5 Boroughs Partnership NHS Foundation Trust

Quality Account

2011 – 2012

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Part 1 – Our Commitment to Quality

1.1 Our Quality Account 2011-12

This is the third Quality Account that has been produced by 5 Boroughs Partnership NHS Foundation Trust. Our Quality Account is published alongside our Annual Report which we will continue to produce each year and make available as a public statement of our commitment to improving quality and safety in the Trust.

In April 2011 the Trust acquired Knowsley Integrated Provider Services (KIPS) as part of the Transforming Community Services initiative. This report includes the quality priorities established for both organisations in March 2011. The quality priorities for the coming year have been established for the Trust as a whole.

The purpose of our Quality Account is to demonstrate the Trust's commitment to improving quality and safety for the people who use our services. It presents:

- Where improvements in quality are required
- What we are doing well as an organisation
- How service users, staff and the wider community are engaged in working with us to improve quality of care within the Trust.

1.2 Chief Executive's Statement

All providers of NHS healthcare services are required to produce a Quality Account - an annual report to the public about the quality of services delivered. We welcome this opportunity to take an honest look at how well we have performed during the reporting year and to outline future improvements we aim to make.

We have worked with the following groups to produce our Quality Account:

- Clinical Governance and Clinical Risk Committee
- Council of Members via our Compliance with Authorisation Committee
- Staff, service users and carers from across the breadth of our organisation.

We have also consulted with key external stakeholders including:

- Overview & Scrutiny Committees
- Local Involvement Networks (LINks).

You can read what our stakeholders have to say about our quality performance in **Appendix 1** (page 114).

One of our Trust values is: 'We value quality and strive for excellence in everything we do'. I am delighted that this Quality Account evidences our commitment to this value across the breadth of our services.

In particular, we took part in 100 per cent of national clinical audits that we were eligible for during the reporting year. The importance of clinical audits is realised when we make changes to improve services based on audit findings.

We have been Creating Time to Care – working with our clinicians to support them to spend more quality time with our service users. We have also been developing a coaching programme to promote a culture of personal responsibility and empowerment. We want to equip our people to deliver on the commitments we make – another of our Trust values.

You can read more about these and other initiatives, and view detailed information about our performance against quality and safety priorities and indicators within the following report.

Simon Barber
Chief Executive

1.3 Chairman's Statement

Recognising the 'Expert by Experience' status of our service users is a key quality priority we have set for 2012-13 – complementing our value: 'We value, encourage and recognise everyone's contribution and feedback'.

I am delighted that this report evidences a 61 percent increase in the number of involvement opportunities carried out by volunteers in 2011 when compared with 2010. We are able to demonstrate where and how we have listened to our service users' lived experience and worked with them to drive through key quality improvements.

For example, by involving service users in the patient safety framework, and taking into account their insight and experience, we have been able to improve the quality of the actions we implement to enhance patient safety within the services we provide.

In a UK-first we also pioneered the full involvement of people living with a Personality Disorder in the development and delivery of a new and innovative Personality Disorder Hub Service which is committed to offering the best possible service to people who meet this diagnosis. For our work in this area we received a nomination in the 'Innovation in Mental Health' category at the HSJ Awards 2011.

As Chairman of the Council of Members, it's great to see that our Member Councillor representatives on the Clinical Governance and Clinical Risk Committee have approved the Quality Priorities for 2012-13, as detailed in this report.

I look forward to seeing how as a Trust we can work with all our stakeholders to deliver on the commitments we have made.

Bernard Pilkington
Chairman

1.4 Our Vision

We work with many partners including primary care trusts, local authorities, social services and the voluntary sector to help us turn our vision of becoming:

> "A leading provider of world-class mental health, learning disability and community services, with a reputation for quality, innovation and excellence"

into a reality.

1.5 The Trust Values

"We **value** people as individuals ensuring we are all treated with dignity and respect."

"We **value** quality and strive for excellence in everything we do."

"We **value**, encourage and recognise everyone's contribution and feedback."

"We **value** open, two-way communication, to promote a listening and learning culture."

"We **value** and deliver on the commitments we make."

More information about the Trust Values are in section **3.5.1** of this report.

1.6 Supporting Statements

In order to help demonstrate the Trust's commitment to quality improvement, supporting statements have been provided by the following:

- Chair of the Clinical Governance and Clinical Risk Committee
- The Trust's Council of Members (Compliance with Authorisation Committee).

These statements are included as **Appendix 1** (page 114).

Go to www.5boroughspartnership.nhs.uk/quality-accounts to view the table of wider engagement.

1.7 Statements from External Stakeholders

Supporting statements have been invited from:

- Overview & Scrutiny Committees
- Local Involvement Networks (LINks)
- Lead Commissioner statement (NHS Knowsley).

These are also included in **Appendix 1.**

1.8 Chief Executive's Written Statement and Signature

I confirm that to the best of my knowledge the information in the 2011-12 Quality Account is accurate.

S Barber

1.9 Responsible Person's Written Statement and Signature

As the responsible person registered with the Care Quality Commission, I declare that the content of the Trust's Quality Account 2011-12 is accurate to the best of my knowledge.

S Hull

Mr S Hull, Assistant Director Nursing and Safeguarding, Registered nominated individual for 5 Boroughs Partnership NHS Foundation Trust with the Care Quality Commission.

Part 2 - Priorities for Improvement

2.1 Quality Priorities for Improvement 2012-13

To demonstrate our continual commitment to quality improvement we have engaged with our service users, local scrutineers, and the Foundation Trust members to agree our quality priorities for the year ahead.

The three quality priorities will demonstrate improvements in patient safety, patient experience and effectiveness of our services; the Trust Board will monitor progress for the quality priorities throughout the forthcoming year.

These three quality priorities have been chosen and designed for the Trust as a whole and are markers for improvement for mental health, learning disabilities and community care. The priorities will align with Trust objectives for 2012-13 and will be quality targets agreed with our commissioners.

Quality & Safety priorities 2012-13	Indicator	Rationale
Safety Falls	To provide evidence on how the Trust has addressed Falls amongst the service user population.	During 2011-12 the Trust achieved its quality priority in relation to reduction of harm. In 2012-13 we are going to focus further on the prevention of avoidable harm as a result of falls. In addition, as part of the National Mandatory CQUIN targets for 2012-13 the Trust will also be monitoring falls using the NHS Safety Thermometer.

Quality & Safety priorities 2012-13	Indicator	Rationale
Effectiveness Shared Decision-Making	To identify examples of shared decision-making between service user and the clinician, recognition of the 'expert' status of the service user, developing person-centred care plans and supporting carers.	Further embedding of person-centred care planning will promote independence and self management of care. Increased engagement with service users will ensure they are involved in decision-making at an earlier stage about their care and treatment. The Trust has also considered service user feedback about the quality and involvement they want with their care planning.
Experience Issues of Concern	The Trust will look at the process for collecting and acting upon issues of concern expressed by service users.	The Trust wants to listen to what our service users think about the service we provide, build on positive experiences they share with us and change where they tell us we can do better.

2.2 Improving on 2011-12 Quality Measures

The Trust's quality priorities for 2011-12 have been monitored by the Trust for the past year. Although the Trust achieved these priorities, they will continue to be reported on for the following year. Details of 2011-12 priorities are included in section **3.1** of this document.

2.3 Trust Quality Improvement Plan

The Trust is developing a Quality Improvement Plan for 2012-13 which includes:

- Quality and safety priority indicators 2012-13 (as above)
- Actions arising from the National Patient Survey results
- Actions arising from the Trust Patient Experience Survey results
- Safety and quality actions from external regulator's visits/ reports
- Actions relating to data quality in the Monitor External Assurance review.

Go to www.5boroughspartnership.nhs.uk/quality-accounts to view the Trust's Quality Improvement Plan 2012-13.

2.4 Statements of Assurance Provided by the Trust Board

As part of our Quality Account, we are required to present a series of statements which have been agreed by the Trust Board that relate to the quality of our services. These statements serve to offer assurance to our members and the general public that we are:

- Performing to national essential standards of quality and safety (CQC Registration standards)
- Measuring and improving our clinical performance in audit and research activity
- Engaging in innovative projects (CQUIN framework)
- Maintaining compliance with our Monitor targets (see section **3.2** of this document).

2.4.1 Review of Contracted Services

During 2011-12 5 Boroughs Partnership NHS Foundation Trust provided and/or sub-contracted 266 NHS services.

The 5 Boroughs Partnership NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services. This is undertaken through regular service reviews against the strategies set out in the Trust's Integrated Business Plan.

The income generated by the NHS services reviewed in 2011-12 represents 100 per cent of the total income generated from the provision of NHS services by the 5 Boroughs Partnership NHS Foundation Trust for 2011-12.

2.4.2 Commissioning for Quality & Innovation Payment Framework (CQUIN)

A proportion of 5 Boroughs Partnership NHS Foundation Trust income in 2011-12 was conditional upon achieving quality improvement and innovation goals agreed with NHS Knowsley - acting as Co-ordinating Commissioner for Halton, St Helens, Knowsley, Warrington, and Ashton, Leigh and Wigan separately through the Commissioning for Quality and Innovation payment framework.

The Trust attracts 1.5% of our contract value as CQUIN payments. The total available within the CQUIN framework is £1.945m.

Further details of the agreed goals for 2011-12 and for the following 12-month period are available online.

Go to www.5boroughspartnership.nhs.uk/quality-accounts to view the Trust's CQUIN targets for 2012-13.

2.4.3 Participation in Clinical Audits & National Confidential Enquiries

The Trust considers involvement in clinical audits to be a key indicator of quality. The importance of clinical audits is realised when it leads to the implementation of initiatives to improve services.

A key example of this in 2011-12 can be demonstrated by the Prescribing Observatory for Mental Health (POMH) re-audit, assessing the monitoring of side-effects to depot antipsychotic medication.

Three audits have been undertaken - the first being the baseline in 2008, the second in October 2009, and the latest audit was completed in May 2011. These audits are undertaken by participating Trusts, therefore the results can be analysed as year-on-year Trust results, comparisons to other mental health trusts, and national standards.

Full implementation of the action plan by the Medicine Management Team has demonstrated a dramatic improvement, and as a result we are now one of the best performing Trusts in the UK.

Actions implemented included: development of monitoring templates; improving service user knowledge and expectations; launch of the Choice and Medication website; communication and discussion of the results with the medical and nursing teams, with a simple message to ask and document issues related to side-effects.

The results of the latest audit showed the following improvements:

- The proportion of patients with no evidence of documentation around side-effects has reduced from 40% to 13%
- The proportion of patients with documentation of a general statement regarding presence or absence of side-effects has improved from 49% to 83%
- Significant improvements were noted for the documentation of specific side effects relating to movement disorders, weight, and side-effects of a sexual nature.

The specific side-effects above are known to be particularly distressing for patients and are often the cause of non-compliance with medication, resulting in an increased risk of relapse and possible admission to hospital. Evidence suggests that side-effects of this nature may only be identified if patients are specifically questioned about them.

The results of this audit demonstrate that we have improved our monitoring of side effects and thus improved the quality of care provided. An action following the latest audit has been the launch the ‘Patient Empowerment Letter’ which is expected to bring further improvements.

During 2011-12, six national clinical audits and one national confidential enquiry covered NHS services that 5 Boroughs Partnership NHS Trust Foundation Trust provides.

