Working To Improve the Health And Welfare Of Local People

QUALITY ACCOUNT 2010 / 2011
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INTRODUCTION

WELCOME TO OUR TRUST

North Staffordshire Combined Healthcare NHS Trust was established as a Trust in 1994 and is responsible for providing mental health and specialist learning disability care to people living in the city of Stoke on Trent and North Staffordshire county and sometimes from outside of these areas.

We currently work from both hospital and community based premises, operating from just over 30 sites in North Staffordshire, our main site being the Harplands Hospital which opened in 2001 and which provides the setting for most of our inpatient units. We provide services to people of all ages with a wide range of mental health and learning disability needs and a list of our core services is shown below in the section ‘services covered by this Quality Account’. Sometimes our service users need to spend time in hospital, but much more often we provide care in outpatients, community resource settings and in people’s own homes. We also provide specialist mental health services such as parent and baby mental health services, mentally disordered offenders and psychological therapies and until September 2009 we provided care for older people with physical health needs, when this service was transferred to the management of a more appropriate community health care provider – North Staffordshire Community Healthcare and Stoke on Trent Community Health Services.

Our 1,744 clinical and support staff (whole time equivalents) have around 375,000 contacts with people each year; and an annual budget of £86million.

We service a population of around 457,000 people from a variety of diverse communities. During 2010/11 our main NHS partners have been the two local Primary Care Trusts (PCTs) – NHS Stoke on Trent and NHS North Staffordshire although a number of major changes to commissioning and provision arrangements will change this significantly in the coming years and we look forward to working with the new Staffordshire Cluster PCT and the newly formed GP Commissioners. We also work very closely with the local authorities in these areas. In addition, we provide a range of clinical and non clinical services to University Hospital of North Staffordshire NHS Trust and a range of support services such as estates, health and safety and health informatics to the two Primary Care Trusts. We have also forged closer links with the two local universities, University of Staffordshire and Keele University. The organisation has been a partner in the development of the Keele University Medical School.

We also work closely with agencies which support people with mental health problems, such as North Staffs Users Group (NSUG), Approach, ASIST, Brighter Futures, Changes, EngAGE, North Staffs Huntington’s Disease Association, Mind, North Staffs Carers Association, Reach, Rethink, Richmond Fellowship.

Our Annual Report for 2010/11 provides an overarching summary of the services, performance and finances for 2010/11. A copy is available from the Trust Secretary.

The diagram below illustrates our purpose, vision and values and how they link to our strategic goals and the strategies that will help us realise our aims. Further information regarding our purpose, vision and values is contained in the Trust’s Annual Report.
Our strategy

OUR PURPOSE:
Working to improve the mental health and wellbeing of local communities

Our Vision
- To provide patient centred mental health, specialist learning disability and related services for people of all ages
- To be the best in all that we do
- To work in partnership to deliver services that promote recovery, wellbeing and independent living.

Our Values
- Person centred
- Transparency and integrity
- Excellence
- Equality and respect
- Supportive and responsive

Our Strategic Goals
1. To deliver high quality person centred models of care, throughout the organisation
2. To be at the centre of an integrated network of partnerships to provide a holistic approach to care.
3. To engage with our communities to ensure we deliver the services they require
4. To be a dynamic organisation driven by innovation
5. To be one of the most efficient providers.

Clinical Strategy
- Financial Strategy
- Workforce Strategy
- Estate Strategy
- Customer Focus Strategy
- IM&T Strategy
- Governance Strategy
- Innovation Strategy
WELCOME TO OUR SECOND QUALITY ACCOUNT

Welcome to our second Quality Account which covers the financial year 2010/11, ie 1 April 2010 to 31 March 2011 and focuses on the quality of services we deliver to patients and service users. Last year we were asked to provide a report on the quality of Inpatient Acute Services for Mental Health and Learning Disabilities only, however, for this year the Quality Account covers all services provided by the Trust and is structured to examine:

- What our organisation is doing well
- Where improvements in quality are required
- What the Trust priorities for improvements are for 2011/12
- How we have engaged our stakeholders in the determination of priorities for improvement

We hope that you find this Quality Account helpful in informing you about our work to date and future priorities to improve local NHS Services. We also look forward to your feedback which will assist us in improving the content and format of future Quality Accounts.

SERVICES COVERED BY THIS QUALITY ACCOUNT

Last year the Trust was required to produce a Quality Account focusing upon the Acute Inpatient Services. For 2010/11 The Trust has included all services provided by the Trust. The Trust’s nine main services are shown below under the three Clinical Divisions:

<table>
<thead>
<tr>
<th>Adult Mental Health Division</th>
<th>Learning Disability &amp; Neuropsychiatry and Old Age Psychiatry Division</th>
<th>Children &amp; Young People’s Division</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults with non-psychotic disorders</strong> (improving access to psychological therapies [IAPT], access services (SPA), community mental health teams including psychological interventions, crisis/home treatment service, in-patient services, parent and baby services, criminal justice service, personality disorder service)</td>
<td><strong>Learning disabilities</strong> (inpatient assessment &amp; treatment; rehabilitation services; and community learning disability teams) <strong>Neuropsychiatry / Old Age Psychiatry</strong> (Dementia services; older people's mental health; brain injury; Huntington's Disease Service; memory clinic service)</td>
<td><strong>Connect child and adolescent mental health services and First Steps</strong> <strong>Children in Special Circumstances</strong> <strong>Child and adolescent mental health services Special Needs and Physical Health</strong> <strong>Darwin Centre</strong> (specialist child and adolescent mental health inpatient services)</td>
</tr>
<tr>
<td><strong>Adults with psychotic disorders</strong> (access services (SPA), early intervention team, assertive outreach team, rehabilitation services, community mental health teams, crisis/home treatment service, criminal justice service, in-patient services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Substance misuse services and liaison services</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Trust does not subcontract out any services to another non NHS body.
1.1 QUALITY OF SERVICES – KEY ACHIEVEMENTS

We have a lot to be proud of. We are a successful high-performing Trust; we have a dedicated workforce, excellent feedback from our service users and have managed periods of major change over the last decade in line with national policy and local need. However, we also understand that we must continuously strive to deliver high quality safe services in all of the services we provide. Our key achievements are shown below and throughout this Quality Account.

Making progress to Foundation Trust Status: During the year we have progressed our devolved service line management structure to put our clinical staff at the heart of decision making and updated our five year Integrated Business Plan (IBP) to ensure it is aligned with our response to the Government’s White Paper – Equity and Excellence – Liberating the NHS. In addition, with the national focus provided by the national directive of QIPPP (Quality, Innovation, Productivity, Partnership and Prevention) we have worked together across the local health economy to ensure that our business plan is fully aligned with the commissioning plans to ensure that we are well placed to provide quality services through increased productivity within the local fiscal challenges. We are mindful that we need to meet the personalised care needs for every individual that we provide services to. Finally, we are progressing our Foundation Trust (FT) application and have submitted a signed Tripartite Formal Agreement (TFA) to the Strategic Health Authority with a plan to have achieved Foundation Trust status by October 2012. We are pleased to be able to report that we have confirmed support from both of our local commissioners.

Registration by the Care Quality Commission and Compliance with Essential Standards of Quality and Safety: Towards the end of 2009/10 we carried out a full self assessment of compliance with the Regulations defined by the Health & Social Care Act 2008 – this Act defines a range of essential standards of quality and safety across all areas that the Trust has to meet and which are important to the people who use our services, the staff who work for us and those who commission our services for the local population. The Care Quality Commission considered and accepted our self assessment and we were successfully ‘Registered’ by the Care Quality Commission on 1 April 2010 (Registration Number 1-114682668).

We understand that achieving the initial ‘Registration’ status is the just the beginning and it is necessary to work hard to maintain compliance with the quality standards across all of the services provided. Internally, we have a comprehensive self assessment process which is operating across the entire year to check the quality of services provided. We also use a range of external information, including feedback from staff and service users and also feedback from the Care Quality Commission. The Care Quality Commission did undertake a ‘compliance review’ during 2010/11 and identified areas for improvement in relation to the processes for reporting incidents and learning from both the incident reporting processes and other key processes in an integrated manner. Significant progress in responding to the findings has already been made and this Quality Account includes the key priorities in this area which will result in improved services going forwards.

National Quality Ratings: Last year we reported that the Care Quality Commission had published formal ratings in which we received a ‘good’ for quality of financial management but regrettably dropped from ‘good’ to ‘fair’ for our quality of services. Our Quality Account last year described the reason for this rating and also outlined the plans in place to ensure that a rating of ‘good’ was achieved in 2010/11.
Although the overall ‘rating’ process was halted by the Department of Health during 2010/11, we are pleased to confirm that we significantly improved our outcomes and achieved all but one of the national indicators. The one national target that we did not achieve was the national indicator for delayed transfers of care. In addition, whilst the Trust achieved the national target in relation to retaining drug misusers in drug treatment programmes, the Trust did not achieve a year on year increase – although it is likely that the Trust would not have been assessed as failing the indicator.

National benchmarking data was published by the Care Quality Commission and this clearly showed that the Trust performed around, or better than, the national average for all other areas and we had projected a rating of ‘good’ for the quality of financial management and a return to ‘good’ for the quality of services for 2010/11 had the national rating process continued.

**Key Quality Indicators:** Section 3 of the Quality Account includes performance against the priorities contained in our previous Quality Account and also includes outcomes across a range of indicators used in addition to the ‘Registration’ process above to measure the quality of services. Where outcomes are not as expected we have identified these as key priorities for improvement going forwards. We are very pleased with our community patient survey results in which overall we were rated in the top 20% of mental health trusts; the feedback we receive about the cleanliness of our premises; and we are extremely pleased to report that we have had no cases of Methicillin-resistant Staphylococcus Aureus (MRSA) and a continued year on year reduction in Clostridium Difficile (Cdiff).

**Key Priorities for 2010/11 – Commissioning for Quality Innovation Scheme:** Last year we aligned our plans for improving the quality of services with the Commissioning for Quality Innovation (CQUIN) Scheme for 2010/11 which is a range of quality related indicators agreed to further improve services for the people who use them. The CQUIN payment framework is a national framework for agreeing local quality improvement schemes and makes a proportion of our total potential income from Primary Care Trusts (PCTs) (1.5%, ie £916,772) conditional on the achievement of ambitious quality improvement goals and innovations agreed between Commissioner and Provider with active clinical engagement. We identified 10 priority areas which contribute to improved safety; clinical effectiveness; and patient experience. Part 3.1 of this Quality Account provides a statement against each of the priority areas but in summary, all schemes were either achieved in full or partly achieved, and even those partly achieved schemes have resulted in quality improvements for those using our services. In total we achieved 86% of the schemes and achieved income of £788,882 against a possible income of £916,772).

**1.2 QUALITY OF SERVICES – KEY PRIORITIES FOR 2011/12**

Our key focus is on the provision of a high-class standard of care to all our patients by putting their needs first and ensuring that service users and carer feedback is integral to all that we do and our clinical strategy is centred on new models of care. In light of service redesign options and the QIPPP priorities (Quality, Innovation, Productivity, Partnership and Prevention) there is clearly a commitment to reduce unnecessary admissions and improve community services with a view to providing more care ‘closer to home’.

We have identified that improvements are needed in the way that services users are cared for across age defined and geographical boundaries and the need for an estate that is fit for purpose. The most important reason we want to change how we do things is because, although our services are good, we believe they can be even better – quality of care can be improved if we adopt emerging best practice in the delivery of mental health services.
We have extensively researched what works well elsewhere in England and to an extent overseas because we want to continuously improve what we do – this research has informed the development of the proposed new model of care. Our new model is also influenced by national policy which in itself also reflects emerging best practice. For example the national dementia strategy; and the new national mental health strategy, ‘No Health Without Mental Health’, which includes a goal of improving quality and making the best of resources. We must also respond to national initiatives such as eliminating mixed sex accommodation. Our Commissioners have confidence in our ability to be their provider of choice, but this is dependent on our ability to deliver high quality safe services which provide value for money. Service users are supportive of the range of services we provide but seek continual improvements in the way that these are co-ordinated, communicated and delivered.

We have been providing an enhanced older people’s community service as a pilot in the Newcastle area. The pilot has proven successful in reducing admissions to mental health beds and reducing length of stay for those people still admitted. This success is consistent with evidence from other Trusts which have introduced crisis and home treatment models into services for older people with mental health needs.

The Board of Directors is committed to fully implementing a robust Quality Governance Framework to ensure the highest standards of quality and safety for those who receive the Trust’s services and the staff who work in the Trust. The Board of Directors is keen to learn the lessons from the reviews undertaken during the year not only in the areas reviewed, but in all areas of the Trust. The priority areas included in this Quality Account focus on safety in delivery of care for patients in a systematic manner to ensure that the whole organisation, from Board level accountability to the role of front-line clinical staff, is equipped to address and ensure that all patients are cared for in environments that have staff focussed and equipped to achieve quality and safety improvements.

Our early implementer status for the Leading in Patient Safety Programme is central to our way forward and we are the first mental health provider in the region to promote such a focus on safety in delivery of care for patients within a sound governance framework that engages ‘Board to ward’. All of these approaches demand precise pathways for diagnosis and treatment and rely heavily on treatment at home rather than in hospital.

In any year Trusts have a number of competing priorities to improve service delivery, value for money and the quality of the service provision. We are committed to working collaboratively with a range of partners and as such have included ‘three steps to engagement’ in the development and publication of this Quality Account which are outlined in section 3.3.

With regard to improving the quality of services, we have selected three priorities that are of significant importance to the Trust and in addition, we have chosen to align our priorities for improvement in the coming year with the Commissioning for Quality Innovation (CQUIN) Scheme for 2011/12 which is a range of quality related indicators agreed to further improve services for the people who use them. In total we have identified 12 priority areas which contribute to improved safety; clinical effectiveness; and patient experience.
The following table identifies 3 additional priorities that are of significant importance to the Trust:

<table>
<thead>
<tr>
<th>Priority</th>
<th>Additional Priority Area</th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Serious Incidents and Incidents</strong>: Implement improved arrangements for reporting, monitoring and scrutinising incidents, improve the time taken to respond to serious incidents and implement new processes for improving the learning the lessons from separate processes, for example: incidents, complaints, clinical audit</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Leading Improvements in Patient Safety (LIPS)</strong>: Ensuring a clear focus on patient safety with the longer term aim to improve the speed of consultant assessment of mental health and physical health of inpatients and work towards a reduction in assaults in inpatient settings</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Back to Essentials Campaign</strong>: Implement the Back to Essentials Programme to ensure that the essential elements of care for patients are in place</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
</tbody>
</table>

The following table identifies the 9 priorities as identified by the Commissioning for Quality Innovation (CQUIN) Scheme for 2011/12:

<table>
<thead>
<tr>
<th>Priority</th>
<th>CQUIN Area</th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td><strong>Patient Experience</strong>: Measuring patient satisfaction of inpatient and community mental health services and taking action to improve satisfaction.</td>
<td></td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>5</td>
<td><strong>Carer Experience</strong>: Measuring the level of support offered to carers of mental health patients and taking action to improve carer support and carer satisfaction.</td>
<td></td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>6</td>
<td><strong>Safer Care – Use of Trigger Tools</strong>: Using specially designed mechanisms to continuously monitor the level of harm events to in-patients and use the information to prioritise safety improvement initiatives.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td><strong>Safer Care – Safety Improvement Initiatives</strong>: Developing and implementing programmes of work to reduce the risks arising from assaults, slips trips and falls or medication incidents.</td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>8</td>
<td><strong>Planned and Effective Discharge</strong>: Reviewing and Improving discharge planning for all in-patients to reduce the length of stay, improve outcomes post discharge and reduce readmissions and poor outcomes after discharge.</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>9</td>
<td><strong>Dementia</strong>: Ensuring the appropriate prescribing of antipsychotic medication for people with dementia and improving the discharge of patients with dementia.</td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>10</td>
<td><strong>Children and Young People’s Services</strong>: Improving arrangements when a person moves from the services provided for children and young person’s service to adult services.</td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>11</td>
<td><strong>Dual Diagnosis (Alcohol)</strong>: Improving effective care for patients who need support for alcohol misuse and who also have mental health care needs.</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td><strong>Community Mental Health Services</strong>: Improving care planning and outcome measuring in community mental health services for adults and older people.</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

All of the areas above are explained further in section 2.2.
1.3 TRUST STATEMENT

Our Trust is pleased to publish this second Quality Account for the financial year 2010/11, ie 1 April 2010 to 31 March 2011. The 2010/11 Quality Account represents the Trust’s commitment to continually drive improvements in services and to be transparent and accountable to the general public, patients, commissioners, key stakeholders and those that regulate our services. Throughout the period covered by this account, the Board of Directors has further developed, and is implementing, a robust quality governance framework, has learnt from feedback and external reviews and is committed to ensuring that all of the Trust’s services are safe and of a very high quality. The Board of Directors will continue to strengthen the quality reporting and monitoring systems across the organisation.

