Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Quality Account

2012/13

Note to editors:

ALL RED is compulsory wording and cannot not be changed. Please leave red.

V5.1

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Part 1: Chief Executive's statement on behalf of the Board

On behalf of the Board of AWP, I am pleased to introduce our Trust's fourth quality account which summarises how we are working to improve both the quality of our services and the experience of everyone who has contact with our Trust.

This quality account describes the progress we have made over the past 12 months and our ambitions for the coming year. These are presented across the three domains of quality for patient experience, clinical effectiveness and safety. Our goal is to deliver person -centred services which are accessible, responsive and recovery focused.

May I thank all those who have worked with us to improve the quality of our services and whose views have helped inform the content of this quality account, including our staff, service users, carers, GPs and commissioners. Their contribution makes sure we focus on the priorities of the local health communities we serve.

The past year has seen significant change in our Trust. Publication of a critical independent report resulted in changes in the senior leadership team and the development and implementation of a major programme of organisational change, 'Fit for the Future'. This set out how our Trust would improve to better meet the needs of patients by putting service users and carers at the heart of what we do, strengthening the clinical voice in decision making, and creating a less centralised leadership model, informed by the needs of our local communities and our commissioners.

We have also developed a more rounded approach to monitoring and improving quality, less driven by top down performance led quality metrics and more on ownership and accountability at local ward and team level. This will ensure consideration of all aspects of quality with the primary indicator being patient experience.

In the coming year we will have an absolute focus on quality and safety ensuring that we are, as a minimum, 'brilliant at the basics'. Our refocused approach will be implemented from April 2013, via the following initiatives:

- Establish clinically led locality management of services
- Put in place a new quality information system, *IQ*, to provide a 'ward to Board' focus on seven key quality indicators agreed with our commissioners
- Implement an integrated quality and safety improvement plan
- Streamline and simplify our quality governance process
- Commit to increased transparency and openness
- Implement an effective service user and carer engagement strategy covering individual, ward/team, locality and strategic levels
- Create a clinical academy function to work with the new locality management teams to ensure trust wide quality standards and delivery of consistent service user experience
- Introduce clinically led quality impact assessments on all expenditure and service changes prior to implementation.

We are bringing management closer to front line services so as to ensure everyone in the Trust is working together to achieve the same goals. We will empower our staff to respond to local requirements so as to help deliver significant quality improvements.

These changes have followed the substantial reshaping of many of our services in the past year to improve access and care, to increase responsiveness and to enable us to support many more people within their own homes and communities.

During 2012/13, the Care Quality Commission undertook inspections on a range of services and while some passed with flying colours, others attracted criticism. This has served to redouble our improvement efforts and to ensure that our quality monitoring systems could be relied on to provide assurance to the Board as to the quality and safety

of our services. We are confident that our new IQ system, backed by locality clinical leadership, quality assurance framework and quality improvement visits by Board members will deliver the improvements we all seek.

As our Trust's new chief executive, I have established an email and telephone staff feedback hotline to enable anyone working for our Trust to raise any quality or safety issue directly with me.

While we must constantly strive not just to be 'brilliant at the basics' but to be the 'best at the rest' I am proud to acknowledge the quality of much of the work undertaken by our staff. It is good therefore to see this being externally recognised by for example, our ECT service achieving an excellent rating under the Electro Convulsive Therapy Accreditation Service and five of our wards achieved accreditation under the Royal College of Psychiatrists' AIMS scheme.

In 2013/14, our 'design, check and check again' approach will ensure that changes made continue to have the impact we expect. We will continue to focus on improving service user and carer experience, ensuring we comply with the best practice standards of the Care Programme Approach and ensure that are services are accessible to those with a learning disability via implementing the Mencap Charter standards across all of our services. As well as ensuring the safety of patients in our wards, we will ensure we also focus on the physical health needs of those in our care.

Following consultation we have refreshed our strategic objectives, vision and values to bring these more in line with the aspirations of our staff and those who use our services. As we move forward in 2013/14 'you matter…we care' will be the experience we expect all those who have contact with our Trust to enjoy, backed by values of passion, respect, integrity, diversity and excellence.

Above all in the coming year, we will redouble our efforts to build closer and more effective relationships with the health and social care communities in each of our areas, working with NHS, third sector and local authority colleagues to deliver the best and most cost effective recovery focused care.

Our Board and our staff are united in a shared goal of delivering increasing quality and I commend this quality account to you.

I verify to the best of my knowledge that the information in this document is an accurate and true account of the Trust's quality of services.

Iain Tulley
Chief Executive

INSERT HERE Signature

Guidance to help you when reading this document:

1. We have used a “traffic light” system to rate how well we have done against the standards we have set for ourselves. These are:

Red	Standard not met / poor result
Amber	Standard nearly met / adequate result
Green	Standard met / good result

2. We have also used arrows to show the direction of change against target level over the past year as follows:

▲ = Improving

► = No change

▼ = Deteriorating

3. There is an explanation of some terms in the glossary in Appendix B.

Introducing Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

AWP is a major provider of recovery focused mental health services. Our objective is to be the organisation of choice for service users, staff and commissioners alike, providing a comprehensive range of specialist Mental Health services in primary, secondary and tertiary care settings, across our existing geographical area.

We are committed to the delivery of accessible, effective, leading edge, innovative and person-centred services which intervene early and effectively and concentrate on recovery and re-ablement. We work together with our health and social care partners to provide service users with increased choice in the way they receive support and care which is closer to their homes and to avoid, where possible, disruptive inpatient stays.

AWP provides services for people with mental health needs, for people with learning disabilities combined with mental health needs and for people with needs relating to drug or alcohol dependency. We also provide secure mental health services and work with the criminal justice system.

We operate from more than 100 sites across Bath and North East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire, as well as providing specialist services for a wider catchment extending across the South West.

In 2012/13 the Trust's community services saw 36,659 individuals from over 36,852 referrals, and had more than 445,000 contacts with service users (either via the telephone or face to face). In addition, 2,225 people were admitted into our inpatient units for more intensive treatment.

Our turnover in 2012/13 was £195m and we employed an average of 3213 (whole time equivalent) staff from a variety of professional backgrounds including psychiatrists, psychologists, mental health nurses and allied health professionals.

Fundamental to delivering quality services is continuing to embed the principles of the NHS Constitution within the organisation. This constitution sets out rights of patients, public and staff, pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

Part 2a: Our priorities for improvement in 2013/14

Following extensive consultation we have developed our priorities for the coming year. Where improvement priorities set in previous years remain incomplete, AWP will continue to work on these in conjunction with this year's priorities to provide more person-centred and recovery focused services. Progress with last years priorities is included in Part 3 of this report.

In addition we have set priorities in our Annual Operating Plan for 2013/14. These are to achieve consistent quality of care across the trust, to make more effective use of electronic patient record for CPA and clinical practice, to improve the variable standards of leadership and management throughout the trust, to reduce levels of delayed transfers of care and to focus on improved relationships with our staff, commissioners, patients and carers.

PATIENT EXPERIENCE

Priority 1: To improve service user and carer experience

Description of issues and rationale for prioritising

Understanding the experience of our service users and carers is key to informing how we make adjustments and improvements to our services to meet the needs and expectations of those using them.

Teams and wards will be responsible for ensuring that all service users and carers have the opportunity to give the Trust feedback on their experiences of our services and the care that has been received.

The actions we will take in 2013/14 are set out in the table below:

Aims	Actions	Success measures
*To improve service user experience by taking prompt action at ward and team level in response to regular feedback from service users and their carers.	Implement real-time service user and carer feedback mechanism via the use of the 'Friends and Family Test' survey at the point of discharge from a ward or team and after all care reviews.	Improved scores for the 'Friends and Family Test'. Improved response rates for the completion of the survey.
To improve carers' experience through improved partnership working and carer support.	Implement the use of the national 'Triangle of Care' self-assessment improvement tool in all services. Carry out surveys of carers' experience of services and implement improvements.	Carers leads in all teams and wards. Improved carers' experience survey results.

* These are part of the 2013/14 CQUIN scheme, explained in the glossary at end of document and set out in detail at the following link XXXXXX

EFFECTIVENESS

***Priority 2**: To improve the delivery of effective care by reducing the incidence of delayed transfers of care and through compliance with best practice standards of the care programme approach and the Mencap Charter.*

Description of issues and reasons for prioritising

Delayed transfers, where patients are ready to return home or transfer to another form of care but still occupy a bed, are a symptom of the system failing to provide the right care, in the right place, at the right time. We need to work more closely with our partners in the care system to reduce the incidence of this in our wards.

We know from our service user and carer feedback, Care Quality Commission (CQC) reviews and clinical audit that we still have improvements to make to our compliance with the Care Programme Approach (CPA). The CPA is the primary framework for assessment, care planning and review of care and it is therefore essential that all key elements are in place to ensure the safe and effective treatment of all people in contact with our services.

People with a learning disability generally have poorer health and are also discriminated against because of their disability and may not get the treatment they need. The Trust wants to make sure that every person with a learning disability who comes into contact with our services has their human rights upheld; this especially includes their right to equal healthcare.

Aims	Actions	Success measures
* To improve the quality of the CPA and care planning to ensure that it is collaborative, personalised and addresses crisis and contingency needs.	To establish a system of local self assessment against core CPA standards including regular local audits of the care record; with focussed resources to support improvement.	Compliance on the following indicators: • CPA annual reviews • 7 day follow up • Supervision rates Improved scores in 'Friends and Family Test' survey
*To ensure that people with a learning disability have fair access to healthcare services, and that services are capable of supporting people with a learning disability.	To implement the Mencap Charter Standards across community services. To make sure that appropriate and reasonable adjustments are made to meet the needs of people with a learning disability.	Nine Mencap Charter Standards met, evidenced through: • Completion of benchmarking tool • Hospital passports recorded in electronic patient record (RiO) • 75% of staff to complete learning disability awareness training.
To improve the effectiveness of inpatient services by	Improved local management of DTOC, working	Reduce incidence of delayed transfers of care to no more than 7.5% in all areas.

reducing the number of delayed transfers of care (DTOC)	directly with care homes and Local Authorities and Clinical Commissioning Groups to facilitate appropriate placements and care packages.	