During that period 5 Boroughs Partnership NHS Foundation Trust participated in 100% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquires that 5 Boroughs Partnership NHS Foundation Trust was eligible to participate in during 2011-12 are as follows:

National Audit of Schizophrenia (NAS)
National Audit of Psychological Therapies
POMH Topic 6C - Assessment of the side-effects of depot antipsychotics
POMH Topic 7C - Lithium Monitoring
POMH Topic 10b - Antipsychotics in CAMHS
POMH Topic 11a – Antipsychotics - Dementia
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The national clinical audits and national confidential enquiries that 5 Boroughs Partnership NHS Foundation Trust participated in during 2011-12 are as follows:

National Audit of Schizophrenia (NAS)
National Audit of Psychological Therapies
POMH Topic 6C - Assessment of the side-effects of depot antipsychotics
POMH Topic 7C - Lithium Monitoring
POMH Topic 10b - Antipsychotics in CAMHS
POMH Topic 11a – Antipsychotics - Dementia
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The national clinical audits and national confidential enquiries that 5 Boroughs Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2011-12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry. As follows:

Name of Audit	Number of cases submitted	% of required cases provided
National Audit of Schizophrenia (NAS) Audit forms completed	87	87%
National Audit of Schizophrenia (NAS) Service User Questionnaires returned	31	15%
National Audit of Schizophrenia (NAS) Carer Questionnaires returned	22	11%

Name of Audit	Number of cases submitted	% of required cases provided
National Audit of Psychological Therapies	235	100%
POMH Topic 6C – Assessment of the side-effects of depot antipsychotics	263	100%
POMH Topic 7C – Lithium Monitoring	164	82%
POMH Topic 10b – Antipsychotics - CAMHS	38	100%
POMH Topic 11a – Antipsychotics - Dementia	510	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	201	100%

The reports of four national clinical audits were reviewed by the provider in 2011-12 and 5 Boroughs Partnership NHS Foundation Trust intends to take actions to improve the quality of healthcare provided.

The reports of 241 local clinical audits were reviewed by the provider in 2011-12 and 5 Boroughs Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Action Plans are completed and agreed at the appropriate committee or group
- A Trust lead is appointed for each action
- Time scales for each action are established and agreed
- Follow up actions are agreed by the Trust.

2.4.4 Participation in Clinical Research

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. It helps us ensure that our clinical staff stay abreast of the latest treatment possibilities and value active participation in research as it leads to successful patient outcomes.

The number of patients receiving NHS services provided or sub-contracted by 5 Boroughs Partnership NHS Foundation Trust in 2011-2012 that were recruited during that period to participate in research approved by a research ethics committee was 300. The total number of participants taking part in studies was 759 - a steady increase from the baseline figure of less than 80 in 2009-10 and 350 last year.

The Trust is strongly committed to supporting the activities of the Comprehensive Local Research Networks (CLRN). It is an active member of the Cheshire and Merseyside CLRN and has participated in a growing number of clinical studies in their research portfolio. The Trust became a full member of the Mental Health Research Network.

The Trust was involved in conducting 41 clinical research studies in mental health and integrated community services during 2011-12. The studies included those that described new treatments (observational studies) as well as ones that tested new treatments (interventional studies). They covered a

range of areas from trials of new therapeutic drugs to testing the effectiveness of new talking therapies. The studies included commercial clinical trials as well as NIHR studies and including international collaborations, researching new treatments across all ages in areas including dementia, schizophrenia, ADHD and self-harm.

The Trust is the top recruiter in the UK for several commercial and NIHR portfolio studies. As a result of this we have been approached by a number of pharmaceutical companies to complete feasibility studies for other clinical trials for Major Depressive Disorder, Dementia and Attention Deficit Hyperactivity Disorder (ADHD). With the success of the current studies two of our Principal Investigators are acting as Chief Investigators with overall responsibility for the clinical trial. The number of sub/co-investigators has increase significantly in this year – with many of our consultants gaining more experience in clinical trials to become principal investigators. More than 40 of our medical practitioners are currently participating in a range of clinical trials.

In order to promote frontline engagement in research the Trust has launched a Research Grant Application Scheme. The first scheme ran in September 2012, for which we received seven applications. Following the success of our inaugural Research Awareness Day, a second day is planned in June 2012.

2.4.5 Quality of our Data

The 5 Boroughs Partnership NHS Foundation Trust attaches a high level of importance to data quality. The Trust believes that excellent data quality is one of the foundations for the delivery of quality care, good patient experience and cost-effective services. It also assists with clinical decision-making.

The 5 Boroughs Partnership NHS Foundation Trust has been taking the following actions to improve data quality:

- Continue to publish monthly data quality and completeness data at Executive, Management and Operational Levels via the Trust intranet
- Continue to publish monthly High-level Trend reports
- Continue to publish quarterly benchmarking reports comparing Trust achievement levels against national, regional and local Trusts
- Continue liaison with and training for operational teams to support improvement of data quality across all services
- Continue to liaise with Consultants and their medical teams in relation to clinical coding and the availability of discharge and clinical information.

5 Boroughs Partnership NHS Foundation Trust submitted records during 2011-12 to 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:

Admitted Patient Care (130 & 190)	100%
Care Activity CDS (Outpatient) (020)	100%
Long-term Psychiatric Census(170)	100%
Mental Health Minimum Data Set	99.0%

The percentage of records which included the patient's valid General Practitioner Registration code was:

Admitted Patient Care (130 & 190)	96.6%
Care Activity CDS (Outpatient) (020)	99.0%
Long-term Psychiatric Census(170)	99.0%
Mental Health Minimum Data Set	98.6%

2.4.6 Clinical Coding

5 Boroughs Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

The Trust commissioned and independent review of clinical coding that was undertaken by Mersey Internal Audit Agency in December 2011. The overall level of assurance was 'high' - the highest level in a 4-point scale. The audit results were as follows:

Primary Diagnosis	100%
Secondary Diagnosis	94%
Primary Procedures	100%
Secondary Procedures	100%

2.4.7 Information Governance Toolkit

5 Boroughs Partnership NHS Foundation Trust's Information Governance Assessment Report overall score for 2011-12 was 91% and was graded Satisfactory. 5 Boroughs Partnership NHS Foundation Trust will be taking the following actions to improve data quality:

- There is an Information Governance Management Group which is responsible for agreeing the assurance and accountability driven work plan and monitoring its progress throughout the year.

2.4.8 Registration with the Care Quality Commission

5 Boroughs Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against 5 Boroughs Partnership NHS Foundation Trust during 2011-12.

5 Boroughs Partnership NHS Foundation Trust has participated in special reviews or investigations by the Care Quality commission relating to the following areas in 2011-12.

5 Boroughs Partnership NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by CQC:
5 Boroughs Partnership NHS Foundation Trust has made the following progress by 31st March 2012 in taking such action:

During 2011-12 the Trust was inspected by the Care Quality Commission as part of their targeted inspection programme to review services for people with

learning disabilities. The review was to establish if in-patients experience effective, safe and appropriate care and treatment and support that meets their needs and protects their rights, and whether they are protected from abuse.

The Trust was subject to two inspections. These were carried out at in-patient units; Auden Unit, based at Hollins Park in Warrington and at Willis House situated in Whiston.

Auden Unit

The report from the Auden Unit inspection was received by the Trust in February 2012. The report includes quotes both from our services users and carers. Feedback from all was very positive, complimentary and encouraging about aspects of care, care planning, respect and skills of the staff.

The Care Quality Commission's overall judgement of the Auden Unit was that patients receive safe and appropriate treatment that meets their needs and protects their rights, however patient-centred care planning needs to be fully embedded.

The report also included moderate concerns as part of the inspection, which require improvements by the Trust. These related to ensuring that our staff can identify safeguarding concerns; they be fully aware of the processes and procedures we have in place and can act on them to safeguard our service users.

The Trust has accepted the findings from the CQC report and has provided the CQC with an action plan that fully covers the areas for improvement. The action plan is now fully completed and the CQC have been informed of the progress made.

Willis House

Willis House was inspected by the Care Quality Commission in December 2011. The Trust has now received the final report and responded to CQC. Since the review was undertaken the Unit has closed as part of a planned redesign of services and the Trust has applied to the Care Quality Commission to de-register this unit which is part of the Trust's registered locations.

The CQC were informed during their inspection that Willis House was due to close as an in-patient facility, and as a result of its recent closure the CQC have revised their final report to reflect this. Although the Trust is not expected to act on the findings of the report due to the facility no longer being used, the Trust acknowledges the findings of the CQC's report and has formulated an action plan that will ensure that lessons are learned.

See section **3.6.2** for a breakdown of performance against 2011-12 CQC Essential Standards of Quality and Safety.

Part 3 - Other Information

3.1 Trust Quality and Safety Priorities 2011-12

This section of our Quality Account presents information relating to the quality of our services throughout 2011-12. We start this section by reporting on our achievement against the Trust Priorities that we set ourselves for 2011-12.

Below are two tables which outline the outcome of quality and safety priorities established by both the Mental Health and Learning Disabilities and Integrated Community Services in March 2011 - prior to the coming together of the services in April 2011. The priorities for the coming year have been chosen and designed for the Trust as a whole which includes mental health, learning disabilities and community services provided by KIPS.

Mental Health and Learning Disabilities

Quality & Safety priorities & indicators 2011-12	Outcome	Commentary
Safety Preventing avoidable harm By March 2012 we will have taken improvement actions, leading to demonstrably safer care by reducing the ratio of harm to incident as measured by the National Patient Safety Agency	**met**	Base line for the reduction of reportable harm to incident ratio 2010-11 was 72%. Actual for March 2011-12 was 80% of reportable incidents resulted in no harm suffered.
Effectiveness Good physical health care By March 2012 the Trust will be able to demonstrate a 10% increase in the number of service users in Community Mental Health Teams who have had physical health incorporated into their care plans	**met**	There has been a 43% increase of service users within the Community Mental Health Teams with physical health incorporated in their care plans.

Quality & Safety priorities & indicators 2011-12	Outcome	Commentary
Experience Ensuring a positive experience of care By December 2011 the Trust will have agreed a meaningful suite of patient experience measures with the Council of Members in each of its business streams and will have published them on the internet	**met**	This phase of the work on patient experience is now complete. Patient experience will be taken forward under a new strategic objective for 2012-13, which takes account of the research undertaken as part of this objective. In relation to the measurement of patient experience, a number of actions have been undertaken. 'Touch points' have been identified for in-patient and community services within each business stream and discussed with the Chief Executive and Deputy Chief Executive. They have also been discussed with members of the wider leadership group including clinical colleagues. These touch points are the key points at which patients can be asked about their experiences at that particular point in their journey within our services, for example, referral into service or discharge from an inpatient to community setting. Six themes have been identified against which the Trust can assess its performance at each touch point. These include our information/communication and our staff attitude. Focus groups, including Trust membership and service users will be established to fully test the touch points as a key milestones for the 2012-13 objective. Work continues around the creation of an innovative and potentially marketing-leading approach to eliciting service user feedback and on academic research around Patient Experience in the NHS. Opportunities around this for the future will be explored in 2012-13.

Knowsley Integrated Provider Services

The following quality and safety priorities were established in March 2011, prior to KIPS transferring into the Trust.

Quality & Safety priorities & indicators 2011-12	Outcome	Commentary
Safety **Care Campus (Intensive Support Team)** The purpose will be to manage people with complex health and/or social care needs contributing to the overall plan to reduce health inequalities, unscheduled admissions to hospital and improve self care and self management throughout the Borough	**partially met**	KIPS has developed a multi-disciplinary approach to case management resulting in the delivery of fully coordinated quality care at an Intensive Support to people with complex health and/or social care needs. The service specification was received from Commissioners in December 11 regarding further requirements for the care of patients with Intensive Support needs. KIPS is now working jointly with commissioners on an implementation plan and workforce changes required to deliver the full care model by May 2012.
Effectiveness **PARIS** This is the KIPS solution to ensure a move towards a single electronic record for all service users	**met**	During 2011–12 KIPS has commenced the implementation of the PARIS system and continues to develop PARIS as the electronic patient record system.
Experience **Centre for Independent Living (CIL)** This provides a wide variety of services which can help individuals to live an independent life. With its own open plan showroom, patients and service users can drop in and try out a range of stair lifts, chairs, beds, mobility, bathing and toileting equipment	**met**	The CIL opened to service users in February 2011. The Centre is a collaboration of statutory and third sector organisations with a user-led management committee providing a variety of services to promote independence. KIPS Independent Living and Design Team, Equipment Store and Wheelchair services are embedded in the partnership.

