Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Quality Account 2015/16

Avon and Wiltshire Mental Health Partnership NHS Trust

Contents

Part 4: How we developed our Quality Account
APPENDICES

Part 1: Chief Executive's statement of behalf of our Board

Communications - SG

About the Trust

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is a significant provider of high quality mental health services across a core catchment area covering Bath and North East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire. The Trust also provides specialist services for a wider catchment extending throughout the south west.

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. From the 1 April 2016 we have been providing Child and Adolescent Mental Health Services. We operate from more than 100 sites and increasingly AWP provides treatment and care in people's own homes and other community settings, reflecting their preferences. Our community services are supported by high quality inpatient services that provide short term assessment, treatment and care.

We wish 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. Our aim is to enable and empower our service users to reach their potential and to live fulfilling lives through providing recovery and reablement focused services that yield positive outcomes for them and their carers.

In 2015/16 the Trust's community services saw 75,863 individuals, received over 67,500 new referrals, and had more than 461,000 contacts with service users (either via the telephone or face to face). In addition, 1,939 people were admitted into our inpatient units for more intensive treatment.

Our turnover in 2014/15 was £197m and we employed an average of 3,270 (whole time equivalent) staff from a variety of professional backgrounds including psychiatrists, psychologists, mental health nurses and allied health professionals.

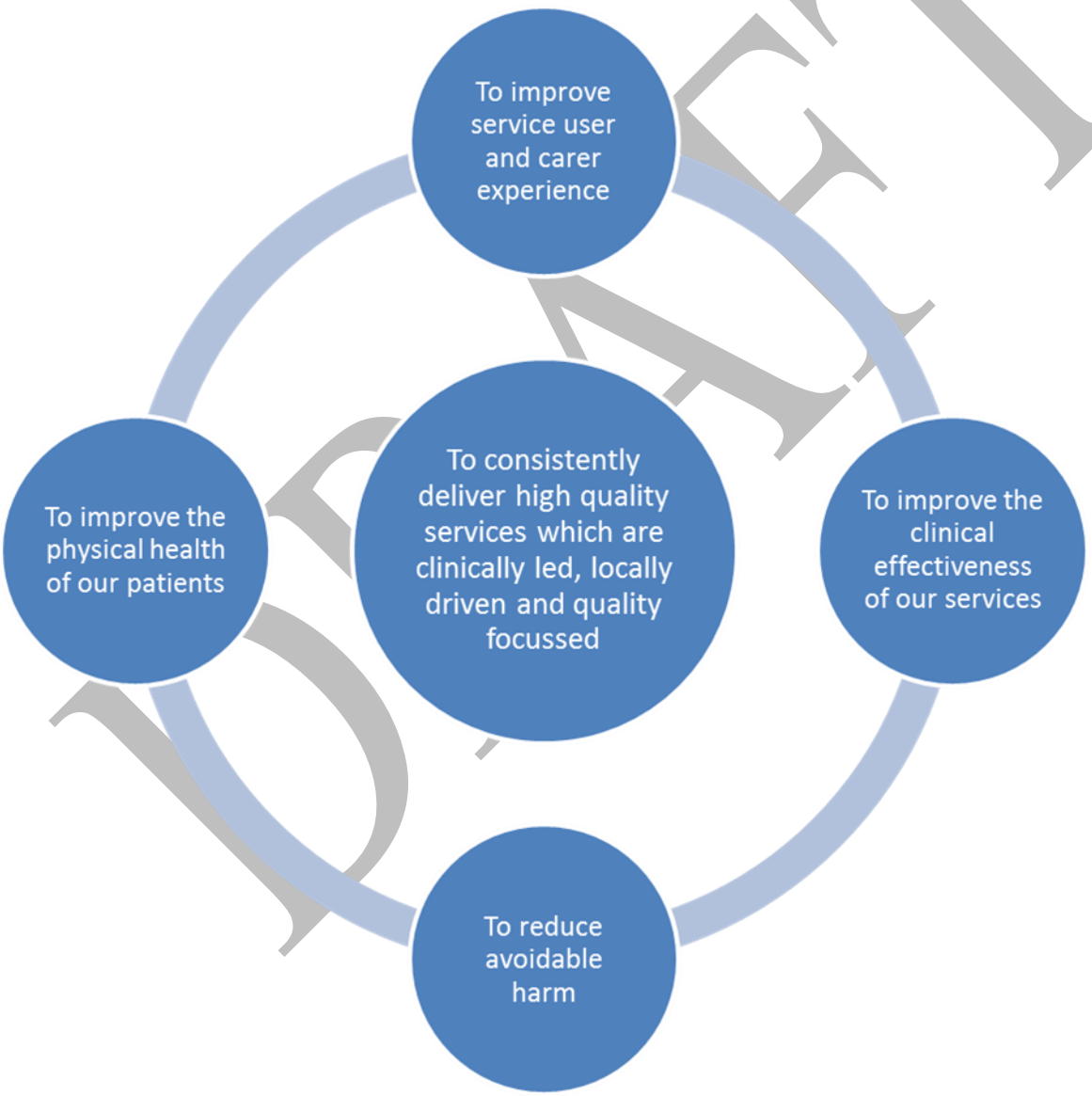
Fundamental to delivering quality services is continuing to embed the principles of the NHS Constitution within the organisation. This constitution sets out rights of patients, public and staff, pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and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

Part 2a: Our priorities for improvement in 2016/17

Quality Account – Draft Quality Priorities for 2016/17

Our aim is to deliver high quality services throughout the organisation, which are clinically led, locally driven and quality focussed.

The priorities we are planning to deliver in 2016/17 are set out below. Progress will be monitored and reported through the Trust's internal quality governance and assurance systems and our external monitoring arrangements undertaken by Commissioners.



Priority 1: To improve the experiences of our service users and carers

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. We actively want to hear the views from all sections of the communities.

We value the contributions of our volunteers and want to increase their presence to improve the experience of our service users.

The actions we will take in 2016/17 are set out in the table below:

Improvement Priority	Actions	Success Measures
To provide services that our service users will be confident to recommend to their friends and family if they required similar treatment.	Implement and embed the new Service User and Carer Engagement and Involvement Strategy.	Demonstrate progress against all actions on implementation plan.
	Explore mechanisms beyond FFT to gather real-time service user experience feedback.	Undertake and address the findings of 3 additional surveys.
	Sustain our improve-ments in the national in-patient and community surveys.	Increase the proportion of high scores for national surveys.
	Continue to demonstrate improvements in FFT results.	Improve FFT response rate to over 20% Over 90% of service users will recommend our services via the 'Friends and Family Test'.
	We will expand the use of	Quarterly reports on

Improvement Priority	Actions	Success Measures
	"you said – we did" mechanisms	responses to feedback.
To enhance carers experience through improved partnership working and carer support.	We will seek carer involvement in validating the quality of 'Triangle of Care' self-assessments and take any improvement actions identified. We will re-launch and fully implement and embed the Carer's Charter	Validate a random selection of Triangle of Care self- assessments from each delivery unit and report. 90% of service users asked if they have a carer or a person who supports them.
To improve engagement with Healthwatch	We will promote Healthwatch events to our Foundation Trust members. We will expand the opportunities for Health-watch to be involved in the Trust's internal inspection regimes.	Feedback from Health-watch.
To improve the range of activities provided for service users by volunteers.	We will increase our Volunteer membership base. We will increase the number of wards and teams welcoming volunteers on a regular basis.	10% increase in volunteer membership. 10% increase in volunteer placements.

Priority 2: To improve the clinical effectiveness of our services

Description of issues and rationale for prioritising

Clinical effectiveness relies upon providing the highest standards of care based on sound evidence-based practice, operating in a system which is safe, free from unacceptable risk and focussed on continuall improvement.

We know from our clinical audit programme , patient feedback, incident investigations and our regulators that we can do more to improve our clinical practice to achieve the best possible outcomes for our service users.

The actions we will take in 2016/17 are set out in the table below:

Improvement Priority	Actions	Success Measures
To improve the quality of care planning for service users.	As a minimum, we will undertake an annual review of service users on CPA. Service users will have a crisis and contingency plan. We will undertake an audit to check service user and carer involvement in crisis and contingency plans and set standards for improvement. Implement the caseload tool across all community teams and extend to intensive and in-patient teams	95% of service users with an annual review. 95% of service users with a crisis and contingency plan. Audit results and improvement plan. 20% increase in the number of teams accessing the caseload tool.
To ensure the right service users get the right choice of medicine at the right time.	We will publish a pharmacy formulary. We will test that our physical healthcare monitoring following the use of rapid tranquilisation achieves national best practice standards.	Publication of formulary. 50% improvement on rapid tranquilisation practice, tested via audit standards.

