make a complaint. These have been produced in English as well as in the top 10 foreign languages used by patients.
- We have produced a new leaflet advising people on how to give feedback, raise concerns and make a complaint
- We have produced guidance for staff on how to respond to concerns in a positive, prompt and compassionate manner, encouraging early resolution
- We have developed a learning resource for staff available on Trustnet
- We are developing a new style training session for staff on managing complaints

4. What are we learning and what action are we taking in response to feedback?

In terms of the FFT, when a patient reports they would be ‘unlikely’ or ‘extremely unlikely’ to recommend a service this automatically flags a ‘linked action’ on Optimum Meridian that services are expected to respond to. A total of 440 linked actions were received in 18/19 compared with 269 in 17/18. Some of this large increase can be attributed to the inclusion of Offender Care services in the linked action process this year; 106 or 24% came from Offender Care. Linked actions from people in prison quite often focused on issues accessing healthcare appointments. This can be due to a number of reasons outside of the control of the healthcare team, including a lack of prison officers to escort people to appointments.

In order to understand the key themes for action we undertook a thematic analysis of the actions and lessons learned on the Datix system and compared these to the themes from the FFT.

4.1 For mental health services the key themes around complaints and negative feedback are:

- Waiting times for assessment and treatment. Waiting was an issue raised in almost all services including offender care, in which patients expressed frustration over the long waiting times to receive healthcare, including simple interventions.
- Staff shortages, resulting in inconsistent care, inconsistency in the care coordinator, appointments being shorter than patients would like, lack of follow up
- Communication between services, between staff, information getting lost or not passed on, patients not feeling informed or involved in their care
- Staff sometimes being described as hostile, lacking respect, not listening or not understanding
4.2 For community health services the themes are similar with an emphasis on:

- Appointments being cancelled at short notice, scheduling issues, poor communication, long waiting times for an appointment and waiting times within clinics
- Some service users in sexual health services continued to express frustration over the appointment booking system appointments, with some stating that it rarely worked and they had no way to get in contact with the service if they had problems
- A number of community patients wanted better information upon discharge and follow ups
- Patients asked for better integration of services, continuity of care and communication between services

Many of the complaints and negative comments we received could have been avoided if our services communicated more effectively, both with patients and families and with the various services involved in providing care. Some complaints also suggest that we need to do more to manage expectations and communicate what our different services can and cannot offer.

Positive feedback often referred to staff responsiveness and compassion when delivering care. This was a positive theme that consistently came through across all services in the Trust.

**What will we do next to improve our response to feedback and complaints?**

- Our central Patient Feedback and Complaints Service (PFCS) and Organisational Learning Manager will discuss with service lines and divisions any specific themes relevant to them at end of each quarter
- A new style training session that supports staff to respond to complaints swiftly and compassionately will be provided throughout 2019/20
- Each division will have an identified member of the PFCS team to go to for support with local concerns and complaints
- We are improving the online learning resources for staff
- We will continue to expand the use of FFT across the Trust

5. **How have we engaged with patients and carers in 2018/19?**

**We have:**

- Worked with the CNWL Carers Council, Patient Involvement Forum and staff to jointly produce the new Trust-wide Patient and Carer Involvement Strategy and action plan
- Created a single point of contact for staff, patients and carers to seek advice on involvement – involvement.cnwl@nhs.net
- Worked with our Patient Involvement Forum and Carers Council to produce guidance and training for staff on how to involve people
- Co-delivered a guide to involving patients and carers in Quality Improvement (QI) and followed this up with training sessions for staff, patients and carers
- Updated our guidance for involving patients and carers in staff interview panels
- Worked with the Carers Council to coproduce a carers’ conference, attended by over 120 carers from across the Trust. We delivered co-produced sessions on topics including: how to look after yourself when caring for others; how to access information on your rights as a carer; how to get involved in Quality Improvement, commonly used medications, as well as open discussion and sharing stories. Discussion on the day informed our involvement strategy and action plan.
- Amended the terms of reference for the Trust-wide Patient Involvement Forum to help recruit more members from community health services
- Co-produced the refreshed carers leaflet
- Provided more training in Optimum Meridian for staff, to help them make better use of the Friends and Family Test data
- Appointed a new Trust-wide Volunteer Service Manager
• Worked with many services across the Trust to support them in involvement and co-production activities
• Delivered a co-produced talk on ‘good practice in patient and carer involvement’ at a national conference for psychological therapy clinicians
• Matched patients and carers to various activities, including presenting at senior leadership training courses; attending a workshop to improve the experience of people under the Care Programme Approach; work to improve Health Based Places of Safety and helping to improve the information provided to patients and carers on medications
• Supported service user to present at events, including national and international conferences
• Piloted co-produced Carer Awareness Training to frontline staff

6. What will we do next to engage more patients and carers?

We will deliver:

• An online resource for patients and carers who want to get involved in partnership working
• A database of patients and carers across the Trust who are interested in partnership working
• A list of partnership work taking place across CNWL
• Guidance, training and protocols for staff on:
  ➢ How to recruit and induct patients and carers
  ➢ How to involve people in a meaningful way
  ➢ How to pay and reward people for their time
  ➢ How to provide people with support and opportunities for development
  ➢ How to involve people in a range of activities, including committees, research projects, Quality Improvement (QI) projects, staff interview panels and others
  ➢ How to involve groups that are often overlooked

• Guidance and materials for patients and carers, including:
  ➢ A guide to being involved in CNWL activities and a clear induction process
  ➢ Individual skills passports for patients and carers, so that skills can be developed over time
  ➢ Information for patient and carers on different involvement methods and how to influence others

• A regular involvement newsletter written by patients, carers and staff
• Regular events bringing together patients, carers and staff, including a regular Carers Conference and regular Patient Conference
• An annual summary of our involvement work
• Clearer information for each borough about how people can access carer’s assessments

Triangle of Care

CNWL have committed to the principles of the Triangle of Care scheme, and in doing so will empower services to be even more inclusive and supportive of carers and families. We have enrolled Harrow and Hillingdon Mental Health Services to start the Triangle of Care process and will roll this out to other services throughout 2019/20. For more details on the Triangle of Care scheme, please see this website.

Overall, this report provides assurance that we are listening and responding to those who use CNWL services but we are not complacent and will do more in the coming year to further improve patient and carer experience and engagement.

For details of performance per Borough or Area, please see Appendix 1.
Appendix 1: Summary of performance by Borough and Speciality Area

Here we present patient and carer feedback according to the Borough or speciality that the patient was seen in, presented below in alphabetical order. For each Borough or speciality, we will address the same four questions:

1. Are we are getting more or less feedback and what does this indicate?
2. What is the feedback about, and is it indicating a growing issue?
3. How well are we responding to the feedback we get?
4. What are we learning and what action are we taking?

The summaries were compiled using:

1. Response rates for the Friends and Family Test (FFT) questions
2. The answers to the following FFT questions:
   - How likely are you to recommend our [ward/service/team] to friends and family if they needed similar care or treatment? We used the numerical data from this question to see how likely people were to recommend the different services in CNWL
   - What is the main reason for your answer? We looked at the written responses to this question to see what the most commonly occurring comments were and to help us understand what service users like the most and least about our services
   - What could we do better? We looked at the comments people made and summarised the key themes
   - Any other comments: We looked at the comments people made and summarised the key themes
3. Rates of compliments, concerns, complaints and comments made to the CNWL Patient Feedback and Complaints Service and the speed of response to these
4. The content of the compliments, concerns, complaints and comments, to see what we could learn from any patterns
5. The recommended actions following complaints and FFT feedback
Addictions Services

Are we are getting more or less feedback than in 2017/18 and what does this indicate?

Addictions services saw an increase in Friends and Family Test (FFT) returns with a response rate of 3.4% in 2018/19 compared to 2.5% in 2017/18. A total of 1269 people completed the FFT, with Hackney Recovery Service achieving the highest number of responses at 481.

The rate of compliments decreased in 2018/19 compared to 2017/18, dropping to 12.20 from 14.57 per 1,000 patients. Addictions Services still have one of the highest rates of compliments across all CNWL services. The rate of concerns and complaints per 1,000 patients decreased slightly.
What does the feedback tell us about patient and carer experience?

93% of FFT respondents said they would recommend the service to other people, which is slightly above 92% in 2017/18.

Feedback from 3,351 FFT comments and the various compliments, concerns and complaints received included the following:

Positive feedback:

- Many patients commented on the helpfulness of the staff and felt staff were caring and supportive
- “The service has always been extremely helpful and caring. The staff have done so much to help me and I know that they would do the same for anyone.”
- Many patients made positive comments about how helpful the groups were

Suggestions for improvement:

- Suggestions included more flexibility and choice with appointments, shorter waiting times and longer appointments
- A number of patients suggested more groups and activities should be on offer: “More evening or after work groups would really help me to be able to attend and increase my involvement with the service.”
- A number of respondents would like their care to be more tailored to the individual

How well are services responding to complaints?

Addictions Services had one complaint in 2018/19. This was upheld and was responded to within the agreed timescale.

What are we learning and what action are we taking?

The one closed complaint within Addictions Services in 2018/19 was about delay in receiving an appointment and about staff behaviour. Although actions taken and lessons learnt were not recorded, the service has clearly described learning and actions in the response letter. The service lead has emphasised to all staff the importance of being compassionate in all patient interactions and has also reviewed processes to ensure that client information is reviewed and processed more quickly to prevent any repetition and delays.
How have we engaged with service users and carers? Examples include:

- There are monthly Strategic Service User Group meetings where service users lead on peer to peer audits and QI projects.
- The Addictions Services ran another successful service-user-led conference in 2018. Attended by 110 people, the day included many examples of how service users, staff and families can work together to overcome addiction. Described as ‘truly inspirational’ and ‘a deeply touching’ event, this is an excellent example of how user-led events can inspire other patients and staff.
- Two service user-led QI projects are in progress relating to decreasing the number of DNAs in alcohol services and re-titrations.
- Two members of the Strategic Service User Group sat on an interview panel for the Consultant position in Hackney service. Another member helped recruit the new Trust-wide Volunteer Service Manager.
- Service User Forums are held in the services and it is from these that members of the Strategic Service User Group are found – there is a drive to ensure service user forums happen in all services on a more regular basis.
- Service users from the Recovery Day Programme (RDP) in Brent took part in a project that is looking at the link between exercise and wellbeing. The group recorded how many steps they can walk in a month and recorded what changes they noticed in their mood and weight. This is linked to the Five Steps to Mental Wellbeing, which has been introduced as part of a Quality Improvement project to look at ways of improving wellbeing within addiction services.
- Service users and staff from the National Problem Gambling Clinic Health and Social Care Secretary met with the Matt Hancock MP to discuss the need to tackle problem gambling.
Brent

Are we are getting more or less feedback than in 2017/18 and what does this indicate?

Brent saw an impressive increase in Friends and Family Test (FFT) responses this year, achieving a 7.4% response rate in 2018/19 compared to 4.6% in 2017/18. A total of 1,845 people completed the FFT, with Brent South Community Mental Health Team achieving the highest number of responses at 339.

The rate of compliments decreased in 2018/19 compared to 2017/18, dropping from 13.60 to 8.94 per 1,000 unique patients seen. The rate of concerns decreased slightly from 6.22 to 5.86 and the rate of complaints decreased from 6.60 to 5.27 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

87% of FFT respondents said they would recommend the service to other people, which is an increase from 83% in 2017/18.

Feedback from 3,386 FFT comments and the compliments, concerns and complaints received included the following themes:

Positive feedback:

- Many patients commented that the staff were good listeners, and were friendly and understanding.
- Some respondents reported feeling involved and informed by staff. One patient quoted: “I felt very supported and involved in decisions about my care.”
- “They are like sunshine in the darkness”
- “I was treated with genuine respect, I felt as though my dignity was intact”

Suggestions for improvement:

- Several people expressed dissatisfaction at the long waiting list and shortage of staff.
- Some patients also felt that they were not treated with respect or listened to by all staff members.
- Some respondents suggested that the services need better integration with social services and other allied health professionals such as OTs and Psychology.
- Services are encouraged to improve communication and relationships with patients and their families.

How well are services responding to complaints?

Brent had one complaint in 2018/19 that was not responded to within the agreed timescales. Out of a total of 36 complaints received in 2018/19, 44% were upheld.

What are we learning and what action are we taking?

Brent CMHTS complaint themes centred on the lack of, or reduced support with care plans, or lack of adequate follow up by care co-ordinators. The main learning identified by Brent CMHTs is the need to maintain stability of care co-ordinators as frequent changes impact negatively on the outcomes for patients.
**Actions taken:** Staff turnover within the Brent Community Mental Health Service remains a challenge. Brent CMHTs are aware of this issue and are currently reviewing their team structures, staffing and working closely with HR services to improve recruitment, retention and stability within teams, including a skills mix review. One service is also reviewing and improving communication around appointments, and action was taken to change the care coordinator for a patient.

**How have we engaged with service users and carers? Examples include:**

- Brent host the co-designed Enrich (Enhanced discharge from inpatient to community mental health care) project. This project brings together staff, peer workers and service users to help reduce unnecessary inpatient admissions, improve recovery-focused outcomes and empower individuals to have more say in how they engage with services.

- Patients and staff from Park Royal Centre for Mental Health are involved in a weekly ‘Go Green’ group. They recently helped clean up their community through an organised litter pick along the Grand Union Canal.

- The award-winning Brent football project marked World Mental Health Day by receiving a Grassroots Football Award from Middlesex FA. The Hendon FC Mental Health Project, run jointly by CNWL’s Brent Early Intervention Service and Hendon FC, received the award for Community Project of the Year. Participants have reported increased motivation, stamina, energy, improved reduction in mental health symptoms, improved sleep, improved concentration, weight loss, improved overall fitness, wellbeing and confidence. Some have returned to University and employment.

- The “Are We OK Brent?” event took place to support people to look after their mental wellbeing. The event included Mindfulness, singing, activities and talks.
Camden Community Services

Are we are getting more or less feedback than in 2017/18 and what does this indicate?

Camden achieved an increase in Friends and Family Test (FFT) returns with a response rate of 4.2% in 2018/19 compared to 2.9% in 2017/18. A total of 3,821 people completed the FFT, with the Podiatry Service in Camden achieving the most responses at 396 returns.

![FFT Response Rates by Month - i Chart](image)

The rate of compliments per 1,000 patients decreased in 2018/19 dropping to 4.65 compared to 11.34 in 2017/18. The rate of concerns decreased from 2.05 to 0.42, and complaints decreased from 0.97 to 0.21 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

96% of FFT respondents said they would recommend the service to other people, which is the same as in 2017/18.

Feedback from 6,631 FFT comments and the compliments, concerns and complaints received included the following themes:

Positive feedback:
- Staff were praised for being friendly, polite and supportive: “All the team are friendly and kind. My baby feels comfortable when they try to keep him quiet. He was happy and laughing with them.”
- Several patients commented on the quick process and useful information they were provided with

Suggestions for improvement:
- The most common suggestions were to improve waiting times for appointments
- Several respondents suggested more information and better communication with them and their families would be helpful
- Some respondents requested longer appointments: “The timing sometimes made me feel rushed, 30 minutes was too short.”
- Several respondents suggested more staff would be helpful. “Not enough staff for the patients that need additional support - bedbound.”

How well are Camden services responding to feedback?
Camden services received 19 complaints in total in 2018/19, of which 55% were upheld. All complaints were responded to within the agreed timescales.

What are we learning and what action are we taking?
Complaints themes centred on delivery of care, staff responsiveness to call bells, and the updating of care plans at the point of discharge.
Actions taken: In response to feedback about staff responsiveness to call bells, the unit reviewed the impact of long day shift patterns and whether this is impacting on staff responsiveness. Daily observations of the quality of care and staff/patient interactions took place. An apology was made to the complainant and actions taken and lessons learnt shared with team members. However, this was not recorded on Datix. In response to feedback on a staff member not returning a call to the patient due to a miscommunication, action has been taken to make sure that concerns are logged. More work needs to be done to improve the recording on Datix.

How have we engaged with service users and carers? Examples include:

- A baby Hub was set up by the Health visiting team to provide parents with more opportunities to talk about their child’s physical, social and emotional development; a good example of how creating an informal environment can encourage parents to ask questions and engage with treatment.
- In Children’s services, staff and families have worked together to develop a template for the MDT report which is now active on SystmOne and allows staff from different providers within the services to contribute to a single shared report.
- Parents of children with complex and additional needs at Swiss Cottage School have been working with the service to look at the annual review process and the information that is shared with families.
- Parents are now being involved in some staff interview panels.
- The Head of Children’s Services has strong links with Camden Special Parents’ Forum through attending events, specific forums for providers, and working with the Parent Participation Lead to implement an action plan.
- Patients and carers continue to attend local physical health steering groups.
- The Minister of State for Care, Caroline Dinenage met with parents of children with autism, to launch the government drive to improve the lives of people with autism. Sarah Hulme, CNWL Head of Children, Young People and Family Services, welcomed Caroline on a tour of the Kentish Town centre where staff and parents shared feedback and ideas.
- Staff have been working with patients and families on a successful QI project to reduce the number of pressure ulcers. The national ‘Stop the Pressure’ campaign was held at St Pancras Hospital, where the patients and families raising were interviewed and featured on a TV programme to raise awareness of pressure ulcers and how to prevent them.
Child and Adolescent Mental Health Services (CAMHS)

Are we getting more or less feedback than in 2017/18 and what does this indicate?

CAMHS saw a slight increase in Friends and Family Test (FFT) returns with a response rate of 3.6% in 2018/19 compared to 3.2% in 2017/18. A total of 1,018 people completed the FFT in 2018/19, with Harrow CAMHS achieving the highest number of responses at 401.

![FFT Response Rates by Month - i Chart](image)

The rate of compliments increased in 2018/19 to 10.67 compared to 6.97 in 2017/18. The rate of concerns per 1,000 patients increased from 2.04 to 2.93 and the rates of complaints increased slightly from 2.55 to 2.75 per 1,000 patients.

![Rate of compliments 2018/19](image)

![Rate of concerns 2018/19](image)

![Rate of complaints 2018/19](image)
What does the feedback tell us about patient and carer experience?

88% of FFT respondents said they would recommend the service to other people. This is higher than the 86% who answered positively in 2017/18.

Feedback from 1,835 FFT comments and the compliments, concerns and complaints received included the following themes:

Positive feedback:

- Young people and families reported feeling listened to and described staff as understanding and supportive
- "We were treated with great respect and care. Not only was our child supported but also the whole family."
- Several respondents commented on receiving helpful information from their service: “Very helpful in giving us other avenues and contacts in different sectors e.g. employment, benefits.”

Suggestions for improvement:

- A recurring suggestion for improvement was to provide more appointments outside of school hours so as to not interfere with the young peoples’ education
- Several respondents commented on wanting reduced waiting times for appointments, and more consistency in the staff they are seen by. “Appointment often cancelled and at short notice.”
- Some respondents reported wanting better communication between staff and families

How well are services responding to complaints?

CAMHS services received 16 complaints in total in 2018/19, of which 82% were upheld. All complaints were responded to within the agreed timescales.

What are we learning and what action are we taking?

Complaints themes centred on clinical assessments and treatment plans provided, and delivery of care and communication with the patient. The main learning for MDT teams is to explain the roles of the various professionals involved in the care of the patient, ensure clear communication regarding
updates and changes to care plans and consider how we engage and involve families in decision making.