3.2 Achievements against Monitor Targets 2011-12

On a monthly basis throughout 2011-12 the Trust reports progress against the Monitor compliance targets. Many of the targets relate to safety, service user experience and effectiveness of care. Our performance is as follows:

Monitor Targets 2011-12	Threshold	Year End Position
Monitor Mental Health and Learning Disability Targets Reported throughout the year		
Patients seen, treated and discharged within 4 hours of arrival at A&E **Quality Rationale** To reduce the time that patients wait to be seen, treated and discharged in A&E departments.	95%	99.89%
Patients receiving contact within 7 days of discharge **Quality Rationale** Evidence shows safer outcomes for patients who receive early follow-up by staff following discharge	95%	98.1%
Patients having a formal review with their care co-ordinator within 12 months **Quality Rationale** Effective care co-ordination facilitates access for individual service users to the full range of community support they need in order to promote their recovery and integration	95%	95.3%
Minimising delayed discharge/ transfer of care **Quality Rationale** The patient experience is adversely affected by delayed discharges once they are fit to be discharged	No more than 7.5%	3.3%
Access to Crisis Resolution/ Home Treatment **Quality Rationale** To ensure patients receive a speedy and effective 'step up' in the support and treatment they receive, yet avoiding hospital admission	90%	99.6%
Meeting commitment to serve new psychosis cases by early intervention teams **Quality Rationale** Patients that are detected and diagnosed with a first episode of psychosis by Early Intervention teams gain prompt and appropriate treatment and it reduces their duration of untreated psychosis	95%	107.6%
Data completeness: Identifiers **Quality Rationale** Data completeness enables the monitoring of outcomes for individuals in terms of morbidity, quality of life and user satisfaction with services	99%	99.4%

Monitor Targets 2011-12	Threshold	Year End Position
Monitor Mental Health and Learning Disability Targets Reported throughout the year		
Data completeness: outcomes **Quality Rationale** Mental health minimum data set (MHMDS) data completeness enables the monitoring of outcomes for individuals in terms of morbidity, quality of life and user satisfaction with services	50%	
Valid employment status		98.0%
Valid accommodation status		97.7%
HONOS assessment in the past 12 months		77.6%
Monitor Community Care Indicators – Reported from Quarter 3, October 2011		
Community Treatment Activity - Referrals	No threshold	69.6%
Community treatment activity – Care contact activity	No threshold	99.7%
Identifier Information	No threshold	78.6%

From October 2011 Monitor established new reporting requirements for foundation trusts that had acquired community services. There are seven areas to the data completeness reporting - the three above which have been reported since quarter three, and a further four that do not require reporting against as Trust systems do not routinely capture the information. These are:

- Referral to Treatment Times - AHP Lead in the Community
- Patients dying at home
- User experience
- Venous leg ulcer treatments.

Monitor Compliance Framework for Walk-In Centres A&E 4 Hour Wait Time

Walk-in Centre	Target and Threshold	Reported			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Halewood	A&E 4 Hour Waiting Time Target: ≥ 95%	99.92%	100.00%	100.00%	99.98%
Huyton		99.93%	100.00%	100.00%	99.80%
Kirby		99.99%	100.00%	100.00%	99.93%
Trust Overall		99.95%	100.00%	100.00%	99.89%

The Trust has three Walk-in Centres as part of our Integrated Community Services, seeing approximately 70,000 patients per year. Their aim is to reduce pressure on A&E services by dealing with minor injuries plus advise and provide treatment for non-life threatening illness. Patients are assessed and treated to discharge or onward referral.

Walk-in centres are subject to the same 4-hour wait target as applied to Accident and Emergency departments. The above table demonstrates the Trust's achievement of all reported targets in 2011-12. The Trust monitors and reports performance against these targets on a monthly basis and these tables alongside further detailed information is reported as part of the Trust's monthly performance report.

3.3 Trust Quality Measures

In addition to the quality priorities we have established for 2012-13 in **Part 2**, and reporting against the 2011-12 quality priorities in **Part 3.1**, the Trust has also established a set of quality measures.

When selecting the Quality Measures we wanted to ensure that we were measuring quality across our different client groups. As a result of acquiring KIPS in April 2011 the quality measures were revised.

These measures cover in-patient and community mental health and learning disabilities and community services across our business streams (listed below) and fit to the same domains of patient safety, patient experience and clinical effectiveness:

- Later Life and Memory Services
- Adult Services
- Child and Adolescent Mental Health Services
- Forensic Services
- Learning Disability Services
- Community Services (KIPS).

The progress of all the quality measures are routinely reported to the Trust Board. The following table shows our progress during 2011-12:

Trust Quality Measures 2011-12 (using March 2010-11 average as the base line, against 2011-12 average)

Domain	Indicator to be measured	RAG Status against March 11 Baseline	March 2011 Base figure	Current Position	Data Source	Detailed Definition
Patient Safety	Proportion of incidents with an account of no harm (Trust)	↑	75.2%	77.1%	Internal Reporting	The percentage of incidents that had an outcome of no harm. Year-on-year improvement
	Healthcare Associated Infections – MRSA Bacteraemia (Trust)	↔	0	0	Department of Health Vital Signs Monitoring Health Protection Agency	Number of MRSA infections that are hospital or community acquired
	Healthcare Associated Infections – C Diff (Trust)	↔	0	0		Number of C Difficile infections that are hospital or community acquired
	The reconciliation of medicines for patients on admission to services (MH / LD)	↑	85.8%	94.2%	Internal Reporting	A process undertaken to ensure medicines prescribed on admission correspond with those that the patient was taking prior to admission

Domain	Indicator to be measured	RAG Status against March 11 Baseline	March 2011 Base figure	Current Position	Data Source	Detailed Definition
Patient Experience	Number of Compliments (Trust)	↑	21	88	5BP Service User Experience Survey	Expression of satisfaction received verbally or written
	Number of Complaints (Trust)	↑	15	20	Internal Reporting	Monthly expression of dissatisfaction requiring a response that could not be resolved locally within 24 hours
	Satisfaction with our services (Trust)	↑	87.9%	89.2%		Percentage of patient experience questions that were scored as Excellent or Good
Effectiveness	Increase in HONOS (in-patient) assessment scores (MH / LD)	↔	92.3%	92.3%	Internal Reporting	Percentage of patients who have had both an admission and discharge HONOS who are showing an improvement
	Breastfeeding (KIPS)	↑	19.1%	20.7%	Quality Tracker	The target is a Knowsley Health and Well-being target
	Immunisations (KIPS)	↑	Figures combined with NHS Knowsley in 2010-11 (methodology changed mid-year)	91.98%	Quality Tracker	Immunisation - Compliance with schedule for those children choosing to have immunisations in clinics by KIPS team

3.4 Trust-wide Achievements

3.4.1 What we do well

Section three of this report has presented quality and safety achievements for the Trust realised throughout 2011-12.

There are several sources of valuable external feedback regarding what the Trust does well. Our Quality Account and our measurements have been informed by:

- National Patient Survey feedback (**Appendix 2**)
- Trust Patient Experience Survey (**Appendix 3**)
- CQC Trust Quality and Risk profile 2011-12.

Areas identified for improvement from each of these sources are included in the Trust Improvement Action Plan 11-12.

3.4.2 Infection Prevention and Control

Continuous monitoring is undertaken by the Trust to ensure that it remains compliant to regulations in relation to cleanliness and infection control. This involves a rigorous programme to prevent MRSA, C. Difficile, and other serious infections in the Trust. This work is championed by our Nurse Consultant in Infection Prevention and Control. The Infection Prevention and Control Team believe that service user involvement in infection prevention and control is crucial to ensure that they are actively involved in this important agenda. Examples of service user involvement include auditing practices on wards such as hand hygiene, cleanliness of environment and equipment, undertaking unannounced spot-checks at the Trust, contributing to policy and patient information leaflet development.

The Trust is required to report on MRSA bacteraemias on a monthly basis. There have been no instances during 2011-12.

3.4.3 National Award-winner

For the second year running the Trust won a prestigious Nursing Times Award – this time in the 'Nursing in Mental Health' category.

The award, which recognises individuals or teams who have developed initiatives that have improved the delivery of mental health care, was presented to Advanced Practitioner in Personality Disorder, Gary Lamph.

Gary has developed an ambitious Personality Disorder Strategy, which sets out to develop strong seamless links between mental health services and the wider system for the benefit of people with Personality Disorder.

The design and implementation of this revolutionary and entirely unique low-cost multi-agency model was led by Gary.

Fully integrated both multi-agency representatives and Experts by Experience (known as EBEs), who are people with lived experience of Personality Disorder, into the development and delivery of the model. The model has no equivalent nationally.

In a UK first, EBEs and Experts by Occupation (EBOs) from mixed multi-agencies who lend their time without any additional costs have jointly delivered Personality Disorder Awareness Training to practitioners. Together they are equipping partners with the tools they need to work more effectively with this vulnerable client group and use evidence-based timely interventions. Doing so has the potential to reduce the risk of transition of people with Personality Disorder to secondary mental health care.

3.5 Workforce Development and Learning

3.5.1 Bringing our Values to Life

Our Trust Values were launched in March 2011. To ensure they are effective and support us to develop a strong, shared culture, and to fully embed them across the organisation an implementation programme has been developed. The key strands of which are: communication and promotion; team values sessions and the development of team charters; incorporating our Values into the Performance and Development Review (PDR) experience and our staff recognition schemes.

Our Values are central to improving the quality of our staff and patient experience. The development of Team Charters throughout our Trust will demonstrate a clear commitment by team members to live our Values consistently. When staff feel valued, respected and their contribution is recognised by their colleagues this results a higher level of team performance and consequently an enhanced experience for our patients and service users.

Similarly, when an individual's contribution is acknowledged and recognised both during their PDR and through the Trust's recognition schemes, this will lead to higher levels of performance and an improvement in the services we provide.

3.5.2 The Development of a Coaching Culture

As part of the Trust's response to the feedback received from our Values workshops, a programme has been developed to support a culture of coaching and coaching conversations throughout the organisation. The aim of our coaching programme is to promote a culture of personal responsibility, engagement and empowerment. By encouraging more involvement in decision-making, and improved innovation and creativity, this will lead to our staff taking greater ownership for the decisions that are made. Enhanced levels of personal responsibility will lead to higher levels of quality of the services that are delivered.

3.5.3 Advancing Quality Programme

Advancing Quality is a quality initiative that has been in existence since 2010 within mental health and the basic principle of Advancing Quality is that interventions are provided at the right time, every time, for all service users.

NHS North West has coordinated work across North West Mental Health Trusts and have devised a number of common measures to drive improvement in relation to Dementia care and Early Interventions in Psychosis.

Through this work a number of quality statements have been developed that are now being used to measure the care a service user receives on discharge from mental health services.

The measures are based on simple, evidence-based interventions and are designed to ensure that services provide consistent high quality care for all.

Further details of the interventions measured can be found in **Appendix 7**.

3.5.4 Patient Safety Framework 2011-12

To ensure that our quality and safety activities are co-coordinated across the different parts of the Trust, we have developed our Patient Safety Framework which consists of:

- Patient Safety Panel (challenge meetings around SUI reports)
- Monthly Safety and Quality Metrics Report (all safety incident reporting in one report)
- Executive-level walkabouts to visit clinical services
- Thematic review of Serious Untoward Incidents using the Safer Mental Health Checklist
- Proactive use of the Safer Mental Health Checklist for open case loads resulting in actions to enhance patient safety
- Monthly Business Stream Risk Reports that include data and analysis of incidents, risks, complaints, claims, audits and CQC compliance
- Targeted improvement plans for each Business Stream to reduce the number of incidents that result in harm
- Clinical Quality Dashboard to feedback key data to frontline staff.

3.5.5 Involving Service Users in Patient Safety

Service Users and carers are seen as a vital component of the Patient Safety Framework. They are involved in the following ways:

- Membership of the Clinical Governance & Clinical Risk sub – board Committee
- Membership of the monthly Patient Safety Panel meetings
- Acting as Serious Incident reviewers.

By involving service users in the patient safety framework and taking into account their insight and experience, we have been able to improve the quality of the actions we implement to enhance patient safety within the services we provide.

3.5.6 Involving Service Users in Other Trust Business

The Trust is committed to providing opportunities to involve service users, carers and members of the public (volunteers) in our business. We acknowledge the unique contribution to services through their experience of living with a health problem and using health services, personally or in a caring role. This expertise is not available from any other source.

The Trust has developed an Involvement Scheme designed to provide a safe and efficient process to enable volunteers to become involved in all stages of designing, delivering and monitoring Trust services.