Improvement Priority	Actions	Success Measures
	We will eradicate blank boxes on DPARs. We will improve our PRN medication recording.	<5% blank boxes reported on audit. We will establish a baseline and audit that rationales for administration of medication are in place.
To improve mortality governance.	We will review all unexpected deaths where AWP is the primary provider of care.	Establish existing baseline for avoidable deaths and achieve a 5% reduction.
To deliver transformed, safe and responsive services.	We will identify Trust-wide standards for care in all of our care pathways. We will deliver the acute care pathway programme realising better ways of providing services across all of our services.	Publication of standards. Implementation of the patient flow bundle by September 2016. Establish standards for all in-patient services by December 2016
To further reduce reliance on paper records	We will reduce all dual recording methodology where one methodology is paper.	Reduced reliance to paper records

Priority 3: To improve safety and reduce avoidable harm

Description of issues and rationale for prioritising

Providing services that are safe and free from harm is our highest priority. We have signed up to NHS England's 'Sign up to Safety' campaign with the following pledges:

- ***Putting safety first***. Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.
- ***Continually learning***. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are.
- ***Being honest***. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
- ***Collaborating.*** Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
- ***Being supportive.*** Help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate progress

Additionally, the actions we will take in 2016/17 are set out in the table below:

Improvement Priority	Actions	Success Measures
To achieve a measurable reduction in avoidable harm.	We will implement the actions we have signed up to as part of the Sign up to Safety pledges. We will minimise the number of avoidable slips, trips or falls. We will further reduce our use of restrictive practices. We will continue to use the Safety thermometer to monitor key safety aspects.	95% of planned actions for 2016/17 achieved. 10% reduction in falls on in-patient units Achieve a 10% reduction in the use of PMVA and seclusion. To be average or above average in our ranking against other mental health trusts
To learn from service user's and carer's experiences when things go wrong.	We will increase the number of patients offered post incident support following restraint. We will audit the	10% increase of patients offered post incident support. Evidence of discharging

Improvement Priority	Actions	Success Measures
	effectiveness of our Duty of Candour arrangements. We will establish a service user/carer led complaints panel to improve the quality of our complaint responses.	/attempting to discharge our duty of candour in 100% of cases 10% reduction in re-opened complaints.
To create a more open and honest reporting culture	We will respond to the recommendations contained within Sir Robert Francis' Freedom to Speak Up Report. We will implement mechanisms to enable our staff to be given feedback about the incidents they report.	Implementation of Freedom to Speak Up action plan Improvement in staff survey incident reporting questions
To ensure our staff are well placed to safeguard.	We will increase staff awareness and vigilance of child sexual exploitation, modern slavery, female genital mutilation and domestic abuse. We will consistently achieve safeguarding training standards.	Annual safeguarding report. 90% compliance for relevant staff at level 1, 2, or 3 safeguarding training.
To ensure we minimise as far as is possible the options for ligaturing on an in-patient ward.	We will continue with our strategies to improve the safety of our environment,	10% reduction in the number of injuries sustained from attempted ligatures.

Priority 4: To improve the physical health and wellbeing of our service users and staff

There is a strong evidence base that individuals with a serious mental illness have much higher morbidity and mortality rates, compared to the general population and that service users of mental health services do not always receive the physical health care intervention they require and that this contributes toward the increased morbidity and mortality.

As well as the economic benefits of keeping staff well and able to work, evidence shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients.

The actions we will take in 2016/17 are set out in the table below:

Improvement Priority	Actions	Success Measures
To improve the physical health of our service user population.	We will speed up the time it takes inpatients to receive a comprehensive physical health assessment (from 72 hours to 24 hours).	85% of in-patients having a physical health assessment within 24 hours.
	In-patients with dementia will be screened with a validated nutrition tool on admission.	95% of in-patients with dementia will be screened using a nutrition tool.
	We will reduce the number of in-patients recorded as smokers on our in-patient users.	85% of in-patient service users have their smoking status recorded.
	We will introduce smoke-free hospitals.	Smoke-free hospitals.
	We will increase the number of in-patients we refer to a stop smoking service.	Publication of strategy.
	We will develop a strategy to help ensure excellent nutrition and hydration care in our in-patient services.	Establish baseline and achieve a 5% reduction.
	We will reduce the	

Improvement Priority	Actions	Success Measures
	number of in-patients attending A&E for reasons other than self-harm. We will encourage our community patients to attend an annual physical health check with their GP.	Feedback from GPs ? To be determined
To improve the health and wellbeing of our staff.	We will introduce a range of heath and wellbeing initiatives for staff. We will achieve a step change in the health of the food offered on our premises (reducing access to drinks and foods high in fat, sugar and salt). We will improve the uptake of flu vaccinations for front line staff.	Achievement of national CQUIN requirements. Achievement of national CQUIN requirements 5% increase in the number of front line staff accepting the flu vaccination.
To support and develop our staff.	To improve the quality of appraisal and management supervision to ensure staff are clear about their role and are supported to develop.	Implement the Career Framework for staff.

Part 2b:Statements relating to quality

The Trust's approach to quality improvement is set out in our Quality Improvement Strategy 2013 to 2017. (Available on our website http://www.awp.nhs.uk/news-publications/publications/trust-strategies/)

The strategy builds on our commitment to be a Trust which is driven by quality, clinically led and which is heavily influenced by the views of service users and carers. Our approach to quality improvement is supported by:

- an organisational environment focused on quality improvement
- a quality assurance system (IQ) aimed to provide a visible 'team to board reporting' system, enabling teams to own their data and compare with their peers
- delivery through quality priorities owned and developed by delivery units and Corporate Directorates.

Our approach seeks to improve quality systems and processes, including those underpinning functions essential for delivering high quality care, such as finance and human resources.

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

The Board and it's Quality and Standards Committee receive and review assurance and progress reports on a regular basis.

2.1 Review of Services

During 2015/16 Avon and Wiltshire Mental Health NHS Trust provided NHS mental health and specialist drug and alcohol services.

AWP has reviewed all of the data available to it on the quality of care in these NHS services.

The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by Avon and Wiltshire Mental Health Trust during 2015/16.

2.2 Participation in clinical audit

During 2015-16, three 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 which it was eligible to participate in.

The national clinical audits and national confidential enquiries that AWP was eligible to participate in during 2015-16 are as follows:

- Prescribing for Bipolar Disorder (Sodium Valproate)
- Prescribing for Substance Misuse: alcohol detoxification
- Prescribing for ADHD in children, adolescents and adults
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential enquiries that AWP participated in, and for which data collection was completed during 2015-16, 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 15a: Prescribing for Bipolar Disorder (Sodium Valproate)	YES	171
POMH 14b: Prescribing for Substance Misuse: alcohol detoxification	YES	27
POMH 13b: Prescribing for ADHD in children, adolescents and adults	YES	50
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	YES	24/39

***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)
NCAPOP - National Clinical Audit & Patient Outcomes Programme

2.2.1 Quality improvement actions from national clinical audit

The reports of four national clinical audits were reviewed by the Trust in 2015-16 and AWP intends to take the following actions to improve the quality of healthcare provided:

POMH 9c: Antipsychotic prescribing in people with a learning disability.

POMH 9c audited the use of antipsychotic medication in service users diagnosed with a learning disability. This was an audit of 55 cases from 6 team that showed good levels of compliance with the standards, above the national average and a significant improvement on the previous audit. No improvement actions were required.

POMH 13b: Prescribing for ADHD in children, adolescents and adults.

As AWP was not delivering child or adolescent ADHD services at the time of the audit, this was an audit of 50 cases from 1 specialist that team showed good levels of compliance with the standards. No improvement actions were required, but there are plans to review the findings in more detail.

POMH 15a: Prescribing for Bipolar Disorder (Sodium Valproate)

This is a new national topic and AWP helped develop the standards by hosting an event in Bristol for the Royal College of Psychiatrists. The report has not yet been received by the Trust. (Getting it April 2016) Data for 171 service users was returned.

POMH 14b: Prescribing for Substance Misuse: Alcohol Detoxification

POMH 14b audited the quality of alcohol detoxification for mental health inpatients needing an unplanned detox. It did not audit specialist alcohol services. There are 20 to 30 such cases per year in AWP, and 27 were audited. Whilst numbers are low alcohol detoxification is dangerous and needs careful management. The final report will be available to the Trust in June 2016. Areas noted by the team were the timely use of pabrinex, continuing regimes started in general hospitals and documenting decision making.

