QUALITY ACCOUNTS
2018/19
## Contents

<table>
<thead>
<tr>
<th>PART 1</th>
<th>About our Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>About our Quality Accounts 2018/19</td>
<td>1</td>
</tr>
<tr>
<td>Statement on Quality from our Chief Executive</td>
<td>2</td>
</tr>
<tr>
<td>About our Trust</td>
<td>3</td>
</tr>
<tr>
<td>Service User &amp; Carer Experience</td>
<td>6</td>
</tr>
<tr>
<td>Freedom to Speak up</td>
<td>8</td>
</tr>
<tr>
<td>Duty of Candour</td>
<td>9</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>10</td>
</tr>
<tr>
<td>Sign up to Safety</td>
<td>12</td>
</tr>
<tr>
<td>Staff Survey Results</td>
<td>13</td>
</tr>
<tr>
<td>CQC Ratings</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PART 2</th>
<th>Our Priorities for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priorities for Improvement 2018/19</td>
<td>19</td>
</tr>
<tr>
<td>Summary of Former Staffordshire &amp; Stoke on Trent Partnership NHS Trust 2018/19 Priorities for Improvement</td>
<td>25</td>
</tr>
<tr>
<td>Priorities for Improvement 2019/20</td>
<td>26</td>
</tr>
<tr>
<td>Statements of Assurance from the Board</td>
<td></td>
</tr>
<tr>
<td>Review of Services</td>
<td>28</td>
</tr>
<tr>
<td>Clinical Audit / Confidential Enquiries</td>
<td>28</td>
</tr>
<tr>
<td>Clinical Research</td>
<td>32</td>
</tr>
<tr>
<td>Commissioning for Quality and Innovation</td>
<td>32</td>
</tr>
<tr>
<td>Registration with Care Quality Commission</td>
<td>33</td>
</tr>
<tr>
<td>Quality of Data</td>
<td>33</td>
</tr>
<tr>
<td>Learning from Deaths</td>
<td>34</td>
</tr>
<tr>
<td>Reporting Against Core Indicators</td>
<td></td>
</tr>
<tr>
<td>CPA 7 day Follow-up</td>
<td>37</td>
</tr>
<tr>
<td>Admission to Acute Wards via Crisis Resolution Home Treatment</td>
<td>39</td>
</tr>
<tr>
<td>Readmission to Hospital within 28 Days of Discharge</td>
<td>40</td>
</tr>
<tr>
<td>Patient Experience of Community Mental Health Services</td>
<td>41</td>
</tr>
<tr>
<td>Patient Safety Incidents</td>
<td>42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PART 3</th>
<th>Other Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Local Quality Indicators for 2019/20</td>
<td>46</td>
</tr>
<tr>
<td>Our Local Quality Indicator Review 2018/19</td>
<td>47</td>
</tr>
<tr>
<td>Performance Against Mandated National Measures</td>
<td>51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annex 1</th>
<th>Statements from Commissioners, Local Healthwatch &amp; Scrutiny Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffordshire &amp; Stoke on Trent CCG’s</td>
<td>52</td>
</tr>
<tr>
<td>Telford &amp; Wrekin CCG</td>
<td>53</td>
</tr>
<tr>
<td>Healthwatch Shropshire</td>
<td>54</td>
</tr>
<tr>
<td>Staffordshire Health Scrutiny Committee</td>
<td>55</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annex 2</th>
<th>Statement of Directors’ Responsibilities for the Quality Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement of Directors</td>
<td>56</td>
</tr>
<tr>
<td>External Auditor’s Opinion</td>
<td>57</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Glossary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Glossary of Technical Terms</td>
<td>60</td>
</tr>
<tr>
<td>Standard Definitions</td>
<td>62</td>
</tr>
<tr>
<td>Externally assured indicator completeness considerations</td>
<td>66</td>
</tr>
</tbody>
</table>


**PART 1**

*About our Quality Accounts 2018/19*

Our Quality Account is our annual report to the public about the quality of healthcare services we deliver and is an opportunity for the Trust to offer its approach to quality up for scrutiny, debate and reflection by the public.

Each year our Quality Accounts are both retrospective and forward looking. We look back at the year just passed and present a summary of our key quality improvement achievements and challenges. We look forward and set out our quality priorities for the year ahead, ensuring that we maintain a balanced focus on the three key domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Our quality priorities are chosen following a process of review of current services, consultation with our key stakeholders and most importantly through listening to the feedback from our service users and carers.

Some of the content of the Quality Accounts is mandated by NHS Improvement and/or by The NHS (Quality Accounts) Amendment Regulations 2012, however other parts are determined locally and shaped through the feedback we receive.

The Quality Accounts are split into three main parts:

**Part 1**

*Provides a statement summarising the Trust’s view of the quality of health services provided or sub-contracted during 2018/19.*

**Part 2**

*Provides a review of performance against the priorities for improvement as identified in our 2017/18 Quality Accounts*

*Sets out our quality priorities for this year (2019/20)*

*Provides a series of prescribed statements of assurance from the Trust Board*

*Provides a report on performance against a set of core indicators using data made available by the NHS Digital Indicator Portal.*

**Part 3**

*This section is used to present an overview of the quality of care delivered by the Trust against a number of local indicators as well as performance against relevant indicators set out in NHS Improvement Single Oversight Framework (2017).*
Statement on Quality from our Chief Executive

Welcome to our 2018/19 Quality Accounts, which offers us a chance to reflect on a year of change and of new beginnings.