Recent work undertaken by volunteers includes:

- Community Groups training staff
- Production of awareness-raising DVD
- Participating in Trust groups including:
    - Capital Planning
    - Spirituality Group
    - Care Plan Working group
    - CAMHS modernisation
    - Documentation Review
    - Charitable Funds Committee
- Attending IMROC (Implementing Recovery - Organisational Change)
- Delivering induction training
- PALS Volunteers
- Undertaking ‘Deep Dive’ audits
- Delivering doctors’ training
- Supporting ward staff
- Participating in ‘Time to Care’ project.

(This is not an exhaustive list.)

In 2010, there were 733 Involvement Opportunities carried out by volunteers and in 2011 this rose to 1,184 - an increase of 61%

3.5.7 Creating Time to Care

Creating time to care was established in 2011 from a strategic objective to improve and enhance time with service users. After a trust-wide staff and service user engagement process key projects were selected for implementation.

Productive Mental Health Wards

Productive Mental Health Wards was developed by the Institute for Innovation and Improvement. The Programme aims to energise and motivating frontline teams whilst teaching them tools and techniques which they can use to enable improvements within their own working environments.

The programme works in alliance with senior management, frontline teams and service users to foster a culture of continuous improvement in quality, safety, value and cost-effectiveness.

During 2011-12 three showcase wards have been implementing the programme and have successfully completed the foundation modules. This has led to a number of noticeable improvements on these wards including improved environment, increased therapeutic interventions and reduction in medical errors. The introduction of Patient Status at a Glance Boards on two of the wards has enabled staff to have confidential visual management of patient information, which reduces interruptions, improves the quality and safety of handovers and reduces errors. Each ward has set five quality metrics which are reviewed weekly and monthly improvement goals are implemented by the team. The ultimate aim of the Productive Programme is to release time spent on non value-added activities and reinvest in quality direct care time.

The showcase teams have commenced the process modules which aim to improve the processes on the wards that support safe and effective delivery of care.

Productive Community Services

The Productive Community Programme follows the same principles as the productive Ward programme, but has been adapted to meet the requirements of community settings. One community team has piloted the programme and has made a number of improvements including the introduction of a Duty Doctor and Clinical Patient information board, which has greatly enhanced multi-disciplinary working.

Mental Health Passport

Mental Health Passports aim to enhance the experience of service users in in-patient services by actively engaging service users and carers in care planning and enabling them to share personal information which is important to them. A champions group is currently working on a standardised approach to the implementation of passports across the Trust.

Documentation Rationalisation

Accurate and timely documentation of care is a cornerstone of providing safe, meaningful and effective care. The Business Transformation Team has been working collaboratively with frontline teams to explore areas

where documentation can be rationalised and improved to support effective documentation and release time to provide face-to-face care.

Creating Time to Care was established in 2011 from a strategic objective to improve and enhance time with service users. Initiatives and projects commenced inclusive of qualitative measures and improvements.

3.6 Feedback from External Scrutiny

3.6.1 Response to issues raised by Regulators or Public Representatives in the last year

This section provides information about our registration with the Care Quality Commission (CQC) and any monitoring the CQC has undertaken with the Trust in the past year. It also provides information about the Quality Account requirements for Monitor.

3.6.2 Care Quality Commission

Since April 2010 the Trust has been registered with the Care Quality Commission for the locations and types of services provided by the Trust. Changes to the registration during 2011-12, included the transfer of services from Knowsley Integrated Provider Services, and their three registered locations.

The registration and compliance to the 16 essential standards of quality and safety have been monitored, scrutinised and reported throughout the year via the Corporate Report and the Safety and Quality Metrics Report, as part of the Trust's continual compliance cycle.

In addition, the above reporting is linked to the CQC's Quality and Risk Profile; a document that is released routinely throughout the year by the CQC. The profile captures all that the CQC know about the Trust in one document, and provides a view of how the Trust is performing against the 16 Essential Standards of Quality and Safety.

The table below shows the Trust's position as at the end of March 2012.

Section	Outcome	Mar-12
Involvement and information	1: Respecting and involving people who use services	Green
	2: Consent to care and treatment	Green
Personalised care, treatment and support	4: Care and welfare of people who use services	Green
	5: Meeting nutritional needs	Green
	6 Cooperating with other providers	Green
Safeguarding and safety	7: Safeguarding people who use services from abuse	Amber
	8: Cleanliness and infection control	Green
	9: Management of medicines	Green
	10: Safety and suitability of premises	Green
	11: Safety, availability and suitability of equipment	Green
Suitability of staffing	12: Requirements relating to workers	Green
	13: Staffing	Green
	14: Supporting workers	Green
Quality and management	16: Assessing and monitoring the quality of service provision	Green
	17: Complaints	Green
	21: Records	Green

The Trust has had two Care Quality Commission inspections at Auden Unit and Willis House. As a result of the reports, the Trust has self-assessed itself as 'Amber' until assurance can be established that compliance with safeguarding can be demonstrated across the Trust.

The Trust responded to the Care Quality Commission's reports with an action plan which is now fully completed for the Auden Unit, and since their inspection, Willis House in-patient unit has closed as part of the Trust's redesign of services.

From an organisational perspective the Trust needs to feel confident that its safeguarding processes are meeting the needs of all our service users. The Trust has put a programme of work in place to assess itself, as part of a trust-wide programme of learning for safeguarding.

The findings from this work will inform any areas of improvement, which we will act upon. We expect our self declaration to return to 'Green' once any actions have been implemented.

3.6.3 Monitor Reporting Requirements 2011-12

Monitor is the regulator of Foundation Trusts and it is required that we publish the following in our Quality Account:

- The Director's Statement of Responsibility (**Appendix 4**)
- External assurance on the content of the Quality Account to ensure it is in line with Monitor's requirements and is consistent with other information (**Appendix 5**)
- External assurance on two mandated performance indicators in the Quality Account: (Any one of the following to be determined by the Council of Members)
    - 100% CPA patients receiving follow up within 7 days of discharge from hospital
    - Minimising delayed transfers of care
    - Access to Crisis Resolution Home Treatment
- Assurance on one locally-selected quality priority indicator in the Quality Account to be agreed by the FT governor/ membership.

3.6.4 Care Quality Commission Mental Health Act Commissioner

The Trust has a dedicated team of Mental Health Law Administrators who work across the Trust and who are the primary link with the Care Quality Commission in relation to the work of its Mental Health Act Commissioners. The Commissioners regularly visit wards to ensure compliance with the provisions of the Act. The Mental Health Act administrators - in partnership with clinical staff - ensure that all elements of the operation and implementation of the mental health legislation are processed in accordance with the requirements of the Act.

A Mental Health Law Implementation Group comprising the administrators and clinical and managerial staff, undertake monitoring of the implementation of the legislation and other operational issues.

In addition, Associate Hospital Managers (who are independent lay people) are an integral part of the operation of the Act. They undertake the duties of the Trust Board for the purposes of hearings and reviews in relation to the detention of patients and are also involved in the operation of this Mental Health Implementation monitoring Group.

3.6.5 External assurance report against Monitor indicators

See Auditor's report - **Appendix 5**

3.6.6 External assurance report against the Quality Account

See Auditor's report – **Appendix 5**

3.7 Engaging with and Listening to Service Users and Local Groups

3.7.1 Engaging with Service Users and Carers

The Trust engages with service users and carers through a variety of ways including through face-to-face contact with staff; membership of our Foundation Trust and Council of Members, and Forums linked to our six business streams (Adults, Later life and Memory Service, Learning Disability, Child and Adolescent Mental Health, Forensic, KIPS Community Services). Executive and Non-Executive Directors, and other Senior Managers attend the Forums for 'Take it to the Top' which offers an open question and answer session and updates on strategic business.

In September last year, Jason Wolf from the Beryl Institute based in the USA visited the Trust during his 'On the Road Tour'. Jason aimed to identify exemplar Patient Experience initiatives and share them through the Institute's website. In his online diary following his visit Jason made reference to the Trust's 'Take it to the Top' sessions.

He said that what stood out in learning about this program was how the service users described the event: "Any Chief Executive who would open himself up for a potential barrage of the unknown in order to bring his facility closer to the needs of the community is a significant action and as one person stated a particularly brave undertaking. This modelling of expected behaviour is one of the best examples I have seen in healthcare of a willingness to step out and engage in a conversation of patient and community needs. By providing people direct access to the top and ensuring honest and straightforward answers, the leaders make a statement about how all staff should behave in engaging with patients, families and the community."

Jason also highlighted other work undertaken by the Trust including the Big Brother Booth, the Personality Disorder Hub Experts By Experience Programme and the Involvement Scheme.

3.7.2 Overview and Scrutiny Committees

The Trust links with five Overview and Scrutiny Committees on health issues and proposed developments of the Trust. The Quality Account has been shared with Local Involvement Networks (LINks) and Overview and Scrutiny Committees and they have been invited to contribute to the 2011-12 Quality Account.

Appendix 1 contains supporting statements from a range of external organisations. This includes:

- The Commissioning PCT
- LINks Groups
- Local Authority Overview and Scrutiny Committees.

3.7.3 Engaging with Third Sector Organisations

The Trust works closely with a wide variety of Third Sector organisations including:

- LINks in Halton, Knowsley, St Helens, Warrington, Wigan, Sefton and Liverpool
- Trans Resource Empowerment Centre supported the development of the Trusts Transgender policies
- Lesbian and Gay Foundation - Providing staff training and policy advice
- Carers Centres and Groups were involved in the development of a Carers Booklet
- Remploy, Richmond Fellowship and Warrington Disability Partnership provide employment support to staff and service users
- Breakthrough Art in Mental Health have provided national opportunities to promote artwork produced by our service users
- Newfound Theatre Group were involved in the launch of our Carers Champions
- No Secrets - Self Harm Support Group deliver training to staff
- Knowsley Older Peoples Voice has been actively involved in the response to the NPSA Alert regarding Syringe Drivers.

3.7.4 Further examples of Engagement and Responsiveness

3.7.5 How can we improve? – ask 'Big Brother'

Having previously piloted the use of our portable 'Big Brother Booth' within our community settings, during the reporting year we gave our in-patients at our hospital at Hollins Park in Warrington the opportunity to feedback on the quality of our services on camera. This included traditionally hard-to-reach audiences including people in our learning disability settings.

For the first time we also used the booth to hear from people who have received healthcare from our newly-acquired Knowsley Integrated Provider Services.

The Booth continues to be a key tool in our award-winning campaign to challenge stigma. We are now working with schools and young people to capture their views both before and after they have received the lessons that are incorporated within our educational packs.

3.7.6 Sticks and Stones Campaign

Our 'Sticks and Stones' campaign to challenge mental health and learning disability-related stigma received two commendations in 2011, from the Association of Healthcare Communications and Marketing and ChaMPS Public Health Network.

During the reporting year we succeeded in achieving a very specific behavioural goal designed to improve the mental well-being of our service users - collecting 106,577 pledges on our online petition not to use words like 'nutter' to describe people with mental ill-health and learning disabilities.

We created 2.3 million opportunities for people to read stories about mental health and learning disabilities in the media – helping to reduce stigma by promoting greater public awareness and understanding of conditions like Personality Disorder.

Specially-designed educational packs produced with the input of teacher volunteers are currently being delivered in schools across our footprint. The packs include lesson plans and activities for children aged four to 16 - supporting teachers to improve the quality of education young people receive around mental health and learning disabilities.

We have increased our Corporate Partnership membership to more than 30 employers – working with them to embed the campaign values within their workplaces and improve the quality of support they provide to employees with mental ill-health.

3.8 Key messages from external stakeholders for 2011-12

3.8.1 Messages from St Helens OSC

- Support the quality priorities identified for 2012-13
- Would welcome further updates of progress against the priorities indicators throughout the year
- Would welcome information specific to St Helens
- Areas of interest are patient safety, falls and safeguarding.

3.8.2 Messages from Warrington LINks

- Keen to see that the Trust is placing emphasis on listening to patient and carer experiences and focussing on capturing lower-level concerns
- Would like to receive progress reports throughout the year as opposed to a once a year event
- Happy that the matrons' role is being reviewed with a view to delivering the quality agenda.