2.2.2 Quality improvement actions from local audits

Local Audits

The reports of some 60 local clinical audits were reviewed by the Trust in 2015-16 and AWP intends to take a number of actions to improve the quality of healthcare provided. Examples include:

AWP-217-16 Community Risk Assessments and Care Planning

Following a CQC inspection in Bristol an audit was conducted in all of the other localities, using the same standards used to assess the Bristol risk assessments and care plans. This audit looked at the records of patients in Complex Intervention, Intensive and Recovery teams. 309 records were reviewed by 18 teams. Overall compliance was 79% which was risk scored orange, so needing urgent dissemination and action planning.

Whilst service users had acceptable up to date care plans and risk assessments it was not always clear that service user and carer views were captured in these and risks identified were not always included in care plans.

This is an example of the more responsive audits we intend to carry out more often – to check if findings in one locality are generalised to the trust as a whole or local. This audit was created, sent out, data collected and the report drafted and disseminated in under a week. This will allow us to focus more time and energy into meaningful quality improvement work within the localities and to share data whilst it is still “live”.

AWP-216-16 Seclusion

This audit is an example of a type of project we also want to carry out more frequently, inspired by our previous themed review projects. This was a highly detailed and technical, “root and branch” review of all incidents of seclusion, which took three months to complete. Results, in the form of an Excel Workbook can be “sliced” to look at findings in a variety of ways – by locality, ward, by Mental Health Act Section, including or excluding rapid tranquillisation, reason for seclusion, whether police were called and so on. The report is currently being written up and will take some time to launch and present in the different localities and teams. Unlike AWP-216 this is designed to be a definitive and thorough review of seclusion practice which will inform training, practice and policy for many years to come.

Emerging findings show us that seclusion practice needs to improve, particularly the frequency of observations, record keeping and physical observations, consequently findings were risk scored orange. Priority actions include simplifying record keeping in RiO, and

streamlining processes for incident reporting to release time to care for service users who need seclusion.

2.3 Participation in clinical research

This financial year AWP has participated in 95 studies; 66 National Institute for Health Research (NIHR) adopted studies, 13 sponsored by commercial companies, and 29 student and non-NIHR research. AWP continues to act as a Participant Identification Centre on NIHR studies with RICE (Research Institute for the Care of the Elderly) and North Bristol NHS Trust.

For our last full year of data (April 2014 to March 2015), comparable figures were: 92 active studies in AWP, 51 NIHR studies, 12 sponsored by commercial companies and 41 student and non-NIHR research. AWP recruited a total of 800 patients into NIHR studies during this period.

The number of patients receiving NHS services provided or sub-contracted by AWP in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 803 (correct at 24 March 2016) (We are awaiting the corrected figure for year end), 623 into NIHR studies and a further 180 into student and local clinician led research. In addition, staff working for AWP have been able to support recruitment of a further 81 people into research studies from other Trusts.

The Trust is committed to research being part of everything we do. We support high quality research into the prevention, treatment and management of mental health problems, addictions and dementia and aim to put research findings into clinical practice. AWP ensures we give everyone who uses AWP services, their carer's and families (as well as our staff) the chance to find out about research they could take part in. This forms our pledge to make Research for All, and AWP are an Everyone Included Trust.

Our Everyone Included approach has been a great success, so far 5 studies have used the approach in 2015/16, and over 30 people have taken part in studies. This is a wonderful achievement as without this approach these people would not have been given the opportunity to take part.

AWP works with the National Institute for Health Research (NIHR) and the West of England Clinical Research Network (WE CRN). The Trust collaborates locally with universities and acute Trusts through Bristol Health Partners (BHP), the West of England Academic Health Science Network (AHSN) and the NIHR Collaborations for Leadership in Applied Health Research and Care West (CLAHRC West).

The Research and Development (R&D) department currently supports the Department of Health contract for the National Suicide Prevention Programme Grant led by Professor Gunnell at the University of Bristol. Along with another Department of Health contract for Autism and Depression with the University of Bath (DR Ailsa Russell). The department also runs the BEST Evidence in Mental Health clinical question answering service in collaboration with the Cochrane Group at the University of Bristol.

The workforce in AWP R&D are funded by the West of England Clinical Research Network and we aim to improve the access of mental health and dementia research to patients across the area.

We have extensive development plans in place for 2016/17.

2.4 Commissioning for quality and innovation (CQUIN payment framework)

Two and a half per cent of the Trust's income in 2015/16 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 2015/16 the Trust CQUIN schemes included a series of initiatives agreed locally for each CCG area along with three nationally set schemes. The Trust achieved measurable improvements and met the target levels aspired to for all of the CQUIN schemes. The Trust is awaiting Commissioners' decisions on payment.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically in an additional document which is available from our website: insert link once published

2.5 Care Quality Commission (CQC) Registration

AWP is required to register with the Care Quality Commission and its current registration status is registered. The Care Quality Commission has not taken enforcement action against AWP during 2015/16, but AWP has received one Section 291 Warning Notice in relation to services in Bristol.

Four residual warning notices from the Trust's 2014 CQC inspection were formally lifted in May 2015 and the CQC re-issued reports for the acute admissions and long stay/forensic/secure services and these were published on 24 July 2015. This identified that there were 57 compliance actions across 9 regulated activities that remained outstanding.

On the 7 and 8 December 2015 the CQC undertook an unannounced inspection of the community mental health services in Bristol. This was a responsive inspection undertaken following concerns raised by whistleblowing, commissioners and a staff grievance. The inspection identified 6 areas of concern and as a result a warning notice was issued under Section 29A of the Health and Social Care Act 2008 and this was served to AWP on 31 December 2015. The CQC notified the Trust that significant improvement in the quality of healthcare provided was required. The Trust was required to undertake certain actions by 1 February 2016. The CQC returned on 17 February 2015 and confirmed the Trust had complied with the specified requirements for improvement by 1 February 2016.

Further actions required to achieve CQC compliance will be re-inspected when the CQC undertake the comprehensive inspection commencing 16 May 2016.

The Trust has a comprehensive programme in place to deliver quality improvements. The Programme has established actions and clear milestones necessary to achieve compliance against the remaining CQC compliance actions, re-focussing locality and Trust priorities against Key Lines of Enquiry (KLOE) through self-assessment and support.

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 used for reporting.

The quality of the electronic patient record is audited monthly via the Trust's Records Management audit, which requires senior clinicians to review five randomly selected records and to rate them against 10 criteria. This is supported by a suite of 'completeness' metrics that check that key information is available for all patients accessing services and that staff are entering data into the system in a timely manner. Results for these indicators are reported internally to Board and externally to Commissioners each month. Additionally, team / ward level information is available in real time to allow managers to track their performance.

The final results for 2014-15 and 2015-16 are presented in table 2 below.

Table 2: Data Quality Indicators	Target	2014-15	2015-16	
Records Management: monthly audit (local indicator)	75%	87.1%	90.4%	▲
Data completeness – core fields for patient identification (national indicator)	97%	99.9%	99.9%	◀▶
Data completeness – outcome fields (national indicator)	50%	79.6%	83.3%	▲
Data quality: completion of NHS number (national indicator)	99%	99.9%	99.8%	▼
Data quality: completion of ethnic category (national indicator)	90%	100%	100%	◀▶
Data quality: completion of risk assessment (local indicator)	85%	99.9%	99.9%	◀▶
Data quality: completion of crisis, relapse and contingency plans (local indicator)	85%	89.5%	97.8%	▲
Data timeliness – system updated in three days of actual event (local indicator)	95%	93.2%	95%	▲

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

- The records management audit has been reviewed during 2015-16 to assess efficacy and consider improvements. A series of updates have been agreed and these will be implemented in early 2016-17.
- The Trust has also agreed to further improve its 'timeliness' metric to focus on clinical, rather than administrative, data within the record. This will be implemented during 2016-17.

Our performance against other key areas of data quality is as follows:
The Trust submitted records during 2015/16 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 100% for admitted patient care.
- General Medical Practice Code was 100% for admitted patient care.

The Trust's Information Governance Assessment report score overall for 2015/16 was 77% and was graded satisfactory (green).

AWP was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

2.7 Safeguarding

The Trust continues to regard safeguarding as a priority to protect the people, their families and the communities we work with. The Trust remains an active member of the safeguarding multi agency partnerships in our area, including Safeguarding Children and Safeguarding Adults Boards, Domestic Violence partnerships, MAPPA Strategic Management Boards and Contest and Prevent partnerships.

The Board was provided with assurance regarding compliance with safeguarding in November including progress on the action plan. This showed:

- The information and evidence from internal and external sources demonstrate that the Trust was compliant with its statutory and mandatory duties and responsibilities in 2014/2015, and had plans to further improve the depth of compliance.

- We overhauled and revamped our safeguarding training programme this year and have continued to achieve good uptake.

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Subject	31.03.2016
Safeguarding Adults & Children L1	92%
Safeguarding Children L2	90%
Safeguarding L3	83%

Part 3: Our care quality achievements in 2015/16

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.