To try to ensure that the account covers the priority areas important to local people, we have consulted with our commissioners and key stakeholders in the voluntary and statutory sectors. Their valuable comments have been listened to and will be acted upon in strengthening involvement in our services going forwards and where appropriate have been incorporated into the body of this account.

On behalf of the North Staffordshire Combined Healthcare NHS Trust, we confirm that the information contained in this 2010/11 Quality Account is a true and accurate reflection of the Trust’s performance.

Signed by the Chairman, Sir Philip Hunter, on behalf of the Trust Board of North Staffordshire Combined Healthcare NHS Trust

Fiona Myers
Chief Executive

Dr Mike Jorsh
Medical Director

David Pearson
Director of Nursing and Allied Health Professionals (AHPs)
PART 2 – PRIORITIES FOR IMPROVEMENT (LOOKING FORWARD) & STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 PLANS FOR IMPROVEMENT

VISION, VALUES, STRATEGIC GOALS AND ANNUAL OBJECTIVES

The introductory section defines our vision, values and strategic goals. During 2010/11, the Trust refined its business plan to guide its service development over the next 5 years. Each year the Trust sets clear annual objectives which define the key steps toward delivery of the strategic goals and for 2011/12 the annual objectives are prioritised towards improving quality (safety, effectiveness and experience for staff and patients) and improved efficiency. This Quality Account sets out the Trust commitment to improve safety; continue to improve the quality of services provided and to improve patient and service user engagement.

ENGAGING OUR PARTNERS AND STAKEHOLDERS – ‘Three steps to engagement’

In any year Trusts have a number of competing priorities to improve service delivery, value for money and the quality of the service provision. We are committed to working collaboratively with a range of partners and as such have included ‘three steps to engagement’ in the development and publication of this Quality Account. The three steps and comments from partners are included in section 3.3 which outlines how key partners have been involved determining our annual priorities. All three steps have been successful and have resulted in key changes in the development and content of this Quality Account. We would like to take this opportunity to thank everyone who has worked with us and provide assurance that your views and comments have helped to shape this Quality Account.

ACHIEVING FOUNDATION TRUST STATUS

With the support of our local commissioners, we are progressing our Foundation Trust (FT) application and have submitted a signed Tripartite Formal Agreement (TFA) to the Strategic Health Authority with a plan to have achieved Foundation Trust status by October 2012. We will continue to build capacity and capability to deliver our priorities through improved strategic planning; working with our partners; developing the quality improvement infrastructure; developing and supporting our workforce; making better use of information and improving feedback mechanisms.

QUALITY & GOVERNANCE DEVELOPMENT PLAN

This Quality Account is underpinned by a comprehensive Quality & Governance Development Plan which includes a whole range of actions to continue to improve the quality of the services provided. The Plan has two specific sections: Section 1: Provides an overarching coordination of all action plans in place in the Trust to improve quality, safety and governance; and Section 2: Contains all individual actions identified at clinical team, division and corporate level in response to ongoing assessments of compliance with the essential standards of quality and safety. The Quality & Governance Development Plan is a ‘living document’ in that it is regularly updated as new actions are identified and others are delivered and implementation is overseen by the Trust’s Quality & Governance Committee.
2.2 P Priorities for improvement and goals agreed with commissioners

Key Priorities for Improvement

With regard to improving the quality of services, we have selected three priorities that are of significant importance to the Trust in addition to aligning our priorities for the Commissioning for Quality Innovation Scheme (CQUIN) described below.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Additional Priority Area</th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Serious Incidents and Incidents:</strong> Implement improved arrangements for reporting, monitoring and scrutinising incidents, improve the time taken to respond to serious incidents and implement new processes for improving the learning the lessons from separate processes, for example: incidents, complaints, clinical audit</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Care Quality Commission carried out a Compliance Review during 2010/11 and identified two key actions relating to the need to improve incident reporting and the safeguarding referral systems. The actions included the need to address gaps between our incident reporting and safeguarding referral systems. The second relates to inconsistencies in how information is monitored and used to improve the quality and safety of services and the need for more localised monitoring to ensure there are early opportunities to reduce the risks to the care and welfare of people who use services. As a result a comprehensive action plan has been developed which includes 12 individual actions to address the findings of the Care Quality Commission. The full action plan can be obtained from the Trust but include updating policy; ensuring that all incidents raised in relation to protection of vulnerable adults and children are addressed via internal reporting and monitoring processes in addition to external reporting; raising staff awareness regarding incident reporting processes; improving training new approaches to trend analysis and learning from incident reporting.

In addition, whilst we have robust monitoring arrangements to ensure that all serious incidents are investigated and action plans developed, we have not managed to ensure that these are completed in a timely manner. As such a priority for 2011/12 is to ensure that serious incidents are fully investigated within the 45 day timescale.

**Targets:**
Implement all 12 actions defined to respond to the Care Quality Commission’s findings (key actions are referred to above)

Improve the time taken to respond to serious untoward incidents by completing reviews within 45 days in cases where there is no unusual complexity preventing this.

Implement processes to learn the lessons from separate processes for example: incidents, complaints, clinical audit, etc.

| 2        | **Leading Improvements in Patient Safety (LIPS):** Ensuring a clear focus on patient safety with the longer term aims to improve the speed of consultant assessment of mental health and physical health of inpatients and work towards a reduction in assaults in inpatient settings |

We have early implementer status for the Leading in Patient Safety (LIPS) Programme and are the first mental health provider in the region to promote such a focus. This priority area will focus on safety in delivery of care for patients in a systematic manner to ensure that the whole organisation, from Board level accountability to the role of front-line clinical staff, is equipped to address and ensure that all patients are cared for in environments that have staff focussed and equipped to achieve quality and safety improvements. Quality and safety are pivotal in the delivery of the QIPPP (Quality, Innovation, Prevention, Productivity and Performance) agenda.
The aims of the programme in the longer term are to ensure Consultant assessment of mental and physical health of inpatients takes place within 3 days; and achieve a reduction of assaults in inpatient settings to zero (timescales to be agreed to achieve this).

**Targets:**
The key target for 2011/12 is to fully understand the causes of safety incidents, ensure recording is robust and undertake a targeted case note review in inpatient areas [20 per month] to support the delivery of the overall aims.

| 3 | Back to Essentials Campaign: Implement the Back to Essentials Programme to ensure that the essential elements of care for patients are in place | ✓ | ✓ |

During 2010/11 the Trust launched the ‘Back to Essentials’ campaign the aim of which is to ensure that the essential elements of care for patients are in place and that staff refresh and renew their knowledge and skills in order to maintain safety and drive standards forward. The campaign focuses on 7 domains of essential care: Person centred care, dignity and respect; Safeguarding; Physical healthcare Medicines management; Communication; Record keeping and risk management; and Legal compliance. The launch involved staff from a variety of professions and disciplines, gathered together to discuss each domain with regard to:
- The ‘population’ at risk
- The main issues to be shared / addressed
- Support systems in existence e.g. policies and procedures
- The education and training available to support staff, service users or carers
- The quality frameworks to provide advice and support
- The quality indicators for each domain and the means by which these will be monitored and reviewed

A programme is now in place for 2011/12 to ensure that each clinical team undertakes a self assessment against pre-determined indicators, identifying actions for improvement where required.

**Target:** Ensure that all of the 7 domains are reviewed on a whole Trust basis during 2011/12 and a full assessment is completed.

**COMMISSIONING FOR QUALITY INNOVATION SCHEME (CQUINS)**

We have chosen to align our priorities for improvement in the coming year with the Commissioning for Quality Innovation (CQUIN) Scheme for 2011/12 agreed with our local Commissioners. The CQUIN payment framework is a national framework for agreeing local quality improvement schemes and makes a proportion of our income conditional on the achievement of ambitious quality improvement goals and innovations agreed between Commissioner and Provider with active clinical engagement. The CQUIN framework is intended to reward genuine ambition and stretch, encouraging a culture of continuous quality improvement in all providers.

Again for 2011/12, as an incentive 1.5% of the total potential income from Primary Care Trusts (PCTs) for 2011/12 has been linked to delivery of these targets. The Trust has agreed 9 CQUIN indicators, including whether each relates to patient safety; clinical effectiveness; patient experience; or more than one and these are shown below:

<table>
<thead>
<tr>
<th>Priority</th>
<th>CQUIN Area</th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td><strong>Patient Experience:</strong> Measuring patient satisfaction of inpatient and community mental health services and taking action to improve satisfaction</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

This priority area helps to ensure that all service activities and improvements are focussed towards improving the experience of patients. The questions included are based upon the patient’s experience questions set by the Care Quality Commission but have been extended further. Service users were consulted in the original drafting of these questions and are an important part of the
experience of people using services. This priority area will ensure that patient experience is sought, action is then taken to respond to the experience of people using the service and patient experience is sought again to ensure that the action taken has resulted in real improvements.

**Target:** For at least 5 of the 6 scores for the questions for community based services to show an improvement; and at least 4 of the 5 questions for the hospital based survey to show an improvement.

| 5 | **Carer Experience:** Measuring the level of support offered to carers of mental health patients and taking action to improve carer support and carer satisfaction |  | ✔️ | ✔️ |
|---|---|---|---|---|---|

Families and carers, young and old, often receive limited help and too often report that they are ignored by health professionals on grounds that they need to protect the confidentiality, and respect the wishes, of the service user. However, families and carers, including children, have detailed knowledge and insight and are often best placed to offer advice. The new mental health strategy 'No health without mental health' acknowledges the importance of families and carers in service users’ recovery. The refreshed carers’ strategy, Recognised, Valued And Supported: Next steps for the Carers Strategy, sets out the key actions to ensure the best possible outcomes for carers and those they support.

This priority area will help us to understand the level of support offered to carers of mental health patients and the action taken to improve carer support and carer satisfaction.

**Target:** To complete a carers’ survey, to develop a responsive action plan and implement all actions and for 75% of respondents to rate the service as good or excellent.

| 6 | **Safer Care - Use of Trigger Tools:** Using specially designed mechanisms to continuously monitor the level of harm events to in-patients and use the information to prioritise safety improvement initiatives | ✔️ |
|---|---|---|---|---|

This priority area focuses on treating and caring for people in a safe environment and protecting them from avoidable harm by using a robust method to measure incidents of harm and implementation of a planned approach to reducing safety risks.

**Target:** To implement the robust trigger tool, prioritise actions to respond to the findings and evidence change as a result.

| 7 | **Safer Care – Safety Improvement Initiatives:** Developing and implementing programmes of work to reduce the risks arising from assaults, slips trips and falls or medication incidents | ✔️ | ✔️ | ✔️ |
|---|---|---|---|---|---|

This priority area is closely aligned with the Leading Improvements In Patient Safety (LIPS) Initiative described in priority 2 above and measures the actual improvements in safety.

**Target:** Reduction of 40% in assaults, 40% of falls and 40% improvement in medication safety.

| 8 | **Planned and Effective Discharge:** Reviewing and Improving discharge planning for all in-patients to reduce the length of stay, improve outcomes post discharge and reduce readmissions and poor outcomes after discharge | ✔️ | ✔️ | ✔️ |
|---|---|---|---|---|---|

This priority area aims to reduce inappropriate admissions, length of stay and occupied bed days. One of the priorities listed in a recent Kings Fund publication ‘Mental Health and the Productivity Challenge’ is to improve discharge and step-down arrangements. Research shows that at least 7% of adult psychiatric beds and 16% for older people being lost to delay. As number of beds and length of stay is reduced it is important that post discharge outcomes and effectiveness of post discharge care is monitored and evaluated. This also includes monitoring those patients discharged early to ensure this does not lead to poorer outcomes or increased risk of adverse events.
<table>
<thead>
<tr>
<th><strong>Target:</strong> Develop a plan to reduce the risk of delayed discharges and evidence implementation of the plan; Achieve a year on year reduction in the length of stay; and Ensure that 90% of adult mental health patients have a 3-month post discharge review.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9 Dementia:</strong> Ensuring the appropriate prescribing of antipsychotic medication for people with dementia and improving the discharge of patients with dementia</td>
</tr>
<tr>
<td>✓</td>
</tr>
</tbody>
</table>

This priority area focuses on the need to reduce the use of antipsychotic medications for people with dementia and the effectiveness of care provided to this patient group is of critical importance across the local health economy and nationally. This indicator will support development of a tool that will allow rapid monitoring of this and will focus on improved training for the wider health economy.

**Target:** 100% of antipsychotic prescribing to be in line with stated guidelines; 100% of patients discharged with an antipsychotic medication to follow the discharge guidance; 100% of patients recorded on the register; 95% of patients with dementia are following the dementia care pathway; and confirmation that all targets in a training plan have been met.

<table>
<thead>
<tr>
<th><strong>Target:</strong> Undertake an initial audit to focus on the process for children being transferred from children’s services to adult services and be able to evidence significant improvements based on the findings and 9 of 10 teams develop and use outcome measures.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10 Children and Young People’s Services:</strong> Improving arrangements when a person moves from the services provided for children and young person’s services to adult services</td>
</tr>
<tr>
<td>✓</td>
</tr>
</tbody>
</table>

The National CAMHS review highlighted the need for improvements in transitions from CAMHS to adult services. Evidence suggests that this is a time of great concern for children and families. In addition, the National CAMHS review ‘Children and Young People in Mind’ strongly supports the ongoing work to develop outcome measures for children's services for mental health and psychological well being. This priority area will focus on ensuring the smooth transfer from children’s to adult services by ensuring that a clear protocol is in place and that the protocol is being followed and ensuring that

**Target:** Undertake an initial audit to focus on the process for children being transferred from children’s services to adult services and be able to evidence significant improvements based on the findings and 9 of 10 teams develop and use outcome measures.

<table>
<thead>
<tr>
<th><strong>Target:</strong> 90% of patients to be screened using the audit tool and 90% of patients with a dual diagnosis (alcohol) to receive care in line with the policy.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>11 Dual Diagnosis (Alcohol):</strong> Improving effective care for patients who need support for alcohol misuse and who also have mental health care needs</td>
</tr>
<tr>
<td>✓</td>
</tr>
</tbody>
</table>

It is established in the UK, one third of patients in mental health services have a substance misuse problem. At the same time around half of patients in drug and alcohol services have a mental health problem. This can make accurate diagnosis and treatment difficult and people with dual diagnosis are at increased risk of poor outcomes. The aim of the priority area is to improve the identification of patients with dual diagnosis so that patients receive the most appropriate treatment and care for their mental health needs.

**Target:** 90% of patients to be screened using the audit tool and 90% of patients with a dual diagnosis (alcohol) to receive care in line with the policy.

<table>
<thead>
<tr>
<th><strong>Target:</strong> Ensure that 100% of patients considered suitable for a Wellness Recovery Plan are offered one; Ensure that 95% of patients with a care plan have evidence of patient involvement in the development of the plan; and develop an outcome monitoring tool and evidence that 35% of service users are monitored using the tool.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12 Community Mental Health Services:</strong> Improving care planning and outcome measuring in community mental health services for adults and older people</td>
</tr>
<tr>
<td>✓</td>
</tr>
</tbody>
</table>

This priority area empowers service users and gives a sense of ownership of care and plans for the future going beyond health needs. WRAP (Wellness Recovery Action Plan) is a service user developed tool which is completed by the service user and it is anticipated that it will help ensure care plans are developed or reviewed, with greater service user involvement, service user focus and recovery focus. In addition this area focuses on recovery models to monitor achievement of outcomes and quality of care.