3.9 Benchmarking against other organisations

Where possible the Trust engages in benchmarking with similar organisations. Examples of this include:

- Trust membership of the North West Performance Benchmarking group (which looks at activity data and quality initiatives such as CQUIN)
- Collaborative working with the North West Mental Health Clinical Audit Network
- Collaborative working with the North West Mental Health NICE Group - working to establish reporting against NICE quality standards
- The Trust uses benchmarking data from the National Patient Safety Agency (NPSA) to provide baselines and definitions of harm
- The incident reporting quality measure and thresholds are based on NPSA benchmark data
- From Benchmark data provided by the National Patient Safety Agency (NPSA) the Trust continues to be a high reporter of incidents in the past year in comparison with other Mental Health Trusts
- The data provided from the National Patient Survey (**Appendix 2**) is benchmarked against the top 20% NHS Mental Health Trusts and the bottom 20% of NHS Mental Health Trusts to provide context and comparisons for staff and service users
- Participation in the Employers' Forum Disability Standard
- Completion of the North West NHS Equality Performance Improvement Toolkit.

Appendices

Appendix 1 - Supporting Statements

Clinical Governance and Clinical Risk Committee

The Clinical Governance and Clinical Risk Committee is one of the two sub-committees of the Trust Board which delegates authority to ensure that appropriate structures, systems and processes are embedded in the organisation to manage patient safety and clinical risk and ensure that services are continuously improving. The Committee reports to the Board following each of its meetings who also formally receive the committee's minutes. The Committee has close links with the Trust's Audit Committee and communicate directly with them over key issues by way of a verbal report from the Chairman who is a member of both committees.

During 2011-12 closer links have been forged with the Members Council by way of the service user representative and, more recently, the Chair of the Compliance with Authorisation Committee. Standing items on the agenda include detailed scrutiny of: serious untoward incidents; compliance with the Care Quality Commission Essential Standards for Quality and Safety; and a Patient Safety Dashboard which displays integrated patient safety data. This enables the Committee to inform the Trust Board of any lapses and ensuring appropriate actions are taken to address any deviation from accepted standards.

The committee was subjected to review by the Trust's internal auditors in 2012 and their results gave an assessment of "substantial assurance" for the Trust on the operation of the Committee.

Dr Colin Dale
Non-Executive Chair Clinical Governance & Clinical Risk Committee

Quality Account – 5 Boroughs 2011/12

In reflection on the year 2011/12, I believe the Trust's quality management processes have continued to evolve positively both in the measures developed and utilised and in the transparency of the monitoring process.

Quality management receives strategic leadership and reports are routinely submitted to the board. External scrutiny is delivered by a quarterly quality review group chaired by the Commissioning lead for Mental Health, NHS Knowsley and draws membership from associate PCTs. This group has reviewed a number of quality measures and has undertaken a 'deep dive' into a range of clinical areas including Learning Disability Services and Adult Services during 2010/11. The consistent pattern evident is of an organisation that has quality management at its core.

Quality management is a continual evolving cycle in which all involved need to seek to challenge whether systems are robust to drive clinical quality. The Trust has shown a willingness to facilitate such challenge and responded positively. There were instances arising in 2011/12 relating to ward design and environmental safety that are subject to ongoing consideration to ensure the highest standards of patient safety is achieved. The Trust and commissioning bodies are seeking to ensure that appropriate capital investment in infrastructure is deployed based on robust environmental risk assessment.

During 2011/12 the Trust agreed a number of quality improvement measures, known as CQUINs, which generated a payment for achievement. This is the third year of such an arrangement. These measures cover a range of topics and are challenging and include system redesign. The Trust has maintained an appetite to deliver such challenging quality improvement measures and sustain them. The Trust with partners have developed and taken forward plans for system redesign which have the quality of care delivery at heart. These will be implemented early in 2012/13.

Commissioning arrangements and relationships are changing during 2012/13 as a result of changes to commissioning roles and responsibilities resulting from legislation. During this transition all commissioning bodies remain committed to work with the Trust to support it further in its attempts to drive quality up further. Commissioners remain vigilant on quality and governance issues and will continue to monitor these areas closely.

Mr C Vose
Sub-Director for Mental Health and Learning Disabilities, Knowsley Health and Well-being

NHS Merseyside

2011/12 Quality Account
NHS Merseyside Statement

In line with the NHS (Quality Account) Regulations 2011, NHS Merseyside can confirm that we have reviewed the information contained within the account and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and is accurate in relation to the services provided. We have reviewed the content of the account and can confirm that this complies with the prescribed information, form and content as set out by the Department of Health.

As Director for Service Improvement and Executive Nurse for NHS Merseyside I believe that the account represents a fair and balanced view of the 2011/12 progress that 5 Boroughs Partnership NHS Foundation Trust has made against the identified quality standards.

Overall NHS Merseyside is supportive of the process 5 Boroughs Partnership NHS Foundation Trust has taken to engage with patients, staff and stakeholders in developing a set of quality priorities and measures for 2011/12 and applaud their continued commitment to improvement.

Trish Bennett
Director of Service Improvement & Executive Nurse, NHS Merseyside

Warrington LINk Statement

5 Boroughs Partnership NHS Foundation Trust Quality Account 2011-2012

The Warrington LINk welcomes the opportunity to be able to comment on the Trust's Quality Account. Warrington LINk and the Trust have a good relationship with LINk members and staff involved in various meetings within the Trust. The LINk agrees with the Trust's main improvement priorities for 2012/13.

The LINk welcomes the Falls Strategy that the Trust plan to develop across the Trust and will review its success in March 2013.

The LINk recognises the work 5BPS has done in engaging with service users and carers, especially on Care Plans and supporting carers, but welcomes the further actions that the Trust will undertake to further improve this and engage more with service users and carers.

The effective process of feeding in comments and issues raised by the LINk continues with the Trust. Monthly comments and issues are shared and within 20 days a response, with actions and outcomes, have been received. Over the last 12 months six issues have been raised by individuals and carers, and several issues raised by one carer regarding Kingsley Ward. A report was also produced documenting 29 service users and carers views on mental health services in Warrington. A response was received by 5BPS. Through the LINks Care Navigation Role a further four issues have been raised and dealt with. The majority of issues can be categorised as communication issues, attitudes of staff and access to services.

LINk members and staff have been involved in various meetings and groups within the Trust and will continue to be involved in 2012-13. Warrington LINks have contributed to Joint Service User and Carer meetings, PPI Meetings within the Trust, and have been involved in Equality and Diversity meetings.

Over the past year the LINk has undertaken one Enter and View visit, with more planned for 2012-13.

Other priorities for the LINk over the past year have been the continued work on the A&E Liaison Service Team. This will remain a priority in 2012 – 13. Another priority for the LINk in 2012-13 will be the new Acute Care Pathway, and engaging with service users and carers on the changes and any impact for them.

Produced by Warrington LINk
April 2012 KL

St. Helens LINk
5 Boroughs Partnership Quality Account Commentary

LINk welcomes the opportunity to provide commentary supporting 5 Boroughs Partnership Quality Account, 2011/12, provided to LINk in a timely manner and presented during a Q&A session on 2nd May.

During the last year LINk members attended various forums and Patient & Public Involvement Advisory Group and 5 Boroughs welcomed partnership-working and the challenges LINk provided.

The coming year's priorities for improvement are challenging and reflect issues community members, service users and LINk members want to see addressed. LINk accepts priorities about preventing falls and raising concerns as stated.

Shared Decision-Making, Person Centred Planning and communication is central to comments LINk gathered from service users and carers and key to quality. Many included actions can be achieved by service users and carers having good quality care plans; a 'cultural shift' is required of Trust staff to deliver this. Staff coaching/mentoring will help, but take time to become common practice.

The Trust has participated in work with Implementing Recovery through Organisational Change (ImRoc). In this Quality Account, its mention is minimal, focusing on broad processes with 'recovery' based on individuals and outcomes they wish to see.

A specific concern is the 'red' indicators in the National Patients Survey indicators, which were less in previous years.

LINk challenges the Trust to ensure that in service redesign and commitment to quality, focus is maintained on specific needs of the discrete areas they provide services to, by gaining further understanding of communities they serve.

Knowsley LINk

5 Boroughs Partnership Quality Account Commentary

Knowsley LINk welcomes the opportunity to provide this commentary in support of the 5 Boroughs Partnership Quality Account for 2011/12. The Quality Account report was provided to LINks in a timely manner and presented thoroughly during a question and answer session held in May.

During the last twelve months the partnership-working and challenges provided through Knowsley LINk has been welcomed by 5 Boroughs Partnership. Knowsley LINk members have regularly attended the Joint Service User and Carer Forum and Patient & Public Involvement Advisory Group; these have proved to be a good point of contact with the Trust.

We have also welcomed the opportunity to work closely with the Knowsley Integrated Provider Services who provide community-based services in Knowsley. Plans are in place to see this continue throughout 2012/13.

It is felt that the Priorities for Improvement identified for the coming year are both challenging and reflective of the issues community members, service users and LINk members are keen to see addressed. Shared Decision-Making and Person Centred Planning are very much at the heart of the comments Knowsley LINk have gathered from Service Users and Carers and are a key aspect of quality. It is also important to stress the need for clear communication between staff, service users and carers and the availability of information at the point of need in achieving the priorities that have been set. The priority focusing on the collection of Patient Experience information is also welcomed. Knowsley LINk members would be keen for progress in this area to be shared with LINk to support the ongoing monitoring of this priority over the next 12 months.

Knowsley LINk would also challenge the Trust to ensure that in service redesign and in their commitment to quality, a focus is maintained on the specific needs of the areas they provide services to - continuing to gain an understanding of the local communities which they serve.

Halton LINk
Your Health • Your Care • Your Say!

Halton LINk Statement

Boroughs Partnership NHS Foundation Trust
Quality Account 2011-12

"Members welcomed the Trust's commitment to share the report widely and to seek the views of the Halton LINk. Members appreciated the opportunity to be able to give feedback at a presentation to the Board on 22nd February 2012.

The LINk recognises and values the good work done by the Trust to gain the views of users and carers and we hope the Trust will continue to build on the relationships developed through frequent user and carer meetings and events.

The Trust has been cooperative with Halton LINk, with representatives attending the Patient & Public Involvement meetings and LINk Host meetings to share their experiences and to keep abreast of the activities the Trust carries out to involve the public with their work. We hope this on-going dialogue with all the LINks, within the geographical area covered by the Trust, is maintained.

The Halton LINk appreciates the improvements made during the past year and welcomes the Trust's list of priorities for the coming year including work to be done on preventing falls. We hope that on-going meaningful dialogue with service users, carers and the wider community will help the Trust ensure their priorities are achieved."

Wigan Borough Local Involvement Network
Health and Care Together
Wigan Borough Local Involvement Network
1st Floor Office CT3, Wigan Investment Centre
Waterside Drive, Wigan, WN3 5BA
Tel: 01942 705 522

Email: info@healthandcaretogether.co.uk

Health and Care Together response to Quality Account

Thank you for the opportunity to review your Quality Account for 2011/12. I have detailed below some points which Wigan LINk would be pleased to have incorporated in the report.

Comments on the Quality Account

Wigan LINk is pleased to read of the many improvements in the services provided by 5 Borough Trust - particularly where these are evidenced from surveys of users and their carers. Whilst there is an implication that standards are the same across all parts of the Trust, it would be helpful in future years to have a specific section of the document relating to each of the boroughs and actions by their respective Health and Well-being Boards and the relevant CCGs. Differing priorities in each area may make it difficult for the Trust to maintain common standards where funding priorities differ significantly.

The Priorities for Improvement in 2012/13, section **2.1**, do not seem to address the single amber indicator from the CQC outcomes: i.e. Safeguarding people who use services from abuse. A more explicit statement of what these shortcomings were and how they are being improved would have been helpful.

You indicate a number of actions to be undertaken in response to the findings of the 241 local clinical audits that have been completed. A useful further action point would be to report back on the percentage of actions achieved by the original target date and also to measure the length of any delay that does occur, along with the reasons for it. In essence the actions you choose to take are by implication the more important ones for your Trust and so it would be helpful to understand why they may not have been achieved.

Section **3.4.3** refers to your staff winning in the Nursing Times Awards – well done to all of them for the work that has been undertaken and we look forward to future references to the benefits that have accrued for patients from the implementation of the Personality Disorder Strategy.

It was good to note also in section **3.5.5** the level to which service users are now being involved in advising on improvements that affect their safety and the increase in Involvement Opportunities mentioned in section **3.5.6**.