SAFETY

Priority 3: *To improve safety and compliance*

Description of issues and rationale for prioritising

We work hard to ensure that our services are as safe as possible for service users, carers, visitors and staff.

It is essential that vulnerable people who have been admitted to our wards are safe and feel safe. Part of this care needs to focus on physical health to ensure the early recognition of patients who may become acutely unwell so that the appropriate clinical response is available quickly. The National Early Warning Score (NEWS) sets a standardised approach to regularly monitoring of critical signs.

Suicide prevention continues to be a key national priority for public health and mental health services. People with mental health problems are a particularly high-risk group and it is vital that mental health services continue to strengthen clinical practice if suicides are to be prevented.

Aims	Actions	Success measures
*To optimise clinical outcomes by the early identification of acutely physically unwell patients in order to make fast, efficient and consistent clinical responses.	Implement the National Early Warning Score (NEWS) in all inpatient services with appropriate staff training.	90% of inpatients to receive routine weekly NEWS physical health checks.
To support the prevention of suicide through local investigation of unexpected deaths and learning.	All teams and wards to use the National Patient Safety Agency Suicide Prevention toolkit for unexpected deaths.	Completed NPSA toolkits for all individuals who have died unexpectedly whilst in contact with AWP services.

The above initiatives will be monitored and reported through the Trusts internal quality governance and assurance systems and as required to our Clinical Commissioning Groups' contract quality governance meetings.

Part 2b: Statements relating to quality

The Trust has a five year Board *Strategy for Quality Improvement, 2010-15*, which is delivered through annual quality improvement plans in each service, addressing the key areas of safety, effectiveness and patient experience. The plans also seek to improve the systems and processes around quality, including underpinning issues essential for delivering high quality care, such as finance and human resources.

The following statements provide information to demonstrate that the Trust is performing to essential standards, that we measure our clinical processes and performance and are involved in national projects to improve quality.

The Board and its Quality and Safety Committee receive and review assurance and progress reports on a regular basis.

2.1 Review of services

During 2012/13 AWP has provided NHS inpatient and community mental health services organised across five strategic business units, including:

- Adult community services
- Adult inpatient services
- Liaison and later life
- Specialised and secure services, including learning disabilities services for people with mental health needs
- Specialist drug and alcohol services.

The Trust has reviewed all the data available to it on the quality of care in the above NHS services.

The income generated by the NHS services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by the Trust during 2012/13.

2.2 Participation in clinical audits

During 2012/13, four national clinical audits and one national confidential enquiry covered NHS services that AWP provides. During that period AWP participated in 100% of the national clinical audits and 100% of national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that AWP was eligible to participate in during 2012/13 are set out in table 1 below.

The national clinical audits and national confidential enquiries that AWP participated in during 2012/13 are set out in table 1 below.

The national clinical audits and national confidential enquiries that AWP participated in, and for which data collection was completed during 2012/13, are listed below in table 1 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1 – Participation in National Clinical Audits		
***National Audit Topics that AWP was eligible to participate in**	**AWP involvement**	**** Cases submitted / cases required**
POMH 1f & 3c: Prescribing high-dose and combination antipsychotics: acute/PICU, rehabilitation/complex needs and forensic psychiatric services	YES	277
POMH 2f: Screening for metabolic side effects of antipsychotic drugs	YES	13
POMH 11b: Prescribing antipsychotic medication for people with dementia	YES	148
POMH 12a: Prescribing to people with a Personality Disorder	YES	19
National Audit of Schizophrenia (Royal College of Psychiatrists)	YES	89/100
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	YES	65/71

***Table 1 :** Showing the National Audits the Trust was eligible to participate in, those it did participate in, and the level of completion of data requirements.

POMH- Prescribing Observatory for Mental Health (Royal College of Psychiatrists)

*** No set number of cases required.*

2.2.1 Quality improvement actions from clinical audit

The reports of five national clinical audits were reviewed by the Trust in 2012/13 and AWP intends to take the following actions to improve the quality of healthcare provided:

POMH 1f & 3c Prescribing high-dose and combination antipsychotics: Acute/PICU, rehabilitation/complex needs and forensic psychiatric services

This audit of 277 cases led to a pilot improvement project. The rapid tranquilisation policy has been amended and guidelines developed regarding use of PRN medication. A high dose monitoring form has been prepared along with teaching tools to raise awareness and aid clinician reflection. A re-audit will be conducted on the pilot ward in late May.

POMH12a Prescribing for people with a Personality Disorder

The audit has led to an action plan requiring Clinical Directors to work with staff to improve practice in the prescribing of medication. Staff must clearly document the reasons for prescribing antipsychotics for people with a personality disorder and undertake a review after 4 weeks. The actions also address the need to avoid prescribing hypnotics or benzodiazepines beyond 4 weeks, unless there is a co-morbid condition.

POMH 2f Screening for Metabolic Side Effects of Antipsychotic drugs

An action plan is being finalised to address the need for physical checks to be undertaken and documented fully. There are a number of interface issues, between primary and secondary care, which need further clarification and are being taken forward.

POMH 11b Prescribing Antipsychotic Medication for People with Dementia

This audit of 150 records has led to an action plan requiring Clinical Directors to remind staff of best practice in relation to antipsychotic prescribing. Staff must carefully document the potential risks and benefits of antipsychotic medication prior to initiation, and undertake regular reviews. Clarification was also sought on where medication issues should be documented within the new electronic (RiO) clinical record.

National Audit of Schizophrenia

The national report was published in December 2012 and an action plan has been developed. Clinical Directors will work with staff to promote the availability of information for service users and carers. Clinical Directors will also work with staff to ensure, along with primary care, that physical health checks are undertaken and interventions offered when appropriate. Medication management will be reviewed with clinicians in relation to prescribing levels above British National Formulary limits and the use of Clozapine. Access to psychological therapies will be increased through the design of care packages.

Local Audits

The reports of some 60 local clinical audits were reviewed by the Trust in 2012/13 and AWP intends to take a number of actions to improve the quality of healthcare provided. Examples include:

- **Risk Assessment Completion (Inpatients & Community)**

Clinical Directors will oversee improved documentation of risks and further development of risk management plans, focusing particularly on community teams.

- **Health Promotion Assessment and Care Planning**

The Trust lead will review the Trust physical examination policy and guidance. The Trust leads for dual diagnosis, dietetics and physical activity will raise awareness of health promotion needs with their link practitioners or team members working within inpatient services.

2.3 Participation in clinical research

The Trust fully endorses the importance of high quality research for improving clinical effectiveness and the service user and carer experience by giving people early opportunities to participate in new assessment and treatment approaches. AWP works with the National Institute for Health Research (NIHR), Western Comprehensive Local Research Network (WCLRN) and collaborates locally with universities and acute trusts through the Bristol Health Partners (BHP) Academic Health Sciences Collaboration.

The R&D department holds Department of Health contracts to host the West Hub of the Mental Health Research Network (West Hub MHRN) and the South West Dementia and Neurodegenerative Diseases Research Network (SW DeNDRoN). The Trust also supports the National Suicide Prevention Programme Grant led by Professor Gunnell at Bristol University. Over the last year AWP has consolidated the BEST Evidence in Mental Health clinical question answering service in collaboration with the Cochrane Group at Bristol University.

This financial year AWP has participated in 61 studies (April 2012 to March 2013) of which 19 were MHRN and 13 were DeNDRON adopted network studies. 1 of the MHRN and 5 of the DeNDRoN adopted studies were sponsored by commercial companies. AWP acted as a Participant Identification Centre for RICE (Research Institute for the Care of the Elderly) on 1 of the DeNDRoN studies. 6 studies were on the UK Clinical Research Network (UKCRN); a further 20 own account and student projects and 1 commercial study were supported.

For our last full year of data (April 2011 to March 2012), comparable figures were: 86 active projects in AWP, 13 of these in DeNDRoN, 15 in MHRN, 17 UKCRN; and 24 were student projects. AWP recruited a total of 559 patients into NIHR studies during this period.

The number of patients receiving NHS services provided or sub-contracted by AWP in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 978. This represents a 75% increase in research participation into NIHR studies from 2011/12.

The trust is currently **fourth** in the UK amongst mental health trusts for research activity.

2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

Two and a half percent of the Trust's income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between AWP and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation Payment Framework.

During 2012/13 the CQUIN goals were split across seven schemes of which six achieved measurable improvements and five met the target levels aspired to.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available electronically in an additional document which is available from our website [awp.nhs.uk/link]

2.5 Care Quality Commission (CQC) registration

AWP is required to register with the CQC and its current registration status is fully registered without conditions.

The CQC has taken enforcement action against AWP during 2012/13. The enforcement actions were three warning notices as outlined below.

AWP has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13:

- A responsiveness review of Fromeside medium secure services at the Trust's Blackberry Hill site in December 2012. The CQC found that the services were not compliant with two of the quality and safety outcomes and issued a warning notice to the Trust. The CQC re-reviewed the service in March 2013 and found that the services were fully compliant and lifted the warning notice.
- The CQC also conducted three planned reviews of Trust services:
    - The review of Callington Road Hospital found that the service was fully compliant with the quality and safety outcomes.
    - The review of Community Services found that the service was not compliant with four quality and safety outcomes.
    - The review of the Lansdowne Unit service for people with learning disabilities and mental health problems found that the service was not compliant with six quality and safety outcomes and the CQC issued the Trust with two warning notices.

AWP intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission.

Action plans to achieve compliance against all non-compliant services were put in place and a series of internal reviews were undertaken. In relation to the Lansdowne Unit the decision was made to close the unit and discussions are underway with commissioners on the re-provision of the services with some areas going to provide a local service for people with a learning disability and a mental health problem.