**Target:** Ensure that 100% of patients considered suitable for a Wellness Recovery Plan are offered one; Ensure that 95% of patients with a care plan have evidence of patient involvement in the development of the plan; and develop an outcome monitoring tool and evidence that 35% of service users are monitored using the tool.

Comprehensive information regarding all of the CQUIN priorities shown above is available from the Trust.
BUILDING CAPACITY AND CAPABILITY

We are committed to developing our capacity and ability to deliver improvements in quality for the people who need our services through:

New Models of Care and Improving the Estate: Section 1.2 introduces the proposed changes to the model of care which also require changes to the Trust estate to ensure that the estate is fit for purpose and enables the delivery of the new model of care. We have reviewed best practice guidance and evidence of what works well in other Trusts, and analysed our own activity data, to build a picture of why we need to make changes to rehabilitation, resource centre and older people’s services which will enable us to close Bucknall Hospital. We have been engaging with external stakeholders since December 2010 and, following extensive feedback on the original proposals, have decided to:

- Proceed with a consultation on the clinical changes required to enable the closure of the Bucknall Hospital site. This will require consultation on changes to older people’s inpatient services, the Sutherland resource centre and Harplands based inpatient rehabilitation.
- Undertake further engagement about the future use of the remaining resource centres and older people’s mental health service (OPMH) day hospitals.

The consultation will proceed throughout 2011/12 and further information can be obtained from the Head of Communications.

Quality Improvement Capacity: To ensure that we achieve our key priorities, we have strengthened our Board membership, appointed two GP Associate Directors and strengthened the clinical leadership and senior management team. A key focus going forwards is to review our internal structures and processes to ensure that both are sufficient and effective to support the delivery of our key priorities.

Workforce: We employ 1,744 staff (whole time equivalents) and the majority of our staff provide professional healthcare directly to our service users. We understand that we will deliver our strategic plans though our workforce and that it is our workforce that has a direct impact on the quality of services provided and the experience of patients. We recognise the need to ensure we invest in resources to promote strong clinical leadership and during the year we have progressed our service transformation that will meet the needs of the future. A key focus for the Trust going forwards is to:

- To ensure that our clinical staff are supported by strong and effective managers who will back good ideas and remove blockages in the system where this may prohibit service redesign and innovative practice. We will actively support and encourage our clinical staff to innovate, collaborate and work across the local economy in order to provide timely and appropriate care for patients where there is a need;
- Continue with the second stage of our Leadership Development Programme to develop our leaders and identify and support leadership talent at all levels through a Development Centre for our Senior Leaders and Managers. This will match existing skills against the competencies required and will inform of future leadership development requirements;
- Ensure that all of our staff have an annual review of their performance;
- Our staff survey took place in the autumn of 2010 and we have responded to those findings by extensively sharing the results and we produced an action plan that we need to continue to implement during 2011/12 to ensure that staff satisfaction levels increase.
Better Use of Information: During 2010/11 the Trust has made significant investments in the purchase and use of IT systems and infrastructure that will enable staff to have access to the information they need to do their day-to-day jobs and on which to base well informed decisions about how best to provide services to their clients. The new data warehouse has now been installed and is currently being tested to ensure that the information produced from it meets our high quality standards. This work will significantly move us forward towards an integrated business intelligence service that will bring together data and information from a wide variety of sources. To ensure that we are able to collect all the data that we need to meet the expectations of Commissioners, patients and the public we have made the decision to redevelop our existing clinical IT system. This will enable us to continue the excellent work already implemented around PIP and Clusters in preparation for Payment by Results (PbR), and to ensure that we meet the changing needs for the collection and production of the Mental Health Minimum dataset (MHMDS).

The requirements of Information Governance are central to the way we operate to ensure that all data that we collect is held safely and securely and is only made available to those people that have a legitimate need to access it. We have invested in an Information Security Officer who will ensure that all staff adhere to the Data Protection Act and other nationally mandated policies and processes. Our new intranet and website were successfully launched during 2010 which has significantly improved the way in which we communicate with users, carers, the public and staff by giving access to information in a user-friendly manner.

To continue the progress in the use of IT to support the Trust’s objectives the key focus is to:
- Fully implement the business intelligence system
- Redevelopment our clinical IT system
- Use technology to facilitate efficiencies in the way we work e.g. mobile working and digital dictation
- Improve our understanding or the patient experience by implementing a patent feedback system

Improving Involvement and Feedback Mechanisms - Improving the Patient Experience: There is no single route to understanding patient experience. A wide range of sources and types of information / feedback need to be drawn on, simply collecting information in itself has no value; it is how the information is used that matters. Many of our teams do collect and use feedback to inform service improvements but this is inconsistent across all services. We need to focus on maximising the impact of feedback through increased service improvement across all trust services. The direction of travel that we are currently moving from towards is a significant shift from collecting and analysing data to using the data to make real improvements. In support of this we have:
- Involved service users, carers and local representative groups across various trust services to shape and inform our Patient Experience Strategy.
- Produced a Patient Experience summary report, to identify and respond to emerging themes and trends from a variety of feedback sources; including patient stories, questionnaires, focus groups etc.
- Introduced the Experience Based Design approach across a number of services.
- Conducted an in depth analysis of person centred care via our Back to Essentials campaign, this includes the use of metrics under the following 5 categories; Respect, Attitude, Professional Behaviour, Communication and Privacy and Dignity. Part of the process includes responsive action planning as required.

We are also committed to ensuring that real experiences are sought and heard and we are planning to include patient feedback at Board Meetings to ensure that the work that we do and the decisions we make are also focussed towards the experiences of people who use our services.

As we move forward we understand that we need to focus more on the ‘so what’ factor so that we are able to describe what has changed as a result of the involvement activities and the feedback received.
2.3 STATEMENT OF ASSURANCE FROM THE BOARD

This section is provided to offer assurance that the Trust is performing well as assessed internally via the Trust’s own processes; externally therefore providing independent assurance; through processes to measure clinical outcomes; through audit and research and development; and through participation in national projects and initiatives.

HOW PROGRESS WILL BE MEASURED AND MONITORED

The majority (77%) of services provided by North Staffordshire Combined Healthcare NHS Trust in 2010/11 were commissioned by the two local Primary Care Trusts, NHS North Staffordshire (33%) and NHS Stoke (44%). NHS North Staffordshire has operated as the Co-ordinating Commissioner during 2010/11. There is a contract in place to ensure that there is clarity regarding the services commissioned for local people and also the expectations of the service provider and expectations for the quality of services. There are significant changes to the commissioning arrangements being progressed which will result in local doctors commissioning services as part of GP Consortia.

Performance & Quality Management Framework (PQMF)
The Trust’s Performance & Quality Management Framework (PQMF) plays a key role in the Trust’s drive for excellence, providing a means to review and improve organisational performance and quality outcomes by linking and aligning individual, team and organisational objectives and results. It provides a means of recognising good performance and managing underperformance. The framework enables the monitoring and scrutiny of performance and the quality of services. Our main Commissioners have worked with the Trust to establish a Clinical Quality Review Group which meets on a monthly basis. Attended by Commissioners and Senior Trust Clinicians, this group has a number of functions including the setting of Commissioning for Quality and Innovation Targets (CQUIN) and other key performance and quality indicators. Through this structure, Commissioners undertake reviews of performance associated with the quality of services and conduct clinical visits to assess for themselves that the standards they set are being adhered to.

Reports are presented to the Trust Board at every meeting during an open meeting to provide progress in meeting the key priorities outlined in our Quality Account. In addition, this Quality Account includes clear reference to our progress in meeting the key priorities outlined in last year’s Quality Account.

Quality Reporting Overview
A new development for 2011/12 is the introduction of a new quarterly Quality Report which will focus on a whole range of activities to oversee the quality of services provided by the Trust and will be used as a tool for measuring quality, reporting on quality and learning from our key processes. This report will also focus specifically on the key priorities outlined in this Quality Account.

COMPLIANCE WITH THE HEALTH & SOCIAL CARE ACT 2008 AND THE ESSENTIAL STANDARDS OF QUALITY AND SAFETY

On 1 April 2010 a new process was implemented and all health and adult social care providers are required by law to be registered with the Care Quality Commission if they provide regulated activities. This process is defined by the Health & Social Care Act 2008. All provider Trusts were required to self assess the level of compliance against the new regulations - ‘Essential Standards of Quality and Safety’, inform the Care Quality Commission of the outcome of that assessment and apply for Registration to provide regulated activities. North Staffordshire Combined Healthcare NHS Trust self assessed against the outcomes defined by the
regulations and declared compliance with all of the outcomes. The Trust’s application for registration has since been considered by the Care Quality Commission and a decision made to register without conditions to provide a range of regulated activities.

We understand that achieving the initial ‘Registration’ status is the just the beginning and it is necessary to work hard to maintain compliance with the quality standards across all of the services provided. Internally, we have had a well established quality and governance self assessment process in place for many years. Initially to support compliance with the standards defined by Standards for Better Health and more recently to support the evidence of meeting the quality standards and outcomes defined by the Health & Social Care Act 2008 and Registration. There is a Board approved Registration Accountability Framework and Self Assessment Methodology in place based on a 6-level compliance process:

- Level 1 – Corporate Compliance Return
- Level 2 – Location / Divisional Compliance Return
- Level 3 – Team / Service Compliance Return
- Level 4 – Team / Service Level Assurance Audits / Internal Assurance: Rolling annual programme of
- Level 5 – Outcome Focus – Internal & External Assurance: Triangulation of data from a variety of internal and external sources (for example: Internal Audit; External Audit; Staff Survey; Patient Survey; Care Quality Commission Quality & Risk Profile; Key Partners; etc.); and
- Level 6 – Outcome Focus – Additional Assurance: Level 6 will develop over time and will focus on identifying new and innovative techniques to obtaining outcome focussed evidence of compliance with the standards and regulations (for example: through the use of real-time patient / carer / partner feedback linked directly to the outcomes / regulations).

With the exception of level 6 which is under development, all other levels are in place and operating effectively.

**CARE QUALITY COMMISSION’S NATIONAL QUALITY RATINGS**

In previous years the Care Quality Commission operated a national process to consider a range of quality standards and targets and assess an organisation’s performance and whether levels of service are being maintained.

Last year we reported that the Care Quality Commission had published formal ratings in which we received a ‘good’ for quality of financial management but regrettably dropped from good to ‘fair’ for our quality of services. Our Quality Account last year described the reason for this rating and also outlined the plans in place to ensure that a rating of ‘good’ was achieved in 2010/11. Unfortunately we are unable to report the overall rating outcomes as the entire ‘rating’ process was halted by the Department of Health during 2010/11, however, we are able to confirm that we significantly improved our outcomes and achieved all but one of the national indicators.

The one national target that we did not achieve was the national indicator for delayed transfers of care although it is important to note that excellent progress has been made and the CQUIN linked to priority 5 will ensure that this is progressed further, indeed early in 2011-12 the target was achieved. In addition, whilst the Trust achieved the national target in relation to retaining drug misusers in drug treatment programmes, the Trust did not achieve a year on year increase – although it is likely that the Trust would not have been assessed as failing the indicator. We are continuing to closely monitor every service users that is not retained in a drug treatment programme for 12 weeks or more to ensure that learning is identified.
National benchmarking data was published by the Care Quality Commission and this clearly showed that the Trust performed around, or better than, the national average for all other areas and we had projected a rating of ‘good’ for the quality of financial management and a return to ‘good’ for the quality of services.

The spider chart below summarised our performance when compared to national averages and expected levels. The red circle indicates the lowest levels of performance, the green circle indicates the highest levels of performance and the mid point between the two circles indicates the expected level. All but one area of performance is above the expected level and many indicate above average levels of performance.

**MEASURING CLINICAL PERFORMANCE**

Clinical Audit, Clinical Excellence and Research & Development all contribute to measuring effectiveness (including both clinical outcomes and patient reported outcomes), safety and patient experience by quantitative and qualitative information. This includes reporting experience and data regarding the impact of services on patients. The clinical audit programme is developed to reflect these needs and the national priorities. Further information is contained below.

**NATIONAL PROJECTS AND INITIATIVES**

This section includes reference to the national projects and initiatives that we are applying to improve the quality of our services. Some areas are mandatory and others we have chosen to apply to allow us to scrutinise our processes and services and compare our outcomes to other providers:

**Commissioning for Quality and Innovation (CQUIN) Framework:** We are fully engaged with Commissioners in the CQUIN payment framework which is a national framework for locally agreed quality improvement schemes and makes a proportion of provider income conditional on the achievement of ambitious quality improvement goals and innovations. The CQUIN framework is intended to reward genuine ambition and stretch, encouraging a culture of continuous quality improvement in all providers. The Trust and Commissioners participated fully and worked together on 10 schemes in 2010/11 successful achieving 86% of the schemes and targets and will be working together on a further 9 schemes in 2011/12.

**NHS Litigation Authority Risk Management Standards:** In January 2011 the Trust was reassessed against the NHSLA Risk Management Standards which are a range of standards to assess governance arrangements; the competency and capability of the workforce; safe environment; clinical care; and learning from experience. We are pleased to report that we were assessed as compliant with 47 of the 50 standards which is a compliance rate of 94%. The pass mark for accreditation is 40 of 50. The areas where we did not fully
meet the standard related to improving policy in relation to the retention and destruction of records, the need to update the security policy in relation to ‘lock down’ arrangements and the need to ensure consistency between the training policy and the observation policy.

**Productivity Improvement Pathway Programme (PIP):** Since 1 May 2009, all Mental Health and Learning Disability (MH/LD) Trusts across the West Midlands have taken part in the newly developed and piloted Productivity Improvement and Pathway Programme led by the Strategic Health Authority. The development of care clusters within Adult Mental Health has been embedded into the Trust’s Clinical Information System and all clinicians are allocating service users to care clusters at assessment and review.

The DOH drive to ensure all service users are allocated to a care cluster by December 2011 has been progressed significantly although the Trust marginally underachieved the target to allocate 70% of service users to a cluster achieving 67% although this will continue to be taken forwards. The Trust, as part of the Programme, is developing and improving its systems to sustain care clusters to support local pricing and the development of a national currency in the future.

Learning Disability services are also taking part in the development of care clusters. Whilst this programme is still in its infancy, the Trust has once again piloted the initial cluster development and will remain actively involved in its future development as part of the NHS West Midlands and DOH programme. The Trust has been able to embed adult mental health care clustering into its clinical information systems and therefore now has further robust clinical information to support the continued development and sustainment of cluster allocation which is supported by effective clinical engagement.

**Quality, Innovation, Productivity, Partnership and Prevention (QIPPP)**

The ‘QIPPP agenda’ which stands for Quality, Innovation, Productivity, Partnership and Prevention, was developed at a national level with an expectation that this would be rolled out through regions to local health economies. QIPPP is identified as the means through which organisations will improve quality and outcomes whilst managing increasing demand on services without further growth in investment.

North Staffordshire Health Economy as a whole developed its system QIPPP Plan linked to Fit for the Future (the plans associated with the reprovision of the UHNS) and key objectives put forward by provider organisations. The Trust played an active role in shaping the plan and will contribute to monitoring performance against it.

**National Quality Improvement Projects (Service Accreditation Programmes) - Managed by the Royal College of Psychiatrists’ Centre for Quality Improvement (CCQI)**

- The Trust has 1 ECT Clinic and it is accredited
- 3 wards (wards 1, 2 and 3 at the Harplands Hospital) for working age adults are accredited

**Clinical Trials**

The trust is involved in several clinical trials the main aim of which is to develop a culture where such activity is promoted and supported as an integral part of the organisation and thus ensure best evidence-based practice in healthcare. For research to be of value it must be used to inform and influence practice and ultimately improved patient outcomes.