Appendix 2 shows a good level of improvement in levels of Patient Experience, which is welcome.

Thank you for this opportunity to comment and we look forward to receiving your next Quality Account.

Yours Sincerely

Chris Arkwright
Chair of Health & Care Together, Wigan Borough LINk

HALTON BOROUGH COUNCIL

Re: 5 Boroughs Partnership NHS Foundation Trust Quality 2011/12

Thank you for the opportunity to comment on your Quality Account. The Health Policy and Performance Board has particularly noted the following key areas:

In 2011/12 the Trust identified three Quality and Safety priorities and indicators to be achieved by March 2012. These indicators were as follows:

Safety: Preventing avoidable harm
Effectiveness: Good physical healthcare
Experience: Ensuring a positive experience of care.

The Board was pleased to see that the Trust did successfully meet the desired criteria for each of these indicators.

The Board notes that during the period 1 April 2011 to 31 March 2012 the Trust received a total of 242 complaints. The main themes of complaints received were as follows:

- Treatment issues
- Communication
- Staff attitude
- Waiting times for appointments/access to services
- Records issues
- Service provision.

The Trust received a total of 1,013 compliments during the same period of time.

The Board notes that the Trust has been able to identify three quality priorities for 2012/13 which will demonstrate improvements in patient safety, patient experience and effectiveness of services. The three quality priorities are:

Safety: Falls – By October 2012 the Falls Strategy will be rolled out and by March 2013 the number of falls will have reduced by 10 per cent.

Effectiveness: Shared Decision-Making – Ensure that service users share in decision-making using such tools as the Triangle of Care.

Experience: Issues of Concern – By October 2012 establish methods of collating, reporting and acting upon issues of concern and compliments expressed by our service users and carers.

The Board welcomes these quality principles, which will address some of the complaints that have been received over the 2011/12 period.

It is noted that from the information received that the Trust has done significant work over the last 12 months to achieve good performance against a series of indicators - taking part in a number of clinical trials and receiving a National Award in Mental Health. Members welcome the opportunity to contribute to the Quality Account process and any opportunities to contribute further in the future.

Yours sincerely

Cllr Ellen Cargill
Chair, Health Policy and Performance Board

Knowsley Overview and Scrutiny Board

Commentary to the 5 Boroughs NHS Partnership Foundation Trust

The Knowsley Overview and Scrutiny Board welcomes the opportunity to provide a commentary on the 5 Boroughs NHS Partnership Foundation Trust Quality Account.

The Board has delegated responsibility for considering Quality Account to the Chair of the Overview and Scrutiny Board in consultation with the Lead and Deputy Lead Member for the Well-Being theme. A meeting was convened on Wednesday, 9 May to consider the Quality Account document received by the 5 Boroughs Partnership NHS Trust. The three members spent time considering the document and made a number of observations, which have formed the basis of the Board's commentary, as set out below.

We focused our discussions around three priority areas. Our first was the Trust's Improvement Priorities for 2012-2013 and the achievements highlighted over the previous year. We discussed where we thought work should be commended and whether there were areas where we felt more information may have been useful. Our final observations referred to the layout, style and format of the document - particularly focusing on how the document related to and/or involved the public.

We felt that the Trust's priorities for improvement highlighted specific areas where improvements should be made although, like other Quality Accounts, we were unclear as to the rationale behind them. In terms of last year's achievements we felt that the Trust's work around patient safety was good - particularly the Patient Safety Framework, which had been put in place to ensure quality and safety activities were co-ordinated. We felt that the Trust's work on training and workforce development was extremely positive - particularly the way service users had been involved in contributing to training practices. Similarly, we thought that the Trust's focus on service user involvement in patient safety and Trust business in general was commendable. Our only comment was that we felt it was important that the Trust ensured that patients and their carers/friends/relatives were at the heart of decision-making around a patients' care needs.

We were reassured to see that the Trust's action plan in response to the CQC inspection has now been fully completed. We agree that the Trust needs to feel confident that its safeguarding processes meet the needs of all service users. We felt that the Trust's performance against local and national targets was good and would like to see the thresholds for Monitor's community care indicators in next year's report.

We also hope that the Trust will begin to capture the information in relation to Monitor's four additional indicators - particularly the one which measured the number of patients dying at home.

We were interested to see the Trust performing well in terms of treatment time at Walk-In Centres but we hope that the Trust recognises that the quality of service provided at the Centres is equally important. We would be interested in seeing the trend in the number of patients treated at Walk-In Centres and the referrals made as a result in order to feel reassured that people are being provided with the high level of care that is expected of the Trust by the community.

We welcomed the use of tables, charts and diagrams and the three part approach to the report layout. However, we thought it would be useful if there was a glossary of terms and acronyms at the back to enable members of the public to make sense of the technical information. We also felt that the Knowsley Integrated Provider Services element was not given sufficient attention within the report and would have welcomed separate information on the two Providers for this year as we understood that the Trust was taking a phased approach to integration of KIPS into 5 Boroughs. Overall we thought that the report was informative and interesting and we would welcome the opportunity to receive updates on progress towards your improvement priorities in order to provide an informed and accurate commentary next year.

This commentary has been provided by Councillor Mal Sharp (Chair of Overview and Scrutiny Board), Councillor Bob Swann (Lead Member for Well-being) and Councillor Kay Moorhead (Deputy Lead Member for Well-being) on behalf of Knowsley Overview and Scrutiny Board.

Warrington Health and Well-being Overview and Scrutiny Committee

Re: Third party commentary to support 5 Boroughs Partnership NHS Foundation Trust Quality Accounts submission 2011-12

I am writing to express our thanks for your invitation to the Health and Well-being Overview and Scrutiny Committee at Warrington Borough Council and to submit comments regarding your Quality Accounts submission for the period 2011-2012.

I am pleased to confirm that - based on the knowledge we have of 5 Boroughs Partnership NHS Foundation Trust - we understand the report to be a fair reflection of the healthcare services provided.

The Committee welcomes future updates on the progress of the priorities set out in the Quality Account during 2012-2013 - in particular those which relate specifically to Warrington.

It is commendable to see the emphasis that the Trust places on listening to patient and carer experiences.

We look forward to continuing the positive relationship we have with 5 Boroughs Partnership NHS Foundation Trust and to working with you to ensure local healthcare continues to be robustly, fairly and relevantly scrutinised.

Yours sincerely,

Cllr Tony Higgins
Chair, Health & Wellbeing Overview and Scrutiny Committee

St.Helens Council

Date: 15 June 2012

Re: Commentary from St Helens Adult Social Care and Health Overview and Scrutiny Committee to support the 5 Boroughs Partnership NHS Foundation Trust Quality Accounts 2011/12

Thank you for taking the time to meet with representatives from the Adult Social Care and Health Overview and Scrutiny Panel and present your Quality Accounts for 2011/12.

On behalf of the Adult Social Care and Health Scrutiny Panel, I would like to confirm that the Quality Accounts have been thoroughly explained and it is my belief that the indicators set out are able to fully demonstrate the effectiveness of the Foundation Trust - particularly in respect of patient safety, clinical-effectiveness and patient experience.

We note the amber indicator around safeguarding people who use services from abuse and welcome the Trust's programme of work in place to assess itself as part of organisational learning for safeguarding. We look forward to seeing improvements in this area.

The Panel welcomes the Trust's priority areas for improvement and would ask if the Falls Strategy had been established in line with other health or social care providers. It was recognised that partnership-working across the borough was crucial to ensure that any strategy of this kind included input from both health and social care providers.

I look forward to continuing to work in partnership with you in the future and to being given the opportunity as a Scrutiny Committee to contribute to the Trust's Improvement Plan and future Quality Accounts.

Yours sincerely,

Councillor Anthony Burns
Chairman of Adult Social Care and Health Overview and Scrutiny Panel

NHS

11 May 2012

Warrington Health Consortium

Many thanks for sharing your Quality Account with us and asking for feedback. I shared the report with a number of colleagues to request their views on the account. One of the observations was around the lack of reporting around the following areas: 3.7.1; 3.9.1 and 3.9.2. The numbers around MRSA and C-Diff offer assurance that there are effective measures in place to ensure patients are not at risk. I must also congratulate you on your impressive number of compliments from 21 per cent to 88 per cent is a terrific achievement and the small increase of 4 per cent to 19 per cent for complaints is also a significant achievement.

A further observation around your Quality and Safety priorities is your intention to reduce the amount of falls by 10 per cent considering that at the last quality meeting there was a notable increase in the data with 18 reported falls in January to eight last month with a worrying trend from June – September last year when there was as many as 18 falls being registered. Is 10 per cent a sufficient reduction or should the Trust not be aspiring to reduce this further?

Regarding the Trust's quality measures I was disappointed that there was no mention around what measures you were hoping to implement to address a steady increase in the number of medication / controlled drug errors during the last 12 months and I wonder what actions will be taken to improve the steady increase in this area of patient safety.

I welcome the programme that you have put together regarding the patient safety framework - particularly your strong emphasis on the thematic review of serious untoward incidents Safer Mental Health Checklist and the emergence of a clinical quality dashboard to feedback to frontline staff are all significant improvements to ensure that there is a cohesive approach to ensuring that quality and safety are shared across the organisation.

The 'Creating Time to Care' strategic objective demonstrates a desire to address the core values of ensuring that the patient remains at the heart of care delivery. The productive ward programme has been recognised as an innovative programme, which will improve the patient experience but also offer an ideal opportunity for frontline staff to demonstrate their skills to make real improvements in the main domains of patient care quality, safety and cost-effectiveness. The inclusion of the five quality metrics, which are regularly reviewed, will identify areas for improvement by the team.

I also feel that the mechanisms in place regarding your proactive approach to seeking 'How you can improve' and reduce stigma are innovative and demonstrate the organisation's willingness to take on board comments from stakeholders where there are areas that may benefit from feedback to improve healthcare delivery.

From a primary care perspective there were some areas that I believe it would be beneficial to receive assurance on in the future, which would include access / location clinics; DNA rates; readmissions; quality of outpatient and discharge letters and adherence to prescribing policies.

Can I also add that one of the comments which I received from a primary care practitioner congratulated the Trust for their 'proactive and co-operative' way of working, which they believe has improved relationships with primary care and will lead to improvements in future developments of mental health provision for the local community.

I believe that this report offers a balanced view of the Trust's quality of care during the last 12 months.

Yours sincerely

John Wharton
Quality Manager

Appendix 2 - National Patient Survey Results 2011

Each year since 2004, all NHS Trusts providing mental health services have taken part in the Care Quality Commission National Patient Survey, which is designed to gather information about service user experiences and assess how Trusts are performing.

The findings of the 2011 survey are reported in two ways. The 'Standardised' version shows the Trust rated as about the same in all questions except one which was rated as 'better' - Does your care plan set out your goals?

In addition to the 'Standardised' results there is a set of 'benchmarked' results which identifies scores for each question and if the Trust is in the top 20 per cent, middle 60 per cent or bottom 20 per cent when compared to other Trusts.

Using the benchmarked approach the Trust has six scores in the bottom 20 per cent and 15 in the top 20 per cent, (Fig 1).