AWP has made the following progress by 31 March 2013 in taking such action:

The three warning notices relating to Fromeside medium secure services and the Lansdowne Unit have been lifted by the CQC. The CQC has judged that the Fromeside service is now compliant with the quality and safety outcomes. Good progress has been made in implementing the action plan for Community Services and internal reviews demonstrate significant improvements.

Full reports of CQC reviews are available at the following link:
http://www.cqc.org.uk/public

2.6 Quality of data

The Trust has a comprehensive and systematic approach to the management of the quality of data held on its patient information system RiO, which is then used for reporting.

There are three statistics, shown in table 2 below, which show the quality of data reported in every Trust performance scorecard report, as well as via 'real time' reports at team and ward level. The first two are nationally set and monitor the completeness of key fields on each service user record, the third is a locally defined measure whict ensures that information is entered onto the system in a timely manner (completeness & timeliness are considered key facets of data quality by the Audit Commission (2009).

Table 2: Data quality measures	Target level	2011/12	2012/13	
Data completeness - core fields for patient identification (national indicator)	97%	99%	99%	►
Data completeness - outcome fields (national indicator)	50%	90%	83%	▼
Data timeliness - system updated in three days of actual event	95%	95%	95%	►

Performance across all three indicators continued on or above target during 2012-13, which reflects the positive approach to electronic record keeping within the Trust, as well as the comprehensive approach to data quality management.

The Trust will be taking the following actions to improve data quality:

- Implement a monthly audit of the electronic record which will assess the quality of ten key elements (for example the risk assessment or the care plan). Five records will be reviewed by each team and ward, with results available for comparison between services and areas.
- Build on care cluster accuracy, by focusing attention on both cluster 'transitions' and also the adherence to the 'red rules' during cluster allocation. Both of which have been signalled as important routes to ensuring cluster accuracy / data quality by the DH (PbR Guidance Feb 2013).
- Provide a care coordinator level report, which details key elements of their service users record, highlighting gaps and possible errors.
- Improve completeness of data collected against the protected characteristics to support the Trust in meeting the requirements of the Equality Act

Our performance against other key areas of data quality is as follows:

The Trust submitted records during 2012/13 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid:

- NHS number was 99.9% for admitted patient care.
- General Medical Practice Code was 100% for admitted patient care.

The Trust's Information Governance Assessment report score overall for 2012/13 was 80% and was graded satisfactory (green).

AWP was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission.

2.7 Safeguarding

The Trust continues to regard safeguarding as a key and developing priority. AWP is an active member of the safeguarding multi agency partnerships in our area, including Safeguarding Children and Safeguarding Adults Boards. This year that has seen significant developments in safeguarding including the ongoing actions following the reports on Winterbourne View Hospital and Mid Staffordshire, and a number of local joint inspections (Ofsted/CQC) of children's safeguarding.

The Trust has implemented procedures, systems and training to work with the Prevent and Pursue elements of the national counter terrorism strategy, winning the NHS South of England "Best of Prevent 2012" award for the south west.

The Trust safeguarding team saw a continuing significant increase in activity and contacts from practitioners in 2012/13 in all safeguarding and public protection processes.

The Trust has also been involved in working with local authorities, commissioners and local multi agency safeguarding partnerships to develop a range of improvements in practice and policy.

This work has prioritised improvements in the following areas:

- Providing practitioner support for MARAC (Multi Agency Risk Assessment Conferences) and MAPPA (Multi Agency Public Protection Arrangements) meetings
- Managing and coordinating safeguarding adult referrals in areas with integrated services
- Reporting of poor practice or safeguarding concerns
- Identifying and delivering specialist safeguarding children training at Level 3 for practitioners who work with parents or adults who care for children.

Part 3: Our care quality achievements in 2012/13

The Trust has a robust performance and quality improvement strategy. From Board level to frontline services, quantitative and qualitative information is scrutinised covering the areas of patient experience, effectiveness and safety. Reports are reviewed monthly by the Board, and across the Trust, including external scrutiny by our commissioners and a range of care forums. This approach has helped to systematically improve the quality of services.

In this section we will describe what we achieved during the year across the areas of patient experience, effectiveness and safety. We describe how have progressed with our quality improvement priorities alongside a series of quality indicators that we routinely use for measuring the quality of services.

We have included some measures, as key quality indicators, which show data for the Trust overall. Area level breakdowns to enable local comparison are available in the detailed Appendix D on our website [awp.nhs.uk/link] or on request, as is further information on the definitions of the measures used.

3.1 National Outcomes Framework Indicators

Set out in the section below are the quality indicators that trusts are required to report in their Quality Account from 2013.

Additionally, where the necessary data is made available to the trust by the Health and Social Care Information Centre (HSCIC), a comparison of the numbers, percentages, values, scores or rates of the trust are included.

3.1.1 Care programme approach (CPA) seven day follow up

National data - CPA seven day follow up

Data Source	Reporting period (for 3 months in quarter)				National Average Q3 2012/13	Highest score nationally Q3 2012/13	Lowest score nationally Q3 2012/13
	Q4 2011/12		Q3 2012/13				
	Number	%	Number	%			
HSCIC	635/642	98.9%	560/566	98.9%	97.6%	100%	92.5%

The Trust considers that this data is as described for the following reasons: The Trust has checked the HSCIC figures and can confirm that they match the numbers that were submitted for the relevant periods.

The Trust intends to take/has taken the following actions to improve this percentage, and so the quality of its services, by maintaining robust monitoring arrangements to ensure that key elements of care, such as contacting service users following discharge, are provided routinely to all service users. This approach has led to consistently high performance for this indicator year on year; and as can be seen above the Trust is above the national average for Q3 of 2012/13, making it one of the best performing in the Country.

3.1.2 Admissions to inpatient services have had access to crisis resolution home treatment teams

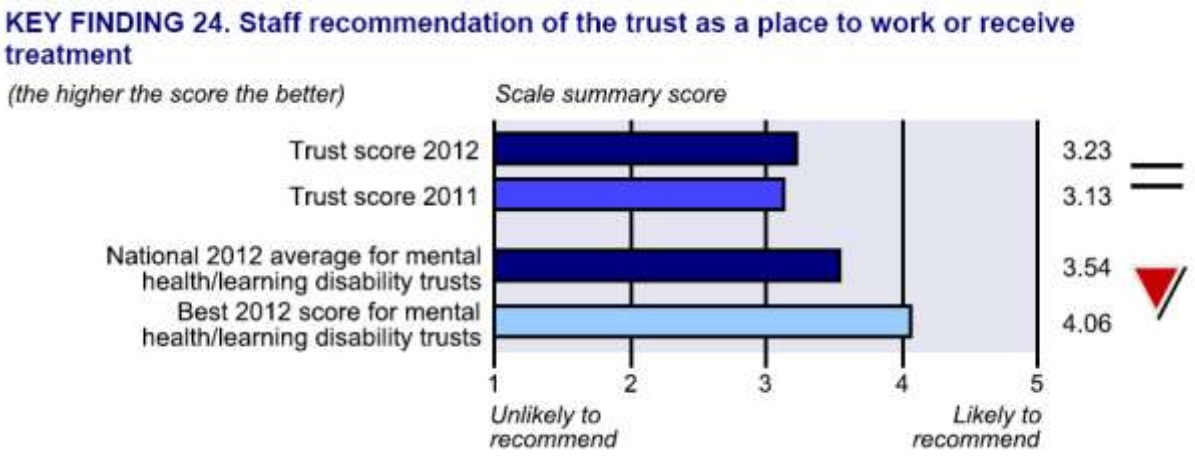
National Data - admissions to inpatient services have had access to crisis resolution home treatment teams							
Data Source	Reporting period (for 3 months in quarter)				National Average Q3 2012/13	Highest score nationally Q3 2012/13	Lowest score nationally Q3 2012/13
	Q4 2011/12		Q3 2012/13				
	Number	%	Number	%			
HSCIC	264/274	96.4%	242/256	94.5%	98.4%	100%	94.1%

The Trust considers that this data is as described for the following reasons: The Trust has checked the HSCIC figures and can confirm that they match the numbers that were submitted for the relevant periods. For Q3 of 2012/13, the Trust performed a little above the lowest national score, but in reality, this equates to 14 admissions that did not have access to an assessment by the crisis team. This is in the context of a 95% target which allows for some cases where the clinical presentation clearly indicates that inpatient care is required, rendering this assessment unnecessary.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by maintaining a robust monitoring process to ensure that key elements of care, such as ensuring that community treatment is considered as an alternative to inpatient care for service users in crisis, are provided routinely to all service users.

3.1.3 Staff survey friends and family question.

This indicator is sourced from the National NHS Staff Survey 2012 representing the views of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.



The Trust *considers that this data is as described for the following reasons*: There were a significant number of changes in the organisation during 2012, including a remodelling of the senior leadership team, consultation about a major restructure of adult services affecting one in seven staff and uncertainty relating to external commissioning impacting on one in four staff members.

The Trust *intends to take the following actions to improve this score, and so the quality of its services, by* introducing a new approach to staff engagement. This will begin with workshop events led by the senior management team to harness the views and ideas of staff about how the Trust can improve the way in which staff view the organisation and the services it provides. The Trust will also use the Foundation Trust membership to work more widely with its staff and gather their views on opportunities for improvement. While further organisational change is planned in 2013, the increased levels of engagement with staff across all groups is intended to identify concerns at an early stage and ensure that managers remain focussed on addressing the concerns of staff relating to service quality and their role.

3.1.4 Patient experience of community mental health services

Data is provided for this indicator from the annual Care Quality Commission Community Mental Health Survey. The indicator is a composite, calculated as the average of four survey questions that relate patients' experience of contact with a health and social care worker.

National Data – Patient experience indicator

Reporting Period	AWP Score	England Average	Highest score nationally	Lowest score nationally
2011	86.90	86.79	91.37	81.87
2012	85.78	86.64	91.77	82.59

The Trust *considers that this data is as described for the following reasons*: The data reflects the Trusts current position as benchmarked against other similar organisations and is scores in line with the national average. Further detail on our results for the national Community Mental Health Survey are detailed in section 3.5.2.