**National Clinical Audits, National Confidential Inquiries and Prescribing Observatory for Mental Health (POMH)**

The Trust is involved with all of the above and further information is contained in section 2.5
LEARNING LESSONS

It is very important that service users, carers and the public have confidence in their local health services at all times. We have undertaken a comprehensive review of lessons to be learnt from the Mid-Staffordshire Hospital Care Quality Commission Investigation and the subsequent Independent ‘Francis’ Inquiry. Any responsive actions that we need to address are included in our Quality & Governance Development Plan and will be taken forward and monitored at regular intervals.

Key lessons include:

- Promoting an open learning culture
- Collecting and reporting patient safety information accurately and at the right level so that it is understandable and able to drive improvements
- Learning the lessons from key processes – for example: Complaints, Incidents, PALS, etc in an integrated manner
- We have introduced the Back to Essentials Campaign to ensure that we are focussing on what is most important

In addition we have used the Audit Commission’s Taking it On Trust Toolkit to assess our Trust and again, we have developed a comprehensive action plan to ensure that we are taking proactive action in a number of areas.

Key lessons include:

- The importance of communicating the Trust’s key objectives and the importance of staff having access to annual personal development reviews. Action has been taken to ensure that a completely new processes is in place and by September 2011 the majority of staff will have had a personal development review based on a cascade of the Trust’s objectives
- The need to improve reporting from board to ward in an integrated manner. Action has commenced to review all reporting processes to ensure that information is clear and meaningful and is able to identify areas for improvement
- The need to focus on improving access to data through improved electronic methods and the need to improve data quality

2.4 REVIEW OF SERVICES

This section is provided to offer assurance that we have included all of the services mandated for inclusion.

During the period from 1 April 2010 to 31 March 2011, North Staffordshire Combined Healthcare NHS Trust provided 9 NHS services. The Trust has reviewed all the data available on the quality of care in all of the NHS services provided by the Trust. The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the North Staffordshire Combined Healthcare NHS Trust for 2010/11. The Trust’s nine main services as referred to above are listed in the introductory section of this Quality Account – see section ‘Services Covered By This Quality Account’.
2.5 PARTICIPATION IN CLINICAL AUDIT

NATIONAL CONFIDENTIAL ENQUIRIES AND NATIONAL CLINICAL AUDITS

Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes against specific criteria and the implementation of change. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery. As such, Clinical Audit is an essential part of the quality assessment framework and a key element of clinical governance.

During 2010/11, 2 national audits and 1 national confidential enquiry covered NHS services that North Staffordshire Combined Healthcare NHS Trust provides. During that period, North Staffordshire Combined Healthcare NHS Trust participated in 1 of the 2 national clinical audits and the national confidential enquiry which it was eligible to participate in and these are shown below:

The national clinical audits and national confidential enquiries that North Staffordshire Combined Healthcare NHS Trust was eligible to participate in during 2010/11 are listed below and those that the Trust did participate in during 2010/11 are shown with ✔

- National Audit of Psychological Therapies (NAPT)
- Prescribing Observatory for Mental Health (POMH)
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

Due to capacity issues, a decision was made by Psychological Services that the Trust was not able to participate in the National Audit of Psychological Therapies in Anxiety and Depression (NAPTAD): Anxiety and Depression although the Trust was registered for this audit.

The national clinical audits and national confidential enquiries that North Staffordshire Combined Healthcare NHS Trust participated in, and for which data collection was completed during 2010/11, 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 that audit or enquiry:

<table>
<thead>
<tr>
<th>TITLE</th>
<th>Percentage of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing Observatory for Mental Health (POMH): Prescribing Topics in Mental Health Services:</td>
<td>95%</td>
</tr>
<tr>
<td>- Monitoring of Patients Prescribed Lithium</td>
<td>37%</td>
</tr>
<tr>
<td>- Medicines Reconciliation</td>
<td>67%</td>
</tr>
<tr>
<td>- Use of Antipsychotic Medication in CAMHS</td>
<td></td>
</tr>
<tr>
<td>National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)</td>
<td>100%*</td>
</tr>
</tbody>
</table>

*This data is collected centrally on a rolling basis as part of the NCI process

The reports of 3 Prescribing Observatory for Mental Health (POMH) audits, (as specified above) were reviewed by the provider in 2010/11. The Trust did not participate in the POMH audit: ‘Use of Antipsychotics in People with Learning Disabilities’ as the Trust was not registered with the Prescribing Observatory at the time that this audit was completed and hence was ineligible to participate.
Going forward into 2011/12 the process for undertaking POMH clinical audits has been changed. The clinical audit department will take a key role in the co-ordination of topic selection, data collection and submission of data, ensuring that appropriate steering groups and sample sizes are put in place in order that data received from POMH audits is meaningful to the Trust. This also ensures that findings can be acted upon appropriately and action plans devised to address shortfalls. The results of POMH audits will be disseminated to the Trust Clinical Effectiveness Group and the Trusts Medicines Management Committee for action and monitoring. Both groups feed into the Trust’s Quality and Governance Committee.

LOCAL CLINICAL AUDIT PROGRAMME IN 2010/11

We reviewed the reports following 9 local clinical audits in 2010/11 which are listed below:

- A Retrospective Analysis of the Implementation of NICE Guidance for Adolescent Inpatient Treatment and The Darwin Centre
- Evaluation of the Impact of New Ways of Working on Services Provided by The Bennett Centre
- Audit of the Use of Antibiotic/Antimicrobial Medication
- Audit of Health Records Across North Staffordshire Combined Healthcare NHS Trust
- Audit of Assessment MRSA Admission Screening
- Compliance with NICE Guidelines: Management of Obsessive Compulsive Disorder at Two Mental Health Resource Centres -- Audit
- Review of the Management of Borderline Personality Disorders by Community Mental Health Teams for Adults of Working Age
- Audit of Vulnerable Adults Safeguarding Procedures
- A Review of Spirituality Needs Across North Staffordshire Combined Healthcare NHS Trust

The following key messages / themes can be noted as outcomes from the above audits which will be taken forward over the coming months in the form of specific actions plans for each audit. Key themes have been drawn from the results / action plans and in some cases are common to more than one completed project. All action plans were devised by a multidisciplinary steering group and are allocated a coordinator and completion deadline to ensure that a positive impact is made on the provision of care. Completed projects are then re-audited within an appropriate timescale to ensure that a positive impact has been made.

The need to review and maintain Trust policy in line with national standards and guidance:
By ensuring that our Trust policies and procedures are kept up to date with national developments and are devised in line with NHS Litigation Authority requirements, the Trust can be confident of a sound basis on which our care is based. Clear policy and procedure ensures that staff are aware of their duties and services are delivered in a consistent manner.

Improve record keeping and documentation to ensure safe and effective care for people who access our services:
Record keeping is essential to providing safe and effective care as well as being a legal requirement. By improving our record keeping, the Trust can be confident in the continuity of care between services and other agencies and service users can be confident that accurate records are maintained about the information provided and the care received.
A review of the contents for junior doctor training and induction so they are aware of Trust policy and procedure:
As junior doctors tend to rotate on a regular and sometimes frequent basis, it is important that the Trust provides appropriate induction to the policies and procedures of the Trust for new junior doctor rotations. This is important to ensure the consistency of care and high quality of service provision by junior staff as service users who may be in contact with services over a period of time may come into contact with more than one junior doctor.

Improving service user outcome monitoring and the provision of information for service users:
Monitoring outcomes for people who access services is often difficult but is important to knowing the benefit of a particular service / intervention. Providing accurate and relevant information (both written and verbal) to service users in a way they can understand will help them to make informed decisions about their treatment and care.

Ensuring safe and appropriate prescribing of medications:
Many service users in contact with the Trust will at some point be prescribed medication therefore it is important that all prescribers of medication do so in a safe an appropriate manner in line with national and local guidance.

The provision of holistic and innovative treatments / support for service users in terms of their spiritual needs whilst in hospital:
A holistic approach to the provision of services can help a person’s recovery therefore looking after someone’s spiritual needs whilst in hospital is considered important by the Trust. Undertaking spiritual assessments and providing information on spiritual care and chaplaincy will be included within all patient information packs, wards, departments, waiting areas and notice boards therefore ensuring service users are aware of the support available to them.

The promotion of the Trust’s Safeguarding Team and the identification of training needs in relation to safeguarding children and vulnerable adults for all staff groups across the Trust:
Nationally, safeguarding issues have been pertinent and considering that many service users who access the services of the Trust are potentially vulnerable adults, it is imperative that all staff are aware of Trust policy regarding safeguarding, where to go to seek advice and also their roles and responsibilities as employees.

To give an example of the type of work undertaken a small number of audits are described in greater detail below as case studies. The case studies include a summary of the project including what the results told us as a Trust, what we are going to do as a result of the findings and how this will impact on service users.
Case Study: A Retrospective Analysis of the Implementation of NICE Guidance for Adolescent Inpatient Treatment at The Darwin Centre

The Darwin Centre is a 15 bedded adolescent inpatient unit which provides specialist care for young people from the age of 12 to 18 with various mental health problems including depression, schizophrenia, psychosis, post traumatic stress disorder, obsessive compulsive disorder, autism, self harm and eating disorders. Assuring the quality of care provided for the adolescents is vital as the unit provides a tailored service to a varied patient population with various mental health problems. A project was therefore prioritised in order to determine the level of adherence to several NICE Guidelines in relation to:

- the provision of an effective and efficient multi-disciplinary service at the Centre
- the quality of care being provided to the service users at the Centre
- the current level of integrated care for adolescents
- group and family work provided at the Centre

Results generally were very positive indicating a high level of adherence to NICE guidance. There was evidence in the notes that appropriate assessments were undertaken (92%-100%). Physical health was assessed and risk assessments completed in all cases (100%). Where a risk was identified, a management plan was evident in all cases (100%). Treatment was initiated taking into account the needs and preferences of the young person and in 95% cases, there was evidence that the young person was involved in decisions regarding treatment.

As a result of the findings, an action plan is now in place to include:

- Consideration will be given at a centre management meeting to devise a checklist as a reminder of the applicable guidance to follow (including NICE guidance) when treating Young People at The Darwin Centre
- Consideration of whether there is a need for introducing the two psychological therapies not presently in use, ie Focal Psychodynamic Therapy (FPT) and Eye Movement Desensitization and Re-processing Therapy (EMDR) as an available psychological treatment
- Staff to be reminded of the need to use the service user feedback mechanism (questionnaire) in order for the Centre to act on feedback from those accessing the service. This is important as it enables the young person and their carer to voice their opinions and directly influence the care provided. The centre also uses this feedback to measure ‘outcomes’ for the people who access their service.
- Consideration of methods to measure response and improvements to psychological therapy provided

Case Study: Compliance with NICE Guidelines: Management of Obsessive Compulsive Disorder (OCD) at Two Mental Health Resource Centres

OCD is said to be one of the more common mental illnesses and because of the shame and secrecy associated with it and a lack of recognition of symptoms can lead to a delay in diagnosis and treatment. There is no cure for OCD; however there are several types of treatments including counselling, psychotherapy and pharmacological therapy. In November 2005 NICE published guidance on OCD which focussed on core interventions in the treatment of OCD from psychological involvement to pharmacological intervention and a piece of work was undertaken within the Trust to assess current practice for the management of service users with a diagnosis of OCD including:

- Family and carer involvement
- Supply of written and verbal information prior to treatment
- Treatment options (including psychological intervention and medication)
- Poor response to treatment

Although only a small sample of cases was reviewed, the findings indicated that some improvements were needed to be fully compliant with NICE guidance. There was evidence that assessments and treatment plans were undertaken with the involvement of family members / carers (75%). Where appropriate, psychological treatment was offered, but there was evidence that this needed to be improved. In only a third of cases was there evidence that information (both written and verbal) about OCD, its likely causes, its course and its treatment was provided.

An action plan was therefore devised so that Centre managers were informed of the importance of advising both verbally and with written material, the common concerns for taking medication for OCD as the provision of good quality information is clearly important to enable service users and their carers to make informed decisions regarding treatment options and the management of OCD. Guidance around prescribing in line with NICE guideline was also made available to all consultants.
Case Study: Audit of Vulnerable Adults Safeguarding Procedures

According to Trust Protocol for the Safeguarding of Vulnerable Adults, ‘all staff employed by the Trust have a responsibility to report any incident of alleged/suspected abuse. Staff responsible for care, treatment and support of vulnerable adults must ensure that any concerns about the individual’s welfare are recorded and that any evidence indicating that abuse may have occurred is recorded.’ The Trust is committed to the training and education of staff with regard to the safeguarding of those vulnerable people being cared for and therefore undertook a project to determine the proportion of staff who:

- Have received training related to the Safeguarding Vulnerable Adults in Staffordshire and Stoke on Trent Inter-agency Policy to allow for a comparison between systems within Adult Safeguarding and that of Children
- Have knowledge of the Interagency Policy
- Are able to recognise the indicators of abuse
- Know when and how to implement the Policy

The findings showed that 53% of staff stated that they had received training with regard to Safeguarding Vulnerable Adults and 75% of staff stated that they were either very confident or somewhat confident in recognising the signs that an adults’ welfare or safety may be at risk. 72% of staff stated that they were either very confident or somewhat confident about acting upon concerns / indicators of abuse that an adult may be at risk from significant harm and 59% of staff stated that they were either very confident or somewhat confident about knowing when to make a referral to Social Care. 14% of staff were not aware of the Vulnerable Adults in Staffordshire and Stoke on Trent Policy and 59% felt that they required further training on how to respond to adult protection concerns.

Considering that many service users who access the services of the Trust are potentially vulnerable adults, it is essential that all staff are aware of Trust policy regarding safeguarding and also their roles and responsibilities as employees and as such, the following actions were devised:

- Raising the profile of the Safeguarding Vulnerable Adults Team:
  1. A link to the Safeguarding Vulnerable Adults Intranet page is to be put on the Weekly NewsRound
  2. Local Safeguarding Adults Group to write article for NewsRound
- Making staff aware that in cases of difficulty accessing training that they are to inform the Local Safeguarding Group:
  1. Updated via Weekly NewsRound
- For the results and recommendations of the audit to be distributed to the Local Safeguarding Group
- Re-audit of staff awareness of Vulnerable Adult Safeguarding Procedures in 2011/12
- To ensure that each member of staff is aware of the specific level of safeguarding training required for their role

LOCAL CLINICAL AUDIT PROGRAMME IN 2009/10 - UPDATE OF CONTENT IN THE 2009/10 QUALITY ACCOUNT

1) A Review of Mental Health Acute Admissions:

Locally major changes have taken place over the last few years within Adult Mental Health inpatient services for example:
- Reconfiguration and reduction of beds within Harplands Hospital
- Changes have been driven by service user opinion as well as national objectives including the same sex accommodation agenda
- Increase in the multidisciplinary and therapy and activities provision
- Role of Crisis Resolution Home Treatment (CRHT) Team in gate keeping admissions
- Providing named care-coordinator
- 7 day follow up in the community

2) Audit of Inpatient and Outpatient Management of Service Users with Bipolar Affective Disorder Against NICE Guidelines:

This Audit was undertaken by a Consultant Psychiatrist under the priority level of ‘Clinician Interest.’ As such, key findings were disseminated by the Lead Clinician to all appropriate staff involved in the management of Service Users with Bipolar Affective Disorder. A new process regarding the Implementation of NICE Guidance was put into place in December 2010.
3) A Re-Audit of Clinical Coding:

As a result of this re-audit a protocol was developed by the Clinical Coding Manager and disseminated to all ward areas. The aim of the protocol is to provide clear guidance on how to complete patient records to ensure accurate coding. In addition, the Clinical Coding process has been added to the Junior Doctor Induction Programme. A further re-audit has also been planned.

4) A Re-Audit of Care Plan Processing Times for Service Users Registered on Enhanced Care Coordination:

A new Commissioning for Quality and Innovation Scheme (CQUIN) has been identified as a priority for 2011/12. This will include re-evaluating the quality of care plans using exemplar templates to ensure that they are of the highest quality and contain relevant and up to date details for service users.