Midlands Partnership NHS Foundation Trust officially launched on 1st June 2018, bringing together mental health, learning disability, specialist children’s services and wider regional and national specialist services with community physical health services.

These Quality Accounts will provide an update on the progress we have made as a new organisation against our key quality priorities for 2018/19 as well as share with you a wealth of information about our quality journey throughout this year of change.

Some of our key achievements over the last twelve months have been:

❖ We participated in the NHS staff survey for the first time as Midlands Partnership NHS Foundation Trust. Our Trust response rate was the highest in the country for trusts providing community services with 62% of colleagues taking time to give their views. The survey results showed that we scored better than average across five of the key themes and average in the remaining five, which is excellent for a newly integrated trust with staff who have experienced major change.

❖ During February and March of 2019 the CQC undertook an inspection of our core services, this was followed by a number of focus group sessions at the beginning of April 2019 and our CQC well led visit during 8th – 10th April. Although we await the outcome of this inspection, the CQC inspectors told us how impressed they have been with the level of enthusiasm demonstrated by everyone they met.

❖ Integrated care is a priority for the Trust and we are moving at pace to realign our services and support integrated care at a locality level across Staffordshire and Stoke-on-Trent.

❖ Our Freedom to Speak up Team was shortlisted in the ‘Creating a Supportive Staff Culture’ category at the 2018 HSJ Awards.

❖ The innovative partnership between two Trusts’ and a private healthcare provider, which aims to bring patients who are currently in secure care outside of the West Midlands closer to home, was “highly commended” at the 2018 HSJ Awards. So congratulations to the forensic services for their participation in this Reach Out project.

❖ Our Tissue Viability Service and Community Nurses were victorious at the 2018 Nursing Times Awards in the Innovation in Chronic Wound Management category. The award recognises the work the service has carried out to improve timely, accurate assessment and diagnosis of lower limb wounds, which has resulted in patients wounds healing quicker.

❖ The Trust’s focus on quality improvements has been profiled in the CQC national report “Quality improvement in hospital trusts – sharing learning from trusts on a journey of QI “.

I would like to thank our staff for their continued hard work, resilience and commitment during this significant time of change. We have continued to deliver consistent high quality care, despite increased demand and financial pressures across many of our services.

As this first year as Midlands Partnership NHS Foundation Trust draws to a close, and a new financial year begins I could not be more proud of everything we have achieved together as a new organisation. This report I hope will give you a flavour of these achievements as well set out our ambitions for the year ahead.

Thank you for taking the time to read this report.

Neil Carr, Chief Executive
About our Trust

Our Trust Services

Midlands Partnership NHS Foundation Trust (MPFT) was formed on 1st June 2018 and is an integrated organisation that provides physical and mental health, learning disabilities and adult social care services. These services were previously provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust and Staffordshire and Stoke on Trent Partnership NHS Trust. We believe there a number of benefits to being integrated, these include:

- Improved access to services
- A joined-up service around the service user and their family reducing confusion, duplication and enabling better co-ordination of care
- Improved information sharing between professionals
- Greater opportunities to support staff recruitment and retention
- Successful delivery of the Sustainability and Transformation Partnerships in Staffordshire and Stoke-on-Trent; Shropshire and Telford & Wrekin.

As an organisation we serve a population of 1.5 million, over a core geography of 2,400 square miles, and employ around 8,500 members of staff. The majority of our services are delivered in Staffordshire, Stoke-on-Trent, Shropshire, and Telford & Wrekin, but through Inclusion, part of our specialist care group, we cover much of England. To ensure that our services retain a local focus or critical mass, they are organised into four care groups; each with a managing director, clinical and care director and head of operations:

- Children & Families
- Specialist
- Shropshire and Telford & Wrekin
- Staffordshire and Stoke-on-Trent
Our Trust Strategy

Our mission, values and behaviours

The Trust’s strategy revolves around our mission that ‘together we are making life better for our communities’ and our core values and behaviours which are centred on a culture of high-quality, sustainable care. This is supported by our strategic framework which sets out our strategic aims and objectives as a new organisation.

Our strategic framework

Our strategic framework is underpinned by a number of supporting strategies aligned to each objective; this includes a strategy for quality, finance, estates, IM&T, workforce & development and commercial services.
Our Quality Framework

Our Quality Framework enables us to translate the Trust’s strategic aim “to deliver high quality health & social care services” into a framework of priorities. Our framework is not simply concerned with regulatory and contract compliance, but is about building on strategic quality priorities identified by the Trust Board in June 2018. The Framework aims to make our Trust services and our staff stand out and play a part in leading excellence in our service sector. Our five key priorities for delivering our strategic quality objective are:

- People who use our services will be happy about the way they are treated and will have genuine opportunities to make an impact on service improvements
- Teams will be supported to make continuous quality improvements the norm
- We will learn from mistakes and take steps to reduce future errors
- Our CQC rating will not fall below an overall rating of ‘Good’ and the CQC will see evidence of outstanding practice in an increasing number of services
- We will engage in a comprehensive programme of research to enable practice to be built on the best available evidence
Service User and Carer Involvement and Experience

Experience and feedback
People’s experiences of our services are important to us as they provide us with key measures of quality. We employ a range of tools to help us understand people’s experiences so that our teams can use feedback to make local changes quickly. Some of the methods we currently employ include:

- **Surveys** - some surveys have been developed locally either with a particular service or for a piece of focused improvement work. Some are prescribed and the Trust must use them, such as the ‘Friends and Family Test’ and the national ‘Community Mental Health Survey’.