The Trust *intends to take the following actions to improve this score, and so the quality of its services, by*:

Implementing the national Friends and Family Test survey to provide team and ward information on service users experience on a monthly basis. This will allow a quick and focused local response to specific issues raised and inform Trustwide improvement actions

All Local Delivery Units will review the national survey results for their area and will plan local actions focused on the areas needing improvement.

3.1.5 Nationally reported patient safety incident data

Patient safety incident data is collected centrally by the National Reporting and Learning Service (NRLS). Two measures are reported below for the rate of incidents reported per 1000 bed days and the rate of incidents which are categorised as causing *severe harm or death*.

Please note that the September 2012 data published in March 2013 and is the most recently available due to a delay of six months from when data is submitted to the NRLS to it being published.

National Data – Patient safety incident data					
Reporting Period (6 months)	**AWP Score**		**England Average**	**Highest score nationally**	**Lowest score nationally**
	Number	Rate			
i) Rate of patient safety incidents reported per 1000 bed days					
01/04/11 to 30/09/11	2185	18.74	21.1	86.22	3.06
01/04/12 to 30/09/12	3026	30.19	23.8	70.29	5.44
ii) Rate of incidents reported that caused severe harm or death					
01/04/11 to 30/09/11	42	1.9%	0.8%	7.0%	0.1%
01/04/12 to 30/09/12	59	1.9%	1.6%	9.1%	0.1%

Notes *Incident data is reported via the National Reporting and Learning Service. Not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

The Trust considers that this data is as described for the following reasons:

The data concurs with our own data and we are pleased to note the increase in reporting (both in terms of numbers and rate per thousand bed days) in the first six months of 2012/13 compared with the same period in the previous year. We believe that this is as a result of actions taken to ensure continuous improvement, such as thematic reviews and executive led patient safety visits both of which have encouraged reporting and promoted a patient safety culture. We note that our percentage of incidents causing severe harm or death is above the national average. However, we are confident that our criteria for serious untoward incidents is appropriately inclusive and we are assured through the topic specific benchmark work that we undertake, particularly in relation to suicide and homicide, that we make every effort to ensure our services are as safe as possible.

The Trust is taking the following actions to improve this percentage rate, and so the quality of its services, by:

The Trust is currently moving to a web incident reporting system and is already seeing significant improvements in its timeliness of reporting incidents to the NRLS. The ability to give more immediate feedback should further help our efforts to engage with staff about the importance of incident reporting and support learning from experience.

3.2 Patient experience - How we did

Understanding the experience of our service users and their carers is fundamental to the Trust ensuring that we provide good quality services. We continuously strive to improve quality in response to service users and carers experiences.

Progress with our 2011/12 priorities to improve patient experience

Last year our priority areas for quality improvements for service user and carer experience were to

- To improve service user engagement in their care planning
- To improve carers experience through improved partnership working and carer support.

3.2.1 To improve service user engagement in their care planning

Service user engagement and ownership of care planning was highlighted as an area for improvement in patient experience surveys and is a fundamental element of a successful path to recovery. Our work over the year involved carrying out two surveys with five questions pertinent to the quality of care planning under CPA. Services carried out improvement actions to address the following key objectives:

- Ensure that all service users are given a written or printed copy of their care plan
- Service users views to be taken account when their care is being planned
- All service users to be offered the opportunity to talk to their care coordinator before their review meeting
- Improved service user awareness that a friend, relative or advocate can attend their care review meeting
- Service users being given the opportunity to express their views at care review meetings.

The first survey was carried out in quarter one and repeated to monitor improvements in quarter three. The results are set out in table 3 below:

Table 3 - Summary of Service User Survey Results 2012/13			
Questions	**Q1**	**Q3**	**% Change**
1. Have you been given a written or printed copy of your NHS Care Plan?	58.8%	69.1%	+10.3%
2. Do you think your views were taken into account when deciding what was in your care plan?	77.7%	89.9%	+12.2%
3. Before the care review meeting, were you given a chance to talk to your care coordinator about what would happen?	62.9%	61.8	-1.1%
4. Were you told that you could bring a friend, relative or advocate to your care review meeting or appointment?	65.9%	68.1%	+2.2%
5. The last time you had a care review meeting, were you given a chance to express your views?	80.6%	91.8%	+11.2%
Average Improvement			7.0%

The analysis of the survey data identified a significant shift towards positive responses with an average improvement of 7% achieved.

Further improvement work on improving CPA practice is planned in 2013/14 see section 2a Our Priorities for Improvement in 2013/14.

3.2.2 To improve carers experience through improved partnership working and carer support

Meeting our carers' experience quality indicators has been challenging particularly in relation to the identification of carers. The information gathered from our surveys has helped us to understand where and how to make improvements. Our performance with our carers indicators in the last quarter of 2012/13 is as follows:

- 66% of service users in adult services were asked if they had a carer
- 82% of service users in older people's services were asked if they had a carer
- 428 out of 440 (97%) newly identified carers, in the last three months, have received an assessment within four weeks
- 359 out of 399 (90%) of carers with an assessed need have a care plan within 4 weeks of assessment

As in 2011/12 the Trust carried out two surveys to assess the effectiveness of the Trust's engagement with carers; gathering feedback from 176 individuals in June 2012 and 190 in November 2012.

The findings of the survey are linked to the six key elements contained in the 'Triangle of Care – carers included' (National Mental Health Development Unit and the Princess Royal Trust for Carers, July 2010) which give guidance on providing quality services for carers.

We have set five areas for improvement:

- Explanation of the role of a carer
- Making carers feel welcome and included
- Signposting to support agencies including being given copy of AWP carers information pack.
- Details of who to contact in office hours and out of office hours in an emergency
- Opportunity to talk about their needs and given a copy of the initial carers care plan.

The results of the second survey, as set out below in **Table 4,** show a fall back in the scores achieved in the previous survey. These results are of significant concern to the Trust and therefore this area of our work will remain a Trust priority during the coming year, as set out previously in Section 2a.

Table 4 - Summary of Carers Survey Results 2012/13

Questions covered the following themes	Trust Wide Results 2012/13		Target	% Change
	Q1	Q3		
Carers' given an explanation of what is meant by the word carer	85.8%	82.6%	95%	-3.2%
Staff explain how they work with you to support the person you care for	92.6%	87.8%	70%	-4.8%
Carers not receiving support through AWP Carer Information Pack (lower % better)	22.2%	33.7%	25%	+11.5%
Carers not receiving the PALS and Complaints leaflet (lower % better)	27.8%	27.4%	30%	-0.4%
Carers have numbers to contact in office hours	93.8%	93.2%	95%	-0.6%
Carers have a named contact	88.6%	85.5%	90%	-3.1%
Carers have a number to contact out of office hours	71.0%	63.7%	85%	-7.3%
Carers offered an opportunity to talk about their needs	65.3%	68.4%	75%	+3.1%
Carers finding this meeting helpful – question	95.6%	83%	95%	-12.6%
Carers given a copy of the care plan/details of what was agreed.	75.2%	63%	95%	-12.2%
Summary				

2 x Green	= Met improvement target
1 x Amber	= Improvement, not met target
7 x Red	= No improvement, not met target

Examples of some of the key improvement actions being taken are set out below. Surveys of carers' experiences will be repeated during 2013/14 and the following actions will be adjusted as required to address the issues identified:

Improvement actions being taken:

- Promotion of good practice guidance for staff
- Easily available templates for carer's care plans
- Carers information packs readily available
- Carer leads in all teams and wards to give advice and information
- Up to date information available on local carer support organisations/groups
- Supervision and training to support staff to feel confident about identifying carers at service user's first assessment

3.2.3 Patient experience indicators

The metrics below in Table 5 reflect key measures of quality.

These indicators are measures of access to services for assessment and how we are making reasonable adjustments to meet the needs of those service users with a learning disability; as well as various elements of patient experience:

- ensuring inpatient accommodation meets the dignity and privacy needs of all sexes
- a score for patient experience from the national CQC survey
- a staff survey indicator of how our staff feel about the services they provide

Table 5: Patient experience – how we did

Indicator	Standard	2011/12	2012/13 (numerator / denominator	
Service users seen for their first appointment within four weeks of their referral	95%	99%	99% (11520 /11646)	►
Compliance to Department of Health standards for eliminating mixed sex accommodation	100% Compliance	100%	100%	►
Meeting six criteria for access to healthcare for people with a learning disability	All criteria met	Fully met	Fully met	►
NHS patient satisfaction question 'Overall, how would you rate the care you have received from NHS Mental Health Services in the last 12 months?'	National Average	Achieved	Achieved	►
Score for staff survey question on recommending the provider to friends or family needing care	National Average 3.54	Below average 3.13	Below average 3.23	▲

The poor performance of the staff survey indicator is a key concern of the Trust Board recognising that this is a key indicator of the quality of our services. Further information on staff experience measures and plans for improvement is included in section 3.1.3 and 3.7.

During 2012/13 we monitored this question via our in house staff surveys and the score improved from 67% in quarter one to 72% in quarter three.

3.3 Effectiveness - How we did

Effective services are defined as providing the right care to the right person at the right time.

Progress with our 2012/13 priorities to improve effectiveness

Last year three priority areas for quality improvements were to:

- Ensure full compliance to CPA standards in all service settings and areas
- Improved physical health care and focus on health promotion activities for inpatients
- To provide timely, accessible, safe and effective treatment for service users with mental health and substance misuse problems

3.3.1 Ensure full compliance to CPA standards in all service settings and areas

The CPA is the primary framework for assessment, care planning and review of care and it is therefore essential that all key elements are in place to ensure the safe and effective treatment of all people in contact with services.

During the year we have seen good progress or maintained standards against the CPA quality measures for CPA. Our key measures are shown in table 6 below.