**Actions taken:** For one complaint regarding the patient not being informed their clinician was on long term leave, the team reflected on how they can support patients and identified that in future clinicians should clearly communicate with their patients when there will be a change in case manager or Consultant, and for the incoming clinician to make an early introduction with the family to offer a new appointment. In the event of a clinician’s longer absence, the line manager will identify and re-allocate the clinician’s cases, and the relevant families will be kept regularly informed of the process. More work is needed to record outcomes and lessons learnt on Datix.

**How have we engaged with service users and carers? Examples include:**

- Young people, parents and families were heavily involved in the design of the new inpatient unit, Lavender Walk
- A new parent and carer partnership programme was launched at an event in November, inviting parents of CAMHS service users to come together to help shape services
- A public consultation took place about proposals to move Kensington and Chelsea CAMHS to Beatrice Place
- Work took place to develop a new joint pathway for Autistic Spectrum Disorder, including a new parent information leaflet that was designed in consultation with service users and parents
- At Hillingdon, CAMHS, service users participated in interview panels
- A service user attended Hillingdon Healthwatch focus group around the local Transformation plan
- Young people have been interviewed by Hillingdon Healthwatch to give feedback to Commissioners
Community Independence Service (CIS)

Are we are getting more or less feedback than in 2017/18 and what does this indicate?

The Community Independence Service (CIS) achieved an increase in Friends and Family Test (FFT) returns with a response rate of 4% in 2018/19 compared to 1.8% in 2017/18. A total of 510 people completed the FFT, with Hammersmith and Fulham Rehabilitation Service receiving the highest number of responses at 154.

The rate of compliments fell from 22.60 in 2017/18 to 13.80 in 2018/19 per 1,000 patients. The rate of concerns decreased from 3.66 to 1.44 and the rate of complaints was zero.

The rate of compliments fell from 22.60 in 2017/18 to 13.80 in 2018/19 per 1,000 patients. The rate of concerns decreased from 3.66 to 1.44 and the rate of complaints was zero.
What does the feedback tell us about patient and carer experience?

In 2018/19, 98% of respondents said that they would recommend Community Independence Services, which is an increase from 94% in 2017/18.

Feedback from 1382 FFT comments and the compliments, concerns and complaints received included the following themes:

Positive feedback:

- Several patients commented on the professional nature of the services, and appreciated staff's caring, supportive nature
- "Courteous and very attentive staff tendered to me whilst I was ill. They were really reassuring and caring with me."
- The service was described as well organised, with many patients saying they were seen quickly and appointments were prompt

Suggestions for improvement:

- This service received predominantly positive feedback.
- Some respondents reported wanting to receive a longer programme of treatment and felt the current programme was too short: "I would like to be allocated the support for a longer period of time."

How well are services responding to feedback?

There were no closed complaints recorded for CIS in 2018/19.

What are we learning and what action are we taking?

There were no complaints to learn from but the service continues to review and act on all feedback.
How have we engaged with service users and carers? Examples include:

- Hammersmith and Fulham CIS have patient representation on their Older People’s work stream and rehabilitation team meeting. They also have involvement in their Integrated Care Pathway development.
- Patients and carers continue to attend local physical health steering groups.
- A patient from Kensington and Chelsea CIS spoke at the CNWL Executive Board
- Patients are featured in reablement videos that are being used across the Trust and on social media
- Service users are being involved in the design of a new leaflet
- In Kensington and Chelsea patients are included in the staff induction programme
- Hammersmith and Fulham held a team meeting with voluntary sector representatives to discuss improved referrals and integration with voluntary services
Eating Disorder Services

Are we are getting more or less feedback than in 2017/18 and what does this indicate?

Eating disorder services saw a decrease in FFT responses with a response rate of 3.9% in 2018/19 compared to 6.4% in 2017/18. A total of 153 people completed the FFT, with the Vincent Square Therapy Service receiving the most at 90 responses.

The rate of compliments decreased in 2018/19 to 8.94 compared to 19.02 in 2017/18. The rate of concerns per 1,000 patients decreased from 4.08 to 2.23 and the rates of complaints decreased significantly from 9.51 to 3.35 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

In 2018/19, 87% of respondents would recommend the service, compared to 89% in 2017/18.

Feedback from 169 FFT comments and the compliments, concerns and complaints included:

Positive feedback:

- Many patients commented on the compassion and attention expressed by staff
- One patient expressed their appreciation of their service: “Compassionate and professional care. I have felt supported every step of the way.”
- Several people expressed satisfaction over the ease of accessing the services

Suggestions for improvement:

- There were very few suggestions for improvement across the services in this area.
- A number of respondents suggested longer sessions
- Several respondents commented on long waiting times as an area of improvement: “Improved communication around waiting times.”

How well are services responding to complaints?

Eating Disorder services received three complaints in total in 2018/19, of which one was upheld. All complaints were responded to within the agreed timescales.

What are we learning and what action are we taking?

In response to feedback, the service was considering its criteria for patients being referred to community services and looking at alternative options available for patients who are not ready for the service. The service also agreed to consider the use of text reminders for appointments.

How have we engaged with service users and carers? Examples include:

- Carers are involved in local CQG meetings, helping to advise on and shape services
- The Community Eating Disorders Service for Children and Young People in Kensington and Chelsea featured in an article that was part of a wider campaign by the BMA’s ‘The Doctor’ magazine that won Best Publication of the Year in the Mind Media Awards. The article and the award helped to further raise the profile of the service and emphasise the benefits of early engagement in services for people with eating disorders.
Harrow

Are we getting more or less feedback than in 2017/18 and what does this indicate?

Harrow saw a rise in Friends and Family Test (FFT) responses this year, achieving a 2.4% response rate in 2018/19 compared to 2.1% in 2017/18. A total of 623 people completed the FFT with Harrow Primary Care Mental Health Services achieving the highest number of responses at 75.

The rate of compliments increased slightly in 2018/19 to 3.60 compared to 3.51 in 2017/18. The rate of concerns per 1,000 patients decreased from 4.44 to 3.94 and the rates of complaints decreased slightly from 5.88 to 5.29 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

90% of FFT respondents would recommend the service, compared to 87% in 2017/18.

Feedback from 1,606 FFT comments and the compliments, concerns and complaints received included the following themes:

Positive feedback:

- Staff were praised for their friendly, helpful nature: “Thank you for being so professional. It is a place where I don't feel judged for being who I am.”
- “I feel I was always listened to and responded to and always treated with respect.”
- Several respondents commented on the effectiveness of their sessions: “The sessions helped me manage my stress and build resilience.”

Suggestions for improvement:

- Several people commented on the long waiting lists. One respondent commented: “My appointments keep being cancelled - 3 times in the last few months.”
- It was mentioned by some patients that they found some staff members to not be very friendly or polite towards them
- Several respondents commented on wanting more involvement in their care: “I would like more of my own involvement in discussions and decisions made about me rather than decisions being thrown in my face.”

How well are services responding to complaints?

Harrow received 47 complaints in total in 2018/19, of which 45% were upheld. All complaints were responded to within the agreed timescales.

What are we learning and what action are we taking?

The outcome codes, actions taken, lessons learnt were not fully recorded on Datix for most closed complaints, although clear actions and learning were identified in most of the responses as highlighted below:
• In three upheld complaints, an update on the patient care plan was not provided at the point of admission or discharge, which is something the service has addressed
• In five upheld complaints, information about the service (for example meal time visits) was not provided verbally during ward visits and generic information regarding services was not given by email or phone
• Staff are now doing more to identify communication needs in the early part of a patient’s journey, for example better use of interpreters and advocacy
• Staff have agreed to provide better information to and consultation with patients and families about medication changes, including information leaflets on newly prescribed medication
• In one complaint a family visited London from Scotland and were unhappy with the welcome they received upon arrival at the ward, and a lack of information about patient belongings on the ward. The importance of better communication and support for families has been highlighted and the team has committed to taking part in the Triangle of Care scheme.
• Some clear learning points were identified by the teams:
  - Staff have been reminded to explain clearly to patients the reasons for their admission
  - Staff have been reminded to take time to explain thoroughly plans for transfers/discharge and write these into the care plan to avoid confusion
  - The team have been reminded to ensure that the generic email is shared with service users and their carers
  - Patients and families need time to discuss the discharge process and agree with staff a management plan when at home

How have we engaged with service users and carers? Examples include:

• A carer and service user co-production forum has been set up and supported by the Head Occupational Therapist and the group makes suggestions to the Community Mental Health Teams (CMHT) on what could be improved. The group is held monthly in Harrow, and is well attended by service users, carers and staff.
• Carer leads have produced a local carer’s support leaflet
• Monthly carers’ surgeries take place at Northwick Park Hospital
• Courses were delivered for relatives and friends of people with the diagnosis of Emotionally Unstable Borderline Personality Disorder (EUPD). Families and Carers Training and Support (FACTS) is a carer-led training course, which has been developed with support from the Anna Freud Centre.
Hillingdon Community Services

Are we are getting more or less feedback than in 2017/18 and what does this indicate?

Hillingdon Community Services saw a slight fall in Friends and Family Test (FFT) responses this year, achieving a 1.5% response rate in 2018/19 compared to 1.8% in 2017/18. A total of 2,582 people completed the FFT with Hillingdon Paediatric Speech and Language Therapy - Early Years Service achieving the highest number of responses at 564.

The rate of compliments decreased slightly in 2018/19 to 2.23 compared to 4.43 in 2017/18. The rate of concerns per 1,000 patients decreased from 1.00 to 0.30 and the rates of complaints decreased slightly from 0.33 to 0.08 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

97% of FFT respondents said that they would recommend the service to other people, which is the same as in 2017/18.

![FFT Satisfaction Rates by Month - i Chart](image)

Feedback from FFT comments and compliments, concerns and complaints received included the following themes:

**Positive feedback:**

- Many patients were impressed with the amount of information and explanation they were given by staff
- One patient commented: “I was very happy with the visit. All my questions were answered, it wasn't rushed and the health visitor was very friendly.”
- Staff were described by many respondents as helpful, friendly and supportive
- “The team of nurses were supportive, the hands on care was kind gentle and professional. We were always included in any decisions that had to be made. The twilight and out of hours team were always very attentive and helpful.”

**Suggestions for improvement:**

- A recurring theme in the feedback was patients wanting more/longer appointments and reduced waiting times
- Some respondents commented on wanting more information and follow up after appointments
- Some patients would like better provision of information about other sources of support in the community

How well are services responding to complaints?

Hillingdon Community Services received 14 complaints in total in 2018/19, of which 69% were upheld. All complaints were responded to within the agreed timescales.

What are we learning and what action are we taking?

Complaints themes centred on communication from the service, timely care and provision of information. Learning from these complaints was included in the response letter to one complaint and stated that the service would take the following actions:
To communicate promptly and clearly providing specific information tailored to the needs of the patient, for example information on medication prescriptions and how to access more supplies
To inform patients if staff are running late when providing follow up assessments or treatments
To co-ordinate care and act on care plans in a more timely manner

These actions were not recorded on Datix.

How have we engaged with service users and carers? Examples include:

- Patients and carers continue to attend local physical health steering groups
- Hillingdon Community Dental Referral Service has continued its work with the Health Visiting Team and Hillingdon’s Children’s Centres promoting healthy weaning advice to new parents. They hosted ‘Bottle to Cup’ events across 15 Children’s Centres in Hillingdon, to encourage parents and carers to introduce a free flowing cup to their baby by the age of six months and discard feeding bottles by the time the baby is a year old.
- Stop the Pressure national campaign held an information table at a HESA clinic
- The QI project ‘Red to Green’ is engaging patients more pro-actively in planning their discharge and helping to reduce wasted bed days in the HICU Unit
- The District Nursing Service has carer representatives attending the End of Life strategy group, providing valuable input to the service redesign and having a direct impact on patient and carer experience
- In the speech and language therapy services, parent strategy sheets were co-produced with parent input around how to enhance children's’ communication skills. A ‘Talk to me’ video produced by the team highlights how parents can help young children learn to talk from birth.
- Harrow 0-19 – Coffee morning held with parents of SEND for their experience of the Health Visiting and School Nursing services
Hillingdon Mental Health Services

Are we are getting more or less feedback than in 2017/18 and what does this indicate?

Hillingdon saw little change in Friends and Family Test (FFT) returns, with a response rate of 1% in 2018/19 compared to 0.9% in 2017/18. A total of 300 people completed the FFT with Hillingdon Memory Service achieving the highest number of responses at 144.

The rate of compliments decreased slightly in 2018/19 to 8.96 compared to 9.93 in 2017/18. The rate of concerns per 1,000 patients increased from 3.73 to 5.22 and the rates of complaints decreased slightly from 4.86 to 4.20 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

87% of FFT respondents said that they would recommend the service to other people, which is better than 85% in 2017/18.

Feedback from FFT comments and compliments, concerns and complaints received included the following themes:

Positive feedback:

- Staff were praised for being friendly, supportive and caring: “I was treated with great care and understanding. This service was a huge help in getting me on the road to recovery and for that I am very grateful.”
- “Care and treatment was always well monitored and family kept informed”

Suggestions for improvement:

- Several commenters raised the issue of the long waiting times for appointments
- Better communication from the service arose as a recurring suggestion for improvement: “Difficult to get hold of, Mead House phones just ring off saying they are busy. E-mails to care coordinator not followed up.”

How well are services responding to complaints?

Hillingdon Mental Health Services received 37 complaints in total in 2018/19, of which 44% were upheld. All complaints were responded to within the agreed timescales.

What are we learning and what action are we taking?

The main themes of complaints were around delivery of care, such as poor information regarding medications, or care plans not being jointly agreed by staff and patients or communicated clearly. Although there were some actions taken and lessons learnt these were not all recorded on Datix.
Some of the learning identified within Hillingdon Mental Health teams:

- Increasing communication between doctors and team leaders, to improve the consistency of information provided to patients and carers
- Professionals will do more to discuss differing points of view away from patients and resolve these issues before discussing plans with service users
- The complaints procedure should be clearly conveyed to all patients and carers using the service
- To create more opportunities for staff reflection when discussing staff attitudes and behaviours and how this may impact the patient

A ‘You said we did’ example from Hillingdon Older Adults Community Mental Health Team:

A patient was unhappy with delays to their appointment time on two occasions and was unhappy with the lack of staff interest in this. Having looked into this, the team found that the patient was seen on time for his first appointment but experienced a 30 minute delay on his second appointment due to the overrunning of the appointment before. The service took responsibility for the delay and attempted contact with the patient to offer a new appointment. The team manager is now monitoring the start of clinic times and reasons for any delays and discussing this feedback with the team. The manager is also making sure that where delays or cancellations occur, patients are kept informed and offered new appointments.

How have we engaged with service users and carers? Examples include:

- Service users and carers have coproduced an information leaflet for patients and carers on self-help online mobile phone apps
- Hillingdon service users have produced the peer led magazine ‘Hope in Hillingdon’. This goes out to team bases, libraries and GP surgeries
- The co-produced discharge information booklet- Staying Well when Leaving the Ward- has been completed and printed for all service users in Hillingdon at the point of discharge
- Service users were involved in the review of the 136 suite at Riverside in Hillingdon
- Interview training for services users took place. At the time of writing, the numbers of service users trained in Hillingdon had increased to 26 and all staff recruitment now includes service user or carer input.
- Two Friends and Family Test events were held at Hillingdon CMHTs and Early Intervention Services EIS in October. These were led by patients to improve the FFT response. The event was successful and will be repeated in 2019.
- Hillingdon mental health service users and carers meet every two months at user groups
- Staff attended the Oak Tree self-help group at to deliver presentations on various aspects of clinical support
- Staff and service users have worked together to secure funding for the peer led Riverside Rangers Football team pitch hire
- Hillingdon CMHT managers and the service manager have met with a group of service users to discuss the duty process with a view to making changes
- The Recovery and Wellbeing College has provided bespoke training to Hillingdon carers and Hillingdon 4 All partners on Setting up a Peer Support Group
- The number of Peer Workers has increased with at least one on each ward and in all Community Mental Health Services, including Early Intervention in Psychosis
Kensington and Chelsea

Are we getting more or less feedback than in 2017/18 and what does this indicate?

Kensington and Chelsea saw an increase in the number of Friends and Family Test (FFT) responses this year, achieving a 3.2% response rate in 2018/19 compared to 1.2% in 2017/18. A total of 741 people completed the FFT with Danube Ward at St Charles Hospital achieving the highest number of responses at 122.

The rate of compliments increased significantly in 2018/19 to 14.73 compared to 3.51 in 2017/18. The rate of concerns per 1,000 patients increased from 4.44 to 6.54 and the rates of complaints increased from 5.88 to 11.01 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

84% of FFT respondents said that they would recommend the service to other people, which is an improvement compared to 78% in 2017/18.

Feedback from 2,025 FFT comments and the compliments, concerns and complaints received included the following themes:

Positive feedback:

- Many patients spoke positively about staff, describing them as “professional, caring, sensitive and helpful”
- “The professionalism, displayed is second to none. The service is a great way to equip yourself with the relevant info; and provides a great support system.”
- “The home treatment team have been a massive support and helped me to want to live when I really didn’t want to. They saved my life. Thank you for everything.”
- Some respondents praised staff for involving them in their care and listening to family members. “Took time to read patient's history, understood family members' concerns and gave timely feedback and clinical decisions taken.”

Suggestions for improvement:

- Across several services, some patients and carers felt that staff do not always listen or keep them informed “I felt that the staff didn't listen to me, they always seemed to be busy with other patients.”
- Several patients would like more activities on the wards
- Some people suggested that more communication between departments and a smoother transition between teams would be helpful
- “The transition from the North team to the South is stupidly complicated and forgets the feelings of the service users”

How well are services responding to complaints?

Services in Kensington and Chelsea received 74 complaints in total in 2018/19, of which 20% were upheld. All complaints were responded to within the agreed timescales. A number of cases required extensions to the original target date but there was no evidence on Datix of how the investigator communicated to the complainant the reasons for this and the new date.
What are we learning and what action are we taking?

Due to a lack of detail on Datix, it was difficult to ascertain if the complaint responses were upheld or not and what actions were being taken.

- Partially upheld complaints were mainly about clinical treatments such as people being unhappy about Mental Health Act assessments, negative staff attitudes, and poor communication regarding care plans.
- Complaints that were withdrawn and dealt with locally were mainly around staff attitudes and poor communication from staff regarding care plans.
- There were a number of complaints about assessment, treatment or discharge being poorly organised or poorly communicated, but these complaints were not upheld.
- Some complaints were withdrawn because these were successfully resolved locally in person or via telephone with an apology, which is good practice. In other cases the complaint had not been pursued because the patient had not given consent.

Actions taken: Additional training for administration staff on appointment booking systems has been arranged, and appointment cancelling and DNA (‘did not attend’) protocols are being reviewed.

Overall, responses to complaints appear to be delayed and not acted on as quickly and learning and actions taken are not often clear in response letters.