- **Mystery shoppers** – sometimes people who use our services are asked to be ‘mystery shoppers’ to help us gain real insights into what the whole experience of receiving care from MPFT is like.

- **Focus groups** – these are set up by the Trust for specific purposes when, for example, services are planning changes or to support research into better care. They are also sometimes set up by external organisations such as the CQC or Healthwatch to provide us with independent feedback.

- **Forums** – service user and carer forums where the service user and carer voice is heard, and speakers are invited to share information about services and feedback is reviewed.

- **Community meetings** – regular community meetings take place in in-patient areas including forensic services. Peer support workers facilitate these meetings for service users and carers to raise issues that are addressed directly by the ward teams.

- **Concerns and Compliments** – people contact the Patient Advice and Liaison Service to request support or information, to raise any concerns they may have and to praise the staff that have cared for them. We review all these contacts to see if there are any emerging themes anywhere in the Trust that we need to learn from.

- **Patient Stories** – people who use our services are sometimes asked to share the story of their journey at the Trust Board of Directors, the Council of Governors and Mental Health Legislation Committee.

However, although many of these lead to real impact in local services, we also want to ensure we can use people’s experiences and ideas in shaping our services to create wider sustainable impact, through our service user and carer involvement services.

Involvement for Impact
Service user and carer involvement is key to developing and delivering responsive services. The Trust recognises that service users and carers are ‘experts by experience’, and therefore make a vital contribution to all aspects of the work undertaken within the services provided by the Trust. For effective involvement, people need to feel supported and for their contribution to be valued, respected and have an impact. It is really important to us that the people who use our services have the opportunity to get involved in shaping those services and influencing the Trust’s work.

The Trust is committed to delivering involvement activities that create greater impact across its services. We have adopted and adapted work undertaken at a national level by the National Service User Network (NSUN) and National Involvement Partnership (NIP) to provide a meaningful framework for involving
people with lived experience in influencing services. The 4Pi National Involvement Standards, developed with mental health service users and carers has universal relevance. The framework supports organisations and individuals to work in partnership and make involvement work well for everyone. The Trust has adopted the 4Pi standards to enable us to evaluate the impact of our involvement activity.

- **PRINCIPLES:** How we relate to each other
- **PURPOSE:** Why we are involving people
- **PRESENCE:** Are the right people involved in the right places
- **PROCESS:** How people are involved and how do people feel about the involvement process
- **IMPACT:** What differences does the involvement make and how can we tell that we have made a difference.

**Involvement Activity 2018/19**

During the year a number of key involvement activities have taken place, these include:

- Involvement for Impact Workshop – “NHS Improvement Experience of Care Week – Patient Surveys”
- Involvement for Impact Workshop – “Service User and Carer Involvement in Quality Improvement Activities”
- Involvement for Impact workshop – “Time to Talk Event – Have your Say”
- Involvement for Impact Workshop – “Is Our Information Accessible?”
- Always Events – pilot on the Mother and Baby Unit
- Service User and Carer Celebration Day
- Patient Stories at Trust Board, the Council of Governors and the Mental Health Legislation Committee
- Better Together – Visions, Values and Behaviours and Website Development
- Patient Experience Network National Awards
- ‘Listen and Respond’ annual event
- Mental Health and Persistent Back and Neck Pain Co-Produced Project
- Mystery Shopper Project
- Service user and carer involvement in recruitment and interview panels
- Co-produced and co-delivered training on autism and carer awareness
- Independent Review of the Mental Health Act Focus Groups
Freedom to Speak up

Our staff at Midlands Partnership NHS Foundation Trust (MPFT) are encouraged to speak up about their concerns whether they are about patient safety, quality of service, or behaviours of colleagues and in the first instance we encourage them to do this through their management structures. Where going through a management structure may not be appropriate, staff also have access to their professional leads, staff side representatives, peers, senior leaders, clinical tutors and Freedom to Speak Up Guardians.

MPFT have two dedicated Freedom to Speak Up Guardians. Staff who approach the Freedom to Speak Up Guardian very often do so when they have already spoken up but have not had feedback about how their concern is being addressed, or where they have concerns about colleagues’ behaviours. When feedback about a concern raised with a manager has not been received, the Freedom to Speak Up Guardian (with the permission of the member of staff) will then explore how the concern is being addressed and ensure that this progress is fed back to the member of staff.

MPFT have an online reporting system where all staff are able to report concerns around patient safety and quality.

The Freedom to Speak Up Guardians support leaders to cultivate a climate with their teams of enabling staff to feel free to speak up. The Freedom to Speak Up Guardians are also supported by a network of Champions whose role it is to promote a positive speaking up culture within their area of work, and to support staff to speak up to their managers or to the Freedom to Speak Up Guardian.

On commencement with the Trust, new staff receive an interactive handbook. This handbook is utilised as part of induction for new starters, as well as acting as a resource for existing staff. Within the handbook a page is dedicated to Freedom to Speak Up. Staff hear a message directly from the Chief Executive, encouraging staff to speak up even if they are unsure about their concern. Staff also receive a dedicated leaflet which explains how staff can speak up and provides contact details of the Freedom to Speak Up Guardians. Managers and leaders are also asked to ensure that there are posters available for staff to view on staff notice boards and other staff areas.
Duty of Candour

Our Trust believes that communicating honestly and openly with services users and their families when things go wrong is a vital component in dealing effectively with, and learning from errors and mistakes. Even before the Health and Social Care Act Statutory Duty of Candour came into force in November 2014 we expected our staff, through their professional and ethical duties, to be open with services users and their carers when things had gone wrong and/or harm had been caused.