Table 6: CPA quality indicators	2011/12	2012/13	% increase
CPA induction % taken onto caseload with a named care coordinator, an agreed care plan, assigned CPA level and care cluster allocated within 4 weeks of assessment	83%	93%	+10%
CPA management % of Service Users Reviewed where the Review was Timely and a Care Plan created or updated within 4 weeks of Review	85%	94%	+9%
Active care coordination % Caseload seen within the last 3 months (CPA only)	97%	98%	+1%
Annual reviews Service Users Receiving a Review (those on CPA for 12 months or more only)	97%	95%	-2%

Our national community patient survey feedback has shown a steady picture with us maintaining a score that is in line with the average for all trusts for the questions relating to care planning, care coordinator and care review.

In section 3.1.1 we also describe the improved results for the survey focussed on understanding service users experiences around their engagement in their care planning.

As noted earlier in section 2.5 CQC registration, the CQC carried out a review of our adult community services in June 2012. This review identified failings in meeting four of the CQC Essential Standards for Quality and Safety. Two of these directly relate to CPA practice: Outcome 1 ‘respecting and involving people who use services’ and Outcome 4

the ‘care and welfare of people who use services’; these issues were rated as potentially having a moderate impact on service users.

In response to this review a significant amount of work has been carried out to improve the areas identified. We have carried out a series of mock inspections to test compliance which also have included an impartial person telephoning service users to discuss their experiences. At this time the Trust is prepared for the CQC to re-visit the community services as we believe the issues identified have been rectified.

3.3.2 Improved physical health care and focus on health promotion activities for inpatients

During the year work has been ongoing in our inpatient units to focus on physical health care. The physical health care needs of people with a serious mental illness are as important as the individual’s mental health care needs and should be addressed as part of a holistic package of care.

During 2012/13 98% or inpatients received a physical health check within 72 hours of being admitted, this is designed to include screening and checks to identify any needs in relation to:

- Weight, body mass index (BMI) diet and physical activity
- Smoking, alcohol and drug use
- Sexual health
- Specific health conditions such as heart disease, diabetes or asthma.

Where needs are identified, activities to meet those needs must be care planned. The Trust has continued to provide training and guidance to staff and developing support tools such as the ‘Healthy lifestyles screening check’ and information leaflets for service users promoting that physical activity does have a positive impact on aspects of mental health and highlighting activities and services we offer.

In January 2013 all inpatient wards took part in an audit to review health promotion (recording on RiO) related assessment and care planning. In summary, although there is some form of health promotion assessment taking place for 99% of inpatients within AWP amongst this sample group, there are clearly areas under the umbrella of health promotion in which greater emphasis needs to be placed on assessment of need; namely: physical activity / sports or exercise, smoking, sexual health and diet.

More positively when needs are identified results showed that these are often care planned, with some services showing less good results in relation to alcohol and drug misuse, smoking and sexual health needs.

Our annual inpatient survey reported the following:

- 84% of service users said they had medical tests about their physical health (e.g. blood pressure, urine tests etc) while they were in hospital
- 42% of service users said they felt that enough care was taken of any physical health problems they had.

Hence in the coming year, as described in section 2a, we are prioritising inpatient physical health again with a specific focus on screening and planning of care for smoking and alcohol and drug misuse; we shall also be refreshing our policy and guidance.

3.3.3 To provide timely, accessible, safe and effective treatment for service users with mental health and substance misuse problems

Rates of excess/harmful alcohol and substance misuse among mental health service users is far higher than in the general population. The role of mental health services is pivotal in the identification of issues and evidence-based interventions to reduce harm.

The Trust has an active dual diagnosis strategy and action plan that is delivered by clinical leads and monitored quarterly. This sets out clear standards around access to services, assessment, appropriate interventions, documentation and training.

In 2012/13 67% of staff have received training and there are specialist dual diagnosis link workers in 80% of our teams. The results of a recent clinical audit showed results for screening were good with evidence of alcohol assessment in 92% of cases (of which 26% were felt to be problematic) and 95% for drug use (of which 45% were felt to be problematic). Although detection was good, only 40% of those who were assessed as having problematic use had documented evidence in the care planning to address these needs.

Work will be ongoing during 2013/14 to increase training coverage to a target of 70%, have identified specialist link workers in all teams and to improve guidance to clinicians on screening and care planning for appropriate interventions.

3.3.4 Effectiveness indicators

This section demonstrates how we are doing on key measures of effectiveness as set out in table 7.

These measures are indicators for:

- physical health care for inpatients and assessment of risk for Venous Thromboembolism
- ensuring service users have a timely review of their care
- monitoring emergency readmissions to wards
- ensuring assessments are made so that service users are only admitted to inpatient care if no other alternative care in the community is appropriate
- monitoring that we are identifying the expected number of cases of psychosis through early intervention for the population of the health community served.

Table 7: Effectiveness – how we did

Indicator	Standard	2011/12	2012/13 (numerator / denominator	
Venous Thromboembolism screening and physical health checks for inpatients within seven days of admission	98%	98%	98% (554 / 566)	►
Care Programme Approach (CPA) annual review	95%	97%	95% (3198 / 3359)	▼
Admissions to inpatient services have had access to crisis resolution home treatment teams	95%	96%	98% (254 / 259)	▲
Minimising delayed transfers of care	<7.5%	7.3% (April 2012)	6.2% (2036 / 32655)	▲
Number receiving early intervention	182	239	249	▲
Emergency readmission to hospital within 30 days of discharge	Less than 5%	4.1%	4.5% (121 / 2676)	▼

3.4 Safety – How we did

It is not only crucial that services are as safe as they can be, but that we can demonstrate this to ourselves, our partners, our services users and carers and to the public. AWP continues to work hard to ensure that our services are as safe as possible.

Progress with our 2012/13 priorities to improve effectiveness

Last year our three priority areas for quality improvements were to:

- CPA: appropriate and rigorous risk management
- Reduction in violence and aggression
- Accreditation for Mental Health Inpatient Services (AIMS)

3.4.1 To ensure appropriate and rigorous risk management as part of the CPA

Effective management of risk and risk taking, in relation to the care of service users, is essential to providing safe and effective care as well as giving the best outcomes for service users, carers, families and communities.

Improvement in this area of the CPA has been specifically identified in recommendations from investigations of homicides and suicides. In order to monitor this aspect of care we have developed a report from our electronic patient record (RiO) to show the total number of current service users with a new risk assessment (or an updated existing risk assessment); current levels reported at the end of March are: 76.1% in community services and 89% for inpatient services.

In order to understand the quality of these risk assessments and to identify where to focus improvements we under took two clinical audits in the last twelve months. The results of these have shown inconsistency of practice across the Trust with each area showing high compliance in some areas of practice and low in others. The quality of risk assessment and management planning appears variable across the Trust with some areas consistently recording high/moderate levels of compliance against most standards while others had low levels of compliance. These findings have supported the sharing of good practice solutions across services to address these inconsistencies.

The data also shows that there are significant failings in most areas to involve families and carers in the risk assessment and management planning process and for care plans and risk management plans to be shared with those involved in the service users care.

Improvement work will be continued in the year ahead with a local focus on more focussed supervision and local scrutiny of the care record. Where poor practice is identified training and additional support will be provided to practitioners. The need for further improvement with our CPA compliance is recognised as we have set out in our improvement plans for the coming year in section 2a.

3.4.2 Reduction in violence and aggression

It is essential that vulnerable people who have been detained under the Mental Health Act and entrusted into our care are safe and feel safe. Work with in our secure services has highlighted areas of good practice to be shared with all inpatient wards to minimise the risk to service users and staff of violence and aggression.

A key indicator on this topic is taken from our inpatient service user survey. Results for 2012 compared with 2011 show no overall improvement in the key question ‘Do you feel safe?’:

- Answers ‘Yes always’ at 53% in 2011 fell to 42% in 2012

- Answers ‘Yes sometimes’ at 29% in 2011 rose to 46%

All staff are required to attend training in the prevention and management of violence and aggression and current coverage is reported at 71%.

All occasions of violence and aggression, whether patient of staff related, are reported through to our central incident reporting system which feeds in to the National Reporting and Learning Service. All wards and teams monitor their incidents, explore learning and are required to report against actions taken to address any issues identified. Themed reviews are carried out centrally across all services to ensure lessons learned and good practice is shared, this is communicated to staff via regular ‘Safety Matters’ briefings.

In addition, the Trust participates in the national pilot of ‘Safe Care’ the safety thermometer data gathering tool being developed for mental health services. One of the data sources collected is in relation to incidents of violence and aggression which, once used more comprehensively across all services nationally, will provide a valuable data pool to support research and learning.

During the year our policies have been reviewed with a specific piece of work to address the guidelines for the immediate treatment of aggression in the particularly complex and vulnerable group - older frail adults. All policies are in line with the NICE guidelines (CG25) for the short term management of disturbed/violent behaviour that sets out how staff should try to prevent violent situations from happening, and what they should do if someone becomes violent.

3.4.3 Accreditation for Mental Health Inpatient Services (AIMS)

AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. It is a comprehensive process of review carried out by the Royal College of Psychiatrist's, College Centre for Quality Improvement that identifies and acknowledges high standards of organisation and patient care, and support other services to achieve these. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided.

During the year each ward has established a multi professional group to self assess and establish improvements to ensure steady progress towards the formal external peer review assessment.

Of the 33 eligible wards in the Trust, five have achieved accredited status and two are currently awaiting assessment. Progress with enabling the peer reviews to go ahead more widely has been hindered by the substantial cost of £2,000 per ward and resources have not been able to be prioritised above other more necessary areas of expenditure. Wards will continue to work towards maintaining their readiness for assessment during 2013/14.

In addition all 11 medium and low secure wards in secure services have taken part in the annual Royal Collage of Psychiatrists peer review process and have been assessed as meeting the best practice standards for secure care. The specialised commissioning group has also officially designated the medium secure service, based at Fromeside, as meeting the medium secure standards.

3.3.4 Safety indicators

This section demonstrates how we are doing on key measures of safety as set out in table 8.