Trust's quality surveillance system, called 'Information for Quality' (IQ), reports data at ward and team level up to local area service delivery unit and Trust level. The system reports across seven key domains as an early warning system to identify areas for improvement.

In this section, we describe:

- what we achieved during the year across the areas of patient experience, effectiveness and safety and,

- how we have progressed with our quality improvement priorities alongside a series of quality indicators that we routinely use for measuring the quality of services.

For each domain of quality, 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 Appendix D and further information on the definitions of the measures used is included in Appendix E.

3.1 National indicators

3.1.1 Care programme approach seven day follow- up

AWP is achieving above the national average against this indicator.

National data – CPA seven day follow up Data source: NHS England				
Trust Performance Reporting period (for 3 months in quarter	**Quarter 2 2015-16**		**Quarter 3 2015-16**	
	Number	**%**	**Number**	**%**
	490 / 502	97.6%	492 / 505	97.4%
	Quarter 2 2015-16		**Quarter 3 2015-16**	
England Average	96.8%		96.9%	
Highest Score Nationally	100%		100%	
Lowest Score Nationally	83.4%		50%	

This is the latest data available – will need updating for final version

3.1.2 Admissions to inpatient services have had access to crisis resolution

AWP is achieving below the national average against this indicator.

National data – CPA seven day follow up Data source: NHS England				
Trust Performance Reporting period (for 3 months in quarter	**Quarter 2 2015-16**		**Quarter 3 2015-16**	
	Number	**%**	**Number**	**%**
	182 / 198	91.9%	180 / 197	91.4%
	Quarter 2 2015-16		**Quarter 3 2015-16**	
England Average	97%		97.4%	
Highest Score Nationally	100%		100%	
Lowest Score Nationally	48.5%		61.9%	

3.1.3 Ensuring that people have a positive experience of care

The Health and Social Care Information Centre (HSCIC) provides patient experience indicator data for the annual national Community Mental Health (CMH) Survey.

2015/16

Domain	England average score	AWP score
Accessibility and waiting	82.1	85.5
Safe, high quality coordinated care	70.4	76.1
Better information, more choice	70.4	72.2
Building closer relationships	76.3	78.6
TOTALS	74.8	78.1

Note: 2014/15 data is not directly comparable to 2015/16 data, due to survey changes.

The CQC does not provide a single overall rating for each trust for this survey, as it assesses a number of different aspects of people's care and results vary across the questions and sections. The full 2015 CMH survey data is available on the CQC website: http://www.cqc.org.uk/provider/RVN/survey/6 (to view, scroll to second half of webpage and click on sections for individual question results).

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. Further detail on our results for the national Community Mental Health Survey are detailed in section 3.5.3.

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

- ensuring that this quantitative and qualitative survey data is used to put in place actions focused on the areas most in need of improvement.
- using the real time Friends and Family Test feedback to better understand service users' experience of current care, sharing praise to build on good practice and responding swiftly to local concerns raised.

3.1.4 Treating and caring for people in a safe environment and protecting them from avoidable harm

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*. The NRLS considers high levels of incident reporting by Trusts to be an indicator of a positive reporting culture. Consequently, high numbers of incidents are viewed positively, particularly when the proportion of serious incidents is low and the proportion of no harm incidents is high.

Please note that the data for the period October 2014 to March 2015 (published in September 2015) is the most recently available due to a delay of six months from when data is submitted to the NRLS to it being published. Further data is expected in March 2016.

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					
01/04/14 to 30/09/14	3772	41.21	36.97	94.00	0.00
01/10/14 to 31/03/15	3527	41.76	38.92	92.53	4.83
ii) Rate of incidents reported that caused severe harm or death					
01/04/14 to 30/09/14	34	0.9%	1.1%	5.9%	0.0%
01/10/14 to 31/03/15	20	0.5%	1.2%	5.1%	0.0%

The number of incidents reported to the NRLS by the Trust in the most recent report is slightly lower than the previous 6 month period, but over the full year (2014 – 15) the Trust reported more incidents than in any year previously. The proportion of incidents graded as 'death' had decreased to 0.5%, and is slightly lower than the rate for our peers (mean for all mental health trusts = 0.7%). The proportion of incidents graded as 'severe' but not 'death' had decreased to 0.0% (mean for all mental health trusts = 0.4%).

Encouraging the reporting of incidents, undertaking root cause analysis investigations for serious incidents and implementing practice change to learn lessons and improve forms the cornerstone of our Sign up to Safety plan.

3.2 Achievement against our 2015/16 Quality Plans

Priority 1: *To improve service user and carer experience*

Aim: To provide services that our service users will be confident to recommend to their friends and family if they required similar treatment.

Planned Actions	Outcome	Status
Development of a new Service User and Carer Involvement Strategy developed in partnership with our service users and carers	We re—launched our Service User Group and our Carer Forum this year and a consultation on the new strategy was commenced. We anticipate that the new strategy will be published in the summer.	Partly achieved
Complete an in depth thematic analysis of patient feedback and findings from incident reporting	We introduced a new approach to reporting on the patient experience, facilitating patient stories to be told at Board with the emphasis on the learning and change outcomes. We introduced a patient experience cycle tool as a really effective way of sharing learning with staff. A number of thematic reviews have been undertaken and Safety Matters Bulletins shared with staff.	Achieved
The use of the Friends and Family Test (FFT) as a mechanism for gathering real-time service user feedback	We exceeded the target we set ourselves (90% of service users recommending our services via the Friends and Family Test) in community services (91%) but did not achieve it for in-patients (81%).	Partly achieved
Development of survey tools to improve the accessibility of the FFT (partially met)	We wanted to achieve a consistent response rate of 15% for community services across all of our service delivery units. We achieved a **17%** response rate by the second half of the year, however we did not manage to achieve consistency as there is significant variation between response levels across our teams and service delivery units.	Partly achieved

Aim: To enhance carers experience through improved partnership working and carer support.

Planned Actions	Outcome	Status
We will continue to use the Carers Trust 'Triangle of	AWP attained its first star in the membership scheme in April	Achieved

Planned Actions	Outcome	Status
Care' self-assessment improvement tool across the Trust and take forward identified improvement actions	2014 as a result of assessing its in-patient, intensive and rehabilitation services. The second star was gained in May 2015 for assessing all community teams. Improvement plans are in place to ensure continuous development.	
Implementation of our Family Friends' and Carers Charter	Our charter was reviewed and confirmed as still valid and continually progressing its implementation is a key priority of the Carers' Forum.	Achieved
Rolling out carer awareness training across all teams	Carer awareness training has been made available to all teams. We set ourselves a target that 85% of teams would complete the carer's training and achieved 66%.	Partly achieved
Simplifying carer recording processes on RiO	We set ourselves the goal of 90% of service users being asked if they had a carer and achieved 80%. There is further work we need to do to simplify recording this information on RiO.	Not achieved
Updating and improving carer information on Carers pages of internal and external website	Our website pages were completely revamped and updated.	Achieved

Priority 2: *To improve the clinical effectiveness of our services*

Aim: To ensure that all service users receive a comprehensive assessment including formulation, assessment of risk, and have a clinically effective care plan that is agreed by the service user

Planned Actions	Outcome	Status
Training and development of staff on formulation, assessment and care planning.	We set itself a standard that 85% of service users' records would have a formulation summary recorded and by the end of February we achieved 84%. (needs updating when March data is available.	Not Achieved
The clinical toolkit will be	We reviewed and updated our	Achieved

Planned Actions	Outcome	Status
reviewed as per yearly review cycle.	clinical toolkit to support staff in risk assessment and care planning. We set ourselves a target of 95% of service users having a risk assessment recorded and achieved >99%	
Guidance on recording assessments and formulations for clinicians will be refreshed following the introduction of open RiO.	We introduced open RiO and further developed and refreshed our guidance for clinicians. We set ourselves a target that 90% of service users have crisis and contingency plan and achieved 97%	Achieved
Checklists for managers will be developed which will enable the review of assessments, formulation and care plans. These will be used monthly.	We set ourselves the target that 85% of service users' care plans would contain the following elements: • statement of need which has been identified during assessment • goals • interventions with timescales • evidence of service user and carer involvement in the development of the care plan • are agreed and signed by the service user We achieved 94%	Achieved
Development of clinical networks to advise on clinical effectiveness and standards	We have established new networks for PCLs, Trauma, Personality Disorder, Rehabilitation, Acute Care, Social Work and Psychological therapies, and continue to support clinical networks for Intensive, EI, Dual Diagnosis and Suicide Prevention. Our Integrated Governance Committee took the decision not to pursue the establishment of Affective Disorders, Neurological Disorders and Older People' networks.	Achieved

Planned Actions	Outcome	Status

Aim: To improve the quality of the electronic patient record (EPR) to aid and reflect clinical practice and decision making

Planned Actions	Outcome	Status
Development and agreement of Trust standards for the completion of a good quality patient record	We completed a significant piece of work in developing new record management standards that are informed by standards in the NPSA Suicide Prevention toolkit. We made substantial changes to our records management audit and this informs the performance data we consider in our IQ system. This change was ready to go live for the start of the new financial year.	Achieved
Tailoring of the new EPR to the needs of service users and staff	We set ourselves the standard of 85% compliance with monthly audits of the clinical record and achieved 94%.	Achieved
Implementation of a new EPR and delivery of training	We implemented our new Electronic Patient Record (EPR) in September 2015 and started customising it for our needs from February 2016. Guidance was issued to support the new system and our existing training provision remains in place. We will seek staff feedback on the system in due course.	Achieved

Priority 3: *To reduce avoidable harm*

Listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patients' safety.