How have we engaged with service users and carers? Examples include:

- Patients and carers coproduced a welcome pack for patients being admitted to St Charles Hospital.
- At St Charles, patients and carers have been involved in the design of the new service user led café and volunteers are being recruited to train as baristas and work in the café.
- Patients have co-produced creative activities taking place, including play reading, theatre visits and re-decorating the ward environment. These are examples of partnership working, innovative thinking and local enthusiasm for connecting service users with their community.
- Joint working with local organisations is strong, including the CONNECT project run with the local Mind service, which is helping to improve people’s experience of transitioning between secondary and primary care services.
- Service users presented on a QI project to the Clinical Commissioning Group.
- A Carers’ Forum has been established at St Charles Hospital.
- Service users and carers have been on interview panels for liaison psychiatrists, a PICU consultant and a Matron at St Charles.
- The Grenfell Health and Wellbeing Service is delivering animation workshops and virtual reality sessions for young people in the Grenfell community. Mindfulness sessions are also being delivered to local people. These are just some examples of engagement activities at Grenfell.
Learning Disability Services

Are we are getting more or less feedback than in 2017/18 and what does this indicate?

Learning Disability Services saw a decrease in Friends and Family Test (FFT) returns with a response rate of 2.5% in 2018/19 compared to 3.2% in 2017/18. A total of 152 people completed the FFT in 2018/19, with Brent Community Team achieving the highest number of responses at 74.

The rate of compliments decreased in 2018/19 to 21.32 compared to 32.19 in 2017/18. The rate of concerns per 1,000 patients decreased slightly from 1.43 to 1.38 and the rates of complaints decreased slightly from 4.29 to 4.13 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

85% of FFT respondents said that they would recommend the service to other people, which is an increase compared to 78% in 2017/18.

![FFT Satisfaction Rates by Month - i Chart](image)

Feedback from 87 FFT comments and the compliments, concerns and complaints received included the following themes:

Positive feedback:

- Several respondents were positive about the service and pleased with the package of care being offered
- Due to a very small number of responses received, no further recurring themes could be drawn

Suggestions for improvement:

- One patient commented on the lack of sensitivity and empathy from staff
- Another patient commented on the lack of communication from the service, with letters not being received or being received late
- Due to a very small number of responses received, no further recurring themes could be drawn

How well are services responding to complaints?

Learning Disability Services received six complaints in total in 2018/19, of which 40% were upheld. All complaints were responded to within the agreed timescales.

What are we learning and what action are we taking?

Complaints themes centred on appointment delays and communication.

**Actions taken** include making efforts to run appointments on time and ensuring that any delays in clinics are communicated to the patients on their arrival and if possible, alternative appointments being offered where needed. This has been discussed at team level.
How have we engaged with service users and carers? Examples include:

- Service users and families have been involved in the development of a new inpatient service for young people aged between 13 to 18 years at Kingswood Centre
- Kingswood Centre took part in the world’s biggest MacMillan Coffee Morning, bringing together service users, staff and families for games and a raffles
- Service users are involved in interviewing and recruiting new staff members
- Service users were supported to take part in a national survey of their experiences of services
- Bespoke training sessions are provided, including a session on how service users and carers can help keep themselves safe - a good example of empowering service users to develop greater awareness and positive behaviours skills
- Quarterly Service User and Carer Events occur in Kingswood Centre. For example, service users planned a carnival and various religious festivals, bringing together staff and service users, enabling people to use their organisational and creative skills.
Milton Keynes Community Services

Are we getting more or less feedback than in 2017/18 and what does this indicate?

Milton Keynes Community Services saw a decrease in Friends and Family Test (FFT) returns, with a response rate of 2.3% in 2018/19 compared to 3% in 2017/18. A total of 2,683 people completed the FFT, with the Adult Hearing Service recording the most responses at 560.

The rate of compliments decreased significantly in 2018/19 to 3.78 compared to 8.16 in 2017/18. The rate of concerns per 1,000 patients decreased slightly from 0.90 to 0.28 and the rates of complaints decreased from 1.04 to 0.23 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

97% of FFT respondents said that they would recommend the service to other people which is a slight increase compared to 96% in 2017/18.

Feedback from 6,063 FFT comments and the compliments, concerns and complaints received included the following themes:

Positive feedback:

- Staff across several services were praised for their supportive, caring and attentive behaviour: “I was in receipt of prompt, professional and caring support very quickly after my stroke. This, I feel, was paramount to get me back on my feet and re-build my confidence.”
- Strong communication was a recurring theme, with many patients saying how helpful it was to be kept up to date around appointment times and to be given clear and full explanations about their care and treatment, with time to discuss and ask questions
- “Such a level of care and kindness, everything was explained so perfectly from reception to the dentist and nurse.”

Suggestions for improvement:

- Across services, feedback showed themes of patients wanting more appointments and shorter waiting times
- “It took a long time to get an appointment and it was only after chasing things up that progress was made. More transparency on timings would be helpful.”
- “Just little bit more information and reassurance”

How well are services responding to complaints?

Milton Keynes Community Services received 23 complaints in total in 2018/19, of which 65% were upheld. All complaints were responded to within the agreed timescales.

What are we learning and what action are we taking?

Complaints received centred on staff attitudes and communication.
**Actions taken**: staff received training to improve their knowledge regarding eligibility of patients for District Nursing Services and knowledge of what else can be offered to patients within the service line; a written protocol on the use of the patient hearing booth at the Adult Hearing Service was put in place to reduce the potential for injury; Health Visiting staff attended ‘Baby Friendly Initiative’ to increase awareness and knowledge.

Actions taken and lessons learnt are clearly recorded on Datix and staff have been reminded about the importance of compassionate communication, awareness of communication style and the impact this can have on patient experience.

A ‘You said we did’ example from Paediatric Speech and Language Milton Keynes

A Paediatric Speech and Language patient had recently moved into the area had been having regular speech therapy prior to him moving to Milton Keynes. His sessions had reduced and with very limited speech he was struggling to communicate. The parent felt that this would impact on all areas of his life and asked for appointments to be booked in a timely way, with goal setting, and for this information to be communicated with all professionals. The parent left contact details. Staff raised this as a concern on Datix. Following investigation it was found that the patient had attended an appointment in September and was on the waiting list for 1:1 therapy. The patient attends a private nursery out of the Milton Keynes area therefore the SLT are unable to visit. The Manager explained this to the parent and advised that targets can be set and the nursery can call SLT to discuss. The manager identified that the parent was not accessing any Early Support services from Education. They have now made contact with the parent to look at the support that can be given. The Parent has e-mailed the SLT Manager to thank her for her help.

**How have we engaged with service users and carers? Examples include:**

- Patients and carers continue to attend local physical health steering groups
- Work continues to support carers’ knowledge and education around a range of care aspects including continence, nutrition, end of life and pressure ulcers.
- Milton Keynes Community Healthwatch were invited to the WICU (Windsor Intermediate Care Unit) to evaluate patient feedback and have used this information to consider how the service is redesigned and developed, for example the introduction of ‘recovery’ type goals.
- #The Big Convo MK has been launched to coproduce a transitions process
- In response to a patient consultation exercise, the District Nursing service introduced a single point of access
- In Dental Services, photo boards with Makaton symbols and ‘easy read’ leaflets have been developed
Milton Keynes Mental Health Services

Are we are getting more or less feedback than in 2017/18 and what does this indicate?

Milton Keynes Mental Health Services saw a decrease in Friends and Family Test (FFT) returns, with a response rate of 4.8% in 2018/19 compared to 5.2% in 2017/18. A total of 1,618 people completed the FFT, with CAMHS Eaglestone recording the most responses at 258.

The rate of compliments decreased significantly in 2018/19 to 4.68 compared to 12.71 in 2017/18. The rate of concerns per 1,000 patients decreased from 4.84 to 1.57 and the rates of complaints decreased from 2.59 to 0.89 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

92% of FFT respondents said that they would recommend the service to other people, which is a slight increase from 91% in 2017/18.

Feedback from 3,987 FFT comments and the compliments, concerns and complaints included:

Positive themes:
- Many respondents felt that staff were helpful and approachable. “I have always been dealt with professionally with compassion. I was never rushed and always felt supported.”
- Patients were very positive about the impact the service has had on them: “The Perinatal Service - its staff saved my life and my family. The support has been exceptional and I was really looked after.”
- Several people commented on receiving helpful information from their service

Suggestions for improvement:
- Many respondents commented on the long waiting times for appointments and suggested more sessions would be beneficial
- Several people raised the issue of inconsistency in regards to staff: “The main issue is the rapid turnover of staff means our son sees a different doctor almost every time.”
- Communication arose as an issue in the feedback across several services. One patient suggested: “More communication and more support.”
- Some respondents suggested more resources such as leaflets and information sheets could be provided for when patients and families are at home

How well are services responding to complaints?

Milton Keynes Mental Health Services received 37 complaints in total in 2018/19, of which 38% were upheld. Milton Keynes Mental Health Services did not respond to two complaints (5%) within the agreed timescales. All remaining complaints were responded to within the agreed timescales.
What are we learning and what action are we taking?

Complaints were mostly about the delivery of care, for example the service not meeting the specific needs of the patient. Two of the partly upheld response letters did not explain how the discharge was agreed and what support was offered to patients on discharge home. In another case, it was not clear what feedback was given to a patient's family regarding what actions were taken or what learning was shared after the bereavement of a patient.

The main learning taken from the complaints was to give patients more time and for staff to provide all the relevant information about services, pathways, crisis teams on discharge so that delivery of care is not delayed. The Campbell Centre is improving support provided to people with Asperger's or Autistic Spectrum Disorder.

A ‘You said we did' example from Specialist Therapies Team Milton Keynes

A patient had been on the waiting list since 2017 and the lack of updates regarding the waiting list times had left them feeling forgotten and unwanted. The service manager spoke with the patient and assured them that they are on the waiting list and nearing the top. They apologised for the wait time. A nurse from the team has offered a review appointment to consider their needs for the remainder of the waiting time. The welcome /referral acceptance letter has been reviewed since the patient was referred and it provides more details of wait times and what to do if concerned.

How have we engaged with service users and carers? Examples include:

- The Early Intervention in Psychosis Team (EIPT) in Milton Keynes offered a 7 week programme for carers to share understanding of psychosis and possible interventions within a safe non-judgmental setting. This gave an opportunity for carers to grow in confidence and feel better equipped to support their family member whilst caring for their own emotional wellbeing.
- The CAMHS Liaison Intensive Support Team (LIST) in Milton Keynes was nominated for the Diggory Excellence in Wellbeing Award due to increased service user engagement by involving them in interview panels and changes to the waiting area.
- The Perinatal Mental Health service is working alongside the local Maternity Voices group for co-production of service information to the wider community and presenting at Clinical Conversations organised by STP Bedfordshire, Luton and Milton Keynes Mental Health.
- The Trust has baby feeding volunteers (including a number of ex-service users) who have been trained to support new mums.
- The Directorate has engaged with BAME communities through invitations to local community group meetings and local parish Breakfast Clubs.
- The use of Peer Workers has grown and this is having a direct impact on patient experience, with Peer Workers transforming the programme of activities available on inpatient wards. Peer Workers have also been involved in the design and delivery of an on-site Recovery and Wellbeing College.
Offender Care

Are we getting more or less feedback than in 2017/18 and what does this indicate?

Offender Care Services achieved a 6.3% response rate in 2018/19, which is an increase from 2.3% in 2017/18. In total, 1,686 FFT forms were completed and HMP Winchester Integrated Primary Care Service received the most returns at 357.

The rate of compliments increased in 2018/19 to 9.60 compared to 7.11 in 2017/18. The rate of concerns per 1,000 patients increased significantly from 9.24 to 26.57 and the rates of complaints decreased slightly from 2.40 to 1.94 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

79% of FFT respondents said they would recommend the service to other people, which is an increase compared to 71% in 2017/18.

Feedback from 3,762 FFT comments and the compliments, concerns and complaints included:

Positive feedback:

- Several patients commented on the friendly, helpful staff: “I was not rushed in and out and got time to talk and cover my problems. Thank you.”
- Many people commented on the usefulness of certain groups offered across services. Some examples included the Thinking and Thoughts session, the Relationship and Wellbeing Group and Phoenix Futures Psychosocial.

Suggestions for improvement:

- Many patients would have liked shorter waiting times for appointments: “It took over six weeks and me being a pest to get a referral for mental health services.”
- Some people reported experiencing problems or delays in receiving medication, even paracetamol: “I waited over 4 months to see a Doctor just to receive pain killers.”
- Several patients suggested that they do not always feel listened to, and wanted to be treated with more respect.
- One patient quoted: “Be kinder and more understanding of us as individuals. Some are always pleasant but others are often rude and unhelpful.”
- Several respondents raised the issue of communication and would like to be kept more informed about their care and taken seriously by staff.

How well are services responding to complaints?

Offender Care Services received 49 complaints in total in 2018/19, of which 36% were upheld. All complaints were responded to within the agreed timescales.

What are we learning and what action are we taking?

Complaints themes centred on delivery of care such care plans not in place, soft diet recommendations not being followed or inadequate follow up.
Actions taken: Services are reviewing their internal patient feedback processes; GP providers and health services are now going to meet regularly to assist with communication and patient handover information; Consideration will be given to putting patients returning from a hospital admission onto the healthcare wing initially, to assess their fitness.

The response letters to complainants included details of actions being taken but these were not well recorded on Datix.

How have we engaged with service users and carers? Examples include:

- In Offender Care services, patient and carer involvement has led to increased numbers of FFT responses and positive feedback from patients
- Across Offender Care, ‘You Said We Did’ boards have now been introduced to demonstrate what action has been taken in response to feedback
- At a number of sites, patient representatives have been recruited to help improve communication and feedback from patients to staff. The patient reps have produced t-shirts to make themselves more visible to other prisoners.
- A training pack has been developed for service user reps
- Young service users at HMYOI Cookham Wood designed a colourful work of art, publicly unveiled at the annual Youth Justice Convention in November. The project helped improve the Health and Wellbeing Team’s appointment rooms and encourages young people to engage with services. The young people involved had restricted access to a standard prison regime because of risk to themselves or others but staff found innovative ways for them to take part in the art project. Several young people are now engaging more with the health service, and specifically Art Therapy - a good example of staff overcoming barriers and engaging patients in their own wellbeing.
Rehabilitation Services

Are we getting more or less feedback than in 2017/18 and what does this indicate?

Rehabilitation Services saw a decrease in Friends and Family Test (FFT) responses this year, achieving a 7.7% response rate in 2018/19 compared to 10.3% in 2017/18. A total of 294 people completed the FFT with North West London Arts Psychotherapies Service achieving the highest number of responses at 129.

The rate of compliments decreased in 2018/19 to 6.62 compared to 12.41 in 2017/18. The rate of concerns per 1,000 patients decreased slightly from 1.13 to 0.83 and the rates of complaints decreased significantly from 5.08 to 0.83 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

86% of FFT respondents said they would recommend the service to other people, which is a slight improvement on 85% in 2017/18.

Feedback from 529 FFT comments and the compliments, concerns and complaints received included the following themes:

Positive feedback:

- Several people commented on the patient, understanding, and welcoming staff
- Many patients praised the therapies that they attended, describing them as a useful outlet for releasing negative thoughts and something to take their mind off of their problems
- “It is a wonderful service which allows one to express our true feelings. It helps us bond with fellow patients too. Very stressful on the wards, it helps us a lot, we love it.”
- “Art therapy brings peace of mind, joy and happiness, and can make me feel well”

Suggestions for improvement:

- Very few suggestions for improvement were received as a vast majority of the comments were praising the services
- Some patients would like fewer restrictions and more choice and involvement around decisions
- One patient commented that: “For some the therapy can be very difficult having to deal with other patients and their problems, and can make me feel left overlooked - but that's a problem in me”

How well are services responding to complaints?

Rehabilitation Services received 2 complaints in total in 2018/19, of which none were upheld. All complaints were responded to within the agreed timescales.

What are we learning and what action are we taking?

A patient complained about not being given their assessment report and this was locally resolved. Services continue to review and act on feedback.
How have we engaged with service users and carers? Examples include:

- In Rehab services, training continues to be provided to service users on various topics, for example basic Life Support.
- Outings are also arranged to help people engage with the local community. The group went to Horton Golf Club and the following week explored Box Hill.
- Independent Living Skills Group took place, including self-care, vocational support and support using technology to facilitate independent living.
- Individual and group work focused on self-management of symptoms, enhancing self-confidence and preparing psychologically for independent living.
- Inpatients and staff at CNWL’s Bluebell Lodge have worked with artists to create extraordinary art that now covers the walls of the locked rehabilitation unit. Creative workshops held in more communal places have encouraged engagement from people who often struggle to engage.
- Residents and staff from Bluebell Lodge went to the Playground Theatre in Latimer Road.
- As part of Therapies Week, the Rehab Units held a ‘Bake off’ competition. The units each took a letter to spell ‘THERAPY WEEK. The cakes were made and designed by service users with support from OTs.
- A service user attended the Goodall Celebration event and shared his personal experiences of recovery - this was extremely well received.
Are we getting more or less feedback than in 2017/18 and what does this indicate?

Sexual Health Services saw an increase in Friends and Family Test (FFT) responses this year, achieving a 3.2% response rate in 2018/19 compared to 1% in 2017/18. A total of 5,751 people completed the FFT with NCL Integrated Sexual Health – Mortimer Market Centre achieving the highest number of responses at 1281.

The rate of compliments increased slightly in 2018/19 to 7.16 compared to 4.89 in 2017/18. The rate of concerns per 1,000 patients decreased slightly from 1.44 to 1.22 and the rates of complaints decreased from 0.45 to 0.35 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

93% of FFT respondents said that they would recommend the service to other people, which is a slight decrease from 95% in 2017/18.

**Note:** There is no UCL or LCL due to these being outside of the perimeters (below 0%, above 100%)

Feedback from 436 FFT comments and the compliments, concerns and complaints received included the following themes:

**Positive feedback:**
- Several patients praised the staff for their friendly nature: “I feel at ease and welcomed when I came here. People smile and treat everyone with respect and you get more than just your physical wellbeing looked at. It's amazing.”
- Many respondents commented on feeling welcomed by the services, and that they were professional environments
- “Doctor is fantastic. Very knowledgeable and kind. Answered all of my questions.”

**Suggestions for improvement:**
- Patients commented on how appointments were often delayed and they were left waiting to be seen, sometimes with little information about how long their wait would be
- The new booking system was raised as an issue by many patients, and it was suggested that the services return to being able to book appointments themselves: “Booking was a nightmare - no one answering phone and one told me the wrong date and I only found out on arrival.”
- Some people mentioned wanting some more information online as a resource

**How well are services responding to complaints?**

Sexual Health Services received 40 complaints in total in 2018/19, of which 87% were upheld. All complaints were responded to within the agreed timescales.

**What are we learning and what action are we taking?**

Complaints themes centred on delays in receiving treatment, not enough time in the clinic and lack of information provided or no one being available to speak to regarding concerns. The other issue was around waiting times and the request for better information regarding appointments, especially at the walk in centres.
Actions taken:

- Arrangements made for staff to receive refresher training to ensure they are aware of walk-in urgent criteria and information that needs to be provided
- Staff are under-going training on how to handle patient feedback and complaints
- An automated test result system is being implemented
- In one complaint, a person suffered bruising as a result of an implant. This is a common side effect but to help ensure greater confidence in the service the staff member underwent refresher training.
- Hepatitis vaccines are being stored in separate areas, to avoid confusion as to which vaccines should be administered
- A number of HIV patients raised concerns about the change to service provision when the provision of their local clinic was taken over by CNWL. A meeting was arranged to discuss their concerns and to feedback the actions taken to improve the service, including
  o A dedicated HIV telephone line
  o Increasing the number of HIV clinics
  o Introducing the facility for HIV patients to be able to call their clinic directly from September 2018

None of the complaints had fully recorded actions or lessons learnt on Datix.