- CPA 7 day follow up – for ensuring all patients are contacted post discharge when most vulnerable
- How service users felt about the safety of services
- Staff sickness absence: we believe a stable, healthy and consistent staff team makes for a safer and more reassuring service for our service users, carers and visitors
- Maintaining services that are free of the risk of hospital communicated and acquired infections

Table 8: Safety – how we did

Indicator	Target	2011/12	2012/13 (numerator / denominator	
Care Programme Approach (CPA) seven day follow up	95%	99%	99% (562 / 566	▶
Percentage answering 'yes always' to the survey question 'During your most recent stay did you feel safe?'	National Average 43%	53%	42% (64 / 153)	▼
Staff sickness absence data cumulative average over past 12 months	4.6%	5%	*4.97% (not applicable)	▲
Meeting objectives for the reduction of infections of Clostridium difficile and Methicillin-resistant Staphylococcus aureus (MRSA)	Reduction	Achieved	Achieved	▶

Notes ***** We have reduced our sickness target from 4.8% in 2012 to 4.6% in 2013. Performance is improving however it remains amber as it is further from the target level aspired to.

The Trust recognises that staff sickness is a key indicator for quality and that we have not achieved the level of sickness absence that we would aspire to. The target for this measure has been stretched further during 2012/13 to reflect the Boards continued focus on this area. This indictor will continue to be closely monitored during 2013/14.

3.5 Service user, carer and patient experience

In 2012, we gathered feedback from service users and carers about their experience of care through the national community mental health survey, the annual inpatient survey and monthly internal surveys across all our services. Complaints, praise and feedback is received via the Patient Advice and Liaison Service (PALS) and there is further feedback from incident data and CQC inspections and visits.

This information is used to inform the priorities for quality improvement.

3.5.1 PALS, praise and complaints

In 2012/13 the Trust received:

- 303 formal complaints
- 1561 enquiries to our PALS team
- 782 items of praise

An analysis of complaints and PALS information is provided in the table below by themes:

Five themes from our feedback*	Complaints	PALS
Access and waiting	83	159
Better information, communications and choice	148	731
Building relationships	74	91
Clean, comfortable place to be	55	67
Safe, high quality co-ordinated care	202	513
TOTAL	562	1561

*Note: complaints or PALS feedback may have more than one theme.

3.5.2 2012 National survey findings

Community Mental Health Survey

The Trust is within the expected range for mental health trusts and scored ‘about the same’ as most other mental health trusts for all sections of the published results of the annual national Community Mental Health Survey (available on the Care Quality Commission (CQC) website).

There was an improvement on the 2011 result for ‘Day to day living’ which scored ‘about the same’ in 2012.

The new - style 2012 benchmarked report means that direct comparisons cannot be made with the 2011 results. However, the Trust scored significantly higher than last year for offering support to service users in finding or keeping work. AWP was within the ‘expected range’ for 36 questions, had no questions that were ‘better’ than most other trusts in the survey, and scored ‘worse’ than the majority of other mental health trusts for

two questions: mental health staff asking service users about their alcohol intake and offering support in getting help with financial advice or benefits.

In community settings and when service users are admitted to wards, full assessments of their needs are undertaken, which include financial issues. They are offered the support which has been identified, either by staff or advisors from local organisations. PALS also provide signposting and advice.

In response to our community survey results we are focusing on the following key areas to make improvements in the Adult and Liaison and Later Life Strategic Business Units:

- All service users to be given a written or printed copy of their care plan
- Care plans covering what the service user should do if they have a crisis
- All service users to have an NHS mental health out of hours phone number and be able to contact their care coordinator or lead professional if they have a problem. To date, adult community intensive and recovery team leaflets have been produced and distributed, with contact details for each area.

The results have been reviewed by both the Strategic Business Units by PCT area, to enable them to identify local good practice and also where there is scope for improvement.

Inpatient survey

The Trust chose to repeat the national adult inpatient survey for the fourth year since it was first undertaken in 2009. 26 mental health trusts took part in this survey nationally in 2012.

Improvements against other Trusts	**AWP**	**All other Trusts**
Hospital food very good/good	74%	60%
Hospital room/ward very clean	65%	57%
Have out of hours phone number	73%	67%
Deterioration against other Trusts		
Medication side effects explained completely	22%	27%

In direct response to national and local feedback a ‘welcome facilitator’ role for all wards has been developed. These posts will support the admission process for service users and carers by providing information, maintaining the link to home and ensuring that service users and their carers feel supported through this process.

An ‘Admissions Checklist’ has been put in place to improve the information provided to service users on their admission to hospital and the documentation of this. The Trust admission booklet for service users and the information for carers have been updated.

3.5.3 Real time survey results

Monthly real time surveys continue to provide immediate feedback on service user satisfaction with current care. A range of methods is available to encourage people to take part: iPads, paper surveys, online via the Trust website and phone.

Each strategic business unit (SBU) carries out a monthly survey and repeats questions on a quarterly basis to allow ongoing comparison. The key themes of the monthly surveys relate to topics identified as areas for improvement in the national surveys. The Acute Adult Inpatient SBU has been using the VOICE (**V**iews **O**n **I**npatient **C**ar**e**) service user survey, developed by Kings College London and published in 2012.

In response to monthly survey results, areas identified for improvement include the following:

- Sufficient ward activities at evenings and weekends – volunteers are being recruited for music, art and craft activities across the Trust
- Information about medication – a medicines passport for all service users is being developed
- Service user involvement in care planning (see section 3.2.1).

3.6 Patient environment

The Trust has taken part annually in the national programme managed by the National Patient Safety Agency called the Patient Environment Action Team (PEAT) assessment. It is a benchmarking tool which helps demonstrate how well individual healthcare providers are performing in key non-clinical aspects of patient care and involves service users and carers in the assessment team.

Our PEAT results for the last two years are shown below and show improved scores for the environment and privacy and dignity categories. Our scores have reduced for food due to additional questions on nutrition and malnutrition therefore results for the two years presented are not completely comparable.

A new process called Patient-Led Assessments of the Care Environment (PLACE) will be replacing PEAT from 2013.

Patient Environment Action Team (PEAT) scores 2011 and 2012					
Environment scores		**Food scores**		**Privacy and dignity scores**	
2011	**2012**	**2011**	**2012**	**2011**	**2012**
1 excellent 11 good 3 acceptable	5 excellent 9 good	11 excellent 1 acceptable 3 self catered	10 good 1 acceptable 3 self catered	11 excellent 4 good	12 excellent 2 good

3.7 Staff survey

Each year the Trust takes part in the national NHS staff survey and has an ongoing process for reviewing the findings and developing improvement initiatives in response.

A summary of the results of the national survey are as follows:

We scored highly against national scores for the themes relating to:

- Staff receiving job-relevant training, learning or development in the last 12 months
- Staff enjoying effective team working

We have achieved improvements in relation to:

- Staff job satisfaction
- Staff having well-structured appraisals in the last 12 months

Results deteriorated in the areas:

- Staff receiving health and safety training the last 12 months
- Staff suffering work-related stress in the last 12 months.

Full details and results for our surveys are available electronically on the NHS Staff Survey website: http://www.nhsstaffsurveys.com

3.8 Innovation – turning great ideas into benefits

Innovation is about doing things differently to improve the quality of our services and service user experience. Very simply, innovation is about turning the good ideas of our staff, service users, carers and partners into real benefits.

Examples below give a flavour of the innovative work we have led and supported in the past year.

Listening to the voice of experience

AWP has embraced an innovative method for improving the experience of service users. Developed by the NHS Institute for Innovation and Improvement, Experience-based Design (EBD) asks people to describe their emotional experience when they come into contact with a particular service. The aim is to understand both positive and negative experiences and use this to redesign aspects of the service.

The basis of the approach is simple - people who use and work in a service are best placed to say how it can improve. The decision of what to improve is a collaborative one and improvements are co-designed by staff and service users.

Pioneered by Bristol Specialist Drug and Alcohol Service, working in partnership with peer mentors (former service users), this approach has made a significant difference. In the light of feedback, immediate changes were made to information leaflets, how ward rounds are conducted and preparation of service users entering detox to build confidence and hope. Peer mentors produced a short film describing the personal experience of Ellie, former service user now peer mentor, of inpatient detox on Acer Unit. 'Finding Hope', directed, performed in, filmed and produced by peer mentors, can be viewed on the AWP website.

This approach has Board level support and is now being used by other services to improve service user experience. The reputation of this innovative work has spread and we have shared our learning as far a field as New Zealand.

Simply the 'BEST in Mental Health'

The Trust has developed an innovative tool for overcoming many of the practical barriers faced by clinicians of translating research findings into clinical practice.

The BEST in MH (Best Evidence Summaries of Topics in Mental Health) service helps to bring high quality research evidence into clinical practice. The BEST Team work closely with health and social care professionals to form answerable questions about wide-ranging aspects of mental health. The Team develop a search strategy tailored for each clinical question and searches the literature databases for relevant, high-quality evidence. The evidence is then critically appraised using tools developed with the Cochrane Collaboration at the University of Bristol, and presented to the clinician as a summary, usually within a fortnight. All summaries are added to a searchable database on the Trust's Intranet for access by all staff.

To date, more than 160 questions have been submitted to the service, covering everything from pharmacological interventions, complementary interventions and psychological interventions to questions concerning diagnostic test accuracy and service design. Summaries are used to inform clinical practice and service development, ensuring they are based on current, high quality research evidence.

The BEST in Mental Health project, the result of collaboration between the University of Bristol and AWP, has been positively received by AWP colleagues and received national recognition when selected as a finalist in the Innovation in Mental Health category of the prestigious Health Service Journal Awards in 2012.

Accelerating Innovation across the West of England

There is no shortage of great ideas, services or products that have the potential to transform health and healthcare but their uptake and spread across the NHS is often slow. Great ideas can remain locked in individual organisations resulting in limiting the potential benefits to individuals and communities.