Our aim is to reduce avoidable harm by 50% in line with NHS England's 'Sign up to Safety' campaign to save lives and reduce harm for patients over the next 3 years.

Planned Actions	Outcome	Status
We will develop and deliver a patient safety improvement plan and set out our actions to meet the Sign up to Safety	We signed up to safety and developed a patient safety improvement plan, which we are continuing to implement.	Achieved

Planned Actions	Outcome	Status
pledges: **1.** Put safety first **2.** Continually learn **3.** Honesty **4.** Collaborate **5.** Support		
We set ourselves a number of success measures for safety: Achieve CQC rating of 'good' in the safe domain. 8% reduction in falls leading to a fracture. Maintain and improve our position in the top 25% of organisations by the rate of incidents reported. Evidence of discharging our duty of candour for 100% of serious incidents 90% of actions completed on the Patient Safety Development Plan	The CQC warning notice about some of our services meant that we did not achieve this measure. Despite the work of our Falls Reduction Group, we had more falls this year than last. Despite increasing the number of our incident reports we did not manage to maintain this position. We are still above average compared to other mental health trusts. We undertook an audit to test our compliance and listened to feedback from our commissioners. We identified that our systems were not robust enough to consistently capture the outcome of our efforts to be open, and we have therefore introduced significant changes and improvements. We completed 89% of actions on the Patient Safety Development Plan.	Not achieved

Aim: To reduce the use and need for restrictive interventions and improve the use of positive and proactive approaches to care

Planned Actions	Outcome	Status
Implementation of Department of Health Guidance 'Positive and Proactive Care: reducing the	We wanted to implement the 'Safewards Model'[1] on all of our wards and have achieved this.	Achieved

[1] A model of care designed to reduce the use of restrictive practices such as restraint or rapid tranquilisation.

Planned Actions	Outcome	Status
need for restrictive interventions'. Adoption of the 2015 update of the Mental Health Act 1983: Code of Practice.		
	We wanted to achieve a 15% reduction in restraint and achieved 6% (12% at Q3)	Not achieved
	We wanted to achieve a 10% reduction in the use of seclusion above 8 hours duration and in fact there was a 24% increase.	Not achieved
	We wanted to improve our score for national inpatient survey question 'Do you feel safe?' and have increased from 34% 41%.	Achieved

Priority 4: *To improve the physical health of our patients*

Aim: To reduce premature death and improve the physical health condition of severely mentally ill patients and ensure physical health needs are identified and treated.

Planned Actions	Outcome	Status
All inpatients will receive a comprehensive physical health assessment within 72 hours of admission to a ward.	We set ourselves the target of meeting 90% (inpatient) and 80% (EI) compliance with the completion cardio metabolic risk factors assessed via the National Audit of Schizophrenia. Audit data shows that we achieved compliance of 96.4% for in-patients and 74% for Early Intervention patients. We aim to achieve an improved score for national inpatient survey question 'Do you feel enough care was taken of your physical health needs?', however the data is not yet available to see if we achieved this.	Partly achieved

Planned Actions	Outcome	Status
The full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors for patients with schizophrenia in our wards and early intervention (EI) services.	We set ourselves the objective of 95% of inpatients with physical health assessment within 72 hours of admission. We achieved full implementation of the Cardiometabolic CQUIN for in-patients with complaiance at 96.4%. (EI audit results not yet available).	Achieved
All inpatients will receive a daily assessment of their physical health condition.	85% of inpatients receive daily physical health assessment and achieved 64%, however this was a new requirement introduced this year and progress continues.	Not Achieved
Care plans to fully reflect actions to address lifestyle and physical health needs	We have undertaken significant improvements in our cardio metabolic monitoring as a result of our CQUIN work.	Achieved

Aim: Ensuring that discharge summaries and care plans are shared with GPs and include comprehensive information including diagnosis, medications, physical health conditions and recovery interventions.

Planned Actions	Outcome	Status
Development of comprehensive guidance and training for clinical practitioners on the inclusion of diagnosis, medications, physical health conditions and recovery interventions in care plans for inpatients	We set ourselves the target of meeting 90% compliance assessed by a local audit of care plans and achieved 74%. We aim to achieve an improved score for national inpatient survey question 'Do you feel enough care was taken of your physical health needs?', however the data is not yet available to see if we achieved this.	Not Achieved

Priority 5: *To provide services that are compliant with the Care Quality Commission's (CQC) Fundamental Standards of care.*

Aim: To ensure that all services are compliant with the CQC Fundamental Standards of care

Planned Actions	Outcome	Status
We set ourselves a number of challenging objectives to achieve this aim: • Self-assessments of compliance at ward and team level • Development of a dashboard to provide information at ward and team level to inform improvement activity • Locally led and independent/peer review quality walk around programme • Mock inspections and independent compliance checks • '15 steps challenge' visiting programme	We undertook all of the actions that we said we would, however, the improvement notice we received from the CQC means that we are not currently fully compliant with their standards, which is what we set out to achieve.	Not achieved
Quality improvement training and specialist support for projects	We exceeded our target of a 20% increase in the number of registered quality improvement projects. We have registered 41 projects since the start of the year as a result of partnership with Medical Education and through the Quality Academy's training and support to staff. This included a one day conference for 150 staff on Quality Improvement methods and tools.	Achieved
Quality improvements plans in place for all service delivery units	Quality improvement plans were implemented in each service delivery unit and monitored via presentations to our Quality and Standards Committee.	Achieved

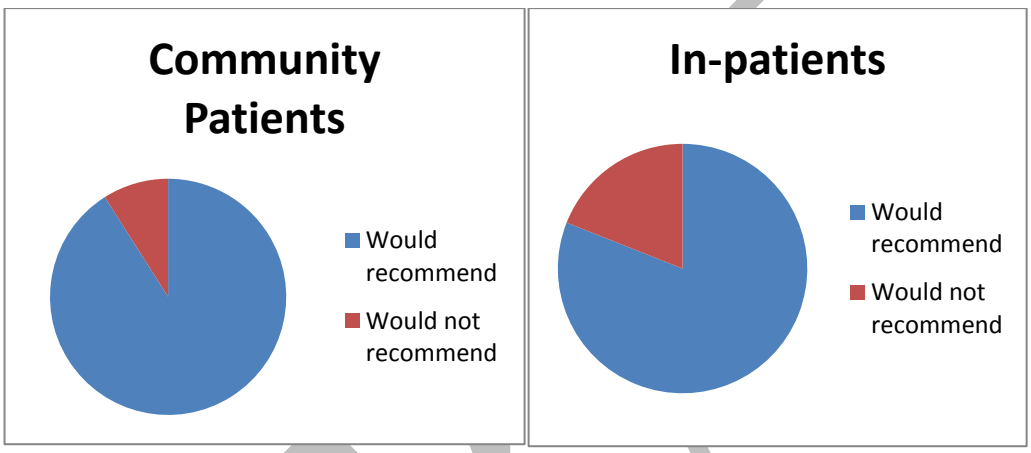
3.3 Patient and Carer Experience

3.3.1 The NHS Friends and Family Test (FFT)

The Friends and Family Test (FFT) is a single question used across the NHS that asks people who use NHS services whether they would recommend the service to friends and family who need similar care or treatment. They also have the option to comment on their care.

This year we received over **10,000** responses to our FFT, a **20%** increase on last year. Monthly reporting shows that we are consistently a top mental health trust for the number of surveys received. The majority of people who respond also choose to comment on their care. This year **78%** of responders commented.

Last year between **88%** and **92%** of AWP participants would recommend our services (the national benchmark was between 86% and 88%). **91%** of community patients would recommend us and **81%** of in-patients.



We have worked to improved the accessibility of the FFT and use feedback kiosks, survey i-pads, telephone surveys as well as paper questionnaires. A British Sign Language version of the FFT is available on the Trust website and a written translation from BSL has also been produced, as well as the paper version for people with learning difficulties and the easy read version for anyone who prefers it, for whom English is not a first language or for those who are cognitively impaired.