5) Audit of Assessment of Physical Health Needs on Admission for Inpatients with Mental Health Problems:

There has been significant work been undertaken as a result of the findings from this audit. The completion of physical health assessments on admission is now monitored weekly to ensure a maximum number of inpatients receive an assessment in a timely manner. Non completion of physical health assessments is followed up to determine if there is an appropriate clinical reason for non completion. The inpatient physical health assessment proforma has received a complete re-draft in consultation with the Medical Director, Nurse Practitioners, and relevant Consultants. The new Proforma is more comprehensive and user friendly thus ensuring a thorough physical health assessment for all inpatients. All admission documentation has been re-drafted to reflect recommendations made from this audit.

6) Prescribing Audit of Risperdal Consta:

This Audit was undertaken by a Consultant Psychiatrist under the priority level of ‘Clinician Interest.’ As such, key findings were disseminated by the Lead Clinician to all appropriate staff involved in the prescribing of Risperdal Consta.

7) Audit of Serious Incidents (SIs – previously called SUIs – Serious Untoward Incidents):

The results of this audit were communicated to the Trust Quality and Governance Committee. During 2010/11 further work was commissioned by the Executive Board regarding potential trends arising from Serious Untoward Incidents and a report is currently being discussed. Work going forward will focus on the quality of risk assessment and risk management to ensure appropriate, high quality risk planning for service users.

2.6 PARTICIPATION IN RESEARCH

Research is the attempt to derive new learning and knowledge. Research aims to find out what happens if we add or change clinical or service practice in some way, or aims to find out in a systematic way the views, opinions, experiences and understanding of stakeholders.

The Trust’s principal aim for Research and Development is to develop a culture where such activity is promoted and supported as an integral part of the organisation and thus ensure best evidence-based practice in healthcare. For research to be of value it must be used to inform and influence practice and ultimately improved patient outcomes.

The number of patients receiving NHS services provided or sub-contracted by North Staffordshire Combined Healthcare NHS Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 87. Areas of research over the year have focussed around, suicides, eating disorders, dementia, bipolar disorder and substance misuse amongst others.
Levels of Research Activity
The Trust is developing a programme of high quality R&D projects across different levels to support the advancement of care to facilitate improved health outcomes for patients. Research initiatives come from a variety of sources such as the Trust’s ‘vision’ and strategic direction, and the NHS R&D programme. During 2010/11, the Trust participated in local (home grown), national and international research studies of varying sizes and complexities. The Trust has pursued close working links with the West Midlands North Comprehensive Local Research Network (CLRN) project portfolio and explored potential partnerships with the UKCRN (UK Comprehensive Research Network) ‘topic specific’ research networks. It is essential that the Trust prioritises and substantially increases its participation in National Institute for Health Research (NIHR) portfolio research.

Opportunities to take part in Commercial research have been considered positively by the Trust and the number of commercial studies in ‘set-up’ and underway during 2010/11 has increased. The Trust is also a ‘preferred site’ for commercial research with the Commercial Research Organisation, Quintiles.

Sponsorship
The Trust continued to sponsor one large multi centre NIHR portfolio trial into stroke “The Stroke Oxygen Supplementation study (SOS)”. SOS is studying the long term benefits or risk of routinely prescribing oxygen to patients for the first 72 hours after a stroke. This trial exists on the CLRN and Stroke Research Network portfolio and receives NIHR support across the UK. 2010/2011 saw the study expand even further with the opening of new sites and increased recruitment – showing once again the high interest and support for this research in both the clinical and patient environments. In this year we now have 98 centres open to recruitment throughout the UK – with a further 40 centres expressing an interest in wishing to be a recruiting centre in the near future. Participant recruitment hit the 3,000 mark in this year – with 1,749 participants recruited in the year bringing the total number of study participants to 3,029. This ensures that we are ahead of our recruitment target, exceeding our predicted recruitment by threefold.

Benefits to Quality of Care / Benefits to the Service User
Participation in research can enhance the quality of care provided; not only through the development of evidence based guidelines which will inform current practice but through the development of staff involved in research including regular CPD programmes with group discussion, external speakers, case studies, personal development plans which include a focus on new learning, mandatory training, and study leave.

Service users can benefit from being involved in research activities in a number of ways. As well as being a participant in a study, service users can help to identify research that is important and relevant, join research proposal meetings, give opinions on designing research proposals, help researchers to develop questionnaires and questions for interviews, review and refine written information intended for service users involved in research, learn about the results of research and help to share research news with patients and the public. During 2010/11 the R&D team devised a patient and public involvement leaflet highlighting how to get involved in research and presented a display at Hanley Museum and Art Gallery about getting involved in research which was attended by members of the public.

Key areas of work over the year have been:
- To maintain the Research and Development infrastructure: We now have in post a research governance facilitator and a clinical studies officer and have a vacant clinical studies officer post which was approved by the Executive Board for recruitment in February 2011.
- Continue to recruit to NIHR portfolio studies and be selected as a site for new portfolio studies. The number of commercial studies has also increased.
- Promote research within the trust: We have continued to increase the number of staff as a member
in the ‘interested researchers’ email grouping, Good Clinical Practice (GCP) training sessions and research open days. We are engaging staff in undertaking research and developing their own research ideas. During 2010/11, 24 members of staff undertook GCP training.

- Maintain and build links with the Mental Health Research Network (MHRN), Dementias and Neurodegenerative Diseases Research Network (DeNDRoN), Quintiles (Commercial clinical research organisation), patient and public involvement and South Staffordshire and Shropshire Mental Health Trust.
- Increasing patient and public involvement in research and the development of an information leaflet to ‘get people involved’ in research activity.
- The development and ratification of a Commercial Research Policy, a Research Governance Policy and a Research and Development Strategy which includes a work plan to drive forward further R&D work streams and address actions indentified as part of an RSM Tenon internal audit in particular:
  - To undertake a mapping exercise to identify a) medics with R&D sessions / PAs already in their job plans and to determine if they are actually undertaking R&D activities and b) medics who are research active who do not have R&D sessions / PAs in their job plans.
  - Once the above has been determined, link in with Clinical Directors for the next round of job plan reviews to ensure those who are research active have this reflected in their job plans if not already.

2.7 GOALS AGREED WITH COMMISSIONERS

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) FRAMEWORK

A proportion (1.5%) of the total potential income from Primary Care Trusts (PCTs) in 2010/11 was conditional on achieving quality improvement and innovation goals agreed with Commissioners through the Commissioning for Quality Innovation (CQUIN) Framework. As an incentive a further 1.5% of the Trust’s total potential income from Primary Care Trusts (PCTs) for 2011/12 has again been linked to delivery of CQUIN targets and the Trust has agreed 9 CQUIN indicators with the Commissioners. The CQUIN indicators for 2011/12 are identified as the Trust’s key priorities going forward and are shown in section 2.2. The CQUIN indicators for 2010/11 were identified as the Trust’s key priorities last year and as such are reported on in section 3.1.

In addition it is important to note that CQUINS agreed in previous years continue to be taken forwards as they become part of the contract for the following year therefore quality is continually improved and monitored.

2.8 STATEMENT FROM THE CARE QUALITY COMMISSION

REGISTRATION
North Staffordshire Combined Healthcare NHS Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions – Registration Number 1-114682668

CARE QUALITY COMMISSION ENFORCEMENT ACTION
The Care Quality Commission has not taken any enforcement action against North Staffordshire Combined Healthcare NHS Trust during 2010/11
CARE QUALITY COMMISSION COMPLIANCE REVIEW

The Care Quality Commission carried out a ‘compliance review’ during 2010/11 and identified areas for improvement in relation to the processes for reporting incidents and learning from both the incident reporting processes and other key processes in an integrated manner. Outcomes in 2010/11 are discussed in section 3 – indicator number 19. A comprehensive Action Plan has been developed and this area is identified as one of our priority areas (priority area number 1) in section 2.2.

One action is related to identified gaps in the linkages between the trust’s incident reporting and safeguarding referral systems and reporting to senior managers and this has now been fully addressed. The second action related to inconsistencies in how information is monitored and used to improve the quality and safety of services, again action has been taken to address the findings and new processes will be embedded throughout 2011/12.

The Trust was found to be compliant with all other essential standards of quality and safety which were reviewed by the Care Quality Commission.

CARE QUALITY COMMISSION’S PERIODIC REVIEW

The Periodic Review, formally referred to as the Annual Health Check, was a process operated by the Care Quality Commission to consider a range of quality standards and targets and assess an organisation’s performance and whether levels of service are being maintained.

Last year we reported that the Care Quality Commission had published formal ratings in which we received a ‘good’ for quality of financial management but regrettably dropped from good to ‘fair’ for our quality of services. Our Quality Account last year described the reason for this rating and also outlined the plans in place to ensure that a rating of ‘good’ was achieved in 2010/11. Although the overall ‘rating’ process was halted by the Department of Health during 2010/11, we are pleased to confirm that we significantly improved our outcomes and achieved all but one of the national indicators.

The one national target that we did not achieve was the national indicator for delayed transfers of care. In addition, whilst the Trust achieved the national target in relation to retaining drug misusers in drug treatment programmes, the Trust did not achieve a year on year increase – although it is likely that the Trust would not have been assessed as failing the indicator.

National benchmarking data was published by the Care Quality Commission and this clearly showed that the Trust performed around the, or better than, the national average for all other areas and we had projected a rating of ‘good’ for the quality of financial management and a return to ‘good’ for the quality of services.

SPECIAL REVIEWS / INVESTIGATIONS

North Staffordshire Combined Healthcare NHS Trust has not participated in any special reviews or investigations by the CQC during 2010/11 other than the Compliance Review referred to above.
2.9 STATEMENT ON DATA QUALITY

NHS Number and General Medical Practice Code Validity: North Staffordshire Combined Healthcare NHS Trust submitted records during 2010/11 to the Secondary Uses service for including in the Hospital Episode Statistics which are include in the latest published data.

The percentage of records in the published data which included the patients valid NHS number was

- 100% for admitted patient care; and
- 100% for outpatient care.

The Trust does not provide accident and emergency care.

The percentage of records in the published data which included the patients valid General Medical Practice Code was

- 100% for admitted patient care; and
- 100% for outpatient care.

The Trust does not provide accident and emergency care.

Information Governance Toolkit Attainment Levels: North Staffordshire Combined Healthcare NHS Trust’s score for 2010/11 for Information Quality and Records Management assessed using the Information Governance Toolkit was 63%, and was graded red, which compares to 80% in 2009/10 although it is important to note that the 2010/11 Information Governance Toolkit is an entirely different approach to that in previous years. Benchmarking data for 2010/11 when issued will be a useful measurement of performance in this area compared to other Trusts.

The Information Governance Toolkit assesses the level of compliance across 45 different areas and we are required to meet level 2 in all areas. Where we failed to meet the level 2 requirements action plans have been developed to ensure compliance. In several cases the target was missed by not having one piece of evidence. The action plans will target these areas in the first instance and will then concentrate on embedding good practice operationally. In general we are implementing an Information Security Management System (ISMS) that will support the implementation of the requirements of the toolkit. An action plan for the overall implementation of the 2011/12 toolkit is also being developed to ensure that our performance against the targets is improved with the overall aim of ensuring that we are fully compliant. Specific actions include:

- Compliance with the toolkit will be a standing item in the Information Governance Steering group meeting agenda
- Earlier communication of the toolkit and its requirements
- Awareness sessions to ensure that all of the requirements are fully understood

Clinical Coding Error Rate
North Staffordshire Combined Healthcare NHS Trust was subject to the Payment by Results clinical coding audit during 2010/2011 by the Audit Commission and the error rates reported in the latest publications for this period for diagnosis and treatment coding (clinical coding) were:

- 97% Primary Diagnosis correct
- 71% Secondary Diagnosis correct
- 100% Primary Procedures correct
- 100% Secondary procedures correct

The audit was undertaken by D&A Clinical Coding Consultancy Ltd who are Connecting for Health registered auditors.
Of the four areas described above, the Trust failed to meet the 75% target in relation to secondary diagnosis coding. All other targets were exceeded. The issue in this area relates predominately to the patients notes not being accurately replicated on a form that is then input to the electronic patient management system as opposed to an accurate identification of a secondary diagnosis or coding. There is little risk to the patient as care and treatment continues as per the paper based records. To improve the position, actions have been, or will be implemented as follows:

- An Executive Director has been identified to lead the improvement plan
- The improvement plan will include:
  - developing a training and awareness plan for clinicians and a session is now booked for September 2011 to coincide with clinicians’ development days
  - develop improved reporting to allow continual monitoring of secondary diagnosis in addition to primary diagnosis
  - review the accuracy of paper forms used to input to the electronic system (KMRs)
  - explore moving to electronic forms to improve accuracy, legibility and timeliness
  - review induction process to include coding overview for clinicians

**Relevance of Data Quality and actions to improve Data Quality:** The quality of data is central to the success of Combined Healthcare therefore ensuring the accuracy and timeliness is key to underpin the high standard of collection, reporting and submission. North Staffordshire Healthcare will be taking the following action to improve data quality:

The existing reactive quality monitoring is being supported through proactive data quality reports and dashboards being made available through the Business Intelligence system that Combined Healthcare are currently implementing. The new data warehouse has been installed complete with a specific data quality and integrity reporting application at its core. These reports will be made available to the relevant people to ensure that quality data is input into the electronic system(s) at source.

Improvement plans for data quality are in place supported by a robust data quality strategy and policy plus an extensive programme of work. Examples of where excellent data quality is supporting key Trust initiatives is the reporting for CQUINS and preparation for Payment by Results (tariff) through the additional coding of interventions with the Clusters developed by the Department of Health (DH) as part of the Yorkshire Care Pathway and PIP projects.

The evidence from the Information Centre’s data quality dashboards shows that Combined Healthcare consistently maintains an excellent standard of data quality with the majority of indicators showing 100%.
NB – Ethnic Category monitoring has now been withdrawn
This section is in three parts:

Section 3.1 - Reviews performance against the key priorities defined in the 2010/11 Quality Account which were aligned with the Commissioning for Quality Innovation Scheme (CQUINS) agreed with our local Commissioners.

Section 3.2 – Add to the information provided in section 3.1 and provides a summary of our performance against a range of quality indicators / metrics which are of interest to people who use our services. Each quality indicator / metric is linked to one or more of the following three headings: Patient Safety; Clinical Effectiveness; and Patient Experience.

Section 3.3 – Includes reference to those involved in the development of this Account and statements from key partners.

Section 3.1 – Performance against the key priorities for 2010/11 as contained in the 2009/10 Quality Account

Last year we aligned our plans for improving the quality of services, with the Commissioning for Quality Innovation (CQUIN) Scheme for 2010/11 which is a range of quality related indicators agreed to further improve services for the people who use them.

The CQUIN payment framework is a national framework for agreeing local quality improvement schemes and makes a proportion of our total potential income from Primary Care Trusts (PCTs) (1.5%, ie £916,772) conditional on the achievement of ambitious quality improvement goals and innovations agreed between Commissioner and Provider with active clinical engagement. The CQUIN framework is intended to reward genuine ambition and stretch, encouraging a culture of continuous quality improvement in all providers.

For 2010/11 we identified 10 priority areas which contribute to improved safety; clinical effectiveness; and patient experience. Each section below describes the area being reviewed; the metric used to measure performance including the unique reference code; and the overall Trust performance.