Academic Health Science Networks (AHSNs) are new organisations that bring together NHS, University, industry and other important stakeholders across a geographical area with the aim of accelerating the spread of innovative, evidence-based care to improve health and care quality**.**

Fifteen AHSNs are being established across England. Our local network covers South Gloucestershire, Bristol, North Somerset, Bath and North East Somerset and is called the West of England Academic health Science Network. AWP has played a key role in developing the West of England Academic Health Science Network and is committed to being an active partner. An early focus of the Network is improving mental health.

To find out more about the plans, priorities and partners of the West of England Academic Health Science Network take a look at the website: www.weahsn.org.uk .

3.9 Equality and diversity

In 2011/12 the Trust agreed with stakeholders a position on how well we were doing on the four broad equality goals contained within the *Equality Delivery System (EDS):

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership

Based on this work AWP developed an Equality, Diversity and Human Rights Strategy and Implementation Plan 2012– 2015 which reinforced our commitment to meeting the duties set out within the Equality Act 2010.

The Trust set three objectives for 2012/13 which are monitored at the bi-monthly Equality and Diversity steering group.

1. To improve diversity data completeness on service users, carers, staff and volunteers and to ensure this equalities information is analysed and used meaningfully to inform services, policies, strategies and targeted interventions.
2. To increase the positive experiences of those who use AWP services and those who work for the Trust.
3. To improve communication with all service users and their carers so that, where appropriate, they are informed about their diagnosis, their choices and places of treatment and care.

Progress against 2012/13 objectives:

The Trust is committed to progressing equality across all the protected characteristic groups (age, gender, disability, religion and belief, sexual orientation, ethnicity, sex, pregnancy and maternity and civil partnerships and marriage) and disadvantaged groups as described in the EDS. We carry out a yearly self assessment to continually monitor our progress and engage our stakeholders in this process.

South West Equality Group has commended AWP for its progress on implementing the Equality Delivery System.

Objective 1 – Data completeness

Data completeness has improved for all groups. This is a result of improved staff awareness on the reasons for requesting data from service users and how this data is used. We have included this topic in our staff Equality and Diversity training. An information leaflet on Equalities Monitoring and Data Collection is now available for all service users and carers.

Separately there has been a simplified system for staff to provide diversity information for central recording to inform decisions relating to workforce strategy.

All services can now access service specific detailed information on diversity to inform strategy, planning and interventions through amendments to internal reporting systems. This improved reporting is a direct outcome of this objective.

Objective 2 – Improving the service user and staff experience

* **Equality Delivery System (EDS)** is a tool for use by NHS staff and NHS organisations to understand how equality can drive improvements and strengthen the accountability of services to patients and the public.

The 2012 Mental Health Inpatient Survey demonstrated an improvement in the number of service users who did not feel they had been treated unfairly due to age, sex, race, religion, sexual orientation, disability or for other reasons. There remains room for improvement in this area for AWP to be consistent with other mental health organisations who fall into the top 20% band. The CQC survey of users of community services does not provide this level of detail.

The national 2012 NHS staff survey results demonstrated no significant improvement against the 2011 results; AWP recognises that there remains progress to be made in this area. New staff networks for disabled staff and black and ethnic minority (BME) staff have been set up in 2013 to specifically address the needs of these groups of staff.

Our EDS process allows for staff, service users and carers to share their experiences with the Trust. This information is used alongside the staff survey and Mental Health Inpatient Survey to inform developments in the organisation.

Objective 3 – Improved communication with service users

As a result of the annual patient surveys the Trust has identified improvement opportunities in relation to the information provided to service users and carers in relation to their treatment. The diversity leads within the Trust services have identified opportunities to provide such material in languages other than English with rapid access to interpretation and translation services in the most commonly used languages. All information provided on the Trust website is now accessible in multiple languages through the use of Google translate services.

AWP has signed up to the Mencap 'Getting It Right' Charter to provide improved support to service users and carers with learning disabilities who access mainstream mental health services. We have developed information in accessible formats, including easy read and photo-symbols, to support them during treatment and complemented this with staff training to increase knowledge and confidence.

Ongoing work

The Trust intends to retain the same objectives for 2013/14 with further relevant work within locally provided services to best meet service user and staff needs.

We recognises that the needs of some service users from protected and other disadvantaged groups can be distinct and specific. The Trust responds by designing services which reflect those needs and by continuing to ensure that the Trust's activities are supported by a comprehensive equality analysis process to identify any area of work which may have an adverse impact on those with a protected characteristic.

The Trust provides a comprehensive programme of equality and diversity training which all staff are required to attend as part of their induction with a refresher course to be completed every five years. The Trust has made a further commitment to continue to support staff to undertake the Race Equality and Cultural Capability (RECC) Train the Trainers course and will deliver this training to staff within the organisation. Staff who have already received this training are supporting us to develop a workforce which is culturally competent.

We continue our commitment to the principles outlined in the Mindful Employer Charter, ensuring that we are positive about recruiting, retaining and supporting those who have experience of mental ill health. The Trust has retained the Two Ticks Disability Symbol following a re-assessment process, demonstrating our commitment to supporting disabled employees.


POSITIVE ABOUT
DISABLED PEOPLE


MINDFUL
EMPLOYER

Part 4: How we developed our Quality Account

This is the fourth year that NHS Trusts have reported formally on the quality of their services.

Much of this report is set out to meet legal requirements. However we also report on our priorities for improvement which have been agreed in partnership with clinicians, service users and carers.

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

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

We have continued to develop the use of the Experience Based Design (EBD) approach, previously used in our secure services, with resources and trained peer mentors offering support. For example our Shared Voices Project, with the Bristol Specialist Drug and Alcohol Service, used the approach and identified specific areas for improvements from service users feedback:

- Clearer information and a system for texting appointment reminders or to request help
- Building confidence and hope through a recovery network, with peer mentors and staff-client partnerships and website tools
- Optimising detox through preparation groups and workshops with peer mentors and recovery

As part of our response to the Public Sector Equality Duty we have improved our engagement with those from protected characteristic groups. Through a series of engagement events, as part of our work on implementing the Equality Delivery System, we have used feedback from our stakeholders to inform our equality objectives for 2013/14.

We have also engaged across the organisation with our staff and clinicians.

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

External assurances and comments

We provided a draft of this Quality Account to the local area team of the NHS Commissioning Board, North Somerset Clinical Commissioning Group as our co-ordinating commissioner, all six local authority health overview and scrutiny committees and local Healthwatch groups and invited them to review the document and provide us with comments.

In the time available, we have responded to these comments wherever possible by adding information or making appropriate amendments while producing our final document. The Trust is grateful to all of the above organisations for helping to verify the content and for their suggestions for improving this document.

The verbatim comments received from the above organisations are available in full in Appendix A of the downloadable version of our Quality Account, including appendices, on our website at [awp.nhs.uk/link]

Concluding comments

We very much hope that the information contained in this document is useful and meaningful, reinforcing the fact that providing high quality and safe services is AWP's highest priority and at the heart of all that we do.

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

Contact us with your feedback or for further information at:

Email: Communications@awp.nhs.uk

Telephone: 01249 468000

Or write to: Quality Account

Communications Team

Avon and Wiltshire Mental Health Partnership NHS Trust

Jenner House

Langley Park Estate

Chippenham

SN15 1GG

Our full Quality Account, including the following appendices, is available on the Trust's website [awp.nhs.uk/link] or by request:

Appendices:

A External assurances and comments

B Glossary of terms – in development

C Statement of Directors' Responsibilities

D Information by PCT and local authority area – in development

E More information on the targets presented in tables – in development

An additional document, Commissioning for Quality and Innovation (CQUIN), is also available via the Trust website.

Appendix A

External assurances and comments

The AWP draft Quality Account was circulated to the local area team of the NHS Commissioning Board, North Somerset Clinical Commissioning Group as our co-ordinating commissioner, all six local authority health overview and scrutiny committees and local Healthwatch groups and invited them to review the document and provide us with comments.

In the time available, we have responded to these comments wherever possible by adding information or making appropriate amendments while producing our final document. The Trust is grateful to all of the above organisations for helping to verify the content and for their suggestions for improving this document.

In addition the Department of Health (DH) appointed external auditors, Grant Thornton, to carry out audit work in order provide external assurance on NHS trusts' 2012/13 Quality Account.

Published below are the statements received from the associated organisation:

1. North Somerset Clinical Commissioning Group, lead Commissioner

The CCG welcomes the opportunity to comment on AWP's Quality Account for 2012/13 and work in collaboration with them, ensuring that the services we commission are operated in a safe, clean and efficient manner.

The Quality Account demonstrates the amount of work that the Trust has concentrated on during 2012-13, with specific focus on improving patient experience and clinical effectiveness. AWP has embraced new approaches such as: 'fit for the future' and 'being brilliant at the basics' that have resulted in some new initiatives being identified for implementation during 2013, which include:

- Introducing a new quality information system to provide a ward to board focus on the seven quality indicators agreed with the commissioners
- Improving carers experience through improved partnership working and carer support
- Implementing the National Early Warning Score (NEWS) in all inpatient services

It was encouraging to see AWP achieving and surpassing some of the standards in patient experience, care programme approach (CPA) and effectiveness, whereby:

- 99% of service users were seen for their first appointment within four weeks of their referral.
- 93% (10% increase) were taken onto the caseload with a named care co-ordinator, an agreed care plan, assigned CPA level and care cluster allocated within four weeks of assessment.
- 98% of patients were screened for venous thromboembolism and physical health check's for inpatients were carried out within seven days of admission was maintained.

The CCG recognises that AWP is working hard to strengthen the processes around specialist safeguarding training (level 3), suicide prevention, incidents causing severe

harm, feeling safe, and meeting carer's expectations and are supportive of the initiatives that AWP are planning for 2013-14. The CCG will continue to monitor these plans through the Clinical Quality Review Group meeting.

The CCG welcomes Mr Iain Tulley the new Chief Executive into post and we look forward to building a strong commissioning relationship in an open and transparent working environment.

2. Local Authority Overview and Scrutiny Committees (OSCs)

Wiltshire Council has collated the following responses to the AWP Draft Quality Account 2012/13:

Bath and North East Somerset (BANES) Council Wellbeing Policy Development and Scrutiny Panel

Do the provider's priorities match those of the public?