Quantitative and qualitative feedback from the Friends and Family Test is reviewed at local quality meetings, and shared locally with staff, service users and carers. It helps us to see where we are doing well and where we need to improve. The majority of feedback is praise; individual praise for staff is regularly shared back with them. **91%** of comments were positive and **9%** negative. We feedback about how we have responded to comments via posters in wards and community waiting areas. Examples of comments we have received include:


I am in the armed forces and have been going through personal problems; this course is helping me to understand stress more. I will be able to give soldiers some ideas on personal level to aid them with their stress but also signpost them to the course so it can help them too.
Very pleased with the service provided over the last 2 years since Mum's diagnosis. Caring and compassionate interactions by the Memory Services staff
Staff are understanding patient and make sure your medical needs are well met, lots of information given including medication and aftercare
The recent changes have disrupted things: I do understand that staff are under pressure
I came to Acer to detox off drugs and when I walked through I felt nervous and anxious but it didn't take long to feel better because the staff here made me feel at ease and very comfortable. I'm grateful to all of the staff for what they have done and I would recommend it to anyone with drug or alcohol problems.
On arriving at Beechlydene I was pleasantly surpirised with the environment, it was light spacious and airy. It has underfloor heating which was lovley. My room was cosy comfortable and well-lit and the shower so refreshing.
You were there when I desperately needed you. Your workers were always understanding, polite and managed to make me smile even on my darkest days.

3.3.2 Our work with Carers and the Triangle of Care

AWP is a member of the national scheme, The Triangle of Care, coordinated and supported by the Carers Trust. It is through this scheme that AWP self-assesses its progress when working in partnership with families and carers of people using our services. We use the self-assessment tool that underpins the six standards in the Triangle of Care that are seen as best practice to engage with families, carers:

The six key standards of the Triangle of Care:

- Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
- Staff are 'carer aware' and trained in carer engagement strategies.
- Policy and practice protocols re: confidentiality and sharing information, are in place.
- Defined post(s) responsible for carers are in place.
- A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
- A range of carer support services is available.

AWP attained its **first star** in the membership scheme in April 2014 as a result of assessing its Inpatient, Intensive and Rehabilitation services. The **second star** was gained in May 2015 for assessing all Community Teams.

Our on-going commitment to the scheme is for staff to continue to monitor their action plans and make improvements. The Carer Leads in place for each Local Delivery Unit are instrumental in overseeing this process and provide support for the local Carer Champions. The Champions are able to provide a knowledgeable resource for colleagues to ensure working in partnership is seen as integral to the recovery of people using services.

The Trust-wide Carers' Forum:

The Forum has continued to involve carers, partner organisation and AWP staff to work in partnership to monitor work in the Local Delivery Units regarding the Triangle of Care, sharing good practice for implementation of the Care Act, especially regarding assessments of carer needs and escalating trust-wide carer issues to the Board. It developed and is overseeing the implementation of the Carer's Charter.

Since January 2016 the Forum has become the main group for carers to represent the views of their peers from groups in their Local Delivery Units. It is now the place for issues to be considered and actions to be overseen. The Director of Nursing and Quality attends and is

able to escalate issues to the Board and cascade responses back to carers, staff and managers for action.

3.3.3 Patient Advice and Liaison Service (PALS)

The PALS service continue to provide free, confidential, impartial advice to service users, families, carers and interested members of the public. PALS help the Trust to know how people feel about our services and how they experience the care we deliver. The information gathered by the team acts as early warning system for the Trust when things are not right, and they help us to improve our services.

Over the past year the team have received 1,802 enquiries. Further information about the work that PALS do is available on our website at: http://www.awp.nhs.uk/advice-support/pals/

	2011/12	2012/13	2013/14	2014/15	2015/16
PALS cases	1688	1485	1631	1887	1802

3.3.4 Complaints

All complaints and concerns will be treated as feedback and an opportunity to learn, develop and improve. The key purpose of our complaints and concerns handling process is to identify what, if anything, went wrong, apologise, describe the learning from the investigation and set out clearly the action the Trust has taken to minimise the risk of it happening again. This year we have received 360 complaints, compared to 314 last year.

Actions arising from complaints can range from system issues, policy changes, to arranging an appointment for someone to review their care. Each action is tracked to ensure completion and they are recorded on a plan which is monitored and has senior management oversight.

	2011/12	2012/13	2013/14	2014/15	2015/16
No of formal complaints	278	302	272	314	360
No of informal complaints	27	103	88	72	78
Total	**305**	**405**	**360**	**386**	**438**
Referred to Parliamentary and Health Service Ombudsman	19	21	7	12	4

3.3.5 Praise

This year the Trust has implemented an on-line praise recording so teams can let us know when they have received a compliment about their service. These are then received by the PALS team and themed so we can see what is being praised and we can look at areas of good practice. This year has seen compliments rise from 724 to 1,122.

	2011/12	2012/13	2013/14	2014/15	2015/16
Praise received	709	782	849	724	1,122

3.3.6 Themes from PALS and Complaints

The table below shows the classification of themes arising from complaints and PALS. The classification list has been revised this year and the Trust has adopted the themes used by the Care Quality Commission. Examples of the fields these themes contain have been given in the table, but these lists are not exhaustive.

Five themes from our feedback*	**Complaints**	**PALS**
Responsive (includes access to services, responsiveness to referrals and inpatient bed management)	93	412
Effective (includes clinical care, CPA, discharge from services, MHA, physical healthcare)	108	341
Caring (includes attitude of staff, privacy and dignity, communication)	99	524
Safety (includes medication, nutrition, personal safety, safeguarding, personal property)	38	176
Well led (incudes policy and procedure, health records, complaints handling, requests for information, user and carer involvement)	22	349
TOTAL	**360**	**1802**

3.3.7 Community Mental Health Survey 2015

The Trust took part in the national community mental health survey and had a response rate of 28%. Its results for the different sections of the survey are shown in the table below:

Section heading	Score out of 10 for your trust (2015)	How this score compares with other trusts
Health and Social Care Workers	7.8	**About the same**
Organising care	8.8	**About the same**
Planning care	7.3	**About the same**
Reviewing care	7.8	**About the same**
Changes in who people see	6.8	**About the same**
Crisis Care	6.3	**About the same**
Treatments	7.7	**Better**
Other areas of life	5.5	**About the same**
Overall views and experiences	7.2	**About the same**
Overall experience	**6.9**	**About the same**

The Trust is better for 'Treatments' (four questions about involvement in decisions about treatment and medication) compared to most other trusts that took part in the Community Mental Health Survey. For all other sections, it is described as performing 'about the same' as most other trusts that took part in the survey. Within this range, the majority of scores were above the average for all mental health trusts.

We had the top score in the country for people being given information about medication in a way they were able to understand. No scores were significantly lower than in 2014. There were notable improvements in the 'other areas of life section': for supporting people to find advice and support regarding employment, finances and benefits, accommodation and peer support. Following 2014 survey actions to ensure that service users have out of hours contact details, there were significant improvements for service users knowing who to contact in a crisis (2014=6.3, 2015= 7.3), however, there is still scope for improvement for people getting the help they want from crisis care (2014=5.7, 2015=5.3).

67% of survey respondents chose to comment. The comments were equally balanced between positive and negative feedback. The majority of positive comments described caring staff and effective services. Resourcing of mental health services and access were the main concerns raised.

3.3.8 Inpatient Survey 2015

The Trust chose to repeat the national adult inpatient survey for the seventh consecutive year. Seventeen mental health trusts undertook this optional survey. Our response rate was 22% and responses were from a more ethnically diverse group than in previous years.

This year, we had improved scores for two thirds of the questions. Following the ongoing Trust wide implementation of the Safe Wards initiative, more service users told us that they always felt safe on the ward (34% in 2014, **41%** in 2015) and more said that nurses always listened carefully to them (39% in 2014, **48%** in 2015). Other improved scores included care for physical problems and people finding talking therapy helpful. More people wanted talking therapies than said they received them on the wards. Where scores were lower than in 2014,

they were generally only slightly lower; for example, in 2014, 58% said that the toilets and bathrooms were very clean compared to **57%** in 2015.

Following actions from the last inpatient survey, the percentage of people saying that there are always enough activities at evenings and weekends went from 8% to **16%**, however, there is still a need for improvement.