How have we engaged with service users and carers? Examples include:

- The work of the peer-led ‘Bloomsbury Network’ continues—each year they help over 1000 people newly diagnosed with HIV access confidential peer support and advocacy. They also produced a user-led short film to tackle perceptions of HIV and encourage others to live proudly.
- Service user forums take place
- Peer support roles continue to have a positive impact
- In Surrey there is now a refreshed service user strategy and group and closer links with the community. Service users have been asked for their views on the new self-testing kits and feedback has been extremely positive
- CNWL took part in National HIV testing week. The Health Promotion Team – CLASH (Central London Action on Sexual Health) visited various places across London such as Camden, Islington, Finsbury Park and Swiss Cottage offering free testing for HIV. CLASH recently won a Noscar (an award given to organisations who positively impact sexual health in minority communities) for their tireless efforts to reach those most at risk of HIV.
- Services promoted the importance of consent during national Sexual Health Week 2018
Westminster Mental Health Services

Are we getting more or less feedback than in 2017/18 and what does this indicate?

Westminster saw an improvement in Friends and Family Test (FFT) returns, with a response rate of 2% in 2018/19 compared to 1.1% in 2017/18. A total of 640 people completed the FFT with Westminster Older People and Healthy Ageing Community Mental Health Team achieving the highest number of responses at 151.

The rate of compliments increased in 2018/19 to 3.19 compared to 1.90 in 2017/18. The rate of concerns per 1,000 patients increased slightly from 2.30 to 5.20 and the rates of complaints decreased from 8.69 to 3.40 per 1,000 patients.
What does the feedback tell us about patient and carer experience?

82% of FFT respondents said that they would recommend the service to other people, which is a slight decrease from 84% in 2017/18.

Feedback from 1,477 FFT comments and the compliments, concerns and complaints received included the following themes:

Positive feedback:

- Patients were positive about many staff members: “There are not enough words to say about the care and support given to me, they have been 100%. I feel most grateful to them all - can't fault them at all.”
- “I feel somebody is behind me. I am not alone”
- “My doctor was very knowledgeable and helpful and my OT was able to get me out and about and doing my own shopping again - I am very grateful for their support and belief in me”

Suggestions for improvement:

- Several people requested a shorter waiting list for treatment
- Some patients complained that communication could have been improved: “Communication has been sketchy with missed appointment letters or letters arriving after the appointment.”
- There were some comments regarding hostile staff: “Train people to be empathetic - they are dealing with very fragile people.”
- Some respondents commented that some services do not have enough staff
- “Everything is good but there are a couple of things like not enough staff about to help or are busy”

How well are services responding to complaints?

Westminster Services received 32 complaints in total in 2018/19, of which 24% were upheld. Westminster did not response to two complaints (6%) within the agreed timescales. All remaining complaints were responded to within the agreed timescales.
What are we learning and what action are we taking?

Complaints were mainly around access, admission and transfer with patients complaining of being discharged too early, although most of these complaints were not upheld. For the partly upheld complaints, another additional theme was around clinical treatments, for example diagnosis or treatments offered being incorrect or insufficient. No actions or learning were recorded on Datix and this was not clear in response letters.

Some suggestions that were fed back to the divisions and services are as follows:

- To provide more sensitive and compassionate responses to all complaints and where indicated provide or offer support to the complainant even when responses are not upheld or where external parties such as the police are involved.
- To provide an evidence trail of why complaints were withdrawn or explain reasons for delays in responses. This should include dates, times, names of staff involved and clients that were spoken to.
- Notes should record brief reasons for a delay in response or the withdrawal of a complaint.
- For staff managers involved in writing complaint responses to seek support and training as required.

In one complaint there was no information on Datix about what support was offered to the family whilst awaiting the final complaint response which was already delayed. The withdrawn complaint that was closed did not explain what attempts were made to find the patient’s new address and if this was done. In general complaints are not responded to swiftly.

How have we engaged with service users and carers? Examples include:

- An Older Adults Service User Group runs monthly in Westminster and is well attended. Activities include service users being on recruitment panels, service users involved in local service design and social outings, for example the group attended a Christmas carol service at St Martin’s in the Field.
- North CMHT organised a Christmas lunch for service users and carers with a service user playing the guitar and singing, attended by 22 people over the lunchtime and early afternoon in a local community hall.
- There is a weekly craft and knitting group attended by service users and carers.
- Regular business meetings with service users take place at the Waterview Centre.
- Weekly community meeting take place on all in-patient wards at the Gordon Hospital.
- Service users attend some recruitment panels.

End of Borough and Area Summaries.
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### APPENDIX 3: Divisional Breakdowns of FFT responses in 2018/19

The upper number in each cell is the 2018/19 figure  
The lower number is the 2017/18 figure  
The arrow indicates increase or decrease between 2017/18 and 2018/19.

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The upper number in each cell is the 2018/19 figure  
The lower number is the 2017/18 figure  
The arrow indicates increase or decrease between 2017/18 and 2018/19.
Quality and Performance Committee

Paper title: Safeguarding Annual Report

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<td>Safeguarding Annual Report</td>
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| Paper author | Catherine Knights, Associate Director of Quality, Safeguarding and Safety  
Karen Cook, Head of Social Work and Social Care  
Jane Thorogood, Interim Named Nurse safeguarding children/ safeguarding children advisor |
| Lead director | Andy Mattin |
| FOI status   | For publication |

**Paper summary**

This report provides an overview of both adult and children’s safeguarding work during 2018/2019.

Key good practice highlights are work around sexual safety in inpatient settings through the establishment of a task and finish group and a production of a highly commended leaflet; a successful domestic abuse conference which launched the Trust DA policy along with a continued focus on identification and support for victims and their children and improved joint working across the Trust safeguarding children teams to ensure a consistent approach to practice in both existing and new services.

The paper outlines key challenges for the period which include preparation for the new Mental Capacity (Amendment) Act with the introduction of Liberty Protection Standards; ensuring that SystmOne is used consistently across adults and children’s services for monitoring and reporting safeguarding issues and the imminent changes to Local Authority safeguarding arrangements which will impact on CNWL’s role as a partner in the new structures.

The report concludes with priorities addressing the challenges in 2019/20.

**Purpose**

☐ For decision  
☐ For discussion  
☒ For information
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<td><strong>Where was this paper previously discussed?</strong></td>
<td>The content of this paper has been discussed at the Trust wide Safeguarding Group</td>
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| **This paper address the Trust objective ( choose all that apply)** | ☐ Quality  
☐ Workforce  
☐ Finance and efficiency  
☐ Partnership and Business Development |
| **Resource implications** | None |
| **Quality considerations** | This paper summarises significant safeguarding issues of which QPC need to be aware. |
| **Risks associated with this report and mitigations (reference to the Board Assurance Framework)** | Safeguarding incidents are a key risk to the Trust, which may identify shortcomings in care provided by Trust systems, processes or staff. |
Executive Summary

This annual report aims to provide QPC with an overview of activity within the Trust with regard to Safeguarding Children and Safeguarding Adults, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and Prevent and covers the period from 1st April 2018 to 31st March 2019. This is the first joint annual report for adults and children and demonstrates many areas that affect both children and adults and also promotes the 'Think Family' agenda.

The purpose of this annual report is to:

- Set the context of safeguarding children and adults within Central and North West London NHS Foundation Trust (CNWL)
- Report on Trust safeguarding children and adults governance and accountability arrangements
- Detail the work and activities of the CNWL Safeguarding Children Team and Safeguarding Adults and Mental Capacity Team during 2018/19
- Provide an update on external safeguarding reviews and audits demonstrating effective practice within the Trust and with health and social care partners
- Demonstrate our compliance with statutory and mandatory training providing assurance to the Board that CNWL staff know how to recognise abuse and how to report this.
- Identify areas for improvement and priorities and objectives for 2019/20
- Provide assurance to the Trust Board and Local Safeguarding Children Boards (LSCBs) demonstrating how the Trust is fulfilling its safeguarding children statutory responsibilities in protecting children from maltreatment.

Key good practice highlights include:
- work around sexual safety in inpatient settings through the establishment of a task and finish group and a production of a highly commended leaflet
- a successful domestic abuse conference which launched the Trust DA policy along with a continued focus on identification and support for victims and their children
- improved joint working across the Trust safeguarding children teams to ensure a consistent approach to practice in both existing and new services.

Challenges and a focus for 2019-20 include:
- preparation for the new Mental Capacity (Amendment) Act with the introduction of Liberty Protection Standards;
- ensuring that SystmOne is used consistently across adults and children’s services for monitoring and reporting safeguarding issues
- the imminent changes to Local Authority safeguarding arrangements which will impact on CNWL’s role as a partner in the new structures.

This report shows the work undertaken in the broad area of safeguarding including work on Prevent, Modern Slavery and Human Trafficking.
Safeguarding Adults and Children
Annual Report
2018/2019
## CONTENTS

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<td>Executive Summary</td>
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1. Introduction and Purpose of Annual Report

This annual report aims to provide QPC with an overview of activity within the Trust with regard to Safeguarding Children and Safeguarding Adults, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and Prevent and covers the period from 1st April 2018 to 31st March 2019. This is the first joint annual report for adults and children and demonstrates many areas that affect both children and adults and also promotes the ‘Think Family’ agenda.

The governance structure and members of the Safeguarding Children Team and the Safeguarding Adults Team is shown in Appendix 1.

The purpose of this annual report is to:

• Set the context of safeguarding children and adults within Central and North West London NHS Foundation Trust (CNWL)
• Report on Trust safeguarding children and adults governance and accountability arrangements
• Detail the work and activities of the CNWL Safeguarding Children Team and Safeguarding Adults and Mental Capacity Team during 2018/19
• Provide an update on external safeguarding reviews and audits demonstrating effective practice within the Trust and with health and social care partners
• Demonstrate our compliance with statutory and mandatory training providing assurance to the Board that CNWL staff know how to recognise abuse and how to report this.
• Identify areas for improvement and priorities and objectives for 2019/20
• Provide assurance to the Trust Board and Local Safeguarding Children Boards (LSCBs) demonstrating how the Trust is fulfilling its safeguarding children statutory responsibilities in protecting children from maltreatment.

The Trust has:

• a duty to safeguard and promote the welfare of children and protect children from maltreatment and work in partnership within the government inter-agency guidelines
• a duty to protect an adult’s right to live in safety, free from abuse and neglect within its care, and to support their families and community networks. Safeguarding Adults is used to describe all work to help adults with care and support needs stay safe from abuse and neglect. The term “adult at risk of abuse and neglect” has been used to replace “vulnerable adult”, (DoH, 2000).

We continue to ensure that the organisation is compliant with both the Safeguarding Adults and Safeguarding Children agenda both nationally and locally. This includes pre-existing legislation and guidance documents, newer legislation and guidance introduced this year, and also preparatory work for reviews likely to be included in future legislation.

Appendix 2 gives an overview of pre-existing legislation, specific revisions and new safeguarding legislation, policy and guidance introduced this year and also preparatory work for reviews likely to be included in future legislation. These include:
In the 2017/18 Annual Report the following were identified as our key priorities for safeguarding children and adults for 2018/19:

**Children:**
- Continued focus on Domestic Abuse - including training for all staff around ‘routine enquiry’ and referral pathways for victims.
- SystmOne roll out in adult mental health and CAMHS services to ensure that the need to safeguard children is incorporated into all training, policies and procedures.
- Work collaboratively with LSCBs to support changes following implementation of the Children and Social Work Act 2017.
- Integration and development of new services in CNWL - ensuring that safeguarding children training, support and access to information is consistent across all services.
- Named professionals across CNWL to undertake leadership roles to reflect LSCB priorities e.g. Neglect, Domestic Abuse, Child Sexual Exploitation/vulnerable adolescents.
- Monitoring the impact on the revision to Trust staff induction and maintaining training compliance

**Adults:**
- Further develop understanding of the Mental Capacity Act by establishing the Essential to Role training programme. Embed the MCA template in practice.
- Roll out making routine enquiries for Domestic Abuse
- Complete and launch the Safeguarding section on the new clinical system.
- Embedding Making Safeguarding Personal using the 8 step model
- Embed new Safeguarding Adults Training Strategy in practice
- Develop 2 new Keeping Safe leaflets – Domestic Abuse and one on Self Neglect
- Providing training to HR and Procurement on Modern Slavery and identifying Champions in these Corporate Services
• Work with each of the Divisions on improving Sexual Safety on Mental Health wards.

Domestic Abuse and the development of SystmOne were key priorities for both Adults and Children during the last year. Our identified priorities form the annual work plan, which is owned by the Trust-wide Safeguarding Group. Progress against the action plan developed from the priorities will be overseen in the Trust quarterly Safeguarding Group meetings and managed through the monthly Named Professionals meetings, with updates included in regular safeguarding reports to the Board.

2. Last Year’s Priorities – What has been achieved?

2.1 Domestic Abuse

Understanding of Domestic Abuse (DA) continued to be a priority for the Trust throughout this period– recognising it’s prevalence across all service areas and demographics and the impact upon everyone affected by it (including children, adults and staff). The Trust has a named lead for Domestic Abuse who has championed and led on all the key achievements outlined below.

Key achievements:

• The Trust hosted a learning event on Domestic Abuse (November 2018) with the aim of raising the profile, increasing staff awareness and more formally launching the refreshed Domestic Abuse policy. The refreshed policy advocates routine enquiry for all females attending CNWL services and selective enquiry for males identified as ‘at risk/vulnerable’. The event was full to capacity – with speakers from a range of specialist services and agencies working with individuals and families impacted by domestic abuse (including adolescent to parent violence, specific concerns for the LGBTQ+ community and survivors relating their own stories). Feedback was extremely positive and demonstrated staff commitment to working with and understanding this complex area.
• Increased awareness for all staff.
  ➢ As part of the Trust’s suite of leaflets for service users, carers and staff on ‘Keeping Safe’ – a leaflet was published during this period on Domestic Abuse. This has been distributed widely throughout CNWL services.
  ➢ There has also been an additional focus on Trust wide communications – using the ‘Clinical Message of the Week’ and the ‘Three Minute Read’ which are circulated to all Trust employees, to highlight important information and developments pertinent to Domestic Abuse. These have more recently included information on Clare’s Law and the proposed changes within the Domestic Abuse bill.
• CNWL continue to work with ‘Standing Together’ (specialist voluntary sector Domestic Abuse service) to provide additional in-house Domestic Abuse awareness throughout mental health services in the Trust. Their focus is more upon infrastructure work in order to ensure that awareness and management of domestic abuse is embedded across all services (as opposed to a focus upon delivering training)
• All MARAC meetings have a CNWL representative in attendance (in each borough). A review of the MARAC representation was carried out last year with a view to ensuring consistency and best practice across the Trust. There are now quarterly MARAC representative meetings with the aim of providing a regular forum for reviewing current arrangements, providing support and updating around Domestic Abuse.

The Trust is constantly reviewing all training packages and this includes training on Domestic Abuse. Whilst DA training is currently included within all safeguarding adult and children mandatory training, the Trust is currently exploring a ‘stand-alone’ E learning package. All Domestic Abuse training is, and will continue to be, compliant with NICE guidelines. Standing Together also facilitated two training dates in March 2019 to increase staff confidence in supporting other team members in carrying out routine enquiry and risk assessment with regards to Domestic Abuse.

There have been a number of high profile cases during this period recognising the impact of ‘coercive control’ (Sally Challen decision Feb 2019, Lincoln – Hart DHR published November 2018).
The challenge is to ensure that these messages are being incorporated into all staff training and briefings as highlighted above – moving away from the idea that risk assessment would necessarily involve identification of physical abuse signs and symptoms.

2019 will see CNWL working alongside the Pathfinder project. Pathfinder is collaboration between NHS Trusts and the Pathfinder Consortium to adopt a shared vision to achieve best practice responses to Domestic Abuse in health settings (across a number of sites). It is a fixed term project (until March 2020) The Tri Borough is one of the pilot sites for the project hence the involvement of CNWL. The Pathfinder Consortium supports the sites to integrate domestic abuse guidance and research into practice. The idea is to replicate what is going well in other areas and support to bridge the gaps. Whilst the Pathfinder project is specifically located within the Tri Borough the learning and resources around Domestic Abuse will be utilised Trust wide.

Also moving forwards into 2019/20 - the ‘Safe and Together Model’ is a perpetrator pattern, children centred, survivor strength based approach to the intersection of Domestic Abuse and child maltreatment. It supports an internationally recognised suite of tools and interventions to help professionals become more ‘Domestic Abuse’ informed. The model provides a framework for partnering with Domestic Abuse survivors and intervening with Domestic Abuse perpetrators in order to enhance the safety and well-being of children. This model is being explored in light of the current Trust wide review of safeguarding training (as cited above). It will support some of the work that has already been done in moving the focus of responsibility away from the Victim/Survivor and towards the perpetrator.

All of the above has taken place against the backdrop of the new draft Domestic Abuse Bill (published in January 2019) which is outlined in the legislation update in Appendix 2.

2.2. SystmOne roll out in adult mental health and CAMHS services

SystmOne was fully rolled out in adult mental health and CAMHS services in January 2019 after an extended period of integration with the previous Jade system. London community and children’s services and Milton Keynes services have already been using the system for more than three years and meetings between safeguarding professionals and the SystmOne team have continued with the focus on the need for a consistent approach to recording safeguarding information across the whole Trust.

Achievements to date have been the standardisation of templates/questionnaires for recording safeguarding supervision, attendance at multi agency professional meetings such as child protection conferences and core groups and recording ‘safeguarding alerts’ for child protection/child in need/looked after child, newly designed safeguarding pages for adults with links to all borough forms and templates and new Mental Capacity Assessment template and Best Interests strategy meeting template.

SystmOne has a Safeguarding Information Node which allows all users to record significant safeguarding events and these can be viewed by all clinicians involved in a child or adult’s care and in all external organisations that use SystmOne. The Named Professional team is currently working on the use of this within all children’s records. The safeguarding node has been implemented within adult mental health recording minimum details (to avoid duplication) to identify adults at risk of harm. This will lead to improved identification and information sharing of adults and children at risk.

The move to SystmOne in adult mental health services has also enabled the services to ‘Think Family’ and ensured that staff understood the importance of linking families in their records. Linking parents/carers and children in clinical records has been highlighted as crucial in several case reviews where a child has died or was seriously injured by a father or father figure in the family who was unknown to professionals working with the family.
2.3 Other Children’s Priorities

2.3.1 Working collaboratively with Local Safeguarding Partners (previously LSCBs)

There is some variance across the LSCB partners in their implementation of the structure changes as required by the passing of The Children and Social Work Act 2017. ‘Working Together to Safeguard Children’ (WT18) states that the safeguarding partners must publish their agreed arrangements for safeguarding and promoting the welfare of children by 29 June 2019 and CNWL representatives have worked collaboratively planning changes to future partnership arrangements.