We believe that AWP's priorities should and do match those of the public.

We would continue to emphasise the importance of improving the feeling of safety for inpatients. We note the key indicator of' Yes – always' feeling safe has dropped. Yet 'Yes-sometimes' feeling safe had showed a marked improvement. We would consider it a priority for the forthcoming year to consolidate work in this area.

Do you believe that there are significant omissions of issues of concern that had previously been discussed with the provider in relation to Quality Accounts?

We believe that AWP's quality accounts touch all of the relevant headlines of concern and are presented in a way which satisfies any concerns that we may have at present.

Has the provider demonstrated they have involved patients and the public in the production of the Quality Account?

There is some evidence of using both patient and carers surveys within the draft quality accounts but more qualitative evidence from patients, carers or other members of the public about their experiences with AWP would be welcomed.

Any other Comments

We noted that AWP has flagged the need to improve carers in the risk assessment and management planning process for care plans. We welcome the proposed improvements to ensure carers are better engaged.

We welcome efforts to meet Mencap charter standards for people with learning disabilities.

Swindon Borough Council Health Overview and Scrutiny Committee

The Swindon Health Overview & Scrutiny Committee is encouraged by the work that is already being undertaken to improve services for quality improvement.

The Health Overview & Scrutiny Committee is committed to having a good working relationship with the Avon & Wiltshire Health Partnership Trust and, based on the Committee's knowledge, endorses the Quality Account for 2012/13.

The Committee welcomes attendance and regular reporting at its committee meetings and hopes that this will continue throughout 2013/14.

The Committee supports the three areas for Quality Improvement and looks forward to continuing to work with The Avon & Wiltshire Mental Health Partnership to provide improving mental health services for the residents of Swindon and the region.

South Gloucestershire Council Health Select Committee

The Trust was invited to a meeting of the South Gloucestershire Public Health & Health Scrutiny Committee on 17th April to present its draft Quality Account 2012-13. Due to timing issues it was not possible for the Committee to receive the full Quality Account so instead the Trust was asked to give a 10 minute presentation and focus on areas of concern, what its priorities are going forward and how it was performing in terms of infection control.

The Committee was pleased to receive information about the Trust's achievements in 2012/13, which included improved service user engagement in care planning and improved identification of carers, however, the Trust acknowledged there was more work to do in terms of communicating and supporting carers.

In terms of carers, members questioned the Trust on Out of Hours support in the community and how carers are identified. In response it was reported that Intensive Crisis Teams are in operation 24 hours a day and the teams are reminded of the importance to identify carers, make sure they are aware of the important person in a service user's life and that electronic reports are cascaded to service users, carers and social services as appropriate.

The Committee was pleased to be told that all quality information would shortly be available on the Trust's website.

Members questioned the Trust on how it addressed safety and quality assurance, to which the Trust responded that previously it had a number of systems for monitoring safety, however this year it has combined them and real-time data is now available in one place for all wards and staff.

The Trust was questioned on the recent Care Quality Commission (CQC) inspection of the Secure Unit at Blackberry Hill Hospital and the concerns about the availability of staff to support patients with escorted leave from the unit. The Committee was pleased to learn about the measures AWP has taken to address this issue and that following a re-visit by CQC a few weeks ago it is now compliant.

The Committee asked about the number and type of contacts the Trust receives and whether the ageing population has had an impact, to which the Trust reported that it is seeing an increase and needs to give this careful consideration and further develop its work with social services and primary care in order to support people, for example those with dementia. The Committee looks forward to receiving an update on how this work has progressed next year.

North Somerset Council Health Overview and Scrutiny Panel

No comment was received.

Bath and North East Somerset Overview and Scrutiny

No comment was received.

Wiltshire Council Health & Adult Social Care Select Committee

It is with regret that as Wiltshire had elections in May for the whole Council and, as the Health Select Committee is not due to meet until the end of May, the chairman decided that the Committee would not be commenting on any Quality Accounts this year.

Bristol City Council – Health and Adult Social Care Scrutiny Commission

The Scrutiny Commission received a presentation of AWP's draft Quality Account at its meeting of 22nd April 2013.

The Commission welcomes the changes made by AWP to managing locally commissioned services with a Bristol team of clinicians, rather than, as previously, a more remote management structure. It believes that this has the potential to ensure more locally responsive services.

Members are concerned however regarding the limited amount of overnight provision for people in mental distress and request that this be addressed.

The Commission is strongly supportive of Callington Road Hospital as a valuable facility and are pleased to hear that all the beds there which are commissioned for Bristol residents will remain.

3. Local Healthwatch Comments

Healthwatch was launched in April 2013 replacing previous organisations called Local Involvement Networks (LINks). Unfortunately due to this transitional period Wiltshire have been unable to provide comments for 2012/13.

Wiltshire Healthwatch

Healthwatch Wiltshire have received and noted the report. We will be following up the highlighted issues in due course and are looking forward to playing an active role with residents, and on Wiltshire's Health and Wellbeing Board, to ensure the needs of the people of Wiltshire are well looked after in this area.

Swindon Healthwatch

Swindon Local Involvement Network (LINk) closed on 31 March and Healthwatch Swindon was established on 1 April 2013. Formally Healthwatch Swindon was not in a position to comment on the draft Quality Account.

During 2012/13 Swindon Local Involvement Network participants continued to work in a variety of ways with Trust staff, primarily through the joint LINk meetings and at a number of working groups - to reflect the views of local people to achieve change or improvement where possible. The Quality Account for 2012/13 demonstrates the breadth and complexity of the Trust's work and of its geographical spread. Healthwatch Swindon will look forward to working with Local Healthwatch in adjacent areas and with the Trust during 2013/14 to ensure that the voices of local people are heard and the best quality mental health care is provided in the most appropriate setting."

B&NES, Bristol and South Gloucestershire Healthwatch

Statement written by Healthwatch on behalf of Bath and North East Somerset (B&NES), Bristol and South Gloucestershire Local Involvement Networks disbanded 31st March 2013.

B&NES, Bristol and South Gloucestershire LINk welcomed the opportunity to contribute to the Quality Report prepared by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). The LINks had a positive and constructive working relationship with the Trust and with the lead on Quality Accounts at AWP and recommended that this relationship is continued.

The LINks recommended that Healthwatch responds to the NHS Quality Account and where necessary applies pressure to ensure that Quality Account documents are

received in good enough time for Healthwatch to develop a thorough response, and that information relevant to the Quality Account is available, discussed and consulted on with Healthwatch throughout the year.

Healthwatch B&NES, Bristol and South Gloucestershire began in April 2013, and they are not in a position to provide a comprehensive response to this year's Quality Account. They look forward to submitting a comprehensive response in 2014.

North Somerset Healthwatch

Thank you for the opportunity to comment on the AWP Quality Account 2012/13 and for a Director of Healthwatch North Somerset to have an active involvement in the work of AWP.

We would point out that it would be helpful to the reader if statements within the Quality Account which could be explained more fully and for the use of acronyms to be explained at an earlier stage, for example:

- Mencap Charter – what is it and how is it applied?
- AIMS – mentioned early in the document but not explained until later
- NHS pledges – again helpful if explained

Although the Quality Account shows some improvements in care, there are areas which continue to cause concern, e.g. reduction in violence and aggression show no improvement with the answer for 'feeling safe always' reduced by 11%. No explanation is given for this and the action to be taken.

Page 31 AIMS - The report states, of the 33 eligible wards. 5 have achieved accredited status, 2 are awaiting assessment, 11 wards in secure services have also been reviewed and found to meet standards by the Royal Collage of Psychiatrists peer review. We appreciate there is a cost associated with the remaining assessments and note that wards are working to maintain their readiness but there's no indication given as to how the Board will address this issue to ensure assessments are completed.

We note the improvement but are concerned by the low score given by staff to the point at Page 18 regarding "Staff recommendation of the trust as a place to work or receive treatment". While the 2012 score is slightly up on 2011 it is below average and quite a way behind the best.

As a new 'consumer champion' organisation, Healthwatch North Somerset has limited 'consumer' comments at this stage. We would though, like to highlight the potential inequalities for service users who live in North Somerset but use GP services in other Local Authority Areas' and the resultant impact on the services available to them.

3. External Auditors – limited assurance report

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Avon and Wiltshire Mental Health Partnership NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death; and
- Proportion of 100 per cent enhanced care programme approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital.

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

Respective responsibilities of Directors and auditors

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners dated 14/06/2013;
- feedback from the following Local Healthwatch groups; BANES, Bristol and South Gloucestershire dated 14/05/2013 and North Somerset dated 29/05/13;
- the Trust's Inpatient Experience Report to Board dated January 2013 and extracts from the PALS system dated June 2013.
- the latest national patient survey dated 12/09/2012;
- the latest national staff survey dated 18/04/2013;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 24/05/2013;
- the annual governance statement dated 03/06/2013;
- Care Quality Commission quality and risk profiles dated March 2013;
- Care Quality Commission Review of Compliance for Callington Road Hospital dated July 2012, Community Teams dated June 2012 and Blackberry Hill Hospital dated October 2012.
- Inspection reports for Blackberry Hill Hospital dated January 2013 and March 2013
- Trust inpatient Survey dated June 2012
- Patient Environment Action Team Scores Letter dated May 2012
- Report to Trust wide Management Group dated 06/02/13.
- Feedback from Local Authority Overview and Scrutiny Committees for BANES, Swindon, South Gloucestershire and Bristol City Councils dated 13/05/13

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

This report, including the conclusion, is made solely to the Board of Directors of Avon and Wiltshire Mental Health Partnership NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities

by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Avon and Wiltshire Mental Health Partnership NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

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

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

Limitations

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

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

Grant Thornton UK LLP

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Bristol

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Appendix C

Statement of directors' responsibilities in respect of the Quality Account

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

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

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

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

By order of the Board

NB: sign and date in <u>any colour ink except black</u>

.....Date.....Chair

.....Date.....Chief Executive