Theme	Positive comments		Negative comments	
Responsive	**2**	**2%**	**4**	**4%**
Effective	**44**	**39%**	**32**	**31%**
Caring	**51**	**46%**	**38**	**36%**
Safety	**13**	**11%**	**19**	**19%**
Well Led	**2**	**2%**	**10**	**10%**
		100%		**100%**

The Trust wide priority areas for action were agreed by the Quality and Standards Committee in November, and are:

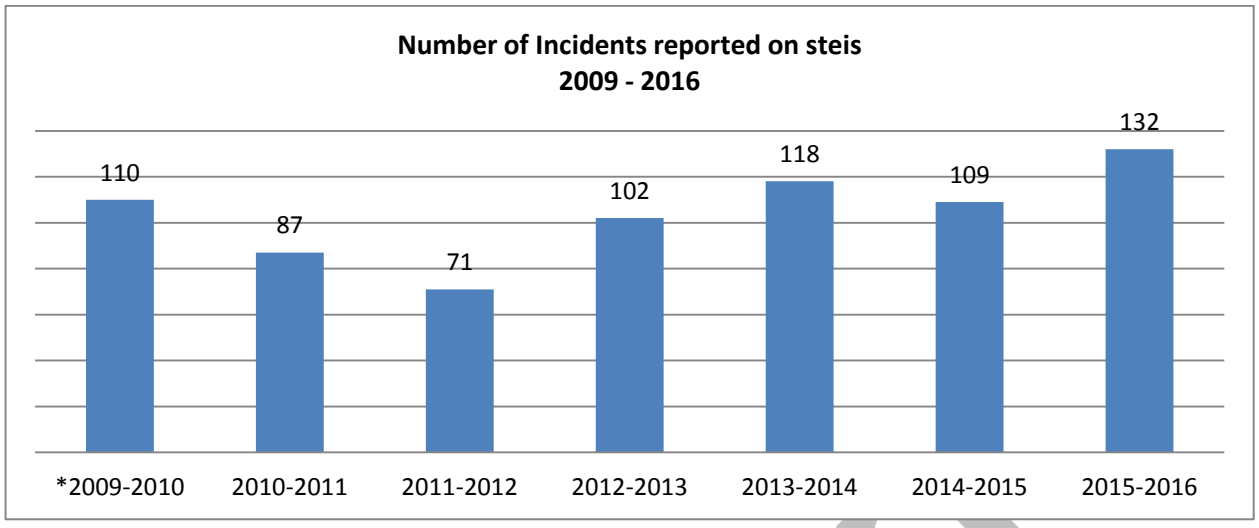
- **Other areas of life** (involving carers, peer support and community engagement).
- **Crisis care.**
- **Impact of changes in care.**
-
- **Involvement in decisions about medicines**

3.4 Safety and Candour

Learning from incidents

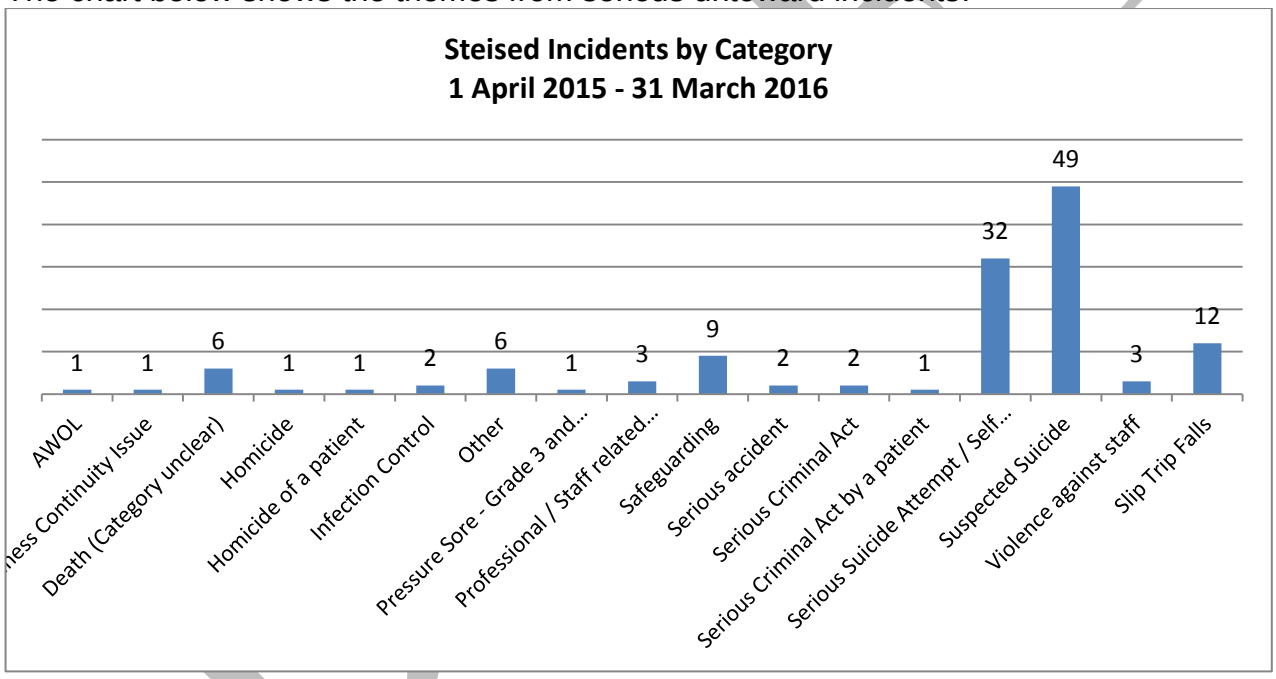
During 2015 - 16 our staff reported 9,911 incidents, of which 132 were considered serious.
A serious untoward incident (SUI) is defined as any event or circumstance arising that led to serious unintended or unexpected harm, loss or damage. Every serious incident is investigated by a senior member of staff to identify the root causes and to share lessons learned to prevent reoccurrence. These investigation reports are quality assured through the Trust's internal governance processes, which includes approval by the Clinical Executive, and also through scrutiny by the Commissioner of the relevant service.

There was an increase in the number of serious untoward incidents reported this year, which is attributed to the new National Serious Untoward Incident framework requiring a broader range of incidents to be reported:

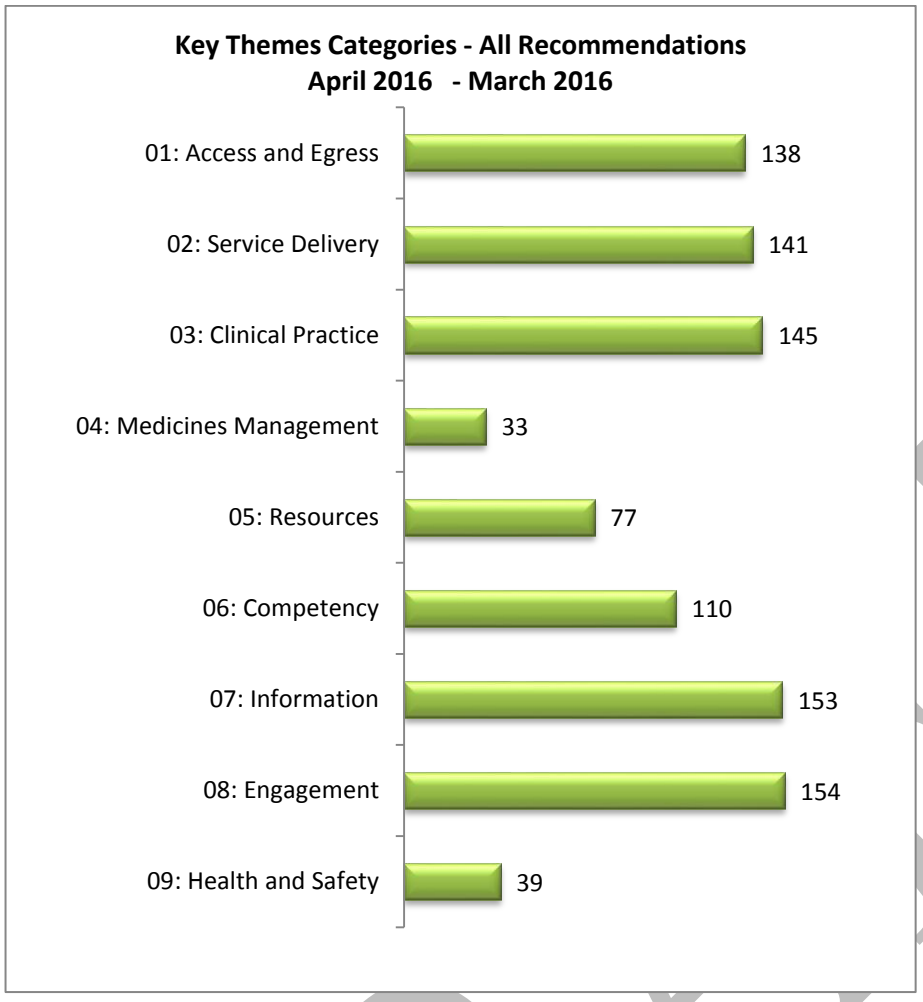


Themes from Serious Untoward Incidents 2015/16

The chart below shows the themes from serious untoward incidents:



There is close monitoring to ensure the implementation of recommendations arising from SUIs. The learning categoris identified from serious untoward incidents are shown in the chart below:



Duty of Candour

AWP is committed to fulfilling its contractual and statutory duties in relation to discharging its Duty of Candour when things go wrong, in the spirit of openness, candour and transparency as follows:

- Openness: Enabling concerns to be raised and disclosed freely without fear and enabling questions to be answered.
- Candour: Ensuring that service users harmed by a notifiable patient safety incident are informed of the fact and that an appropriate remedy is offered.
- Transparency: Allowing true information about outcomes to be shared.