All schemes were either achieved in full or partly achieved, and even those partly achieved schemes have resulted in quality improvements for those using our services. In total we achieved 86% of the schemes and achieved income of £788,882 against a possible income of £916,772).
<table>
<thead>
<tr>
<th>1</th>
<th>Area of Performance: <strong>Improve the dementia patients’ experience by working closely with other organisations to provide safe and effective care across different organisations</strong></th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target:</td>
<td>Trust Metric: KPI 1.1 – A clear dementia care pathway developed and implemented with 80% of people with a diagnosis of dementia following the pathway and 75% of staff trained by the end of the year.</td>
<td></td>
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<tr>
<td>Performance:</td>
<td>We have worked closely with a GPs and other partners and developed a comprehensive care pathway for people with a diagnosis of dementia and 88% of the identified staff group have been trained in the operation of the pathway. The final stage was full implementation, and this stage did identify that some changes needed to be made before full implementation hence the scheme was not fully achieved.</td>
<td></td>
<td></td>
<td>82% of this scheme has been achieved (£112,763 of possible £137,516 achieved)</td>
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<tr>
<th>2</th>
<th>Area of Performance: <strong>Early identification and support for people who have untreated psychosis</strong></th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target:</td>
<td>Trust Metric: KPI 1.2 - Clear recording systems and action plan in place to work with referrers, for example GPs, with the longest durations of untreated psychosis and those with the lowest referral rates by the end of the year.</td>
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<tr>
<td>Performance:</td>
<td>We have worked with those who refer to our services to understand the reasons for low referral numbers and longest periods of untreated psychosis and developed plans to make improvements.</td>
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<td></td>
<td>100% of this scheme has been achieved (£45,839 achieved)</td>
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<tr>
<th>3</th>
<th>Area of Performance: <strong>Increasing safety through improved medicines management</strong></th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target:</td>
<td>Trust Metric: KPI 1.3 – Reduce delayed and missed doses of medication to less than 3% by the end of the year.</td>
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<tr>
<td>Performance:</td>
<td>We achieved a reduction in delayed and missed doses of medication throughout the year but did not meet the final target to achieve less than 3% of delayed and missed doses of medication as performance at the final audit was 3.1%</td>
<td></td>
<td></td>
<td>90% of the scheme has been achieved (£41,255 of possible £45,839 achieved)</td>
</tr>
<tr>
<td>Area of Performance</td>
<td>Improve nutritional screening and support</td>
<td>Patient Safety</td>
<td>Clinical Effectiveness</td>
<td>Patient Experience</td>
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<tr>
<td><strong>Target:</strong></td>
<td>Trust Metric: KPI 1.4 – Develop and implement a nutritional screening tool with 95% of patients screened on admission and all patients needing support have a nutritional care plan put in place by the end of the year</td>
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<tr>
<td><strong>Performance:</strong></td>
<td>We developed and implemented a method of screening patients on admission to assess and respond to their nutritional needs. 95% of patients were screened and where action was identified this was responded to on 94% of occasions which was below the target of 100%.</td>
<td></td>
<td></td>
<td>77% of the scheme has been achieved (£71,049 of possible £91,677)</td>
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<tr>
<th>Area of Performance</th>
<th>Improving support through a clear understanding of accommodation and employment needs</th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target:</strong></td>
<td>Trust Metric: KPI 1.5 – Develop and implement processes to assess accommodation and employment needs with 90% of patients assessed and 100% of those assessed as requiring support receiving the necessary support by the end of the year.</td>
<td></td>
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<tr>
<td><strong>Performance:</strong></td>
<td>We developed and implemented new processes to assess accommodation and employment needs. We assessed 94% of accommodation needs and 92% of employment needs and took action to respond to all (100%) identified needs.</td>
<td></td>
<td></td>
<td>100% of this scheme has been achieved (£45,839)</td>
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<tr>
<th>Area of Performance</th>
<th>Increasing the opportunity for people to be treated in their own home through support from the Crisis Resolution Home Treatment Team</th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target:</strong></td>
<td>Trust Metric: KPI 1.6 – Ensure that 95% of people who access services do so via the Crisis Resolution and Home Treatment Team by the end of the year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Performance:</strong></td>
<td>During 2010/11, 99% of people accessed services via the Crisis Resolution and Home Treatment Team.</td>
<td></td>
<td></td>
<td>100% of this scheme has been achieved (£45,839)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area of Performance</th>
<th>Increasing the opportunity for people to return to their own home through support from the Crisis Resolution and Home Treatment Team</th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target:</strong></td>
<td>Trust Metric: KPI 1.7 – Ensure that more people are referred to the Crisis Resolution and Home Treatment Team to improve discharges by achieving a target of 14% referrals to the Team and increasing the assessment rate indicator to 90% by the end of the year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Performance:</strong></td>
<td>We achieved improvements in the number of people referred to the Crisis Resolution and Home Treatment and the speed of response therefore improving support with discharge planning but did not manage to achieve the targets.</td>
<td></td>
<td></td>
<td>70% of the scheme has been achieved (£96,262 of possible £137,516)</td>
</tr>
<tr>
<td>Area of Performance</td>
<td>Improving health by supporting people to quit smoking or to reduce tobacco use</td>
<td>Patient Safety</td>
<td>Clinical Effectiveness</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Target:</td>
<td>Trust Metric: KPI 1.8 - Develop and implement processes to assess smoking and tobacco use and ensure that 90% of individuals are offered a brief intervention to quit or reduce use by the end of the year.</td>
<td>Patient Safety</td>
<td>Clinical Effectiveness</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>Performance:</td>
<td>We developed and implemented new processes to assess, record and respond to the smoking and tobacco use of people who use our services. We took action to respond on 93.5% of occasions by offering brief intervention to support people to quit smoking.</td>
<td>Patient Safety</td>
<td>Clinical Effectiveness</td>
<td>Patient Experience</td>
</tr>
</tbody>
</table>

100% of the scheme has been achieved (£91,677)

<table>
<thead>
<tr>
<th>Area of Performance</th>
<th>Productivity Improvement Programme</th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target:</td>
<td>Trust Metric: KPI 1.9 – Implement the Productivity Improvement Programme and achieve all of the milestones throughout the year. This is a large scale programme to ensure that all patients are allocated to an appropriate pathway to meet their needs with a key focus on ensuring that 70% of patients are all on the appropriate pathway by the end of the year.</td>
<td>Patient Safety</td>
<td>Clinical Effectiveness</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>Performance:</td>
<td>We achieved all key milestones throughout the year but marginally underachieved the year-end target with 67% of patients allocated to a pathway of care.</td>
<td>Patient Safety</td>
<td>Clinical Effectiveness</td>
<td>Patient Experience</td>
</tr>
</tbody>
</table>

87% of the scheme has been achieved (£160,435 of possible £183,354)

<table>
<thead>
<tr>
<th>Area of Performance</th>
<th>Understanding and improving the overall patient experience</th>
<th>Patient Safety</th>
<th>Clinical Effectiveness</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target:</td>
<td>Trust Metric: KPI 1.10 – Undertake two patient satisfaction surveys, one for inpatients and one for community based services. One survey should be at the beginning of the year and the other at the end and achieve improvements in the levels of satisfaction</td>
<td>Patient Safety</td>
<td>Clinical Effectiveness</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>Performance:</td>
<td>We developed and implemented two satisfaction surveys. We showed improvements in a significant number of areas in the inpatient survey. In relation to our community based survey whilst we did not manage to improve our results, our original results were good.</td>
<td>Patient Safety</td>
<td>Clinical Effectiveness</td>
<td>Patient Experience</td>
</tr>
</tbody>
</table>

85% of the scheme has been achieved (£77,926 of possible £91,677)
Section 3.2 – Performance in 2010/11 as measured against a range of quality indicators

This section of the Quality Account provides a summary of our performance as measured against a range of quality indicators / metrics which are of interest to people who use our services, indeed most were selected for inclusion by key stakeholders. The information is presented under the three main headings of: Patient Safety; Clinical Effectiveness; and Patient Experience. Each section describes the area being reviewed; the metric used to measure performance including the unique reference code; and the overall Trust performance.

PATIENT SAFETY

11 Area of Performance: Environments & Cleanliness

<table>
<thead>
<tr>
<th>Metric (Method of Calculating Performance):</th>
<th>Trust Metric: KPI 2.14 / 5 Environments / cleanliness as assessed by the Patient Environment Action Teams (PEAT)</th>
</tr>
</thead>
</table>

Performance

We are very proud of our record for cleanliness and in April 2011 we received the following ratings:

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Environment Score</th>
<th>Privacy &amp; Dignity Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bucknall Hospital</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td>Dragon Square Community Unit</td>
<td>Excellent</td>
<td>Good</td>
</tr>
<tr>
<td>Learning Disabilities Unit</td>
<td>Excellent</td>
<td>Good</td>
</tr>
<tr>
<td>Hilton Rd</td>
<td>Good</td>
<td>Excellent</td>
</tr>
<tr>
<td>The Bungalows, Chebsey Close</td>
<td>Good</td>
<td>Excellent</td>
</tr>
<tr>
<td>Darwin – (Clydesdale Centre)</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td>Harplands Hospital</td>
<td>Good</td>
<td>Excellent</td>
</tr>
</tbody>
</table>

Patient Environment Action Teams are made up of Modern Matrons, the Support Services Manager, who manage the area to be audited, Estates Operational Manager, Head of Support Services, Infection Control nurse and representatives from North Staffs Users and LINks (Local Involvement Network) representatives who represent the general public.

12 Area of Performance: Incidents (Clinical and Non-clinical)

<table>
<thead>
<tr>
<th>Metric (Method of Calculating Performance):</th>
<th>Trust Metric: QI 3.11 Incidents</th>
</tr>
</thead>
</table>

Performance

The traffic light in this area is shown as amber due to a backlog in reporting of incidents early in 2010/11 but primarily due to issues raised by the Care Quality Commission with regard to the need to ensure that all Safeguarding Referrals are reported as incidents via the Trust’s internal processes. The backlog in reporting was addressed early in the year and all Safeguarding Referrals are reported as incidents following a full review of internal processes and the introduction of revised processes and scrutiny arrangements.

Did the health / social care worker treat you with dignity and respect? Result: 9.4 out of 10 agreed

National Community Mental Health Survey 2010

Quality Account 2010/11
We proactively support the recording of incidents and ensure that they are investigated, monitored and reported both to Committees of the Board and across the Trust as a whole. Incidents are analysed to understand the route cause and improved arrangements have been put in place towards the end of 2010/11 to ensure that key trends are analysed and disseminated and action is taken and lessons learned. The total number of incidents for 2010/11 is shown in the table above and in the following charts to show incidents by area, by type and by severity.

Total incidents relating the services covered by this Quality Account by area:

![Chart showing total incidents by area for 2010/11](chart1.png)

Incidents by type

![Pie chart showing incidents by type](chart2.png)

Serious, major and fatal by area

![Bar chart showing serious, major and fatal incidents by area](chart3.png)
There were 837 NPSA incidents reported during 2010/11.

For comparison purposes there were 601 NPSA reportable incidents in 2009/10. Calculated as a percentage rate per 1000 bed days this equates to 8.52 compared to the West Midlands median rate of 15.

Trusts are required to report certain incidents to the National Patient Safety Agency (NPSA). NPSA describes these incidents as “Patient Safety Incidents which are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS funded healthcare. The following data shows the number of incidents and their classification by area and type which were reported to NPSA by the Trust in 2010/11.
<table>
<thead>
<tr>
<th>14</th>
<th>Area of Performance: ‘Never Events’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric (Method of Calculating Performance): Trust Metric: QI 3.9 Never Events</td>
<td></td>
</tr>
<tr>
<td>A Never Event is a serious, largely preventable, patient safety incident that should not occur if the available preventative measures have been implemented. An example would be an inpatient suicide using curtain or shower rails.</td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>Nil - There have been no ‘never events’ in the Trust</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15</th>
<th>Area of Performance: Serious Incidents (SIs) (Clinical and Non-clinical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric (Method of Calculating Performance): Trust Metric: KPI 3.1 / 2 Investigating and Reporting of Serious Incidents</td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>During 2010/11 there have been 51 serious incidents reported by the Trust of which 12 were reclassified following initial inquiries and within 45 days – these are therefore no longer classified as a serious incident. Of the remaining 39 serious incidents in 2010/11:</td>
</tr>
<tr>
<td></td>
<td>• In the case of 31 (79%) serious incidents, the investigation, including development of action plans and sharing of key findings and action with commissioners and the Strategic Health Authority, was not completed with 45 days. 8 of the investigations remain ongoing and have exceeded the 45 day deadline</td>
</tr>
<tr>
<td></td>
<td>• Of the cases referred to above, in 13 cases the internal investigation was completed with the timescale but for a variety of reasons, the requirement to formally advise commissioners and the Strategic Health Authority of key findings and actions within 45 days was not met.</td>
</tr>
<tr>
<td></td>
<td>• In 3 cases the delay was unavoidable</td>
</tr>
<tr>
<td></td>
<td>• In 5 cases all requirements were met</td>
</tr>
<tr>
<td></td>
<td>A robust system for completing investigations, identifying recommendations, agreeing action plans with Commissioners, and agreeing formal closure will be implemented during 2011/12. Indeed this has been identified as a key priority area for 2011/12.</td>
</tr>
</tbody>
</table>

A number of common themes have arisen from investigations and recommendations including:

- The need for clinical staff to receive training in clinical risk management and risk planning. As a result of this, a previous Trust initiative, CRTI (Clinical Risk Training Initiative) is to be revised and implemented.
- Following an increase in detained patients failing to return from authorised and unauthorised leave, collaborative work has been undertaken with Staffordshire Police and there is now greater proactive discussion and action planning supported by increased training for staff.
- A number of investigations have arisen as a result of under 18s being admitted to Adult Acute wards and there is now access to an out of hours CAMHS on call advisory service along with increased access to specialist CAMHS admission beds.
### 16 Area of Performance: Healthcare Associated Infection (HCAI): MRSA

**Metric (Method of Calculating Performance):** Trust Metric: KPI 3.4 MRSA Bacteraemia (numbers)

**Performance**

Nil - We are delighted to report that we have had no Methicillin resistant Staphylococcus aureus (MRSA) bloodstream infections since 2007 which is, in part, due to the introduction of the MRSA screening programme for all admissions to hospital inpatient wards and units.

### 17 Area of Performance: Healthcare Associated Infection (HCAI): MRSA Screening

**Metric (Method of Calculating Performance):** Trust Metric: QI 3.13 MRSA Screening (%). Elective and emergency hospital inpatient beds.

**Performance**

Overall 89% as an average for 2010/11. Assessed as amber as we targeted 100% We are very proud to achieve a high level of screening throughout 2010/11 and the Trust has achieved in excess of 95% for the last 5 months of the year. Where performance dropped below 100% it was often down to patients declining screening.

![MRSA Screening Chart](image)

### 18 Area of Performance: Healthcare Associated Infection (HCAI): Clostridium Difficile

**Metric (Method of Calculating Performance):** Trust Metric: KPI 3.5 Clostridium Difficile (numbers)

**Performance**

2 cases of Clostridium Difficile were identified in year.

The Trust’s target was in excess of the Department of Health’s target and the Trust is pleased to report that it has achieved this target with a further reduction of 40% in reported Clostridium difficile (CD) cases compared to the equivalent period last year.

The document Equity and excellence: Liberating the NHS (Department of Health 2010) details the three domains of quality in the NHS Outcomes Framework. Patient safety, including infection prevention and control is a key quality issue which may impact upon positive patient outcomes and therefore continues to be a priority for the Trust. Preventing and minimising the risk of infection, have been the focus of the actions taken during this period.

We have seen a further reduction in Clostridium Difficile infections and no reported Methicillin resistant (MRSA) or Methicillin sensitive Staphylococcus aureus (MSSA) blood stream infections. Five outbreaks of infection were reported and managed as norovirus and all were successfully contained within the affected area. We are pleased to report consistent year on year reductions in healthcare associated infections over a significant number of years and is looking forward to the challenge of reducing the number of infections still further.

Quality Account 2010/11
CLINICAL EFFECTIVENESS

19 Area of Performance: Achieving National Quality Standards

Metric (Method of Calculating Performance): Trust Metric: KPI 18.1 Registration under the Health & Social Care Act 2008 for meeting the essential standards of quality and safety

Trust Performance - Registration:

Registration: The Trust is pleased to be registered without conditions for the first year of this new national process. The Trust’s Registration number is 1-114682668

Trust Performance – Ongoing Compliance:

Ongoing Compliance: The Care Quality Commission carried out a compliance review during 2010/11 and checked compliance with 5 of the 16 essential standards of quality and safety. For 4 of the 5 the CQC concluded that the Trust was compliant, however, ‘minor concerns’ were noted regarding compliance with outcome area 16 (assessing and monitoring the quality of service provision) and identified the need to make improvements. Most actions have already been delivered in full and any outstanding actions will be delivered early in 2011/12. This is discussed in further detail in section 2.8 and has resulted in the identification of one of our key priorities as outlined in section 1.2

Internal monitoring processes have provided evidence of compliance with all other essential standards of quality and safety throughout the year.