Some partnerships in the London Boroughs have elected to maintain a similar model to that of the previous LSCBs by continuing with the multi-agency relationships that were already in place. Strategic oversight and involvement will be led by the CCG, Local Authority and the police with health providers in operational groups continuing to take an active role in identification of local safeguarding priorities, audits and specific task and finish groups. CNWL have been involved and contributed to the following:

- Hillingdon - ‘Vulnerable Sub Group Meetings’ for adult/children at both operational and strategic level. MARAC and the now established High Risk Panel (Merged group of MASE / Youth Violence and Vulnerability and Harmful Sexual Behaviour).
- Brent - Multi -agency discussion group around a cuckooing\(^1\) case where two members of a family who were known to CNWL LD and CAMHS services were subjected to this type of exploitation and abuse. It is planned that Brent LSCB will be facilitating a learning event around the emergent themes and specific agency learning.
- Harrow safeguarding partnership - Harmful Sexual Behaviour in school. CNWL involved in initial planning and contributing to training that will be delivered to staff in both primary and secondary schools
- Milton Keynes a Peer Review Challenge was convened in October where multi agency partners were brought together as part of the section 11 process to discuss areas of good practice and identify any areas where improvement is needed or where further assurance is required.
- Milton Keynes - a Fabricated Induced illness (FII) task and finish group was established to review the existing multi- agency practice and guidance in use. This was in response to a series of concerning FII cases over the past 1-2 years.

Safeguarding adolescents has been a priority for most safeguarding partnerships which in ‘Working Together ′ is framed as ‘Contextual safeguarding’ as it recognises the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse over which parents and carers have little influence. Many boroughs have undertaken reviews of their multi agency sexual exploitation (CSE) forums and have expanded the focus to include other forms of exploitation and abuse that young people are subject to such as child criminal exploitation, County lines and serious violence.

2.3.2 Integration of new services in CNWL

In July 2018 Harrow 0-19 services joined CNWL and there has been much work undertaken by all staff involved to ensure that safeguarding systems and processes are integrated smoothly. Preparation is underway for the integration of some community children’s services from the Ealing Community out of Hospital contract which goes live this summer. The involved Named Professionals from Ealing and CNWL will continue to meet together to ensure that effective safeguarding systems

\(^1\) Cuckooing: Criminal gangs target the homes of vulnerable people to be used for drug dealing – a process known as “cuckooing” (after the bird that invades other bird’s nests) and victims are often left with little choice but to cooperate.
2.3.3 Named professionals leadership roles

During the past year each Named Professional has adopted an identified leadership role in an area of safeguarding children which reflect both local and National priorities, including:

- Domestic abuse
- Child criminal exploitation (CCE) and serious youth violence
- neglect
- FGM
- children with perplexing presentations and fabricated induced illness
- the role of fathers

These leadership roles have been selected to ensure the whole team keep abreast of emerging National and local safeguarding priorities through attendance at relevant workshops/uploads and distributing relevant research information across the team which is then shared across the Trust. Work is being undertaken across all Universal children’s services to ensure that the role of fathers in a child’s life is fully acknowledged and supported.

The FGM lead is part of a London regional FGM Health group where discussions are underway with regard to mandatory collecting and recording of FGM information as well as sharing good practice and emerging issues. This also includes changes to our internal recording systems to ensure they comply with recording and reporting needs as required through the FGM national reporting system (FGM-IS).

2.4 Other Adult Priorities

2.4.1 Mental Capacity Act (MCA)

This past year has seen a focus on the MCA for the Safeguarding Adults Team. An interactive e-learning package has been developed with an associated competency test at the end. This training focuses on the key principles of the Act and how to conduct a mental capacity assessment and best interest decisions. This will be mandatory for all clinical staff and is based on the National Competency Framework. It is currently in the testing phase and will be launched during Q2 2019/20.

The development of a mental capacity assessment template for SystmOne is important for CNWL. It will provide assurance that staff are carrying out legally literate mental capacity assessments for all important decisions whilst complying with the first principle of the Act which is the presumption of capacity. It will also ensure that the assessment will be decision and time specific. This will support the Clinical Messages of the Week that have been produced during 2018-19 on the MCA. The implementation of the mental capacity template has been identified as an area for a QI project within the team.

The CQC have highlighted some areas that needed to improve their skills and knowledge in MCA. The Safeguarding Adults Team will provide focussed support to these teams but the aim of the training and the template will be a consistent improvement across all staff in their legal literacy.

The team have kept staff abreast of the developments of the Mental Capacity Bill that went through parliament during 2018-19. The Mental Capacity Amendment Act received royal assent on the 16th May 2019. The legislation provides for the repeal of the Deprivation of Liberty Safeguards (DoLS) contained in the Mental Capacity Act 2005 (MCA), and their replacement with a new scheme called the Liberty Protection Safeguards (LPS). The LPS establishes a process for authorising arrangements enabling care or treatment which give rise to a deprivation of liberty within the meaning of Article 5(1) of the European Convention on Human Rights (ECHR), where the person...
lacks capacity to consent to the arrangements. It also provides for safeguards to be delivered to people subject to the scheme.

These legal changes are summarised in more detail in Appendix 2. The government is currently working on the LPS code of practice, which it has committed to publish for public consultation later this year. A number of regulations will also need to be drafted before the legislation can be implemented. The key change for CNWL is that the Trust (‘the hospital manager’) will become a ‘responsible body’ within the meaning of the Act if the arrangements are carried out mainly in an NHS hospital. Whereas DoLS apply to those aged 18 and over, the LPS apply to people aged 16 and over and will affect both our childrens and adults services. Early discussions have taken place with the Mental Health Act Team within the Trust but will form a major focus for the Safeguarding Teams this coming year.

The Deputy Adult Safeguarding Lead is co-chairing a Capacity and positive Risk Taking Task and Finish group as part of the Bi-Borough SAEB priorities. This group is focussed on:

- Development of interagency protocols to Court of Protection decisions (professional awareness and legal literacy)
- Help SAEB prepare for changes to Liberty Protection Safeguards
- Develop practice around managing risk and decision making

### 2.4.2 Sexual Safety on Mental Health Wards

Ensuring patient’s sexual safety whilst on mental health wards is paramount in providing high quality, safe services whilst maintaining their privacy and dignity and is a CNWL priority. In September 2018, CQC published their report ‘Sexual safety on mental health wards’. The key recommendations of the CQC report were:

- Clearer guidance to staff
- Training so that staff can better support the sexual wellbeing of patients
- Strengthening of the reporting system
- Investment in the physical and therapeutic environment of wards so that they better promote sexual safety.

The Trust has established a Task and Finish Group to further develop the work already undertaken and manage this under one structure. The overall purpose of the group is to ensure that CNWL are fulfilling their responsibility to protect people using mental health inpatient care from harm – specifically from sexual safety incidents.

CNWL has been asked to pilot a strengthened Datix recording process and guidance on severity ratings of incidents including psychological harm by the CQC Lead for Sexual Safety and praised for its detailed work in this area. Further sexual safety leaflets were recently printed for our sites following the impact these have had for both people who use services and our staff. A training package is in development for staff led by the Clinical Education Teams.

### 3. Changes to Trust induction and ensuring Safeguarding Training compliance.

In November ‘Trust Induction’ became ‘The Trust Welcome Day’ with a change of priority from the delivery of mandatory training to a focus on staff engagement and the values of the Trust, its priorities and people. Within 4 weeks of commencing work in CNWL all staff will be expected to complete mandatory E-learning workbooks and assessments relating to both adult and children’s safeguarding to ensure they have the essential knowledge, skills and competency to undertake their roles within the Trust.

Safeguarding training and competency levels are outlined in intercollegiate documents which were updated in 2018 for adults and 2019 for children. The levels of training for Safeguarding Adults will...
more align with children’s safeguarding. Our current Level 1 package aligns to Level 1&2 and our Level 2 training aligns with Level 3 training. The e-learning packages have provided staff with greater opportunity to engage with safeguarding at their own pace and has reduced the burden placed on clinical sites in needing to release staff for training and associated issues relating to travel, room bookings. However, both safeguarding adults and the named professionals recognise the importance of continuing face to face multi-professional training and continue to deliver bespoke small group/team based sessions. These bespoke sessions can be a general refresher session for all staff or focus on a key theme pertinent to the staff group eg. Domestic Abuse, MCA, FGM etc.

Safeguarding Specialists and Named Professionals continue to access multi-agency training and disseminate information about training events external to the Trust to encourage shared learning.

Safeguarding Children Training Compliance
Training compliance was achieved with the Trust meeting the CGG targets, as detailed in the table below

Table 1: Safeguarding Children Training Compliance figures

Table 2: Safeguarding Adults Training Compliance figures
Safeguarding Adults Training has seen a decline in compliance across all 3 Divisions – down 2% from 96% compliance to 94% compliance overall for the Trust (98 staff for Level 1 are non-compliant and 280 staff for Level 2 are non-compliant). This is disappointing but is a reflection of the more robust competency assessment at the end of the e-learning workbook and potentially the change in Trust Induction. At least 100 staff over the past 12 months have failed the online test more than 3 times and the expectation is that they will have a 1:1 session with a Safeguarding Specialist or attend Face to Face training.

4. Prevent

In collaboration with NHS England and the Home Office, CNWL now offer an e-learning package to all members of clinical staff. There has been a sharp uptake of the e-learning training, which has enabled us to exceed the national target of 85% compliance. CNWL are currently at 96% for Prevent basic awareness and 90% for Workshop to Raise Awareness of Prevent (WRAP) – a 5% increase for both.

Table 3: Trust Prevent Training Compliance figures

![Prevent Training Compliance](image)

Despite the move to e-learning the Safeguarding Specialist in each division is still available to provide a minimum of 6 face to face trainings a year; these will be available to book via LDZ with bespoke team based sessions available should specific services (i.e. forensic services) request additional training.

The NHS England Prevent Lead is currently in the process of re-writing the current training packages. The Lead is aiming to rollout the resources by the end of 2019; in the interim the current training packages are valid.

This year has seen a change of personnel for the Trust’s Prevent Lead as the previous post holder left and Elizabeth Folarin has joined the Trust. The plan is that the Board will be updated on bi-annual basis with significant developments and / or concerns communicated on an ad-hoc basis though CNWL safeguarding management structure. In keeping with NHS England Prevent Guideline Document, the Trust will continue to submit quarterly data to NHS Digital and be represented at all Channel meetings.

Targets for 2019/20
• Maintain compliance with the national target as well reaches CNWL’s training compliance of 95% in relation to its WRAP training.
• Have a quarterly partnership meeting with all Prevent borough leads and CNWL Channel representatives. This will enhance greater inter agency working, spot trends and share effective working practices. Moreover, such quarterly meetings will provide greater assurance to the Board that the Trust is effectively discharging their Prevent duties.
• The later part of 2019 will see the start of an annual Diggory division ‘Exploitation Day’ where services within the division will come together to enhance the skills to effectively report and manage issues of exploitation. Prevent will feature prominently at this event with input for from NHS England and SO15 (Police counter terrorism unit). Learning from this day will be shared across Divisions.
• The NHS England North West London hub has identified far right extremism to be a greater threat to the local population. The Trust will look into delivering workshops on ‘Understanding Far Right Extremism’ which have been successfully delivered at Brent local authority via the Small Steps charitable organisation.

In addition to this the safeguarding team are seeking to circulate (via the Clinical Message of the Week) brief anonymised case studies in order to both demystify concerns around Prevent. This will seek to address issues such as information sharing, demonisation of groups and general process. The aim will be to articulate the need for a considered approach toward a range of issues in addition to highlighting good practice on both a local and national basis.

5. CAMHS Developments

The CAMHS service have benefitted from a designated Named Safeguarding professional who has provided support, advice and bespoke training since July 2018. The post holder left this post in May 2019 and the dedicated support to CAMHS is under review. With the developments within CAMHS of Lavender Walk and Crystal House this has been a significant improvement in ensuring that the new staff are clear in relation to safeguarding processes in Kensington and Chelsea and Brent respectively.

6. Modern Slavery

CNWL is committed to ensuring that there is no modern slavery or human trafficking in any part of its business activity. National Crime Agency figures showed that the number of potential trafficking and modern slavery victims reported to the authorities has risen by 36% in a year. In 2018, 6,993 potential victims were referred into the government system, up from 5,142 in 2017 and 3,804 in 2016. Alongside this the Local Government Association has released figures from the National Crime Agency (NCA), showing council referrals of suspected victims have risen from 131 in 2013 to 1,306 in 2018 - this has increased by 66% between 2017 (789 referrals) and 2018. These figures will only represent known cases and are not reflective of the full scale of the problem in the UK.

We are continuing our work to raise the profile of modern slavery across the Trust by:
• Clinical Message of the Week on Modern Slavery
• Identification of a Trust Lead for Modern Slavery who will ensure that the Trust is represented in regional and local anti-slavery partnerships
• CNWL are in the process of developing bespoke training for corporate staff in Procurement and Human Resources on the implications of the Act. This was an action from 2017-18 that has had to be rolled over to 2018-19 as other priorities have taken precedence. However advice and training about modern slavery and human trafficking is available to all staff through the statutory and mandatory safeguarding training.
• Ensuring that we have a transparent Modern Slavery Statement on our External website in line with the Modern Slavery Act 2015.
Staff from various services across the Trust attended the joint HSAB, HSCB and Safer Harrow Annual Conference 2019 on Modern Slavery and Human Trafficking. This conference was very well received and thought provoking and staff encouraged sharing key messages with colleagues in their respective areas of work. In Milton Keynes the Safeguarding Specialist attended training on Modern Slavery and Adult Exploitation delivered by Willow Trust in February 2019.

The Modern Slavery Single Point of Contacts for the Three Boroughs (Westminster, Kensington and Chelsea and Hammersmith and Fulham) has put together a referral pathway on how to respond to potential victims of human trafficking. The pathway was presented at a recent LSAB and is being reviewed before final launch. The pathway will then form the basis of multi-agency training developed by the Local Authority.

7. Other developments over the year

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<td>• Introduction of a Quarterly Safeguarding Children Newsletter.</td>
<td>• Continue to embed the work on sexual safety in practice at Park Royal which was the trailblazer for the work undertaken Trust wide and recognised nationally.</td>
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<td>• There is now an IDVA (Independent Domestic Violence Advisor) which the Hillingdon mental health wards and Colham Green Rehab unit can access</td>
<td>• Introduction of monthly staff safeguarding adults reflective space sessions</td>
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<td>• Safeguarding Adults champion identified in each team.</td>
<td>• Following the Brent section 11 audit in 2017 where it was noted that some staff were unaware of the role of the LADO (Local authority designated officer) and how this fits into allegations made against staff and staff responsibilities the Named Professional in CAMHS has delivered some specific training to staff on the management of allegations against staff and other adults that work with children.</td>
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<td>• Named Nurse linked into strategy meetings/ developments for safeguarding children</td>
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<td>• Work is underway within the Westminster partnership following an external review of child protection conferences which focussed on the process from a child and family perspective. Changes may be made to the format and invites to the conferences which may impact on participation by health.</td>
<td>• The Lighthouse is a facility in Camden, set up in partnership with organisations in the voluntary and public sectors to provide a safe space to support children and young people, from 0-18, in their recovery from sexual abuse or exploitation. It will also support adults aged 18-25 with learning disabilities, if the Lighthouse service best meets their needs. Cross-border and multi-agency partnerships have supported the development of the first Child House model, and this has taken commitment, promotion and investment to establish. CNWL staff are aware of the service and through multi-agency partnerships will actively support referrals, assessments and treatment.</td>
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| • A focused piece of work led by the Trust’s Safeguarding Adults Lead and the Bi-Borough Interim Head of Safeguarding and Quality, Royal Borough of Kensington and Chelsea and Westminster City Council was established at the end of 2018 to improve processes and recording. This followed concerns about data recording on the Local Authority system (Mosaic) and over-reliance on an email inbox and a single person to monitor this. A new process flow chart has been established and CMHT staff in both boroughs will take over the monitoring of safeguarding referrals in both boroughs and data entry on Mosaic used for reporting and monitoring activity. | • There are Safeguarding Champions on all SPRU wards. They've attended...
Champion training and have been given a Champion's Handbook (draft). Bi-monthly SG Supervision will be provided in addition to ad-hoc advice and support.

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<tr>
<th>Champion Training</th>
<th>Harrow</th>
<th>Milton Keynes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Introduction of monthly staff safeguarding reflective space facilitated by the Safeguarding Specialist and Named Professional – this gives the opportunity for complex case discussion and encourages staff to Think Family.</td>
<td>• Raised awareness of Modern Slavery amongst all staff by ensuring all staff has a pocket sized Safeguarding Guide that includes information about Modern Slavery and ensured teams have access to Recognise and Report posters. • 13 Champions identified across mental health and community services who meet regularly with a focus on improving skills and knowledge in safeguarding • Focused piece of work on neglect/self-neglect. In March 2019 the Threshold tool was shared with the Champions Group which brought some clarity to when it is appropriate to raise a concern in cases of potential neglect and self-neglect.</td>
</tr>
</tbody>
</table>

### 7.1 Policy Updates

There were several major internal policy updates over the year. These are:

1. Safeguarding children and young people policy
2. Allegations against people that work with children policy
3. Children not brought to medical appointments
4. Supervision guidelines
5. Consent to Care and Treatment Policy
6. Pressure Ulcer Prevention and Management
7. Advance Care Planning Policy for Patients Approaching End of Life

The Mental Capacity Act Policy was extended whilst waiting for the Royal Assent of the new Mental Capacity (Amendment) Act. It is likely that we will wait until the development of the updated Code of Practice before finalising a new policy.

### 8. Grenfell

The Three Borough LSAB is regularly updated about Grenfell and safeguarding and discusses emerging lessons learnt. These are shared with the CNWL Trust Safeguarding Meeting to ensure these are cascaded to each Division.

#### 8.1 Recent Service Innovations

The team has developed a variety of innovative resources to compliment the core evidenced based screen and treat offer.

#### 8.2 Animations consultations

The Grenfell Animations project is aimed at developing and co-producing a set of short animations with young people around topics related to trauma. Several staff from GHWS have been involved in the early development phase of this project, the GHWS children’s team undertook consultations with five groups of young people from North Kensington. It is intended that, once produced, the animations will be widely and freely shared on a digital platform.

#### 8.3 Grenfell Family Model

In recognition of the fact that the Grenfell fire affected many families of multiple generations,
clinicians from the adult, outreach and children's sub-teams of GHWS have been collaborating on the development of a GHWS Family Model. This is aimed at bringing together clinicians from the different parts of the service, in order to assess, formulate and treat families using a systemic, whole family perspective. A GHWS Family Panel meets on a monthly basis, consisting of clinicians from across GHWS who have experience in work with families.

8.4 Family TRT Adaptation
Teaching Recovery Techniques (TRT) is a manualized psychoeducation and stabilization programme for children aged 6-18, utilizing evidence-based techniques, including elements of trauma-focused CBT. All clinical staff in GHWS children's team were trained in TRT and TRT groups have been run on several occasions within the service. However, clinical staff in the team who had trained in TRT recognised that it may be usefully adapted to a family format, particularly for those young people whose siblings, and/or parents are also experiencing symptoms of post-traumatic stress following the Grenfell fire. The team therefore piloted the use of the TRT manual with family groups and this has so far demonstrated good outcomes.

9. Gordon Hospital
9.1 Clinical Oversight Group
Following several safeguarding adult allegations at the Gordon Hospital against a number of inpatient staff, an Improvement Programme was developed and core members meet on a weekly basis to drive the work programme forward. The outcomes feed into a Strategic Oversight Group that ensures that our Local Authority and CCG partners are updated on progress.

9.2 CCTV
CCTV has most recently been installed at the Gordon Hospital which provides evidence in allegations of harm against patients.

9.3 Datix Huddle Meetings
Datix Huddle meetings take place on a weekly basis where safeguarding adult concerns raised are discussed and lessons learnt where relevant. The Safeguarding Adults Specialist also attends handovers, white board meetings and ward rounds on a weekly basis to raise awareness and help identify safeguarding concerns on the wards.