Following the Mid Staffs enquiry, Sir Robert Francis defined Duty of Candour as “The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.”

We expect all staff to report any patient safety incident or near-miss immediately through our electronic reporting system Safeguard. When such an incident has resulted in moderate harm or greater, then staff apply the Statutory Duty of Candour as follows:

- Notify the service user / carer within 10 working days of the incident being reported
- Contact the service user / carer to provide all the facts known about the incident and a way that they can understand
- Speak to the service user / carer in a place and at a time when they are best able to understand and retain information
- Offering a personalised apology
- Ensure that the service user / carer knows who to contact to raise further questions or concerns
- Agree and carry out any further investigation which may need to take place
- Fully record the details of the apology / discussion in the service users records
- Followed up with a written notification

In addition to the statutory requirements for Duty of Candour the Trust has employed a dedicated Family Liaison Officer. The Family Liaison Officers role is to engage with patient and families following moderate or above harm / or death whilst receiving Trust services. The Family Liaison Officer offers a range of support functions to relatives including:

- Talking through the incident and ensuring questions raised by families are included within the investigation process
- Offering initial bereavement support and advice and signposting to relevant bereavement services
- Explaining the Coroners inquest process and supporting families through this difficult time
- Explaining processes for raising concerns, including PALS and complaints.
- Offering where appropriate families the opportunity to share their experiences and the opportunity to work in partnership on service improvement initiatives
Quality Improvement (QI)

The Trust has a Quality Improvement programme, which has been in place for six years. This gives everyone in the organisation a consistent approach and structure to improving our practices and services. The programme delivers a suite of resources for staff, service users and carers including:

- training for all staff in our QI methodology (that of the Virginia Mason Production System, a world-wide recognised method for improving healthcare)
- training and support for team leaders and clinicians to become leaders in QI, so enabling their teams to practice QI within their own services and to take part in QI projects
- specialist QI training for senior leaders in the organisations so they may sponsor and support long-term, wide ranging QI programmes

Against this programme described above, we have achieved the following to date:

- 552 staff trained in First Steps in QI
- 85 leaders trained in Leading QI
- 33 senior leaders trained as Certified Leaders in QI, with another 30 in training in 2019/20

Staff continue to embrace the ethos of the QI framework, ‘In Pursuit of the Perfect Patient Experience’. They are practicing aspects of quality improvement which enhance their working environment, improve safety, reduce time spent on wasteful activities, increase service user focused time, and eliminate variation so that all service users and carers receive the right care, in the right way, at the right time.

More staff are practicing ‘Daily Lean Leadership’ across the organisation, which provides teams with a focus, direction and a method of management for daily work. Many teams now have ‘huddle boards’ in place, and you will see teams huddling at these boards every day. They contain all the information the team needs to discuss improvement activities; both the challenges and their ideas. There is a clear focus on improvement, planning and problem-solving; and the boards display all the teams’ QI work, ideas for future projects and feedback from service users, carers and partners. We currently have 44 boards in use, with many more in development as teams share this good practice across their Care Groups. The District Nursing Specialist Practice students have also launched Huddle Boards within all 17 District Nursing teams.

The QI programme not only delivers training, but also QI events. These can be weeklong events, taking a few months to prepare (called Rapid Process Improvement Workshops (RPIWs)) or shorter two or three day events (called ‘kaizen events’).

So far the Trust has completed:

- 71 RPIW and kaizen events
- 54 Leading QI projects
The outcomes of each QI event vary, but commonly they include improvements to:

- Time saved
- Reduction in the number of processes where quality is not perfect
- Improved working environment and increased safety
- Reduced motion and set-up time for staff
- Efficiency gains in time and cost
- Improved patient experience
- Improved customer satisfaction
- Improved staff engagement
- Production of standard work for teams to reduce variation

Recent RPIWs have taken place in the following teams:

Norbury Ward

The team wanted to improve the process from making a decision to commence constant observations to when the care plan and risk assessment are updated after discontinuation of constant observations. Following the RPIW, the team reduced the time taken to update care plans following changes to observations by 87% and improved the recording of the purpose of observations by 100%.

Stafford Sexual Health Team

The team reviewed the processes surrounding referrals for HIV services, wanting to ensure the service is patient focussed. Following the RPIW, the team reduced the time from preparing for clinic until the service users leave the appointment from 51 days to 21 days. They also eliminated the need for non-complex cases to be routinely seen by a consultant, ensured 100% of service users received an annual health check and medication review, and reallocated £14,000 of surplus stock.