The independent chairs appointed to undertake root cause analysis invesigations into serious incidents are required to verify that all necessary and appropriate steps have been taken to ensure staff have been candid and open. We audited these processes in 2015/16 and listened to feedback from our Commissioners and found some shortcomings in processes for evidencing that we had discharged our duty. We have therefore changed and strengthened our arrangements and there is now Executive level confirmation that the duty of candour has been discharged.

3.5 Patient Safety Improvement Plan

We developed a set of actions to fulfil the pledges we made when we 'Signed up to Safety' and they can be found as Appendix 1.

3.6 Staff Feedback

3.6.1 National Survey Findings

The Trust values the hard work of our staff and their dedication to providing high quality mental health care that promotes recovery and hope. We have committed to supporting and developing our staff as a strategic priority.

Survey results are analysed by each of our Localities and from a whole organisation perspective to provide a Trust wide picture. Results are used to develop and refine plans to improve staff experience of working at the Trust.

The Trust wide results of the 2015 Annual Staff Survey are reported below:

Staff Survey Response Rate Response

2014	
Trust	**National average**
51% (1790 staff)	42%
2015	
49.9% (1750 staff)	46.1%

Comparison with other MH Trusts

Year (No of key findings)	**2014 (29)**	**2015 (32)**
Above national average	10% (3)	9% (3)
On a par with national average	10% (3)	47% (15)
Below national average	80% (23)	44% (14)

We are pleased with the positive response rate and value the feedback received from staff.

Survey results have improved compared with 2014. We are pleased that the actions of our Localities, HR and Organisational Development Teams are making a difference.

In the past year we have maintained a focus on staff engagement through leadership and team development, staff health and wellbeing; and staff recognition and benefits schemes.

Staff engagement has been shown to link with care quality and safety and we are pleased that our staff engagement score has improved.

Year	2014	2015
AWP Staff Engagement Score	3.6	3.68
Average MH Trust Staff Engagement Score	3.72	3.75

Highest 5 Ranking Scores	Trust 2015	National average for mental health/ learning disabilities
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	93%	91%
Percentage of staff appraised in last 12 months	91%	89%
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	19%	21%
Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell	54%	55%

Lowest 5 Ranking Scores	Trust 2015	National average for mental health / learning disabilities
Quality of non-mandatory training, learning or development	3.91	4.01
Percentage of staff agreeing that their role makes a difference to patients / service users	85%	89%
Quality of appraisals	2.97	3.11
Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	39%	49%

Percentage of staff / colleagues reporting most recent experience of violence	85%	84%

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	36%	32%

*National averages for mental health and learning disability Trusts

We remain committed to improving staff experience and wellbeing and will build on the positive improvements in the coming year.

3.6.2 Staff Friends and Family Test

The Staff Friends and Family test is carried out in Q1, Q2 and Q4 for the financial year with Q3 results provided by the NHS National Staff Survey.

Year on year data is provided from the annual NHS Staff Survey. The indicator is the percentage of staff who answer either 'agree' or 'strongly agree' to the question:

If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation:

National Data – National NHS Staff Survey – Friends and Family Test				
Reporting Period	**AWP Score**	**Average (median) for mental health nationally**	**Highest score nationally**	**Lowest score nationally**
2015	50%	59%	82%	37%
2014	48%	66%	93%	36%

I would recommend my organisation as a place to work:

National Data – National NHS Staff Survey – Friends and Family Test				
Reporting Period	**AWP Score**	**Average (median) for mental health nationally**	**Highest score nationally**	**Lowest score nationally**
2015	46%	56%	73%	34%
2014	42%	54%	74%	34%

Culture of Care Barometer:

We have now completed a pilot stage of the Culture of Care Barometer (incorporating the Staff Friends and Family Test questions) which will measure staff confidence in reporting areas of concern, support received from local managers and whether staff see senior leaders living Trust values. The aim is that the results of the barometer survey will assist Locality

Management Teams to target specific staff issues in teams working with staff to plan and improve staff engagement and experience at a local level. The Culture of Care Barometer will be implemented Trustwide in the coming year.

Part 4: How we developed our Quality Account

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

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

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

External assurances and comments

To be added

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

Appendices:

1 Sign Up to Safety Action Plan

Appendix 1

SIGN UP FORM

Organisation name:

Avon and Wiltshire Partnership NHS Trust

In signing up, we commit to strengthening our patient safety by:

- Describing the actions (on the following pages) we will undertake in response to the five campaign pledges
- Committing to turn these actions into a Safety Improvement Plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years .

- Identify the patient safety improvement areas we will focus on
- Engage our local community, patients and staff to ensure that the focus of our work reflects what is important to our community
- Make public our commitments and plans.
- The Safety Improvement Plan details the driver diagrams / work plans for four main safety themes. These include:
    - Suicide prevention
    - Falls prevention
    - Use of restrictive practices
    - AWOL (failure to return from leave)

Chief Executive or organisation leadership sponsor:

Dr Hayley Richards

Name Signature Date

Please tell who will be the key contact in your organisation for Sign up to Safety:

Title:	Mr	First name:	Alan	Last name:	Metherall
Email:		alan.metherall@nhs.net		Job title:	Deputy Director of Nursing

The five Sign up to Safety pledges

1. Putting safety first. Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans

We will

- Maintain full compliance with the CQC Safe domain and achieve a rating of Good*
- 8% Reduction in falls leading to a fracture. *
- Implement Safewards across all our wards to:
    - 15 – 20 % reduction in all restrictive practices*
    - 10% reduction in the use of seclusion above 8 hours duration *
- 100 of boxes on medication charts will be completed (no blank boxes)

2. Continually learning. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are

We will

- Personalise incident reports and investigations wherever possible but using names and only animalise reports where families request or where rules and the law requires.****
- Develop a case management approach to responding , reviewing and learning from incidents**
- Completed the establishment of a dedicated clinically led patient safety team**
- The Quality Academy will support teams in developing and using Quality Improvement tools
- Improve patient feedback through the extended use of 15 Steps
- Embed the NPSA Inpatient and Community Suicide Prevention Tool Kits as the core framework for clinically-focused suicide prevention.
- Support and adoption of Human Factors approaches towards patient safety **

3. Being honest. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

We will

The Board will role model and demonstrate leadership at Board level***

Evidence of discharging our Duty of Candour for 100% of serious incidents*

Openly report incident data using the Trust Information for Quality system "IQ" to enable staff, service users, carers and our external stakeholders e.g. CCG Commissioners.

Maintain and Improve our position in the top 25% of organisations by the rate of incidents reported. *

Improve score for national inpatient survey question "Do you feel safe" *

Continually review and revise processes , policy and procedures relating to our Duty of Candour, placing patients and families at the centre of what we do.

4. Collaborating. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use

We will

- Undertake shared investigations wherever possible with relevant partners and stakeholders***
- Lead a project in one locality as part of the zero suicide collaborative**
- Increase the use of patient stories by people with lived experience ***
- Support " everyone included" within Research and Development

5. Being supportive. Help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate progress

We will

Host an initial Trust wide Patient Safety Conference which will become an annual event**

Introduced a patient safety award as part of the staff awards

Using Social Movement theories to develop Patient Safety Champions across the Trust including our Membership.

Ensure all relevant job descriptions detail the required level of knowledge skills and experience for Quality Improvement and Human Factors.**

Roll out training for the Safety Champions in Human Factors in patient safety **

Work with our academic providers to ensure quality improvement and human factors training are embedded into pre-registration courses.**

Bright Ideas programme to run through 2015 2018

Links to our Pledges

- * Quality Account 2015 2016 Success Measure http://www.awp.nhs.uk/media/717530/awp-quality-account-2014-15.pdf
- ** Executive Report – establishing a Clinically Led Patient Safety Team
- *** The Health Foundation http://www.health.org.uk/
- **** Clinical Human Factors Group http://chfg.org/