9.4 Training
Training has been offered to inpatient staff on safeguarding adults, MCA, Deprivation of Liberty and Professional Boundaries. A Masterclass session for Consultants and medical staff was delivered in June 2019 by the Clinical Lead for Safeguarding Adults and the local Safeguarding Specialist.

10. Assurance
The London-based Specialists are required to complete quarterly Safeguarding Health Outcome Framework documents for their local CCGs, contribute to local Safeguarding Adult Board (SAB) annual reports and to report on their activity through their Divisional Safeguarding groups which meet quarterly and to the Trust Safeguarding group. This allows for a high level of consistency and information sharing. CNWL also contribute to LSCB/LSAB Annual Reports and also complete an annual Safeguarding Adults at Risk Assurance Tool (SARAT) in London and similar annual assessments in Milton Keynes which contribute to the priority setting of the LSCB/LSAB (Appendix 3).

10.1 Inspections
10.1.1 CNWL
CNWL has recently been inspected by CQC and retained its ‘Good’ rating. The safety domain improved to ‘Good’ from ‘Requires Improvement’. CQC generally found that staff understood
safeguarding, could recognise abuse and knew how to raise a safeguarding concern. Below are excerpts from the CQC Well-Led report related to safeguarding:

The trust had appropriate measures for safeguarding in place.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked in partnership with other agencies. Staff were all aware of different types of abuse. A senior member of staff was the designated safeguarding lead for each hospital site.

10.1.2 Camden
A Joint Area SEND inspection was undertaken by Ofsted and the CQC in March 2019 to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014. The overall report was positive about the multi-agency provision to children in Camden and there were no specific recommendations relating to safeguarding.

10.1.3 Barnet
The CQC conducted a Borough-wide review of health services for Children Looked After and Safeguarding arrangements in Barnet in February 2018 and the report was published in June. CNWL’s sexual health services in Barnet were included as they operate as part of a network of care, which is accessed by adults who may be vulnerable and young people under 18.

The review outlined actions to be carried out by the sexual health service and all but one has been completed which is the ‘spotting the signs’ toolkit and gang involvement assessment which need to be incorporated into the assessment template on ‘Cellma’. The delay is due to issues with the System provider and is being monitored by service leads. It is planned to go live soon following a test period. Barnet’s looked after children services are currently being re-inspected by OFSTED. CNWL’s Sexual Health provides a service to children in Barnet. There are no current plans for the Sexual Health service to be incorporated in this inspection.

10.1.4 Ealing
A CQC Children Looked After and Safeguarding review (CLAS) review was undertaken in March 2018 with the CCG action plan published in July 2018. There was a recommendation for CNWL and LNW University Health care to “Work together to ensure better mechanisms are in place to enable young people attending Northwick Park Hospital in mental health crises are able to access timely support and further that ward staff are trained to assist in the support process.”

A paper was submitted to Ealing CCG in October which outlined evidence of completion of all action points raised in the review and included details of the CAMHS urgent care team structure and the standardised urgent care pathway, evidence of training delivered to junior doctors in A/E regarding common MH presentations in children, terms of reference and meeting minutes of regular interface meetings between CNWL and LNWUT.

10.1.5 Brent Inspection of children’s social care services May 2018
The overall grading was ‘good’ with the comment “Effective health screening and support ensures that children in care and care leavers improve their physical health. Of particular note is how emotional well-being is prioritised. Close attention is paid to the early identification of the impact of trauma. Consequently, children and young people receive a variety of targeted interventions, and this is reducing the need for more specialised interventions. Specialised support is provided for carers and professional consultation is provided for social workers to help them understand the impact of trauma. Where needs escalate, children and young people are promptly triaged and interventions are prioritised and delivered for as long as they are needed.

10.1.6 Medway
Following the BBC Panorama programme on Medway Secure Training Centre in 2016, there have been various inspections and recommendations on how young people are safeguarded within the
The majority of these recommendations have been actioned or are on target. It is currently undergoing changes to become a ‘secure school’ with the Ministry of Justice placing an emphasis on education and healthcare.

10.2 Audits

10.2.1 The Safeguarding Children Team

The Safeguarding Children Team continues to undertake internal audits throughout the year as well as contribute to multi-agency audits with local safeguarding partnerships. Examples of audits completed over the year are outlined in Appendix 4. Key themes from the audits are shared across Divisions to ensure Trust wide learning.

10.2.2 Bi-borough External Audit

A Bi-borough External Audit was undertaken in February 2019. The audit evaluated recording practice in order to examine operational compliance with the Revised Department of Health Statutory Guidance (Chapter 14), which accompanied the Care Act 2014 and the Revised London Safeguarding Adults Policy and Procedures 2016. The initial audit findings raised concerns about CNWL’s safeguarding practice as well as process. In Kensington and Chelsea 3 cases out of 11 were identified as below required standard. On immediate review:

1) One case was not safeguarding and should not have been submitted for the audit.
2) One case had additional information on the system that wasn’t made available to the auditor which clearly demonstrated that safeguarding practice was sound.
3) One case was an offender care service user who was managed through care planning and risk assessment processes outside of safeguarding.

There were 7 cases audited in Westminster and none were identified as below required standard.

There is an agreed action plan in relation to the External Audit that is being monitored by the Borough Directors.

10.3 Peer Reviews

The aim of Peer Reviews is to support self-evaluation and service development within Local Authorities. Peer Reviews are commissioned by the host Director of Adult Social Services (DASS) and scoped and shaped by them with their senior management team to provide external critique of an issue of concern to them. Reviews are undertaken by teams of peers from across London each led by a DASS. During each review a range of people will be interviewed, staff at all levels, service users and their carer’s, and external organisations/ partners relevant to the theme of the review.

Bi-borough had a Peer Review in March 2019 focused on safeguarding in which CNWL played an active role in the preparation stages and the actual review. Key messages from the review can be found in Appendix 5.

Brent and Hillingdon have their Peer Reviews planned for June and July 2019 respectively and CNWL staff will participate in these as required.

11. Learning from child safeguarding practice reviews (formerly serious case reviews) and safeguarding adult reviews

Each Division monitors child safeguarding practice reviews (CSPRs) and safeguarding adult reviews (SARs) in their Divisional Safeguarding meetings and feedback on lessons learnt from completed reviews is shared at the Trust wide Safeguarding meeting. Examples of which can be found in Appendix 6. In all boroughs there is a focus on multi-agency learning and bitesize summaries (7 minute reads) for staff.

The Safeguarding Teams in CNWL continue to contribute to CSPRs, SARs, DHRs and MDRs in all
areas of CNWL when they occur.

12 Priorities for 2019/20

12.1 Joint Safeguarding Priorities:
- Preparing for the implementation of the new Mental Capacity (Amendment) Act
- Develop Lessons Learnt briefings for staff and stored on Learning Repository
- Continued partnership working and involvement in the LSCB/LSAB restructuring
- Promoting awareness across all services and work collaboratively with external partners signposting to reduce crime, to identify and support victims particularly in areas such FGM, breast ironing, forced marriage, modern slavery, radicalisation, domestic abuse, serious youth violence and child criminal exploitation and County Lines.
- Continued focus on ‘Think family’ through Clinical Messages of the Week, more shared training and joint working between adult and children’s services, role of fathers and improved recording of family groups on SystmOne.
- Further development of SystmOne safeguarding information including the use of shared S1 records (Safeguarding Node) between adult and children’s services, communicating key changes in the use of S1 Safeguarding pages to improve recording and working with the Information Team to set up Tableau reports on safeguarding
- To revise Safeguarding Training Strategy

12.2 Children’s Safeguarding
Key themes from case reviews, audits and emerging issues over 2018/19 have informed the priorities for 2019/20, which are listed below:

- Devise Safeguarding Children Strategy for 2019-22
- New models of care e.g. Ealing mobilisation – ensuring safeguarding is embedded.
- Focus on Children and young people’s mental health- New CAMHS services - Lavender Walk and Crystal House and the extended hours at Collingham.
- To review the provision of formal safeguarding children supervision and who needs to receive this in the Trust

12.3 Safeguarding Adults
- Review training provision for Safeguarding Adults to improve compliance.
- To review the provision of formal safeguarding adults supervision and who needs to receive this in the Trust
- Making Safeguarding Personal – embed positive person-centred outcomes in practice and record these clearly on SystmOne
- Develop guidance on neglect and self-neglect across the Trust
- Continue the Trust-wide work on sexual safety

13. Conclusion

Safeguarding remains a key priority for the Trust. CNWL strives to ensure that local processes meet best practice standards and that lessons are learned from both national and local reviews. Work in 2017/18 demonstrated the energy and commitment of Trust staff to deliver a high quality service to the population CNWL serves and reflected in the most recent CQC inspection.

Named professionals, safeguarding adult specialists and safeguarding advisors are continuing to raise safeguarding awareness within the Trust, taking appropriate action in response to emerging issues, offering training and supporting improvements in the service. CNWL has been a committed partner on all of the LSABs/LSCBs and will continue a central role in working with partners in local restructured arrangements.
The review of the Mental Capacity Act and the subsequent Amendment Act will require considerable work in the coming year to be prepared as a ‘Responsible Body’ as well as addressing and improving the legal literacy of all staff on the Mental Capacity Act.

The priorities identified above will enable the already considerable achievements in safeguarding practice to be protected and further improved so we can continue to identify best practice and achieve greater consistency in processes and practice across the Trust. This is the first joint safeguarding annual report and the first time a number of joint priorities have been identified to support the ‘Think Family’ approach to protect children, young people and adults with care and support needs from abuse.

June 2018
Catherine Knights, Associate Director of Quality, Safeguarding and Safety
Karen Cook, Head of Social Work and Social Care/Adult Safeguarding Lead
Named Nurse Group
GOVERNANCE AND ACCOUNTABILITY

1. Internal Governance

1.1 Board of Directors

The Director of Nursing & Quality provides executive leadership for safeguarding in the Trust. The Associate Director for Quality, Safeguarding and Safety is accountable for safeguarding, both for children and adults, and for the day to day management of the safeguarding team. The Board of Directors received regular updates on safeguarding issues and serious incidents are reported to the Board under Part II. The Board also received bespoke annual safeguarding children training which this year was on Domestic Abuse.

1.2 Trust Safeguarding Committee

The Trust quarterly Safeguarding Group continues to be chaired by the Associate Director of Quality, Safeguarding and Safety.

Membership consists of:

- Trust Named Doctors, Nurses and Allied Health Professionals for Safeguarding
- Associate Director of Quality, Safeguarding and Safety
- Divisional Directors of Nursing
- Safeguarding Advisors from Offender Care, Addictions and Sexual Health
- HR

1.3 Key Trust Safeguarding Roles

Whilst safeguarding is a responsibility of all Trust employees, the following individuals fulfil key roles:

<table>
<thead>
<tr>
<th>Name</th>
<th>Key Role and Whole Time Equivalent (WTE)</th>
<th>Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andy Mattin</td>
<td>Executive Director of Nursing and Quality</td>
<td>HQ</td>
</tr>
<tr>
<td>Catherine Knights</td>
<td>Associate Director of Quality, Safeguarding and Safety</td>
<td>HQ</td>
</tr>
<tr>
<td>Susan Bray</td>
<td>Named Professional 1.0 adult MH</td>
<td>Jameson</td>
</tr>
<tr>
<td>Jane Thorogood</td>
<td>Interim Trust Named Nurse 0.2</td>
<td>HQ</td>
</tr>
<tr>
<td>Lisa Crawshaw</td>
<td>Named Nurse 0.5 Hillingdon</td>
<td>Goodall</td>
</tr>
<tr>
<td>Emma Kay</td>
<td>Named Nurse 0.5 Hillingdon</td>
<td>Goodall</td>
</tr>
<tr>
<td>Adam Seomore</td>
<td>Named Nurse 1.0 Camden/Inner London Children’s community Services</td>
<td>Goodall</td>
</tr>
<tr>
<td>Tracy O’Brien</td>
<td>Named Nurse 1.0 Milton Keynes</td>
<td>Diggory</td>
</tr>
<tr>
<td>Sue Westbury</td>
<td>Named Nurse 1.0 Harrow 0-19 services</td>
<td>Goodall</td>
</tr>
<tr>
<td>Elizabeth Folarin</td>
<td>Integrated Safeguarding/Mental Capacity Specialist &amp; Prevent lead</td>
<td>Diggory</td>
</tr>
<tr>
<td>Darren Tippetts</td>
<td>Sexual Health Safeguarding &amp; Health Advice Lead 0.1</td>
<td>Diggory</td>
</tr>
<tr>
<td>Dr Mike McClure</td>
<td>Named Doctor 0.1 MH&amp;AS</td>
<td>Jameson/Goodall</td>
</tr>
<tr>
<td>Vacant</td>
<td>Named Doctor 0.2 Hillingdon</td>
<td>Goodall</td>
</tr>
<tr>
<td>Dr Allison Ward</td>
<td>Named Doctor 0.2 Camden</td>
<td>Goodall</td>
</tr>
<tr>
<td>Dr Olakkengil Paulson</td>
<td>Named Doctor 0.1 Milton Keynes</td>
<td>Diggory</td>
</tr>
<tr>
<td>Karen Cook</td>
<td>Safeguarding Adults Lead/Head of Social Work and Social Care</td>
<td>Corporate</td>
</tr>
<tr>
<td>Dr Karim Dar</td>
<td>Safeguarding Adults Clinical Lead</td>
<td>Goodall/Corporate</td>
</tr>
<tr>
<td>Mark Easter</td>
<td>Deputy Safeguarding Adults Lead</td>
<td>Goodall/Corporate</td>
</tr>
<tr>
<td>Julie Akorley</td>
<td>Westminster &amp; Kensington and Chelsea and MCA Lead</td>
<td>Jameson</td>
</tr>
<tr>
<td>Elaine Singaram</td>
<td>Brent and Harrow</td>
<td>Jameson</td>
</tr>
</tbody>
</table>
1.4 The Safeguarding Teams

The wider safeguarding team consists of Named Professionals, Safeguarding Adults and MCA Specialists and safeguarding advisors who are jointly responsible for providing advice and support to staff and the provision of training and supervision. The team ensure that safeguarding policies and procedures are updated regularly in line with National guidance as well as communicating safeguarding messages widely across the Trust through newsletters, clinical messages and team updates. They contribute to multi-agency working and information sharing such as providing support to the Multi-Agency Safeguarding Hubs (MASH), membership of LSAB/LSCB subgroups etc. The teams also provide regular representation at other external groups reviewing risk to children, young people, adults and their families. These include Multi-Agency Public Protection Arrangements (MAPPA), which are in place to ensure the successful management of violent and sexual offenders; Multi-Agency Risk Assessment Conferences (MARAC), where information is shared on the highest risk domestic abuse cases and attendance at other critical meetings where the most vulnerable young people are discussed who are at risk of criminal and sexual exploitation and gang activity.

The Safeguarding Adults team has seen some changes in 2018-19 with one member of the team leaving and one changing roles. This enabled us to review the Jameson posts and now have an Inner and Outer London post. We also appointed a new Prevent Lead for the Trust which is hosted in Diggory Division.

1.5 Safeguarding supervision

Offers a formal process for professional support and learning for staff working with children, young people and/or their parents or carers and it provides an opportunity to develop practice and achieve high standards of care. Regular safeguarding supervision is provided by either the safeguarding children team or the relevant line manager through one-to-one and group sessions as appropriate in line with Trust policy. It is through skilful supervision that ‘The voice of the child’ is heard and a recent QI project undertaken in Camden identified this as an important supervisory outcome which clinicians found particularly helpful.

Supervision arrangements are in place for all Named Professionals with support from Designated Professionals and peer supervision takes place within the CNWL Named Professional Group. Several Named Professionals attend a well-established supervision group facilitated by the Tavistock. Safeguarding advisors receive both individual and peer group support.

Safeguarding clinical supervision for the Safeguarding Adults and MCA Specialists is provided by the Deputy Safeguarding Adults Manager within the team and their posts are line managed by the Divisional Directors of Nursing. There are various reflective practice forums/groups across the Trust. Safeguarding is expected to be discussed in every staff member’s supervision. The CCGs have asked that staff requiring bespoke safeguarding supervision are identified and reported on regularly.

2. External Governance

2.1 Local Safeguarding Partnerships (formerly LSCBs)

The Trust is represented and takes a full and active role in working with safeguarding partnerships where it provides services and this is tabulated below:
The new local safeguarding children partnerships will continue to evolve through 2019-20 and it is likely that there will be some changes to the names and types of subgroups within the partnerships. There may also be additional requirements to attend safeguarding partnership meetings where CNWL has acquired a new service. CNWL representatives will continue to attend subgroups such as quality assurance, vulnerable/exploitation, learning and development and health group meetings which are currently in existence and will actively contribute to any proposed changes to ensure that there is representation across the boroughs where CNWL provides health care.

2.2 Local Safeguarding Adult Boards (LSABs)

<table>
<thead>
<tr>
<th>LSAB</th>
<th>Representative</th>
<th>Title of representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brent</td>
<td>Eric Craig</td>
<td>Interim Borough Director</td>
</tr>
<tr>
<td>Camden</td>
<td>Helen Willetts</td>
<td>Divisional Director of Nursing, Goodall</td>
</tr>
<tr>
<td>Harrow</td>
<td>Tanya Paxton</td>
<td>Borough Director</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>Kim Cox</td>
<td>Borough Director</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>Louise Morton</td>
<td>Divisional Director of Nursing, Diggory</td>
</tr>
<tr>
<td>Three borough</td>
<td>Catherine Knights</td>
<td>Associate Director of Quality, Safeguarding &amp; Safety</td>
</tr>
</tbody>
</table>

Feedback from multi-agency safeguarding meetings is disseminated via Borough / Service Directors through Borough Interface Meetings and the relevant Management Team meetings; as well as via Divisional Safeguarding meetings.

The focus of Trust attendance and representation is on:

- Building relationships with partners across each borough e.g. education, children’s social care, adult social care, other health providers, police and voluntary sector
- Working collaboratively to ensure safeguarding partnership priorities are met including participation in audit activity
- Responding positively to queries and challenge regarding the full range of mental health and community services
- Providing consistent representation to optimise the opportunity to increase influence and impact

As well as representation at safeguarding and sub group meetings (including chairing sub groups) the Trust has also ensured attendance and participation at the following:

- Annual Conferences
- Business Planning Days
- Learning lessons from Serious Case Review Events/Safeguarding Adult Reviews
- Participation in multi-agency training
- Section 11 Audit Presentation and Challenge Events (the Trust representative ensures completion of any resulting action)
APPENDIX 2

LEGISLATION AND GUIDANCE ON SAFEGUARDING
Overview of Pre-existing Legislation and Guidance

Mental Capacity (Amendment) Act 2019

Deprivation of Liberty Safeguards (DoLS) were introduced into the Mental Capacity Act 2005 by the Mental Health Act 2007. DoLS provide a framework for approving the deprivation of liberty for people who lack the mental capacity to consent to necessary treatment in a hospital or care home.

The Supreme Court determined that deprivation of liberty occurs when:

- The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anor [2014] UKSC 19*.

This judgement significantly widened the definition of deprivation of liberty, meaning more people were subsequently considered to have their liberty deprived. There was a ten-fold increase in the number of deprivation of liberty applications following the judgment. It has also been criticised for being overly bureaucratic. The key changes will have significant impact on the NHS (both CCGs and provider Trusts) as they will have the responsibility for approving Liberty Protection Safeguards in NHS settings or NHS funded care settings.