Holly Ward

The ward wanted to use the RPIW to ensure that when people are admitted to the ward there is a robust and consistent approach to undertaking initial assessments and a formulation meeting within one week. Following the RPIW, the time from a patient’s admission to a detailed care plan following a multi-disciplinary meeting being produced has reduced from 25 days to 8 days, and the proportion of patients who do not have an initial formulation meeting booked within one week has reduced from 84% to 0%.
1) PUT SAFETY FIRST
Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally:
- We will work towards reducing harm by 30% across our services each year

2) CONTINUALLY LEARN
Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are:
- We will use systematic continuous improvement methodology to help us learn and adapt our efforts to improve safety.
- We will ensure that every improvement project incorporates the voice of the patient/service user

3) HONESTY
Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong:
- We will share with our service users, families and the public our progress on reducing harm.
- We will publish publicly our key safety data on a monthly basis

4) COLLABORATE
Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use:
- We will support learning and sharing from improvement work across our organisation, and beyond our organisation, through internal events and through the academic health science network

5) SUPPORT
Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress:
- We will ensure that every team in the organisation has space to reflect, listen and learn about the quality and safety of the service being offered

Sign up to Safety

In June 2014 NHS England launched “Sign up to safety”. This campaign was designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. This ambition is bigger than any individual or organisation, and achieving it requires us all to unite behind this common purpose. We need to give patients confidence that we are doing all we can to ensure that the care they receive will be safe and effective at all times.

The five Sign up to Safety pledges
Organisations and individuals who sign up to the campaign commit to setting out actions they will undertake in response to five key pledges. As a Trust we have committed to the following actions:
Staff Survey Results

In 2018 all our staff were invited to take part again in the Staff survey. 4861 staff responded representing 62% of the workforce. The annual survey covers a significant number of key areas including:

- Percentage of staff who feel engaged
- Percentage of staff who witness and report incidents and near misses
- Percentage of staff contributing towards improvements at work

Key Trust results, benchmarked against the national average for combined mental health, learning disability and community Trusts are as follows:

**Staff Engagement**

Staff engagement themes results

Despite having undergone a merger in the period just preceding the survey, the Trust rating was in line with the average for combined mental health, learning disability and community trusts.

**Witnessing and reporting incidents and near misses**

The Trust actively encourages staff to report all incidents and near misses. This enables team and ward leaders to respond quickly to address any risks.
Question 16a – In the last month have you seen any errors, near misses, or incidents that could have hurt staff?

Question 16b – In the last month have you seen any errors, near misses, or incidents that could have hurt patients/ service users?
Question 16c – The last time you saw an error, near miss or incident that could have hurt staff or patients/service users, did you or a colleague report it?

The results show that the Trust is slightly better than average than the benchmark for the number of staff who both witness and report incidents or near misses.

**Percentage of staff contributing towards improvements at work**

Question 4b – I am able to make suggestions to improve the work of my team/department.
Question 4d – I am able to make improvements happen in my area of work

The results show that the Trust is performing slightly below the average for organisations of a similar type. Some of the work towards us achieving this improvement is described in the Quality Improvement section in Part 1 of this document.

**Trust response to these results**

The Trust’s aim is to be the best; and to work towards becoming ‘outstanding’. The staff survey results are probably the most comprehensive feedback the Trust will get as an organisation and therefore will remain a huge focus for our organisational development agenda going forward as a new organisation.

Our Engagement Plan approach focus for 2019 is outlined below:

- **‘Outstanding’** engagement and communications
- Continue to embed a joint engagement approach of **We said, We Did**
- Continuous **Engagement Plans**, which will continue to embed an everyday staff survey approach
- Consistent engagement with all staff around the staff survey
- Speed – staff survey kept on agenda – continuous feedback
- Results shared and cascaded promptly, shared with Care Groups and Directorates within a month to service leads
- Inclusive process – staff to continue to feel more included in planning improvements, and more recognition by leadership
- Measurable impact – connecting staff voice with action taken and improvement at a local level
- Focus and build on areas of success as well as areas of improvement
- Maximising relationships with Managing Directors and Workforce Consultants to align all of the above
The following contains the headlines of the actions that we have committed to undertake as an outcome of the staff survey:

- Continue with the Trust’s Listening Into Action approach and embed this into the merged Trust as part of work around culture, not just organisational wide but at team level
- Disseminate the survey reports to locality leads, through care group and directorate management teams with the requirement for care groups and directorates to develop their own engagement plans and input into the Trust’s wider engagement plan for staff survey results
- Staff engagement sessions planned for 2019-2020 for staff to meet and engage with senior leaders (three months plus post appointment)
- Workforce and Development will provide, where required, support to managers to act on the results of the staff survey
- Our refreshed Leadership and Talent Management approach will be further embedded within the organisation
- Targeted support will be provided for teams who are feeling challenged or undergoing change towards new ways of working
- Further embed the Trust’s enhanced staff survey approach into its vision, values and behaviours work, Trust Induction and other engagement forums
- Implement a refreshed approach for staff recognition within MPFT to support the value and recognition of staff and ultimately quality of care provided
- Local managers to report back progress against their staff survey engagement plan on a quarterly basis and this progress will be reported though continuous staff survey communications to demonstrate to all staff that their feedback is taken seriously and results in change (August 2019)
CQC Ratings

The CQC is currently inspecting Midlands Partnership NHS Foundation Trust for the first time and we anticipate that the report will be available in June, with our new ratings. Therefore the previous rating awarded to South Staffordshire and Shropshire Healthcare NHS Foundation Trust in 2016 remains. At that time, the Trust was rated as good overall, and good against each of the questions Safe, Effective, Caring, Responsive and Well-led. One core service was rated as outstanding (Community based mental health services for older people). The remaining 10 core services were rated as good overall.

All actions associated with the inspection were addressed in 2016. The CQC will assess how well improvements have been sustained as part of our current inspection.
Priorities for Improvement 2018/19

In this section of the report we review the priorities for quality improvement that we identified in last year’s Quality Accounts. The three quality priorities we set are all important to the safe and effective delivery of care and are aligned to our Commissioning for Quality and Innovation (CQUIN) schemes. The priorities were chosen following a process of reviewing our current services, consulting with our key stakeholders and listening to the views of our service users and carers.