Fig 1. Top / Bottom 20 per cent responses to the National Patient Survey 2011

	Question – Red (Bottom)	5BP score	Threshold for lowest scoring 20 per cent
1	Do you know who your Care Co-ordinator (or lead professional) is?	78	79
2	Were you told that you could bring a friend, relative or advocate to your care review meetings?	74	74
3	Were you given a chance to express your views at the meeting?	81	81
4	Did you find the care review helpful?	68	68
5	Did you discuss whether you needed to continue using NHS mental health services?	64	67
6	In the last 12 months, have you received support from anyone in NHS mental health services in getting help with financial advice or benefits?	62	62

	Question – Green (Top)	5BP score	Threshold for highest scoring 20 per cent
1	Did this person listen carefully to you?	90	89
2	Were you given enough time to discuss your condition and treatment?	86	85
3	Do you think your views were taken into account in deciding which medicines to take?	74	74
4	Has a mental health or social care worker checked with you how you are getting on with your medication?	84	82
5	Can you contact your Care Co-ordinator (or lead professional) if you have a problem?	88	87
6	Do you understand what is in your NHS care plan?	76	72
7	Does your NHS care plan set out your goals?	65	64
8	Have NHS mental health services helped you start achieving these goals?	71	71
9	Does your NHS care plan cover what you should do if you have a crisis?	73	72
10	Before the review meeting, were you given a chance to talk to your Care Co-ordinator about what would happen?	74	74
11	Do you have the number of someone from your local NHS mental health service that you can phone out of office hours?	67	66
12	The last time you called the number did you have any problems getting through to someone?	89	83
13	Has anyone in NHS mental health services ever asked you about your alcohol intake?	71	70
14	Has anyone in NHS mental health services ever asked you about your use of non-prescription drugs?	54	52
15	Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?	74	66

Fig 2. The results from the Trust's Patient Experience Survey in March 2012 compared to most similar question from the 2011 National Patient Survey

Trust Patient Experience Survey (Community Mental Health Teams) Questions Numbers correspond to those on the actual questionnaire	National Patient Survey 2011 Questions	National Patient Survey 2011 Results	Trust Survey Per Cent of Good and Excellent
1 Dignity and Respect: In relation to dignity and respect, how would you rate the care and treatment you receive from our staff?	Did this person treat you with respect and dignity?	93	95
3 Your Care Plan: How do you rate the level of involvement you have in the development of your care plan?	Do you think your views were taken into account when deciding what was in your care plan?	72	88 
4 Care and Treatment: How well do you feel our staff deliver what is contained in your care plan?	Have NHS mental health services helped you start achieving these goals?	71	91 
5 Medication: How would you rate the information you have been given by our staff about your medication?	Were you given information about the medication in a way that was easy to understand?	72	87 
6 Staff: How would you describe the amount of time you were given to discuss your condition and treatment with the staff?	Were you given enough time to discuss your condition and treatment?	86	92 
7 Crisis: Have you been given a telephone number in mental health services to contact in an emergency?	Do you have the number of someone from your local NHS mental health service that you can phone out of office hours?	67	84 
10 Overall: Overall, how would you rate the care and support you receive from our staff?	Overall, how would you rate the care you have received from mental health services in the last 12 months?	72	94 

Appendix 3 - Trust Patient Experience Survey

Mental Health and Learning Disability

The Annual National Patient Survey provides data regarding patient experience. To gain a real-time understanding of service users' experiences of services we also operate an internal Patient Experience Survey.

The survey tool (questionnaire) was designed in partnership with service users; carers and staff from the Operations and Corporate Directorates.

Each business stream has adapted the wording and format of the survey tool to best meet the needs of their service users. Each survey covers 10 themes identified within the appropriate National Patient Survey (community or in-patient).

An easy-read version has been developed for use in Learning Disability Services and carers/families/advocates are invited to support the survey in Later Life and Memory Services and Learning Disability Services.

The common themes identified from the National Patient Surveys are:
1 In-patients. Service users are asked to rate the quality of their experience of:

- Admission
- Being treated with dignity and respect
- Cleanliness of the ward
- Quality of information
- Level of involvement in the development of care plans
- How well staff delivered what was identified in a care plan
- Information about medication
- Amount of time spent with staff
- Feeling safe while on a ward
- Their 'overall' experience while on the ward.

2 Community Services: Service users are asked to rate the quality of their own experience of:

- Being treated with dignity and respect
- Quality of information
- Level of involvement in the development of care plans
- How well staff delivered what was identified in a care plan
- Information about medication
- Amount of time spent with staff
- Provision of contact details for crisis support
- Information, advice or support relating to employment, training or further education
- Cleanliness of Trust premises
- Their 'overall' experience of receiving services.

Service users are asked to complete questionnaires as they are discharged from the ward and a percentage of service users are offered the questionnaires in community settings. During the past three months response rates from the in-patient surveys have averaged 64 per cent and monthly averages of 175 community surveys have been received.

The results are presented by Trust-wide in-patient, Trust-wide community and by business stream (Adults Services, Later Life and Memory Services; Learning Disability Services; Forensic Services and Child and Adolescent Mental Health Services) and by individual ward and team.

Each survey identifies further ways for service users to feed their experiences back to the Trust including Complaints and PALS. Each survey also promotes the Patient Opinion website where service users and carers are encouraged to describe their experiences in their own words. Postings from the Patient Opinion website are in the Trust's monthly Performance Report.

Examples of the 2011 Results

- Over 85 per cent of service users from in-patient services answered 'Good or Excellent' to the question relating to 'Medication' - How would you rate the information you have been given by our staff about your medication?

- Over 93 per cent of service users from in-patient services answered 'Good or Excellent' to the question relating to 'Safety' - How safe do you feel on your ward?

- Over 90 per cent of service users from community services answered 'Good or Excellent' to the question relating to 'Care and Treatment' - How well do you feel our staff deliver what is contained in your care plan?

- Over 91 per cent of service users from community services answered 'Good or Excellent' to the question relating to 'Staff Time' - How would you rate the amount of time our staff are able to spend with you?

- Over 99 per cent of service users from learning disability community services answered 'Yes' to the question relating to 'Dignity and Respect' - Do you feel _____ listened to you?

Knowsley Integrated Provider Services (KIPS)

A Generic Satisfaction Survey has been designed to gain patients' perception on the various services provided by KIPS.

The results are compared with the results from previous audits and compared to the standards set by the Commissioning for Quality and Innovation Payment Framework (CQUIN) targets.

The eight objectives of the Generic Satisfaction Survey are:

- Gain patients' perception of the staff delivering their care
- Gain patients' perception on the treatment they received
- Determine if patients' felt involved in the decisions about their care
- Determine if patients were given advice/information in relation to signposting
- Determine the overall satisfaction with care received
- Determine patients' understanding of the process for comments/suggestions or complaints
- Gain patients' perception of information/advice provided
- Assess aspects of patient's wellbeing and lifestyle.

Each individual service participating in the Generic Satisfaction Survey tailored the methodology to suit the needs of their service users.

A total of 42 services took part in the Generic Satisfaction Survey for September 2011 in comparison to 35 services in the previous survey undertaken in December 2010.

A total of 3,781 surveys were given to patients and 1,914 were returned - giving a response rate of 51 per cent compared to 42 per cent in 2010.

The survey also contained a number of questions to determine if aspects of patients' well-being and lifestyle were being addressed.

Each individual service used their own results to write conclusions, make recommendations and produce an action plan.

Appendix 4 Director's Statement of Responsibility

The Directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Account.

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

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011-12

- The content of the Quality Account is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2011 to May 2012

    - Papers relating to Quality reported to the Board over the period April 2011 to May 2012

    - Feedback from the commissioners dated 21 May 2012

    - Feedback from governors dated 10 May 2012

    - Feedback from LINks dated:

Halton LINks	2 May 2012
Knowsley LINks	10 May 2012
St Helens LINks	10 May 2012
Wigan LINks	4 May 2012
Warrington LINks	3 May 2012

    - The Trust's Complaints Report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated April 2012.

    - The latest National Patient Survey: Survey of people who use community mental health services 2011

    - The latest National NHS Staff Survey 2011

    - The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2012

- CQC quality and risk profiles dated:

Release 7 – April 2011	Release 12 – October 2011
Release 8 – May 2011	Release 13 – November 2011
Release 9 – June 2011	Release 14 – December 2011
Release 10 – July 2011	Release 15 - February 2011
Release 11 – August 2011	Release 16 – March 2011

- The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered

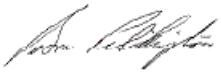
- The performance information reported in the Quality Account is reliable and accurate

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Account is robust and reliable; conforms to specified data quality standards and prescribed definitions; is subject to appropriate scrutiny and review and the Quality Account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account regulations published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Account (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board



..... Date...29/05/2012

Chairman

…….... Date...29/05/2012

Chief Executive

Appendix 5 Monitor External Assurance Statement

Independent Auditor's Report to the Council of Members of 5 Boroughs Partnership NHS Foundation Trust on the Annual Quality Account

I have been engaged by the Council of Members of 5 Boroughs Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of 5 Boroughs Partnership NHS Foundation Trust's Quality Account for the year ended 31 March 2012 (the 'Quality Account') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 (subject to limited assurance) consist of the national priority indicators as mandated by Monitor:

- Minimising delayed transfers of care
- Admissions to in-patient services had access to crisis resolution home treatment teams.

I refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Account in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that:

- The Quality Account is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual
- The Quality Account is not consistent in all material respects with the sources specified in Section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Accounts 2011-12
- 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 NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Accounts.

I read the Quality Account and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and considered the implications for my report if I became aware of any material omissions.

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

- Board minutes for the period April 2011 to May 2012
- Papers relating to Quality Accounted to the Board over the period April 2011 to May 2012
- Papers relating to Quality Accounted to the Clinical Governance and Clinical Risk Committee over the period April 2011 to May 2012
- Feedback from the Commissioners dated May 2012
- Feedback from Governors dated May 2012
- Feedback from LINks dated May 2012
- The Trust's Complaints Report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2012
- The latest national patient survey
- The latest national staff survey
- Care Quality Commission quality and risk profiles from 2011/12
- The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2012
- Any other information included in our review.

I considered the implications for my report if I became aware of any apparent mis-statements or material inconsistencies with those documents (collectively the 'documents'). My responsibilities do not extend to any other information.

I am in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. My team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Members of 5 Boroughs Partnership NHS Foundation Trust as a body, to assist the Council of Members in reporting 5 Boroughs Partnership NHS Foundation Trust's quality agenda, performance and activities.

I permit the disclosure of this report within the Annual Report for the year ended 31 March 2012 to enable the Council of Members to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law I do not accept or assume responsibility to anyone other than the Council of Members as a body and 5 Boroughs Partnership NHS Foundation Trust for my work or this report - save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000').

My limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- Making enquiries of management
- Testing key management controls
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Account
- Reading the documents listed above under the respective responsibilities of the Directors and auditors.

A limited assurance engagement is less 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 NHS Foundation Trust Annual Reporting Manual.

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

In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined

locally by 5 Boroughs Partnership NHS Foundation Trust NHS Foundation Trust.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that for the year ended 31 March 2012:

- The Quality Account is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual
- The Quality Account is not consistent in all material respects with the sources specified above
- The indicators in the Quality Account, subject to limited assurance, have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Accounts.

Julian Farmer
Officer of the Audit Commission

Audit Commission,
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Middlebrook,
Horwich,
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BL6 6QQ

25 May 2012

Appendix 6 Performance against CQUIN targets 2011-12

Mental Health and Learning Disability Services

Indicator Name	Goal	Year-end position
EFFECTIVENESS AND SAFETY		
Physical health screen and examination for people commencing on depot medication	All patients commencing on depot medication will receive a physical health screen and examination before commencement for those who have had no physical health screen and examination in the previous 12 months	Indicator met in all quarters
SAFETY AND EXPERIENCE		
Prescribing of major tranquilisers	Production of a report outlining the level of major tranquilisers prescribing for patients with a diagnosis of dementia	Indicator met in all quarters
Induction of new care pathway education programme	A series of 12 workshops for stakeholders including GPS outlining the new care pathway for dementia. Workshops will be held equally in each area (Ashton, Leigh and Wigan, Warrington, Knowsley, Halton, St Helens). Workshops will be scheduled to maximise participation from primary care professionals	Indicator met in all quarters
Carers Distress	To use a rating scale which is mutually acceptable to the Trust and the Commissioner and is evidence-based with carers to determine which interventions have the greatest impact on reducing carers distress	Indicator met in all quarters

Indicator Name	Goal	Year-end position
OUTCOMES		
Acute Care Pathway	To review the Acute Care Pathway and implement a new care pathway that results in demonstrably better access for service users and improved response times for General Practitioners	Indicator met in all quarters. Due to the delay in consultation stage this indicator has been re-negotiated to reflect this
SAFETY		
Harm Reduction	The Trust will systematically introduce processes with the aim of reducing four specific areas of harm in each of its business streams (excludes Forensic and KIPS as is covered in a separate contract)	Indicator met in all quarters
Safer Mental Health Checklist	Piloting of the safer mental health checklist (within adult services and in a named borough)	Indicator met in all quarters
Review of Risks and Absconds	Trust will submit a paper for the publication to a relevant professional journal and present the findings at a conference on the outcome of the pilot	Indicator met in all quarters
EFFECTIVENESS, QUALITY & EXPERIENCE		
Advancing Quality	To improve the quality of care delivered to patients in Dementia	Indicator met in all quarters
	To improve the quality of care delivered to patients in Early Intervention	Indicator met in all quarters