In March 2017, the Law Commission published a report, Mental Capacity and Deprivation of Liberty, recommending an overhaul of the DoLS process. It recommended that DoLS are repealed and replaced by a new scheme called the Liberty Protection Safeguards, which would streamline the process for approving a deprivation of liberty which enable people who lack capacity to consent to be deprived of their liberty (for the purpose of providing them with care or treatment). The Government’s final response, published in March 2018, broadly accepted the Law Commission’s recommendations and the Mental Capacity (Amendment) Bill was introduced to the House of Lords on 3 July 2018.

The Mental Capacity (Amendment) Act was approved by Parliament on 24 April 2019 and received Royal Assessment in May 2019. The legislation provides for the repeal of the Deprivation of Liberty Safeguards (DoLS) contained in the Mental Capacity Act 2005 (MCA), and their replacement with a new scheme called the Liberty Protection Safeguards (LPS)

The LPS establishes a process for authorising arrangements enabling care or treatment which give rise to a deprivation of liberty within the meaning of Article 5(1) of the European Convention on Human Rights (ECHR), where the person lacks capacity to consent to the arrangements. It also provides for safeguards to be delivered to people subject to the scheme.

The government is currently working on the LPS code of practice, which it has committed to publish for public consultation later this year. A number of regulations will also need to be drafted before the legislation can be implemented. The plan is for implementation to be May 2020 with a year of dual running with the DoLS system run alongside the LPS to enable those subject to DoLS to be transferred to LPS in a managed way.

The legislation does not define deprivation of liberty. Instead, it retains section 64(5) of the MCA, which provides that references to deprivation of a person’s liberty have the same meaning as in Article 5(1) of the ECHR. The means that the meaning of deprivation of liberty will continue to be led by case law, such as *Cheshire West* and the decisions of the European Court of Human Rights. It also amends section 42 of the MCA to require that the code of practice under LPS must include guidance about what kinds of arrangements would give rise to a deprivation of liberty.

Main changes:

- Whereas the DoLS only apply to hospitals and care homes, the LPS can be used in other settings, for instance supported living, shared lives and private and domestic settings.
• The LPS are also not tied to accommodation or residence; they could be used, for example, to authorise day centre and transport arrangements.

• Authorisations can also be given for arrangements being carried out in more than one setting.

• The LPS applies to people aged 16 and over whereas the DoLS apply to those aged 18 and over. This brings the LPS into line with the rest of the MCA which applies to 16 and 17-year-olds (with a few exceptions). It would also mean that a court application is no longer required to authorise the deprivation of liberty of a 16 or 17-year-old who lacks the relevant capacity.

• The LPS replace the “supervisory body” under the DoLS with the “responsible body”, as the agency charged with authorising the arrangements that give rise to a deprivation of liberty.
  ➢ if the arrangements are carried out mainly in an NHS hospital, the responsible body is the “hospital manager” (in most cases, the trust that manages the hospital in England);
  ➢ if the arrangements are carried out mainly in an independent hospital, the responsible body is the “responsible local authority” in England (normally the authority meeting the person’s needs or in whose area the hospital is situated);
  ➢ otherwise, if the arrangements are carried out mainly through the provision of NHS continuing health care, the responsible body is the relevant clinical commissioning group in England; and
  ➢ otherwise the responsible body is the “responsible local authority” (in most cases this will be the authority that is meeting the person’s needs or in whose area the person is ordinarily resident).

Under LPS, a responsible body may authorise arrangements if the following “authorisation conditions” are met:
• the person lacks capacity to consent to the arrangements;
• the person has a mental disorder within the meaning of section 1(2) of the Mental Health Act 1983; and
• the arrangements are necessary to prevent harm to the person and proportionate in relation to the likelihood and seriousness of harm to the person.

In the case of the assessments for the first two criteria (referred to as the “capacity” and “medical” assessments) the responsible body can rely on previous assessments or assessments for any other purposes, if it is reasonable to do so.

Before arrangements can be authorised, consultation must take place with the following individuals in order to ascertain the person’s wishes or feelings, (unless it is not practicable or appropriate to do so):
• the person;
• anyone named by the person as someone to be consulted;
• anyone engaged in caring for the person or interested in the person’s welfare;
• any donee of a lasting power of attorney or an enduring power of attorney;
• any deputy appointed by the Court of Protection; and
• any appropriate person and any independent mental capacity advocate.

In addition, before authorising arrangements, the responsible body must:
• be satisfied that any duty to appoint an appropriate person or independent mental capacity advocate has been complied with; and
• have arranged a pre-authorisation review which has been completed.

There will be a pre-authorisation review which must be carried out by a person who is not involved in the day-to-day care or providing any treatment to the person, and (in relevant cases) does not have a prescribed connection with a care home. A pre-authorisation review can be completed by either an approved mental capacity professional (AMCP), or some other health or care professional (the government has said it will set out which professions can undertake this role in the
statutory guidance). The AMCP is a new role which is intended to build upon the existing best interests assessor role. Local authorities are responsible for the approval of individual AMCPs and ensuring there are sufficient numbers of AMCPs for their area. This is intended to provide the degree of independence required by Article 5 of the ECHR.

In the following cases, the pre-authorisation review must be undertaken by an AMCP:

- if it is reasonable to believe that person does not wish to reside in, or receive care or treatment at, a particular place;
- the arrangements provide for the person to receive care or treatment mainly in an independent hospital; or
- the responsible body refers the case to an AMCP and the AMCP accepts the referral.

In deciding whether the first of these applies, the responsible body must consider the views of any “relevant person” (a person engaged in caring for the person or interested in the person’s welfare) about the wishes of the person that are brought to its attention.

The AMCP is required to:

- meet with the person and consult all those listed above as requiring consultation (if it is appropriate and practicable to do so); and
- review the information and determine whether the authorisation conditions are met.

In cases which are not referred to an AMCP, the reviewer must:

- review the information; and
- determine whether it is reasonable for the responsible body to conclude that the authorisation conditions are met.

The responsible body cannot authorise arrangements unless the person carrying out the pre-authorisation review has determined that the authorisation conditions are met (in AMCP cases) or that it is reasonable for the responsible body to conclude that the authorisation conditions are met (in non-AMCP cases).

**Care home arrangements:**

If the person is aged 18 or over and the proposed arrangements would be carried out wholly or partly in a care home, then potentially a different process could apply. In such cases, the responsible body can decide if:

- it will arrange the necessary assessments and other evidence to be provided; or whether the care home manager should do so.

If the care home manager is performing this role, then he or she is required to provide a statement to the responsible body confirming that:

- the person is aged 18 or over,
- the arrangements give rise to a deprivation of the person’s liberty (with reasons);
- the arrangements are not mental health arrangements or requirements (see below);
- the “authorisation conditions” are met;
- they have carried out the required consultation (see above), and
- they are satisfied (with reasons) that if it is reasonable to believe that person does not wish to reside in, or receive care or treatment at, a particular place, that neither applies, or that a decision cannot be made as to whether either applies.

The statement must be accompanied by:

- a record of the assessments confirming that the authorisation conditions are met;
- evidence of the consultation carried out, and
- a draft authorisation record.

This information must be presented to the responsible body, which then decides whether to authorise arrangements based on this information (as well as other information, such as the pre-authorisation review arranged by the responsible body). The responsible body can also decide for the care home manager to undertake the review and/or renewal processes.
Length of authorisation
An authorisation can have effect immediately, or up to 28 days later. An authorisation can last for an initial period of up to 12 months and can be renewed for a second period of up to 12 months and thereafter for periods of up to three years.

The responsible body can at any time determine that an authorisation should cease. An authorisation also ceases to have effect if the responsible body believes or ought reasonably to suspect that any of the authorisation conditions are not met. In other words:
- the person has, or has regained, capacity to consent to the arrangements;
- the person does not have a mental disorder; or
- the arrangements are no longer necessary and proportionate.

Any authorised arrangements also cease to have effect if at any time they are not in accordance with requirements of a community power under the Mental Health Act 1983, such as guardianship or a community treatment order, to which the person is also subject.

Appointment of an independent mental capacity advocate (IMCA)
Under the LPS the responsible body is required to take reasonable steps to appoint an IMCA if:
- the person has capacity to consent to the appointment and makes a request, or
- the person lacks capacity to consent, unless the responsible body is satisfied that being represented and supported by an IMCA would not be in the person’s best interests.

The duty however does not apply if there is an “appropriate person” to represent and support the person. In most cases, this will be a family member or friend of the person. An appropriate person must consent to this role and cannot be someone who is engaged in providing care or treatment to the person in a professional capacity or for remuneration. In addition, the person themselves must consent to the appointment of the appropriate person, or if the person lacks capacity to do so, the responsible body must be satisfied that the appointment is in the person’s best interests. The appropriate person has a right to IMCA support.

Working Together to Safeguard Children
This updated version was published in July 2018

This defines safeguarding and promoting the welfare of children as:
- protecting children from maltreatment
- preventing impairment of children’s health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best outcomes

The 2018 update differs from previous versions with regard to:
- multi-agency safeguarding arrangements- LSCBs to be replaced by Safeguarding partnerships
- Local and national child safeguarding practice reviews will replace SCRs
- The Child Safeguarding Practice Review Panel to be established at a National level
- Child death review process changes

There is a new section on ‘contextual safeguarding’ which relates to children who are at risk of harm in their external environment eg School, neighbourhood, friendships, gang-related activity.
This places duties on a range of organisations, like CNWL, and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. These organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including:

- A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- A senior board level lead to take leadership responsibility for the organisation’s safeguarding arrangements;
- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;
- Clear whistleblowing procedures, which reflect the principles in Sir Robert Francis’s Freedom to Speak Up review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed;
- Arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);
- A designated professional lead (or, for health provider organisations, named professionals) for safeguarding.
- Safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;
- Appropriate supervision and support for staff, including undertaking safeguarding training;
- Clear policies in line with those from the LSCB for dealing with allegations against people who work with children.

This outlines the roles and responsibilities of the health service in relation to safeguarding and defines the safeguarding responsibility and duty of Health Provider organisations.

Overview of the revisions, amendments and development of safeguarding children
devolution, policy and guidance that impacted on Trust safeguarding arrangements in 2018/19

The Children and Social Work Act 2017
The Children and Social Work Act 2017 received Royal Assent on 27 April 2017. It mainly applies to England only and includes a wide range of provisions relating to support for children in care and care leavers; the welfare and safeguarding of children and regulation of the social work profession. Key provisions are:

- **Looked after children and care leavers**

English local authorities must ‘have regard to the need’ to take certain actions in their work for children in care and care leavers. Which means acting in the best interests of children and young people, promoting their physical and mental health and well-being; taking into account their views, wishes and feelings, promote high aspirations; stability in their home lives, relationships and education or work and preparation adulthood and independent living.

• **Local safeguarding arrangements**

The Act effectively abolishes Local Safeguarding Children Boards, removing the Children Act 2004 duties relating to them. In their place, it puts duties on three ‘safeguarding partners’ - the local authority, any Clinical Commissioning Groups operating in the area and the Chief Officer of Police - to make safeguarding arrangements that respond to the needs of children in their area.

Two or more areas can also combine their safeguarding arrangements, and one partner can undertake functions on behalf of the corresponding partner within the combined area (eg one Clinical Commissioning Group may carry out the functions of another Clinical Commissioning Group for the overall area).

Their main responsibilities for the partners are:

- To involve ‘relevant agencies’ in their area
- To identify and supervise the review of serious safeguarding cases in their area
- To publish their local safeguarding arrangements
- To arrange for independent scrutiny of their local safeguarding arrangements
- To publish a report every 12 months on what they and the relevant agencies have done as a result of the local safeguarding arrangements and how effective the arrangements have been in practice

The government has given local authorities until 29 September 2019 to transition to the new partnership arrangements for safeguarding.

• **National Child Safeguarding Practice Review Panel**

This will replace the existing national panel that looks at serious case reviews and in an essence abolishes serious case reviews as they currently work. This will be responsible for commissioning and publishing national reviews and investigating cases which will lead to national learning. The current SCR system will be replaced with a system of national and local reviews. This will ensure that reviews are proportionate to the case they are investigating, and improve consistency, speed and quality. Under the new system, lessons from reviews will be captured and shared more effectively so that they can inform good practice. Local partners will be required to carry out reviews into cases which are considered to lead to local learning. These should be published.

• **Child death reviews**

This section of the Act provides for the functioning of child death review partners in a local authority area. At a national level, the ownership of government policy for child death and related issues will be transferred from the Department for Education to the Department of Health. Much of the detail on the constitution and proceedings of the review partners will be clarified in updated guidance. The child death review partners must arrange for the review of every death of a child usually resident in their area, and of children not usually resident in their area if they consider it appropriate.

• **Protecting whistle-blowers**

The Act extends the protection against employment discrimination for whistle-blowers in the NHS to whistle-blowers in children's social care roles. Regulations to prevent discrimination against people who have made protected disclosures, and compensate workers where it occurs, will be created that apply to both local authorities and other providers of statutory social care services. Discrimination is determined to be where an employer "refuses the applicant's application or in some other way treats the applicant less favourably than it treats or would treat other applicants for the same position."

• **Relationships and sex education in England schools and Personal, Social, Health and Economic education**
The Act puts a duty on all primary schools to provide relationships education and on all secondary schools to provide relationships and sex education. Previously, only state-maintained secondary schools had any obligation in this regard.

Relationships / relationships and sex education must be appropriate to pupils' age and religious background. Schools will be required to publish their policy on their relationships and sex education

- Social work profession in England

The Act establishes a new regulator for social work, Social Work England (SWE). The Secretary of State will also have new powers to set ‘improvement standards’ for social workers and introduce assessments for practitioners.

Draft Domestic Abuse Bill published January 2019

- A new statutory definition of domestic abuse which will include economic abuse and coercive control. The Bill also included measures to prevent perpetrators from cross examining victims in court and introduced new domestic abuse protection orders and the establishment of a Domestic Abuse commissioner to help drive through service improvement and improved monitoring procedures.

- The statutory definition to be supported by guidance and additional measures to encourage improved identification and reporting of domestic abuse. This will be important for local authorities in establishing a shared understanding of domestic abuse across directorates.

- The government also launched a report into the social cost of domestic abuse, estimated at £66 billion.

- Additional measures to support the implementation of the Bill include: £220,000 to develop and pilot a training programme for social workers on coercive control; domestic abuse specialists to be introduced into job centres; £8 million for specific groups affected by domestic abuse including LGBT+, older people, male survivors, disabled survivors and a further £1.1 million continued funding for helpline services.

Secure Tenancies (Victims of Domestic Abuse) Act 2018

A bill to make provision about the granting of old-style secure tenancies in cases of domestic abuse.

Following agreement by both Houses on the text of the Bill it received Royal Assent on 10 May. The Bill is now an Act of Parliament (law).

HM Government Serious violence strategy April 2018

This has been launched as a response to tackle the steady rise in violent crime over the past five years. The approach is not solely focused on law enforcement but aims on creating partnerships across a number of sectors such as education, health, social services, housing, youth services, and victim services to tackle violent crime; often referred to as a public health approach.

The strategy is framed on four key themes: tackling county lines and misuse of drugs, early intervention and prevention, supporting communities and partnerships, and an effective law enforcement and criminal justice response. This strategy aims to establish a balance between prevention and law enforcement.

A consultation was recently undertaken in May 2019 on whether to introduce a new legal duty to support the multi-agency action needed to prevent and tackle serious violence. The consultation paper sets out options for supporting a multi-agency or ‘public health’ approach through the introduction of a new legal duty. It also includes a non-legislative option, for partners to work together voluntarily to tackle serious violence.

CNWL staff working with children and young people who may be affected by serious violence were...
asked to contribute to the Trust response to the consultation.

**Children Act 1989 (Amendment) (Female Genital Mutilation) 2019**

This is a private member’s bill introduced by Lord Berkeley of Knighton, the purpose of which is to enable the courts to make interim care orders under the Children Act 1989 in child cases relating to FGM, in addition to FGMPOs. If a court was satisfied that there were reasonable grounds for believing that the child is suffering, or is likely to suffer, significant harm, an interim care order could be made.

The interim care order would mean that a local authority would have shared parental responsibility for the child concerned until a final court hearing.

**Female Genital Mutilation Protection Orders (FGMPOs)**

Were introduced as part of the Serious Crime Act 2015 and the Female Genital Mutilation Act 2003. An FGMPO may contain “prohibitions, restrictions or requirements” as the court considers appropriate, to protect a girl who has either been, or may become, a victim of FGM.

This could include, for example, surrendering passports to prevent the person at risk from being taken abroad for FGM, prohibiting travel, or prohibiting others from making arrangements for FGM to be performed on the person being protected.

FGMPOs can be obtained in either the Family or Criminal Court. This is a civil law measure which can be made by a court.

**Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff/ Fourth edition: January 2019**

This is a revision of the 2014 document and is amended to acknowledge that many previously NHS funded services are being commissioned and provided by non-NHS organisations. It recognises that staff need to be aware of differing and emerging forms of abuse such as social media, modern slavery, human trafficking and recognition that young people are vulnerable to abuse in a range of social contexts.

The guidance identifies five levels of competence and sets out indicative minimum training requirements for each level. The competencies relate to an individual's role and not their job title and apply to all staff delivering, or working in settings which provide healthcare.

The education and training principles highlight the need for flexible learning opportunities to enable the acquisition and maintenance of knowledge and skills and that there are many areas of overlap with adult safeguarding training. It recommends that education, training and competencies are reviewed annually as part of staff appraisal in conjunction with individual learning and development plans.

There is also a template for practitioners to record relevant education and training, including reflective practice and case discussions enabling them to demonstrate attainment and maintenance of knowledge, skills and competencies throughout their career. The education, training and learning logs can be used as an up to date passport to demonstrate safeguarding knowledge, skills and competence as individuals move from organisation to organisation.

**Keeping Children Safe in Education 2018**

This statutory guidance for schools was published in September 2018 and takes into account changes to statutory guidance from ‘Working Together’ 2018. The updated guidance includes a new section (Part 5) on Child on child sexual violence and sexual harassment and covers in detail:

- how schools should respond to incidents of sexual violence and sexual harassment, emphasising the need for effective training and policies in schools and colleges
- the need for risk assessments in school following reports of incidents of sexual violence or sexual harassment
- the action needed to take to support victims and alleged perpetrators of sexual violence or harassment.
The guidance adds further information on the management of safeguarding in a school, including emphasising that staff need to act immediately if they have a concern about a child. The guidance includes new or more detailed information on safeguarding issues including:

- child criminal exploitation: children being used to carry drugs or money from urban to rural areas
- homelessness
- domestic abuse
- child sexual exploitation
- children missing from education.

This is an EU law that sets out guidelines for the collection and processing of personal information and aims to give individuals more rights over how their data is used. GDPR is incorporated into the UK’s Data Protection Act 2018. The GDPR explicitly states that children’s personal data merits specific protection. It also introduces new requirements for the online processing of a child’s personal data.

Children have the same rights as adults over their personal data. These include the right to:

- Be provided with a transparent and clear privacy notice which explains how their data will be processed
- Be given a copy of their personal data
- Have inaccurate personal data rectified and incomplete data completed
- Exercise the right to have personal data erased if they wish.