As the new Trust formed on 1st June 2018 we have looked back in detail at the three key priorities identified in South Staffordshire & Shropshire Healthcare NHS Trust 2017/18 accounts, as well as summarising those priorities identified in the former Staffordshire & Stoke on Trent Partnership Trust 2017/18 accounts.

Priority 1- Reducing restrictive practices within adult low and medium secure services inpatients

Why did we chose this area?
The overall aim of this improvement goal was to develop an ethos in which people with mental health problems are able to fully participate in formulating plans for their well-being, risk management and care in a collaborative manner. As a consequence more positive and collaborative service cultures develop, reducing the need for restrictive interventions.

What were we aiming for?
The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, in order to improve service user experience whilst maintaining safe services.

Our measures of success were?
We would like to see a reduction in the number of restrictive practices.

Progress during 2018/19:

- We have developed and launched Mandatory Least Restrictive Practice Training with Annual Refreshers. The training package was developed in conjunction with patients as well as experts by experience who were former patients within secure services. 64% of eligible staff have attended the revised training programme during the last 12 months with all staff providing positive feedback. The remainder of the staff are allocated training places over the coming months.
- We have shared best practice with Partners in the West Midlands as part of the New Care Model, and are continuing to engage in the national conversation being led by NHS Improvement and the Restraint Reduction Network.
- Corporately, the Trust has re-established an over-arching Strategic Least Restrictive Practice Group
- During the last year, the Trust has revised the Restrictive Practice Policy which has had a positive impact on the number of incidents reported.
- The Least Restrictive Practice Forums in Stafford and Shrewsbury are attended by service user representatives from all wards. The forums have a solution
focussed approach to challenging cultures and supporting positive and proportionate changes in practice.

- We have introduced mobile telephones into both the medium secure and low secure environments.
- We have rolled-out of the ‘Safe-wards’ model across all of the wards. This internationally recognised and utilised model has proven positive in reducing conflict and containment. The introduction has been found to reduce incidents and develop individual coping mechanisms to prevent incidents of violence.
- As part of the ‘Safe-wards’ roll out, wards have begun implementing Discharge Message Boards. These boards have been co-produced by service users and staff and display messages from discharged service users to offer encouragement and motivation to others.
- ‘You Said – We Did’ Boards have had a positive impact on understanding patients views around restrictive practices and is supportive of our ambitions to reduce restrictive practices. An example of this would be the introduction of intranet access across wards.

Number of Restrictive Practice Incidents from 2016-17 to 2018-19:

The number of restrictive practices incidents have increased compared to last year. This is mainly attributable to the following five areas;

- We have revised our Restrictive Practices Policy and as part of the implementation have focused on encouraging staff to record all use of Physical Interventions onto the Patient Incident Reporting System.
- The wards now have their own De-escalation Management and Intervention (DMI) Link Workers who provide expertise to clinical teams around restrictive practices and encourage the reporting of episodes of Restrictive Practice.
- There has been a noticeable increase in the number of external escorts to acute hospitals, predominately for individual patients with physical related illness and long term condition management who were required to have restrictive measures in place.
The Ministry of Justice now direct the use of mechanical restraint since the mandatory implementation of a risk assessment process. This means despite the increase in the number of mechanical restraint incidents, the Trust is demonstrating compliance with best practice.

- There has been an increase in the acuity of some of our patients.
- We have increased the number of beds on Newport Medium Secure Unit, from a 6 to 8 bedded unit.

Next Steps:
- Following the launch of a new national incident reporting requirement, the Trust is set to make changes to its incident reporting system. These changes will be capturing more detail and specific information related to restrictive interventions and will further enhance our ability to learn and improve practices.
- Recently, we have joined the re-launched Positive and Safe Champions Network which enables various providers to come together to share best practice and learning, whilst developing solutions to challenges posed by delivering least restrictive practices in a secure environment.

Priority 2- Effective communication between Trust clinicians and primary care clinicians for patients with severe mental illness

Why did we choose this area?
With over 490,000 people with severe mental illness registered with a GP, it is important to ensure a stronger emphasis on collaboration and communication between primary and secondary care. This is necessary given that in the longer term and certainly following discharge from secondary care, people with severe mental illness should be supported to manage their health within primary care.

Appropriate sharing and exchanging of information between practitioners about diagnosed physical and mental health conditions is essential for safe practice. The rationale for this CQUIN is to ensure essential information needed for safe and effective care of patients, who are also seen by secondary care mental health services, is communicated to primary care professionals.

What were we aiming for?
That 90% of patients have either an up to date care programme approach (CPA) care plan or a comprehensive discharge summary shared with their GP.