20 Area of Performance: Mental Health Activity

Metric (Method of Calculating Performance): QG.43 Mental Health Activity

Performance: 327 people were assessed under Section 136. Of these assessments:

- 12% resulted in formal admission under the Mental Health Act
- 19.5% people were admitted to hospital informally
- 0.5% person under the age of 18 was assessed
- 68% were not admitted

From the above data, it can be seen that the vast majority of people assessed under Section 136 of the Mental Health Act are not admitted to hospital.

This data shows the number of assessments carried out under Section 136 of the Mental Health Act (police power to remove a person to a place of safety). The Harplands Hospital Section 136 Assessment Suite is nominated as the formal place of safety and all service users are assessed there. This data shows the outcome of the assessments in terms of admission to hospital and the number of cases where the person was under the age of 18 years.
21  **Area of Performance:**  Delayed Transfers of Care

**Metric (Method of Calculating Performance):**  KPI 2.11  Delayed Transfers of Care

**Trust Performance:**  Using the same calculation method as used by the Care Quality Commission in previous years, the Trust’s rate for delayed transfers of care is 8.83% against a target of 7.5%. Significant progress has been made in reducing the number of people whose transfer was delayed from 15% in 2009/10 to 8.83% in 2010/11 although the Trust has not yet managed to achieve the target of 7.5%.

Benchmarking data for 2009/10 when our delayed rate was much higher than the present time shows that we did not compare well when compared to other Trusts as seen from the graph below:

![Graph showing delayed transfers of care comparison]

22  **Area of Performance:**  Staff Satisfaction

**Metric (Method of Calculating Performance):**  KPI 11.1: Staff satisfaction as measured by the annual national staff satisfaction survey

**Trust Performance:**  The national Staff Survey took place in November 2010. The survey results were published by the Care Quality Commission and are based on a random sample of staff. The response rate was of 49% (47% in 2009/10) which is below average for mental health/learning disability trusts in England at 54%

Benchmarked results are broadly consistent with 2009 outcomes. Of the 38 indicators:
- Best 20% - 18%
- Better than average - 8%
- Average – 16%
- Worse than average – 29%
- Worst 20% - 29%

![Comparison between 2009 and 2010]

![Comparison of 2009 and 2010 results]
We have developed a response to address the key messages from our staff and also to respond to the NHS Confederation’s Staff Pledges by developing a series of themes for improvement as follows:

- Theme 1: To improve performance development reviews (PDRs)
- Theme 2: To improve engagement with our staff
- Theme 3: To improve well-being and work-life balance
- Theme 4: To improve work roles, teams and environment
- Theme 5: To improve health and safety

**Staff Achievement Awards**

The REACH staff awards 2011 received more than 100 nominations, across seven categories. This was an excellent response, recognising the depth of excellence and achievement of staff within the trust.

- We received inspiring nominations for individuals and teams, from a wide variety of services and professional backgrounds as well as a large number of nominations from service users and carers.
- Sponsors of this year’s awards were: Mills & Reeve, Keele University, NHS Institute, NHS West Midlands, Warwick Medical School, Staff Side and North Staffs Users Group.
- The event now occurs separately from the Annual General Meeting to fully dedicate time to recognising the achievements of staff.

### Area of Performance: Implementation of National Guidance

<table>
<thead>
<tr>
<th>Metric (Method of Calculating Performance)</th>
<th>Implementation of national guidelines for interventional procedures</th>
<th>Implementation of national clinical guidelines</th>
<th>Implementation of national technical appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Performance:</td>
<td>A total of 50 Interventional Procedures, 24 Clinical Guidelines and 34 Technical Appraisals circulated by the National Institute of Clinical Excellence were reviewed by the Medical Director and adopted by this Trust. These guidelines are implemented on a Trust-wide basis.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Area of Performance: Physical Health Checks

<table>
<thead>
<tr>
<th>Metric (Method of Calculating Performance)</th>
<th>KPI 3.21 Physical health checks</th>
</tr>
</thead>
<tbody>
<tr>
<td>This was one of the Trust’s CQUIN targets for 2009/10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust Performance:</th>
<th>Quarter 2010/11</th>
<th>Response Rate</th>
<th>Outcome for % of Physical Health Checks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>76%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Quarter 2</td>
<td>88%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Quarter 3</td>
<td>99%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Quarter 4</td>
<td>99%</td>
<td>91%</td>
<td></td>
</tr>
</tbody>
</table>

The outcomes shown are the percentage of physical health checks completed although further action is necessary to ensure that these include all necessary elements which form a full physical health check.

In the last 12 months, did anyone in mental health services ask you about any physical health needs you might have? **Result: 5.1 out of 10 agreed**

National Community Mental Health Survey 2010
Area of Performance: Waiting Times

Metric (Method of Calculating Performance): KPI 2.17 18 week waiting time targets

Performance

5.5% at March 2011 - The Trust monitors the waiting time for outpatient appointments which show the proportion of people on the waiting list for a service who have been waiting for their first appointment for treatment for more than 18 weeks. The Trust target is for no one to have to wait over 18 weeks although the Trust has not yet achieved this target. Significant improvements have been made during the year reducing the percentage waiting in April 2010 when more than 10% waited over 18 weeks to 5.5% in March 2011.

Area of Performance: 7 Day Follow Up

Metric (Method of Calculating Performance): KPI 2.9 Follow up of patients within 7 days of discharge

Trust Performance:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Target</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>95%</td>
<td>99%</td>
</tr>
<tr>
<td>2</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>3</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>4</td>
<td>95%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Benchmarking data for 2009/10 shows that we compare well when compared to other Trusts as seen from the graph below:

Area of Performance: Crisis Resolution Gatekept Admissions

Metric (Method of Calculating Performance): KPI 2.13 Admissions Gatekept by Crisis Resolution Teams

Trust Performance:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Target for % of Admissions Gatekept</th>
<th>Outcome for % of Admissions Gatekept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>95%</td>
<td>99%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>95%</td>
<td>99%</td>
</tr>
</tbody>
</table>
### Area of Performance: Service Users on Care Programme Approach (CPA) Care Review

**Metric (Method of Calculating Performance):**

| KPI 2.5 | Number of patients on CPA who have received a care review in the past 12 months (Target 100%) |

<table>
<thead>
<tr>
<th>Trust Performance:</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>92%</td>
<td>93%</td>
<td>91%</td>
<td>91%</td>
<td>89%</td>
<td>92%</td>
<td>91%</td>
<td>92%</td>
<td>92%</td>
<td>91%</td>
<td>91%</td>
<td>92%</td>
</tr>
</tbody>
</table>

In the last 12 months have you had a care review meeting to discuss your care plan? **Result: 8.1 out of 10 agreed**

---

### Area of Performance: Patients in Settled Accommodation

**Metric (Method of Calculating Performance):**

| QI 2.29 | Percentage of patients who are in settled accommodation |

<table>
<thead>
<tr>
<th>Trust Performance:</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>83%</td>
<td>84%</td>
<td>89%</td>
<td>86%</td>
<td>86%</td>
<td>88%</td>
<td>88%</td>
<td>88%</td>
<td>88%</td>
<td>87%</td>
<td>88%</td>
<td>87%</td>
</tr>
</tbody>
</table>

Benchmarking data for 2009/10 shows that we compare well when compared to other Trusts as seen from the graph below:

In the last 12 months, have you received help from anyone in mental health services in finding and/or keeping your accommodation? **Result: 6.8 out of 10 agreed**

---

### Area of Performance: Patients in Employment

**Metric (Method of Calculating Performance):**

| QI 2.28 | Percentage of patients who are in employment |

<table>
<thead>
<tr>
<th>Trust Performance:</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Benchmarking data for 2009/10 shows that we compare well when compared to other Trusts as seen from the graph below:

In the last 12 months, have you received help, from anyone in mental health services, with finding or keeping work? **Result: 6.8 out of 10 agreed**

---

National Community Mental Health Survey 2010
Patient Experience

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Area of Performance: Patient Experience

#### Metric (Method of Calculating Performance):

| KPI 16.1 Patient experience as measured by the annual national patient survey in relation to community based care – the most recent survey results were published in September 2010 |

#### Trust Performance:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
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</tbody>
</table>

We are very proud of our most recent survey results as overall the Trust is rated in the top 20% performing Trust’s in the country. Of the 38 questions:

- 25 were better than other Trusts (top 20%)
- 13 were about the same as other Trusts (average range)
- None were in the lowest 20%

Benchmarking data for 2009/10 shows our excellent performance when compared to other Trusts as seen from the graph below:

At the start of 2010, a questionnaire was posted to a random sample of 850 adults who had used our community mental health services. 365 people completed the survey which is a response rate of 43%. Service users were asked about various aspects of their experiences and key results and a number of comments from those who completed the survey are shown below:

<table>
<thead>
<tr>
<th>Questions relating to Health and Social Care Workers</th>
<th>Score out of 10</th>
<th>How this score compares with other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Social Care Workers</td>
<td>8.9</td>
<td></td>
</tr>
</tbody>
</table>

‘After many years with mental health problems, for me it’s all coming together. I feel I matter now. I do have a voice and I am heard.’

‘My occupational therapist, counsellor and current Psychiatrist are very good. They give me time and freedom to express what I want to. They show empathy and unconditional positive regard. These skills and personal qualities have meant that the relationships I have had with them have been therapeutic.’

National Community Mental Health Survey 2010

<table>
<thead>
<tr>
<th>Medications</th>
<th>8</th>
<th></th>
</tr>
</thead>
</table>

‘My Care Coordinator gives me plenty of time and listens when we meet every four months and we discuss possible reductions in medication. She also sends a full report to my G.P.’

National Community Mental Health Survey 2010
In 2010, the Trust became a successful early adopter site for Patient Opinion, a social enterprise organisation that has been commissioned by the Department of Health to provide a free online feedback platform to all mental health trusts across England.

The Trust receives on line comments that are responded to in a timely and effective way via a direct dialogue via the commenter and responder. General comments range from compliments about staff teams and services, to concerns around the emerging options for future local mental health services. We have been asked to present our positive approach to embracing Patient Opinion at the 2011 National Patient Opinion Conference. All comments relating to Combined Healthcare can be viewed via: http://www.patientopinion.org.uk/service.aspx?nacs=RLY

Overall, how would you rate the care you have received from Mental Health Services in the last 12 months? **Result: 7.2 out of 10 answered positively** (better result than other Trusts)

**Patient Opinion**

<table>
<thead>
<tr>
<th>Service</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking Therapies</td>
<td>7.8</td>
</tr>
<tr>
<td>Care Coordinator</td>
<td>8.6</td>
</tr>
<tr>
<td>Care Plan</td>
<td>7.1</td>
</tr>
<tr>
<td>Care Review</td>
<td>7.7</td>
</tr>
<tr>
<td>Day to Day Living</td>
<td>6</td>
</tr>
<tr>
<td>Crisis Care</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Overall: **7.2**

‘Just thank you so much. The NHS is doing a great job and I owe you all for helping me. I couldn’t have managed my illness without you. I can now look confidently to the future. All aspects, CPN, Crisis Team, Psychiatric Doctor and GP etc have been good.’

National Community Mental Health Survey 2010

‘The fact that I can get in touch with someone right away if I need them is very comforting and reassuring.’

National Community Mental Health Survey 2010
Area of Performance: Complaints

Metric (Method of Calculating Performance):
QI 16.4 / 5 Complaint Acknowledgements, Responses and Trends

<table>
<thead>
<tr>
<th>Performance</th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints</td>
<td>75</td>
<td>84</td>
</tr>
<tr>
<td>Number acknowledged within timescale</td>
<td>96%</td>
<td>94%</td>
</tr>
<tr>
<td>Number responded to within timescale</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

In 2010/11 3 complaints were referred to the Ombudsman by complainants who were not satisfied with the response provided by the Trust. The Ombudsman has reviewed all complaints and declined to investigate further.

In 2009/10 3 complaints were referred to the Ombudsman of which 2 they declined to investigate and 1 was investigated by the Ombudsman although the Trust position and handling was upheld and no recommendations were made.

All complaints are reviewed and key actions taken as a result of complaints are shown below:

- Discharge / transfer arrangements and communicated with patients, especially when third party agencies are involved with the ongoing care/treatment arrangements.
- There has been a change of staffing on a ward to deliver a positive patient experience.
- Shared care guidelines regarding antipsychotics have been introduced.
- Annual CPA reviews include the presentation of side effect monitoring tools if applicable.
- Action has focussed on improving and strengthening communication processes, keeping service user, carers, and relatives informed regularly of any changes i.e. to services, care and treatment.
On 1st April 2009, New Complaints Regulations (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009) came into force. The Regulations contain new timescales for responses and new principles of good complaint handling which are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

A 16-page booklet, ‘Listening, Responding and Improving’, was published by the PALS and Complaints team following the introduction of the new complaints regulations.

### Area of Performance: Patient Advice and Liaison Service (PALS) & Compliments

#### Metric (Method of Calculating Performance):

Ql 1.8 Numbers and types of contacts via PALS and Compliments

<table>
<thead>
<tr>
<th>Performance specific to the services covered by this Quality Account:</th>
<th>During the course of the year the following contacts, requests and issues were received and addressed from clients within the services detailed in this Quality Account:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td>Compliments</td>
</tr>
<tr>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

There are no specific timescales attached to the PALS service, however, the ethos is person-centred and staff liaise closely with clients to agree acceptable outcomes and timeframes. There is a high degree of satisfaction with the service indicated by both open and anonymous feedback.
Compliments: Our staff regularly receive thank you cards and letters from patients and service users, grateful for care we have provided in support of their recovery. Some service users contact PALS to express their appreciation and some examples are:

"The Bennett Centre staff have been there for me during a very hard time in my life. They give me support and to be very honest, this is what keeps me going. I would like to thank all those that are helping me."

"Just a few words to thank all of you at the Hazelhurst Unit for the kind support and help that you have given me during the last four years. My particular thanks go to V. for helping me to survive my emotional roller-coaster of a journey - you have been my rock and my safety net during my journey and it has been a great source of comfort to know that you have just been a phone call away when I have needed you. Many thanks and fond wishes to you, E."

User and Carer information initiatives: During the year, the trust continued to develop a growing range of health information publications for patients, service users, their carers and loved ones. A new information strategy group, made up of representatives of users, carers and each of our business divisions, met regularly to discuss a range of initiatives to improve the quality, breadth and availability of information about our services and health-related topics. As a result, progress has been made in developing a trust-wide system to deliver, manage and review information products to a consistently high standard.

In addition, our PALS Manager has provided support to teams throughout the Trust in the development of patient and carer information for their clients. During the year, PALS helped teams to produce 28 new publications on a wide range of topics from a suicide prevention work-book to our leaflet, ‘Looking after your confidential personal information’.
34  Area of Performance:  **Food Provision**

Metric (Method of Calculating Performance): KPI 2.16 Food and nutrition as assessed by the Patient Environment Action Teams (PEAT)

Performance We are very proud of our excellent record for the food provision and in April 2011 received a rating of ‘excellent’ in all 6 areas assessed

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Food Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bucknall Hospital</td>
<td>Excellent</td>
</tr>
<tr>
<td>Dragon Square Community Unit</td>
<td>Excellent</td>
</tr>
<tr>
<td>Learning Disabilities Unit Hilton Rd</td>
<td>Excellent</td>
</tr>
<tr>
<td>The Bungalows, Chedsey Close</td>
<td>Excellent</td>
</tr>
<tr>
<td>Darwin – (Clydesdale Centre)</td>
<td>Excellent</td>
</tr>
<tr>
<td>Harplands Hospital</td>
<td>Excellent</td>
</tr>
</tbody>
</table>

35  Area of Performance:  **Same Sex Accommodation**

Metric (Method of Calculating Performance): QI 3.15 Shared Bedrooms

<table>
<thead>
<tr>
<th>Metric</th>
<th>QI 3.16 Shared Bathrooms</th>
<th>QI 3.18 Overall Compliance</th>
</tr>
</thead>
</table>

Trust Performance: We are proud to confirm that mixed sex accommodation has been eliminated in our trust.