A child may exercise these rights on their own behalf as long as they are competent to do so. Even if a child is too young to understand the implications of their rights, they are still their rights, rather than anyone else’s such as a parent or guardian (Information Commissioner’s Office, 2018).

GDPR and online data
The provisions of GDPR help children to keep themselves safe online by giving them more control over the information they share.

GDPR gives children the ‘right to erasure’. This means they can request online platforms to remove their personal data, including pictures, text or status updates.

If a child has shared any material online that they no longer wish anyone to see, they have a legal right to get this material removed, even if the content was posted by someone else.

Apps, sites and games must make it clear to users how and why they are using data. Under this law, children aged 12 or under need to seek parental consent to open a social media account, because they need to be 13 years or older to meaningfully understand how their data might be used.

GDPR and child protection
GDPR emphasises the importance of asking children for consent before sharing personal information. If a child is mature enough they should be given the opportunity to decide whether they agree to their confidential information being shared. If a child doesn’t have the capacity to make their own decisions a parent or carer should be asked (unless this would put the child at risk).

However, if there is a child protection concern, information must be shared with the relevant agencies, even if consent has not been given. GDPR does not affect this principle.

Joint inspections of arrangements and services for children in need of help and protection (JTAI)
These inspections are undertaken jointly by Ofsted, the Care Quality Commission (CQC), Her Majesty’s Inspectorate of Constabulary and Fire & Rescue Service (HMICFRS) and Her Majesty’s Inspectorate of Probation (HMI Probation).

JTAIs are carried out under section 20 of the Children Act 2004 and are an inspection of multi-agency arrangements for:

- The response to all forms of child abuse, neglect and exploitation at the point of identification
• The quality and impact of assessment, planning and decision making in response to notifications and referrals
• Protecting children and young people at risk of a specific type (or types) of harm, or the support and care of children looked after and/or care leavers
• The leadership and management of this work
• The effectiveness of local safeguarding arrangements in relation to this work.

All inspections involve a ‘deep dive’ of cases and reports are arranged by the following themes:
• children experiencing abuse and neglect
• child exploitation
• children living with domestic abuse
• child sexual abuse in the family environment

-Assaults on Emergency Workers (Offences) Act 2018-

To make provision about offences when perpetrated against emergency workers, and persons assisting such workers; to make certain offences aggravated when perpetrated against such workers in the exercise of their duty; to require persons suspected of certain assaults against such workers which may pose a health risk to provide intimate samples and to make it an offence, without reasonable excuse, to refuse to provide such samples; and for connected purposes.

Following agreement by both Houses on the text of the Bill it received Royal Assent on 13 September.

The Bill is now an Act of Parliament (law).

Mental Health Units (Use of Force) Act 2018

To make provision about the oversight and management of the appropriate use of force in relation to people in mental health units and similar institutions; to make provision about the use of body cameras by police officers in the course of duties in relation to people in mental health units; and for connected purposes.

Following agreement by both Houses on the text of the Bill it received Royal Assent on 1 November.

The Bill is now an Act of Parliament (law).
### LSCB PRIORITIES – 2017-19

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<thead>
<tr>
<th>Borough</th>
<th>LSCB Priorities</th>
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<td><strong>Brent</strong></td>
<td>1. Domestic abuse  \ 2. Neglect  \ 3. Child sexual abuse  \ 4. Child &amp; parental mental ill health</td>
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<tr>
<td><strong>Camden</strong></td>
<td>1. Troubled Adolescents  \ 2. Parental mental health  \ 3. Child Sexual Abuse  \ 4. Youth violence, gangs, young people held in custody overnight  \ 5. Online safety</td>
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<tr>
<td><strong>Harrow</strong></td>
<td>1. Early support  \ 2. Understanding Risk,  \ 3. Engagement,  \ 4. Effective Collaboration</td>
</tr>
<tr>
<td><strong>Hillingdon</strong></td>
<td>1. To ensure that partners work together to protect Hillingdon’s children from identified risks to their safety and welfare;  \ 2. To oversee the implementation of the Early Intervention and Prevention Service in Hillingdon;  \ 3. To ensure that Hillingdon LSCB can evidence the effectiveness of single agency and multiagency safeguarding arrangements, in order to satisfy ourselves that risks to children and young people are identified early to protect them from harm;  \ 4. To ensure that arrangements for assessing the safety of home-educated children and young people are robust;  \ 5. To assess the safety of children and young people with a disability. This will include an audit and analysis of training undertaken by professionals working with children with disabilities;  \ 6. To assess the effectiveness of safeguarding in the various communities of the borough.</td>
</tr>
<tr>
<td><strong>Milton Keynes</strong></td>
<td>1. Neglect  \ 2. Early intervention  \ 3. Missing people  \ 4. Emerging areas of vulnerability</td>
</tr>
<tr>
<td><strong>Three Borough (KCW, H&amp;F)</strong></td>
<td>1. Reducing the harm of domestic abuse and coercive control  \ 2. Tackling peer on peer abuse – including CSE and serious youth violence  \ 3. Hearing the voice of children and young people</td>
</tr>
</tbody>
</table>
### Kensington and Chelsea/Westminster/Hammersmith and Fulham Board - Emerging Themes and Board Priorities

- Variety and Quality of Care Provision
- Improving the range of health and care provision for people with different types of dementia.
- Hoarding and Self Neglect
- Working together to win the trust of people with capacity to make their own decisions and are reluctant to accept care from statutory services, with the result that their health and care needs are not being met.
- Mental Capacity Act 2005 Increasing staff confidence with application of the Mental Capacity Act 2005; ‘no decision about me, without me’.
- Physical Health Improving the physical health of people with mental health needs and learning disabilities.
- Safe Discharge from Hospital Looking at people’s experiences of discharge from hospital to be sure that they are safe.

### Hillingdon

- Priority 1. To ensure that there are effective arrangements across agencies to reduce the risk of abuse and neglect of vulnerable adults in the borough.
- Priority 2. To ensure that partners understand, and provide an appropriate response to, vulnerable adults who require support with mental health.
- Priority 3. To ensure that all agencies place the 'Making Safeguarding Personal' model at the centre of their response to vulnerable adults.
- Priority 4. To ensure that Hillingdon Safeguarding Adult Board has the capability and tools to effectively hold agencies to account, in order to satisfy ourselves that vulnerable adults are safeguarded within the borough.

### Brent

There are 7 Areas of Priority:

- To raise awareness and understanding of safeguarding adults within the Brent Safeguarding Adults Board (BSAB) workforce and wider community
- Continuing to work together to understand and meet the challenges of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)
- To increase the voice of service users and carers, and their representatives in the work of the SAB
- Continue to work to progress the making safeguarding personal agenda
- Training and Workforce Development is used to support the delivery of SAB priorities and to add value
- Better Quality Data – to work with partners to develop a multi-agency data set to monitor key safeguarding activity within the SAB partnership and to hold partners to account
- An effective Board is established through good Governance, Leadership, Responsibility, Partnership and Accountability

### Harrow

- The HSAB ensures effective communication with its target audiences
- The Harrow SAB’s work is influenced by user feedback and priorities
- The HSAB is reassured that there is access to justice for those who want it
- The HSAB is reassured that partnership priorities are informed by local intelligence about risk and prevalence
- The Harrow SAB ensures that community safety for vulnerable people is a high priority for action
- The Harrow SAB ensures that dignity is a high priority for local care providers
- The HSAB is reassured that staff are well informed about the new safeguarding areas e.g. modern slavery, domestic abuse and sexual exploitation (including forced marriage)
- The Board supports elected Councillors and others in similar roles to recognise abuse and report their concerns
- The HSAB has an effective Quality Assurance framework in place which includes relevant approaches to overseeing effective practice
- Staff are confident in balancing risks with user empowerment
- The Harrow SAB is reassured that DoLS processes are an integral part of its prevention arrangements
- The Harrow SAB is reassured that Making Safeguarding Personal (MSP) is well embedded in practice
- The HSAB and HSCB work collaboratively ensuring a “whole family” approach to safeguarding work
- Learning is embedded in practice and leads to continuous service improvement

**Milton Keynes**

Our business priorities in 2017/18 are:

- Develop a clear annual assurance cycle for all partner agencies;
- Developing a coherent multi-agency approach to learning, workforce development and practice competence;
- Developing and communicating clarity about safeguarding thresholds through a proper threshold model;
- Developing practice understanding of different forms and models of safeguarding interventions;
- Building up capacity within the third sector and community groups;
- Ensuring service user’s experiences inform the Board’s work;
- Embedding making safeguarding personal and implement;
- Communication and engagement with service users, families, communities and staff;
- Responding to emerging safeguarding risks (Modern Slavery);
- Joint themed audit of services to children and adults living with Domestic Violence.

**Camden**

Our next steps for the 12 months ahead

- Examining reasons for fall in Section 42 cases – not in line with the pan London trend.
- Monitoring the implementation of the Establishment Concerns Process
- Progressing full implementation of the Integrated performance dashboard
- Continuing to work together to understand and meet the challenges of the Mental Capacity Act and the DOLs
- Continuing to work to progress the Making Safeguarding Personal agenda
- Conducting the annual Adults Safeguarding Conference
- Progressing the completion of any SAR action plans
- Progressing the work plans of the 3 sub-groups
APPENDIX 4

Detail of Audits

1. A multi-agency **Tri Borough** audit around children and violence/exploitation was completed in 2018. Both CNWL mental health and school nursing services undertook audits and attended a whole day discussion around the audit results. Themes emerged around;
   - Children experiencing DA at a very young age
   - Children moving between parents and between boroughs
   - Many early referrals to CAMHS but limited success due to non-engagement.
   - Many children with identified SEND
   - Many children out of mainstream school
   - Missed opportunities to engage with fathers

   These themes are being taken forward throughout the Trust via training and team briefings.

2. CNWL also participated in a **Brent** multi-agency audit and ‘round table discussion’ regarding a case involving exploitation and potential ‘cuckooing’. Members of the family were known to Brent LD and CAMHS services. This discussion contributed to a multi-agency workshop as part of the Brent children/adult safeguarding conference in 2018. It is also being used as a test case for the development of ‘7 minute briefings’ by the LSCB learning and development forum.

3. In **Harrow** a multi-agency audit around sexual abuse in the family was completed in February 2019. CNWL findings demonstrated that there was limited joined up working between CAMHS/AMHS. Previous auditing of cases (2015) elicited similar feedback and limited evidence of ‘Think Family’ approaches.

   Recommendations for practice
   - full checks should be completed by CSC to identify which agencies are involved with the family – and these checks should be repeated in full if the case is reopened
   - all partners should ensure that their history of involvement is shared with CSC and not just whether they are currently involved or not.
   - CSC should review its notification process for decision-making following strategy meetings i.e. to consider its process for letting all partners know if a case is not going to progress to a child protection investigation/or conference
   - all partners to consider whether existing systems promote a ‘think whole family’ approach by seeking details of all family members, including the identification of their respective needs

4. In **Camden** a multi-agency audit of services for adolescents receiving mental health services was conducted in January – February 2019. The main focus of the report is in the way in which agencies worked together to meet the needs of a group of children who had a diagnosed mental illness or serious difficulties in functioning linked to their emotional and mental well-being.

   Recommendations
   - Obtaining the wishes and feelings of children and young people and evaluating this in future audits
   - Development of an overall model of multi-agency service provision for children and young people who suffer from a mental disorder
   - Addressing the impact of child sexual abuse in work with children and young people with mental health problems
Appendix 5
Key messages from London Bi-Borough Safeguarding Adults Peer Review feedback session

1. Purpose

The purpose of this report is to provide key messages from the Peer Review process to include what is working well, areas for consideration and the plans we have in place to tackle them. The Peer Review took place over a three day period between Wednesday 13th March to Friday 15th March 2019. The Lead Reviewer was Bindi Nagra Executive Director of Health and Adult Social Care London Borough of Enfield who lead a team of 6 specialist professionals from across London Councils.

2. Key Messages

Strong leadership and the positive changes over the last 18 months demonstrated that despite differences in the two boroughs there were also many similarities in ensuring safeguarding outcomes of the residents are met. The Peer Review team feedback that staff from both boroughs were happy, doing excellent jobs and felt supported. In particular it was acknowledged that service user engagement was very good, and the Peer Review team were impressed with the ambitions of the Local Account Group in supporting the Councils.

3. What is working well

Clear evidence of focus on high risk groups through approaches to hoarding, homelessness, rough sleepers and modern slavery. There was a good level of partnership response across council departments and with our statutory partners in working with individual needs and at a strategic level. In particular the Quality Assurance Team were making a positive difference, enhancing market oversight and improvement work.

4. Key areas for consideration and plans to address them

The range of high risk groups could be confusing within the safeguarding governance and escalation process. It is recommended that many different boards across the councils feed into the Safeguarding Adults Executive Board and it would be helpful to review the governance arrangements and potentially to rationalise the number. This will be taken forward by the Safeguarding Executive Board.

Secondly a review of how the various commissioning, quality assurance, service development functions interlink in a way that drives both provider improvement and sector, market improvements will also be reviewed.

Lastly a more proactive approach to analysis will help to answer local ‘data’ variability questions and identify emerging trends. This piece of work has already been actioned by the Safeguarding Executive Board and will feed into wider council workforce development initiatives to further embed commissioning for individual outcomes.
### Milton Keynes/Buckinghamshire - Family T

14 week old twin girls born 10 weeks prematurely were found to have suffered significant non-accidental injuries. The babies had only been in foster care in Milton Keynes for a few days and had been placed by Buckinghamshire children’s services. Father and twins were seen once by CNWL health visiting service. The full report is awaiting publication.

**Key learning**

- Importance of information gathering and liaison with other professionals when children move into foster care especially when a parent is still providing care
- Recognition of potential safeguarding risks when a parent describes not coping and feeling angry and the extreme vulnerability of small babies

### Milton Keynes learning review parents who misuse substances:

A safeguarding learning presentation was developed following the death of an 8 week old baby in Feb 18 while co-sleeping with his mother on the settee. Mother had a long history of mental health difficulties and alcohol misuse problems. The case followed two other recent serious case reviews involving the death of small babies co-sleeping with their mothers. Both of these mothers had mental health difficulties and known to mental health services as well as histories of substance misuse. The presentation was shared across community and mental health services but with a key message for mental health services in relation to advising parents against co-sleeping and the risk of overlay.

**Key learning:**

- Importance of being aware of, and understanding, the risks posed by co-sleeping with small babies, discussing these, and giving advice around safe sleeping arrangements
- Lullaby Trust posters on Safer Sleep for babies and guidance on Sofas are Not Safe were shared with mental health services.

### Milton Keynes:

A Think Family Approach learning slide/poster was mainly developed in response to an incident in Sept 2018 with 4 year old child suffering significant injuries after being assaulted by his father while visiting him at his father’s home. Father was known to adult mental health services and had a long history of depression as well as a history of suicidal ideation, PTSD and violent behaviours. A bespoke training session and learning presentation has been developed in relation to this case which is being used during training sessions across mental health services

**Key Learning:**

- Identifying and including names of children in adult client/patients records in SystmOne even when the client/patient is not currently having access to his/her children or not living with them
- Have a low threshold for being concerned about the safety and welfare of a client/patient’s own children to ensure early effective family support
Key learning on Think Family in Adult Services:

- Understanding the effect of the family situation on the child
- Ensuring joined-up working between adult and children’s services
- Consistently considering the impact of parental mental ill-health on children
- Identifying early risk to children
- Risk assessments ensure a joint focus on the needs of any children in the family
- Care plans to include the needs of the child and parenting goals

Harrow/Lewisham

This involved a young child who was removed from his mother due to long term neglect and was placed with his aunt. He was subsequently physically abused by his aunt. Information regarding the child’s background was not handed over to the professional network in the new borough so staff were unaware of what support he might need.

Key learning

- Professional understanding of parental learning disability and how parents may need enhanced support in this role (specifically if they do not meet the threshold for statutory services).
- The importance of advocacy services to parents/carers to ensure that child protection processes were understood.
- The need for training professionals regarding the impact of Adverse Childhood Experiences (ACE)

Harrow CAMHS

A Harrow CAMHS service user who was last seen by CAMHS in Oct 2018 following an initial assessment. Harrow CAMHS was later informed in January 2019 that the service user was a looked after child (LAC) from Richmond who was residing in Harrow and had been found dead in her home. Domestic Abuse was suspected. The Police were already involved. The case was closed to Harrow CAMHS at the time and she was in the process of being transitioned to adult mental health services. Case review is underway and will follow the SILP (significant incident learning process) model.

Northwick Park Hospital

A Multi-agency ‘Learned Lessons’ Review was held in December 2018 regarding a young person who had waited in custody a total of 30 hours for a Tier 4 bed after a Mental Health Act assessment. A number of key professionals attended from CNWL. The main learning was in regards to making sure pathways for assessment are in place and also that staff know who and when to escalate.

Hillingdon

A Child Safeguarding Practice Review is underway for 7 year old boy (child O) who was unlawfully killed by his mother when she administered a fatal dose of insulin before committing suicide herself. A MASH referral had previously been received by the school nursing service regarding mother’s alcohol misuse and the difficult parental relationship.

Key learning and actions underway for CNWL school nurses

- Responding to and planning following information sharing from children’s social care
- Consideration of a duty system within school nurse teams to ensure important information is documented and followed up appropriately
- MASH standards and procedures to be updated for school nursing service
Hillingdon LS:
This related to a 16 year old who committed alleged murder of an adult whilst he was subject to a CP plan. LS is now a looked after out of area and is awaiting trial. A consideration meeting was held in Hillingdon in October 2018 and case was not referred for a Child Safeguarding Practice Review. All agencies have submitted chronologies and there is an internal safeguarding practice review.

- Feedback: Will be discussed at the Outer London Safeguarding Operational Group, in Supervision (1:1 and Groups), Team meetings and Children’s Service Lead meeting.

<table>
<thead>
<tr>
<th>Early Learning for health:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Record Keeping (including poor groups and relationships, lack of parental responsibility recorded, no action plan recorded, involvement in CP process)</td>
</tr>
<tr>
<td>• Recognising and recording voice of the child at all contacts</td>
</tr>
<tr>
<td>• Health assessments should be robust and completed in relation to the risks identified on a CP plan.</td>
</tr>
</tbody>
</table>

Key learning from Safeguarding Adult reviews is summarised in the following tables. In July 2017 Michael Preston-Shoot and Suzy Braye published a Learning Lessons from 27SARs across London. The key learning is summarised below and has influenced our key priorities for 2018-19.

Table 1: Key learning about the quality of direct practice with individuals

<table>
<thead>
<tr>
<th>Poor or lack of mental capacity assessments</th>
<th>Absence of or inadequate risk assessments</th>
<th>Lack of personalised care and focus on needs and wishes of the individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to involve carers</td>
<td>Lack of curiosity regarding history/behaviour</td>
<td>Focus on relationship</td>
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<tr>
<td>Being able to respond flexibly and with persistence to challenges of engagement</td>
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Table 2: Key learning about organisational factors that influence how practitioners work

<table>
<thead>
<tr>
<th>Poor record keeping processes</th>
<th>Knowledge and confidence of staff</th>
<th>Management oversight of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff working with inadequate resources and/or low staffing levels</td>
<td>Lack of supervision and support</td>
<td>Lack of clear policies and guidance</td>
</tr>
<tr>
<td>Commitment of the organisation to the legal literacy of staff</td>
<td>Culture of the agency</td>
<td>Commissioning gaps or insufficient contract monitoring</td>
</tr>
</tbody>
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