Our measures of success were?
- Alignment of GP and Trust registers for people with severe mental illness.
- Implementation of shared care protocols between the Trust and primary care providers regarding physical health checks for people with severe mental illness.
- An audit of CPA review / discharge letters to ensure they are sent to GPs in a timely way and contain key information regarding diagnosis, prescribing and cardio metabolic risk factor monitoring.
Progress during 2018/19:

- Locally we revised the CQUIN during 2018 to detail a new way of working across our local economy (as detailed below). As part of this new arrangement, we now measure and report on through the shared evaluation of the joint review model rather than the CQUIN % performance in its entirety.
  - We have initiated the formation of a Strategic Collaborative with partners to include Experts by Experience, Staffordshire Clinical Commissioning Group and Primary Care colleagues, to design a local approach to align registers and develop robust shared care protocols regarding physical health checks for people with severe mental illness.
  - Jointly, we held a Reducing Mortality in Patients with Severe Mental Illness Workshop with our local Clinical Commissioning Group involving GPs, Commissioners, Clinicians from the Trust and Primary Care, Leaders, and Expert’s by Experience.
  - Five task and finish groups are set up to meet the overall objectives of the Strategic Collaborative Plan which include representatives from the Strategic Collaborative membership, experts by experience and experts within their fields of expertise. These are Model Specification; Clinical; Reconciliation of Practice Based Registers and People Open to us; Evaluation and Innovation and Lifestyle and Prevention.
  - In collaboration we have piloted new way of working between Trust clinicians and GPs with regard to completing annual physical health checks and subsequently agreed a new specification and pathway to pilot the delivery across Staffordshire.

Our audit results are?

![% CPA Review or Discharge Summary Letter sent to GP](mpft.nhs.uk)
The Trust has made significant improvements from the previous year’s results as illustrated in the graph above. Overall, whilst we did not achieve our target that 90% of patients had either an up to date care programme approach (CPA) care plan or a comprehensive discharge summary shared with their GP, the described adapted local initiatives have made positive collaborative progress in respect of improving the patient safety, patient satisfaction and clinical effectiveness across primary and secondary care providers and this is planned to continue during 2019-20 and beyond.

Next Steps:
- In partnership, we will continue to progress and work collaboratively with partners to improve the shared care for patients with severe mental illness to reduce the mortality gap.
- We will evaluate the new model and specification and continue to strive for excellence.
- Our aim is to publish a poster or article nationally around our Strategic Collaborative journey.
- During the year we will repeat the audit of people who have had a CPA review or were discharged to evaluate the effectiveness of the new shared care model.
- We will aim to achieve 90% by April 2020

Priority 3- Healthy food for NHS patients, visitors and staff

Why did we chose this area?
Public Health England’s report “Sugar reduction – The evidence for action” published in October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country. Almost 25% of adults in England are obese, with significant numbers also being overweight. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. Sugar intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences. It is important for the NHS to start leading the way on tackling some of these issues, starting with the food and drink that is provided and promoted in hospitals.

What were we aiming for?
That:
- 80% of drink lines stocked must be sugar free.
- 80% of confectionery and sweets do not exceed 250 Kcal.
- At least 75% of pre-packed sandwiches and other savoury pre-packed meals available contain 400Kcal or less per serving and do not exceed 5.0g saturated fat per 100g.

Our measures of success were?
- An independent audit of all food outlet sources on Trust premises to demonstrate that all achievements have been met.
Progress during 2018/19:

- We have commissioned an external auditor to complete an independent review of all food outlet sites across the Trust to evidence robust compliance (Food for Life, Soil Association).
- We have maintained the four changes that were required in the 2016/17 CQUIN deliverables.
- We worked in partnership with charity managed outlets to further promote the healthy eating agenda.
- Fruit is now located adjacent to the checkouts in food and drink outlets.
- The Trust has removed all non-compliant cardboard food and drink branding displays.
- The Trust has achieved the aims in the Quality Account during 2018/19 and is fully compliant with the Healthy Food CQUIN for 2017-19. At the time of writing this report, Commissioners have yet to confirm this achievement.

Next Steps:

- During 2019-2020, alternative healthy meal options will be introduced at Haywood Hospital and we are considering the introduction the ability for staff to order healthy options for collection, if they work outside of café opening hours.
- We will ensure our Nutrition and Hydration Strategy encapsulates the ethos of the CQUIN so that we continue to sustain and further improve the healthy eating agenda across the Trust. We will share lessons so that other initiatives improve the health and wellbeing of patients, visitors and staff.
Summary of Former Staffordshire & Stoke of Trent Partnership NHS Trust 2018/19 Priorities for Improvement

Most of the priorities identified by Staffordshire & Stoke of Trent Partnership NHS Trust in their 2017/18 Quality Accounts have been reported on elsewhere within this document. There are however two priorities, as presented below, that do not feature elsewhere in these accounts that we have provided a summary of achievement for:

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>What were we aiming for?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the assessment of wounds</td>
<td>To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.</td>
</tr>
</tbody>
</table>

**Progress Update 2018/19**

The Trust has demonstrated a significant improvement in the number of wound assessments completed.

In 2017/18, we were performing at 16% and since then there has been a significant increase to 91% in 2018/19.

Our Community Teams have improved and sustained a good standard of documentation with the majority of teams achieving over 96% compliance.

**Progress Update:**

We have commenced an enhanced Four Day Tissue Viability Training Programme to include wound assessment. All new community nurses are required to attend as part of their induction programme and following this complete a wound care competency. Training and competency compliance is monitored by the Trust Wound Care Steering Group.

The improved completion of wound assessments has positively shortened the time in which patients now receive compression therapy which is significant in supporting healing.

**Next Steps:**

We will revise the wound care assessment form making it available on the patient electronic record system. This will reduce the time it takes for our Community Nurses to document their assessments.

Our Tissue Viability Nurses will complete a 6 month audit to monitor wound care assessment compliance to ensure sustainability. This audit will be presented to our Wound Care Steering Group.