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. We are committed to deliver care with privacy and dignity of which providing every patient with gender appropriate accommodation is an integral element, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.
Section 3.3 – Engagement and Statement from Key Partners

ENGAGING OUR PARTNERS AND STAKEHOLDERS – ‘Three steps to engagement’

North Staffordshire Combined Healthcare NHS Trust is committed to working collaboratively with a range of partners and as such has included three key steps in the development and publication of this Quality Account. All three steps have been successful and have resulted in key changes in the development and content of this Quality Account. We would like to take this opportunity to thank everyone who has worked with us and provide assurance that your views and comments have helped to shape this Quality Account.

Step 1 Development Stage:

We developed a survey to seek the views of key partners, staff, service users and members of the public about what they liked and disliked about our previous Quality Account and what should be retained and what should be changed. We made the questionnaire available on-line via our public website and it was also available as a paper version and we took the opportunity to write to our staff, key partners, GP Consortia leads and service user representative groups to alert them to the questionnaire and to include reference to the questionnaire in a public Trust Board meeting. All feedback received was responded to in the design of our Quality Account.

Step 2: Agreeing Priorities:

The questionnaire referred to above also included a section about the priorities that staff, key partners and service user representative groups would expect to see in our 2010/11 Quality Account. In addition, we have held a number of engagement meetings, attended events and have received written communications from our partners to agree our key priorities for 2011/12 as follows:

- Commissioners – NHS North Staffordshire & NHS Stoke
- Staffordshire Overview & Scrutiny Committees
- Stoke-on-Trent LINks
- Staffordshire LiNks
- North Staffordshire Users’ Group
- North Staffordshire Carers’ Association
- Reach
- Beth Johnson Association
Step 3: Sharing the Draft Quality Account:

In line with the Department of Health Guidance we also produced a draft Quality Account and shared this with key partners as follows:

- Local Commissioners
- Local Involvement Networks (LiNks)
- Local Authority Overview and Scrutiny Committees

We invited each partner to provide a statement for inclusion in the Trust’s Quality Account. The statements are shown below:

...it is really all about the journey and not just the destination...

“I was pleased to be invited to contribute to the Trust’s Quality Account in terms of setting the Trust’s priorities for the coming year and feel that my suggestions in the areas of improving care coordination, discharge planning and information for service users have been included in the priorities as set by the Trust. In future years I would also like to see more examples of what has changed as a result of involvement activities. I also suggested that the Trust includes real examples from the national service users survey or comments from service users throughout the document to support what the Trust is saying as it is really all about the journey and not just the destination - the impact that improvements have made to the service quality as experienced by the service user, and am assured that the Trust will include this approach in the final version.”

Lorien Barber, North Staffs Users Group

...people with learning disabilities who use services are the experts...

“It is essential that people are involved in speaking up about services and are offered real opportunities to be heard. People with learning disabilities tell us they want to take part in service audits and reviews, to check the quality of services, to make recommendations for change and to highlight good practice in services. People with learning disabilities who use services are the experts, their stories are evidence of what is not working and what is making a positive difference in their lives. We are happy that Reach has been asked to share people’s views and that people’s comments have helped to shape the Quality Account. We look forward to working with North Staffordshire Combined Healthcare Trust in the future to build on people’s involvement and participation in speaking up about services.”

Patsy Corcoran, Reach
COMMENTS FROM KEY PARTNERS

...happy to confirm that the information provided in the Quality Account is accurate...

As the main commissioners of services at North Staffordshire Combined Healthcare NHS Trust (NSCHT), NHS North Staffordshire and NHS Stoke are pleased to comment on the Quality Account for 2010/11. As part of the contract monitoring process, NHS North Staffordshire, NHS Stoke and Staffordshire and Stoke Joint Commissioning Units meet with the Trust every month, to monitor and seek assurance on the quality of services provided by North Staffordshire Combined Healthcare NHS Trust. In addition, monthly sub groups have been established to focus on serious incidents and CQUINS (quarterly meetings). The Quality Account covers many of the areas that are discussed at these meetings which seek to ensure that patients receive safe high quality care.

In relation to CQUIN targets, the PCTs were pleased with the level of achievement in 2010/11. Although certain indicators were not fully achieved, improvements were demonstrated in every area and in some cases targets for full achievement were only narrowly missed. The PCTs recognise that real improvements in quality can be made even where stretch targets are not met and would like to see qualitative summaries of changes made to practice and outcomes for patients in future quality accounts.

The PCTs have worked closely with the Trust to agree quality improvements for 2011/12 using the CQUINS framework. The process for developing CQUIN scheme this year has included greater involvement by lead clinicians. The range of indicators will, if achieved, lead to material quality improvements for a wide range of patients as well as meeting the requirements of QIPP for acute mental health. The PCTs support the drive for continuous quality improvement and are pleased that the quality accounts include a commitment to revise the models of care in line with best practice and move towards the type of care promoted in the new national mental health strategy.

The quality accounts include reference to the need to improve incident reporting systems, in particular ensuring that systems become more robust and that when things go wrong they are reported rapidly and that following timely investigations lessons are learned from serious incidents. During 2010/11 the PCTs formally identified this as an area requiring improvement and have noted that one of the 2 key actions highlighted by the CQC compliance review also related to incident reporting. North Staffordshire Combined Healthcare NHS Trust has put in place an improvement plan and this will be monitored by the PCTs.

The PCTs are also fully supportive of the continued development of care pathways, initiatives to improve patient safety and the development of patient outcome measures. The PCTs are pleased that North Staffordshire Combined Healthcare NHS Trust has developed a Patient Experience Strategy and would encourage the Trust to increase its focus on utilising patients / carers / staff / public feedback as part of its aim to continuously improve quality. The PCTs would suggest that in future years North Staffordshire Combined Healthcare NHS Trust make the Quality Accounts more meaningful to service users by describing how patients or service users have benefitted or will benefit in future from quality improvements or planned changes. Key messages might be made more relevant by illustrating them with a broader range of examples relating to real patient experiences.

Having reviewed the information in the Quality Account against the information the PCTs and their partners have recorded on the areas covered, the PCTs are happy to confirm that the information provided in the Quality Account is accurate. The PCTs are also happy to confirm that the account provides a balanced reflection of the quality of services provided.

NHS North Staffordshire & NHS Stoke – Commissioning Primary Care Trusts
We are directed to consider whether a Trust’s Quality Account is representative and gives comprehensive coverage of their services and whether we believe that there are significant omissions of issues of concern. Our approach has been to review the Trust’s draft Account and make comments for them to consider in finalising the publication, before providing this final commentary.

There are some sections of information that the Trust must include and some sections where they can choose what to include. We focused on what we might expect to see in the Quality Account, based on the guidance that trusts are given and what we have learned about the Trust’s services through health scrutiny activity in the last year. We also considered how clearly the Trust’s draft Account explains for a public audience (with evidence and examples) what they are doing well, where improvement is needed and what will be the priorities for the coming year. We were expecting this year’s Quality Accounts to demonstrate increasing patient and public involvement in the assessment and improvement of the quality of services that health trusts provide.

We are pleased that, as a result of our comments, the Trust has:

- included a list of services;
- added an explanation of how partner and stakeholder input has informed the Account;
- included information about improving the estate;
- clarified the Commissioning for Quality Innovation (CQUIN) Scheme for 2010/11 income achieved;
- added benchmarking information to elements of the review of quality performance; and
- responded to minor comments about the format of the Account.

In particular, we asked for service-based examples to be added wherever possible to illustrate how action taken by the Trust leads to improvements in care quality. The Trust has responded to this request - and given priority in 2011/12 to learning lessons, which should mean that they can give a wide range of examples in next year’s Account.

We encourage people to provide feedback to the Trust on the Quality Account as this will help with next year’s publication.

Staffordshire Health Scrutiny

Due to the timing of the City Council elections and the publication of the quality accounts, the Scrutiny Committee for Health Issues has not been able to consider the North Staffordshire Combined Healthcare’s 2010/11 Quality Account.

Stoke on Trent Overview & Scrutiny Commission
...we consider it to be a fair reflection of the healthcare services provided...

Stoke-on-Trent LINk would like to thank North Staffordshire Combined Healthcare NHS Trust for providing the opportunity to comment on their Quality Account for 2010/11. We consider it to be a fair reflection of the healthcare services provided and we put forward the following suggestions for improving the quality and range of its provision in Stoke-on-Trent:

1. Ensure that Dementia Care is seen as a key priority, that sufficient funding allocated and staff-training made available, to meet the fast-increasing needs of the community.
2. Ensure that improvement continues in the nutritional screening and support of patients, particularly the more vulnerable elderly population.
4. Ensure efficient co-ordination and co-operation between services as we move towards increased care in the community.
5. Ensure a more enriching experience for acute in-patients at Harplands by the provision of a range of holistic therapeutic activities, particularly during evenings and at weekends.
6. Ensure the speedy and efficient reporting, follow-up and satisfactory closure of serious incidents with concerned parties.
7. Ensure that a fuller range of services is available, including CBT, is made available, as required, and with minimal delay for patients.

Stoke-on-Trent LINk thanks North Staffordshire Combined Healthcare NHS Trust for improving its range of public involvement activity during the year, including much input from staff, presentations and arranged familiarisation visits. Whilst Stoke-on-Trent LINk acknowledges that North Staffordshire Combined Healthcare did commence the process of working with partners in agreeing the Trust priorities in March 2011, Stoke-on-Trent LINk would like the opportunity for earlier and regular discussions in agreeing priorities. Stoke-on-Trent LINk acknowledges receipt of a formal draft on 28th April 2011 although the draft did not contain all Q4 outcomes (for example in relation to CQUIN outcomes which were still being agreed with Commissioners) until 31st May, making the final response time shorter. Also the presentation, expertly delivered, informative and given jointly to Stoke-on-Trent LINk and Staffordshire LINk on May 11th did present the final agreed priorities but did at times rather unexpectedly move between the previous year’s Quality Account (2009/10) and the current version. This said, we would welcome:

- Stakeholder engagement in the development of the Quality Account beginning nearer the start of the reporting year.
- Closer involvement in the commissioning process, alongside other interested bodies to ensure that Quality Accounts are locally meaningful and reflect local priorities.
- The opportunity to work closely with the trust in ensuring that the content is understood by all.
...we are pleased that the Trust came to present their draft Quality Account which provided an opportunity to participants to comment and give feedback...

In the Trust’s Quality Account for 2009/2010 Staffordshire LINk commented that they would ask the Trust to consider a more user friendly way of presenting the information in 2010/2011 and, perhaps through a presentation of the report to a meeting of LINk participants which would be more effective and engaging. Staffordshire LINk are pleased that the Trust took note of this and a joint meeting with Stoke-on-Trent LINk was arranged for representatives of the Trust to come and present their draft Quality Account which provided an opportunity for participants to comment and give feedback.

Authors of the Quality Account must appreciate the area of distribution for which the document is intended, ie the general public. The document must be written in as near lay terms as possible with as little jargon as possible. During the process of reviewing the draft Quality Account it was necessary for a LINk participant to read parts several times and seek clarification of terms from other sources and it would be useful for a Glossary of terms to be incorporated to explain / define acronyms and jargon where it is necessary that they be included in the Account.

The Quality Account reports on the areas of Patient Safety, Clinical Effectiveness and Patient Experience as prescribed by the Department of Health and results in some technical information that may be difficult for some members of the public to understand. Part 2 sets out the Trust’s priorities for improvement. LINk participants are keen to see that the first priority relating to patient safety is to implement improved arrangements in relation to serious incidents and incidents. However, the report refers to 12 individual actions to address the findings of the Care Quality Commission following a Compliance Review during 2010/11, but fails to state what these are.

Staffordshire LINk would wish to thank the Trust for giving them the opportunity to comment on the Quality Account.

Staffordshire LINks (Local Involvement Networks) Trusts
### STATEMENT OF CHANGES

The majority of comments from partners were received at an early stage and have been incorporated in full in later drafts. The statements above include a small number of additional suggestions for change. The section below describes whether the suggestions have been responded to in the final draft of the Quality Account:

<table>
<thead>
<tr>
<th>Comment:</th>
<th>Request responded to:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS North Staffordshire &amp; NHS Stoke – Commissioning Primary Care Trusts:</strong></td>
<td>Included</td>
</tr>
<tr>
<td>NHS North Staffordshire and NHS Stoke have worked closely with the Trust in reviewing early drafts of the Quality Account and have made many suggestions for improvement all of which have been responded to in this final document. There are no further changes to be made based on the commentary above.</td>
<td></td>
</tr>
<tr>
<td><strong>Staffordshire Health Scrutiny:</strong></td>
<td>Included</td>
</tr>
<tr>
<td>Staffordshire Health Scrutiny has worked closely with the Trust in reviewing early drafts of the Quality Account and has made many suggestions for improvement all of which have been responded to in this final document. There are no further changes to be made based on the commentary above.</td>
<td></td>
</tr>
<tr>
<td><strong>Stoke on Trent LINks (Local Involvement Networks):</strong></td>
<td>Not applicable</td>
</tr>
<tr>
<td>There are no further changes to be made based on the commentary above.</td>
<td></td>
</tr>
<tr>
<td><strong>Staffordshire LINks (Local Involvement Networks):</strong></td>
<td>Included</td>
</tr>
<tr>
<td>Request for a glossary of terms to be included</td>
<td></td>
</tr>
<tr>
<td>Ensure that the 12 actions in response to the Care Quality Commission’s Compliance Review are explained in more detail than simply stating 12 actions</td>
<td>Included</td>
</tr>
</tbody>
</table>
GLOSSARY OF TERMS

ASIST  Advocacy Services in Staffordshire
APC  Admitted Patient Care
CAMHS  Child & Adolescent Mental Health Service
CDS  Commissioning Data Set
CLRN  West Midlands North Comprehensive Local Research Network
CPA  Care Programme Approach
CPD  Continuing Professional Development
CPN  Community Psychiatric Nurse
CQC  Care Quality Commission
CQUIN  Commissioning for Quality Innovation scheme
DOH  Department of Health
ECT  Electroconvulsive therapy
EngAGE  Stoke on Trent Forum for people over 50 to give their views
HRG4  Health Resource Group (standard groupings of clinically similar treatments)
IAPT  Improving Access to Psychological Therapies team
IM&T  Information Management and Technology
IT  Information Technology
KMRs  Korner Monthly Return - This is a form used for coding purposes
LINk  Local Involvement Network
Metric  Method of calculating performance
Mind  Mental Health charity network
MRSA  Methicillin-resistant Staphylococcus Aureus
NewsRound  Staff Newsletter
NHSLA  NHS Litigation Authority
NHS North Staffordshire  A Primary Care Trust and one of the main Commissioners
NHS Stoke  A Primary Care Trust and one of the main Commissioners
NICE  National Institute for Health and Clinical Excellence
NIHR  National Institute for Health Research
NPSA  National Patient Safety Agency
NSCHT  North Staffordshire Combined Healthcare NHS Trust
OCD  Obsessive Compulsive Disorder
OP  Out-patients
PALS  Patient Advice and Liaison Service
PAs  Programmed Activity
PCT  Primary Care Trust
PIP  Productivity Improvement Pathway Programme
POMH  Prescribing Observatory for Mental Health
QIPP  Quality, Innovation, Productivity, Partnership and Prevention
R&D  Research and Development
Reach  Local advocacy project supporting people with learning disabilities
Rethink  Mental Health membership charity
RSM Tenon  RSM Tenon is the Trust’s Internal Auditor
SPA  Single Point of Access (to mental health services)
Staff Side  Staff representatives
SUS  Secondary Users Service
UHNS  University Hospital of North Staffordshire NHS Trust
If you would like further copies of this document, or would like it in large print, Braille or an alternative language, please contact:

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