Indicator Name	Goal	Year-end position
PATIENT EXPERIENCE		
ESSEN Scale	To encourage the development of service developments / improvements informed by the output from previous use of the ESSEN Scale. Service developments should aim to improve the service user experience and clinical outcomes	Indicator met in all quarters
EFFECTIVENESS		
HONOS	The data submitted through this CQUIN will inform the future process of agreeing an appropriate tariff for secure mental health services	Indicator met in all quarters
EFFECTIVENESS		
Length of Stay	This CQUIN is intended to incentivise providers to better understand their current lengths of stay and develop strategies to reduce them	Indicator met in all quarters
EFFECTIVENESS		
25 Hours Meaningful Activity	This CQUIN promotes a balanced and structured day involving meaningful activity linked to service users agreed care plans that promote recovery. Implementation of CQUIN will enhance the experience of care and enhanced clinical outcomes	Indicator met in all quarters
Involvement, Choice and Responsibility	This CQUIN promotes the notion of service users and care staff working in real partnership in order that service users can move through a shared pathway in a timely manner. It is assumed that in doing so the length of stay can be reduced and the experience of care improved	Indicator met in all quarters

Knowsley Integrated Provider Services (KIPS) 2011-12

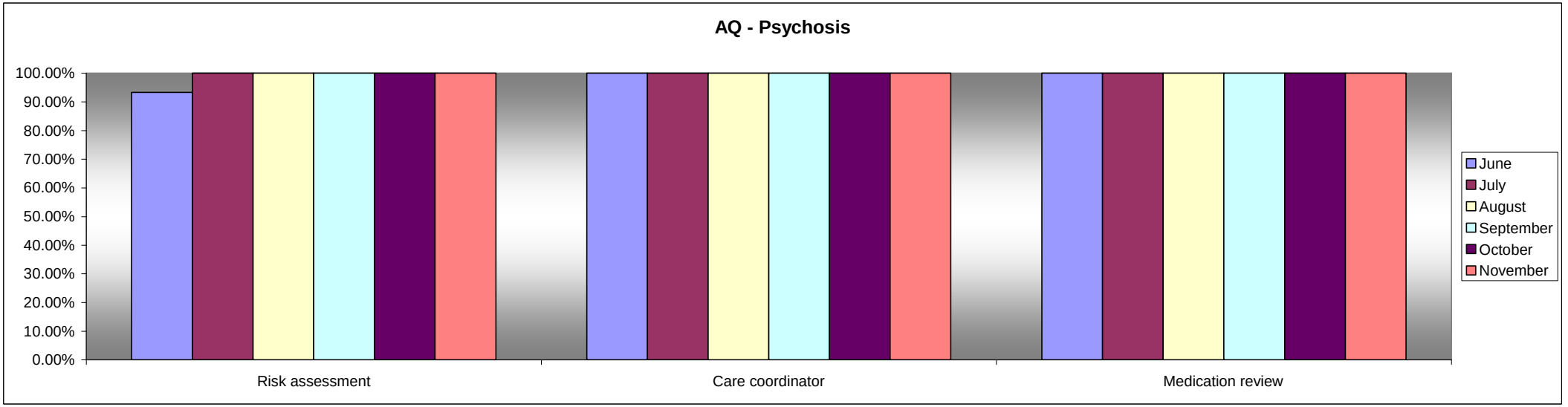
Indicator Name	Goal	Year end position
EFFECTIVENESS		
DNA Rate Improvement	To reduce the DNA rate in specific services with high DNA	Achieved in eight of the 13 services – CQUIN partially met
EFFECTIVENESS		
TCS Health and Well-being Pathway – Brief Intervention Survey	To establish a baseline of the percentage of people who receive brief intervention from KIPS services	Indicator met in all quarters
PATIENT EXPERIENCE		
Patient Survey - Stretch Targets	To improve patient satisfaction	All services were reviewed twice during 2011-12 with an average response rate of 50 per cent
EFFECTIVENESS		
High Impact Actions – Keeping Nourished	To monitor the percentage of DN who have received MUST training and to monitor the percentage of clients who need a MUST assessment who meet the eligibility criteria	Indicator met in all quarters

EFFECTIVENESS		
TCS Mental Health Pathway – Dementia	To monitor the percentage of staff in applicable services that have received dementia awareness training	Indicator met in all quarters
PATIENT EXPERIENCE		
TCS Learning Disability Pathway – Reasonable Adjustments	To establish the baseline information required to monitor the percentage of people with LD who receive reasonable adjustments to access services AND to monitor this. To monitor the percentage of appointments for people with LD that have reasonable adjustments made	Indicator met in all quarters
EFFECTIVENESS		
TCS Children and Families Pathway – Health Visiting	To evidence the number of children who require support above universal provision and then monitor if they have received this	Indicator met in all quarters
EFFECTIVENESS		
High Impact Actions – Falls Prevention	To identify falls champions for the following services - District Nursing, Matrons, Podiatry, Continence, Community Therapy/ Intermediate Care, Walk-in Centres. Within these services: 100 per cent of all new referrals to those services over 65 are asked if they have had a fall (as per NICE guidance) and 100 per cent of those who have had a fall have a completed stage 1 falls assessment and have been referred on as appropriate. KIPS - also to develop a three-level training package which will be rolled out as per plan	Indicator met in all quarters

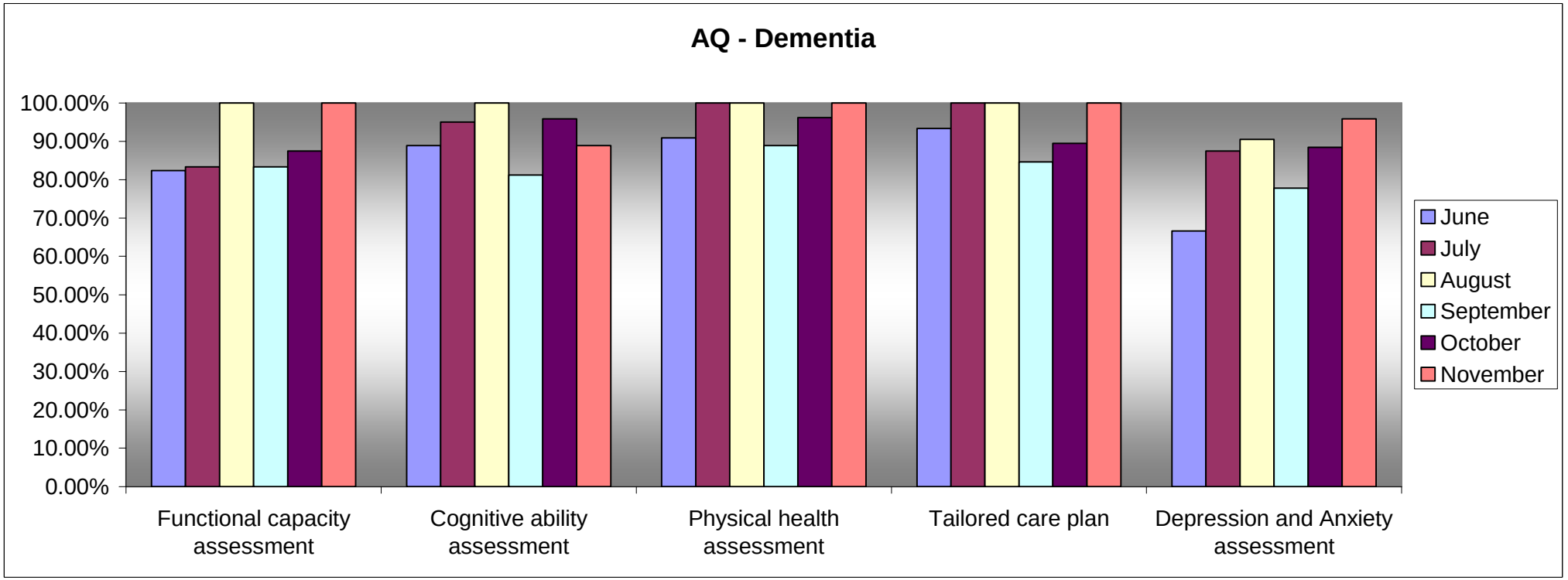
Appendix 7 Advancing Quality Programme

An explanation of advancing quality is included in this report at section **3.5.3**

	Total			June			July			August			September			October			November		
First-Episode Psychosis	**Num**	**Dem**	**Rate**	**Num**	**Dem**	**Rate**	**Num**	**Dem**	**Rate**	**Num**	**Dem**	**Rate**	**Num**	**Dem**	**Rate**	**Num**	**Dem**	**Rate**	**Num**	**Dem**	**Rate**
Risk assessment	69	70	98.57%	14	15	93.33%	9	9	100.00%	17	17	100.00%	7	7	100.00%	11	11	100.00%	11	11	100.00%
Care coordinator	70	70	100.00%	15	15	100.00%	9	9	100.00%	17	17	100.00%	7	7	100.00%	11	11	100.00%	11	11	100.00%
Medication review	67	67	100.00%	14	14	100.00%	8	8	100.00%	17	17	100.00%	7	7	100.00%	11	11	100.00%	10	10	100.00%
Composite Process Score (CPS)	**206**	**207**	**99.52%**	**43**	**44**	**97.73%**	**26**	**26**	**100.00%**	**51**	**51**	**100.00%**	**21**	**21**	**100.00%**	**33**	**33**	**100.00%**	**32**	**32**	**100.00%**



	Total			June			July			August			September			October			November		
Dementia	Num	Dem	Rate	Num	Dem	Rate	Num	Dem	Rate	Num	Dem	Rate	Num	Dem	Rate	Num	Dem	Rate	Num	Dem	Rate
Functional capacity assessment	108	120	90.00%	14	17	82.35%	15	18	83.33%	20	20	100.00%	15	18	83.33%	21	24	87.50%	23	23	100.00%
Cognitive ability assessment	106	115	92.17%	16	18	88.89%	19	20	95.00%	19	19	100.00%	13	16	81.25%	23	24	95.83%	16	18	88.89%
Physical health assessment	132	137	96.35%	20	22	90.91%	24	24	100.00%	22	22	100.00%	16	18	88.89%	25	26	96.15%	25	25	100.00%
Tailored care plan	86	91	94.51%	14	15	93.33%	17	17	100.00%	13	13	100.00%	11	13	84.62%	17	19	89.47%	14	14	100.00%
Depression and Anxiety assessment	114	134	85.07%	14	21	66.67%	21	24	87.50%	19	21	90.48%	14	18	77.78%	23	26	88.46%	23	24	95.83%
Composite Process Score (CPS)	546	597	91.46%	78	93	83.87%	96	103	93.20%	93	95	97.89%	69	83	83.13%	109	119	91.60%	101	104	97.12%



Appendix 8 Complaints Report 2011-12

Compliant with Regulation 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

During the period 1 April 2011 to 31 March 2012:

We received **242** complaints.

We closed **237** complaints. Of these:

- **204** (86.1 per cent) were closed within a timescale agreed with the complainant
- **33** (13.9 per cent) were closed outside of this agreed timescale.

Of the **237** closed complaints:

- **155** (65.4 per cent) of all complaints closed had none of the issues complained about upheld.
- **82** (34.6 per cent) of all complaints closed were well founded (had some or all of the issues complained about upheld).

During the reporting period, we were informed of eight complaints that were referred to the Parliamentary and Health Service Ombudsman. The Ombudsman reported on the investigation of one complaint, partly upholding the complaint against the Trust.

Breakdown of themes of complaints received (top 5) for MH/LD:

- Treatment issues (34 per cent)
- Communication (25 per cent)
- Staff attitude (13 per cent)
- Waiting times for appointments/ access to services (8 per cent)
- Records issues (3 per cent)

Breakdown of themes of complaints received (top 5) for ICS:

- Treatment issues (41 per cent)
- Service provision (18 per cent)
- Staff attitude (17 per cent)
- Waiting times for appointments/ access to services (14 per cent)
- Communication (10 per cent)

We received **1,013** compliments.
We received **10** MP enquiries
We dealt with **110** concerns.