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>What were we aiming for?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalised care and support planning</td>
<td>To improve the lives of patients with one or more Long Term Condition (LTC) by receiving specific support related to their LTC to improve the patient’s confidence and autonomy to self-manage their LTC.</td>
</tr>
</tbody>
</table>

**Progress Update 2018/19**

Our specialised long term condition (LTC) teams have held meetings to review performance and share learning to improve the quality of conversations being held with patients and carers.

Training has been provided to ensure clinical staff are competent in holding these care and support planning discussions with patients and carers. During 2017/18 – 95% of staff were trained and deemed competent.

Throughout the year, we have monitored progress closely and this has indicated that we have significantly improved our ability to hold care and support planning conversations with our patients and carers.

This is evidenced by demonstrable improvements in the self-care score’s for all of the patients and carers identified in the CQUIN cohort.

The Trust has gone beyond the CQUIN cohort and has implemented this quality initiative to all patients who have one or more LTC.

Currently, the Trust is in process of determining 2018/19 CQUIN achievement with Commissioners.
Priorities for Improvement 2019/20

Our three improvement priorities for 2019/20 were chosen following a review of our current services, consulting with our key stakeholders and reviewing feedback from our service users.

The three key priorities for improvement identified are:

- 72 hour follow up for people discharged from inpatient mental health wards
- Six month review for all discharged stroke patients
- To improve patient experience / feedback response rates across all services

In addition to linking our priorities to the three domains of quality; patient safety, clinical effectiveness and service user experience, we have also chosen to align our priorities to the Commissioning for Quality and Innovation (CQUIN) scheme as agreed with our commissioners.

Progress against these improvement initiatives will be monitored routinely and in partnership with our commissioners. The Trust Board will receive a quarterly report on progress and achievement and this will be published on the Trust website under the Board Meeting Papers Section. This progress report is a component of a Trust Wide Assurance Report which not only provides an update on these three priority indicators but on all quality and clinical performance; alongside Trust finance, business, medical, human resources and operational performance.

Key to the achievement of these quality priorities is the capability and capacity of clinical staff. Through leadership from our operational directors and clinical leads we will ensure that clinical staff are provided with the right information, training and clinical supervision to put these initiatives into practice.

The details of our three key priorities for improvement are:

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Priority Area</th>
<th>Why have we chosen this area?</th>
<th>What are we aiming to achieve?</th>
<th>Our measures of success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>72 hour follow up for people discharged from inpatient mental health wards</td>
<td>72 hour follow up is a key part of the national work to support the suicide prevention agenda. The National Confidential Inquiry into suicide and safety in mental health (2018) found that the highest number of deaths occurred on day 3 post discharge</td>
<td>That our service users have timely and well planned discharge</td>
<td>That more than 80% of service users discharged from our inpatient mental health wards are followed up within 72 hours of discharge. This will be monitored through our regular key performance indicator reporting to the Trust Board</td>
</tr>
<tr>
<td>Quality Domain</td>
<td>Priority Area</td>
<td>Why have we chosen this area?</td>
<td>What are we aiming to achieve?</td>
<td>Our measures of success</td>
</tr>
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</tr>
<tr>
<td><strong>Clinical Effectiveness</strong></td>
<td>Six month review for all discharged stroke patients</td>
<td>Improved stroke rehabilitation is a key pillar of the stroke improvement landscape and is also one of the key commitment areas within the NHS Long Term Plan. The six month reviews also provide an opportunity for enhanced personalisation of care through identification of further support needs e.g. through social prescribing.</td>
<td>To ensure that people who have had a stroke receive appropriate review and follow up. To encourage people to focus on their life after a stroke and help them to achieve their goals.</td>
<td>That at least 55% of eligible stroke survivors receive a six month follow up within 4-8 months of their stroke.</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td>To improve patient experience / feedback response rates across all services</td>
<td>Gathering patient experience is key to understanding whether the services we provide are meeting people’s needs and are of high quality. Currently our patient feedback response rates vary across Trust services and we need look at the ways we ask for feedback to maximise opportunities to help us to learn and improve.</td>
<td>To have reviewed our feedback methodologies and ensure that we offer a range of options for gathering experience and providing feedback. To review and update our current feedback systems.</td>
<td>That we will have improved our overall feedback response rate by 20%.</td>
</tr>
</tbody>
</table>
Statements of Assurance from the Board

Review of Services

During 2018/19 the Midlands Partnership NHS Foundation Trust provided and /or subcontracted 173 relevant health services.

The Midlands Partnership NHS Foundation Trust has reviewed all the data available to them on the quality of care in 173 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Midlands Partnership NHS Foundation Trust for 2018/19.

Clinical Audit / Confidential Enquiries

During 2018/19 14 national clinical audits and 2 national confidential enquiries covered relevant health services that Midlands Partnership NHS Foundation Trust provides.

During that period Midlands Partnership NHS Foundation Trust participated in 93% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Midlands Partnership NHS Foundation Trust was eligible to participate in during 2018/19 are as follows:

<table>
<thead>
<tr>
<th>National Audit</th>
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<tbody>
<tr>
<td>• National Diabetic Foot Care Audit (NDFA)</td>
</tr>
<tr>
<td>• The Falls and Fragility Fracture Audit Programme (FLS-DB) Clinical audit</td>
</tr>
<tr>
<td>• Sentinel Stroke National Audit Programme (SSNAP)</td>
</tr>
<tr>
<td>• In-Patient Falls Audit</td>
</tr>
<tr>
<td>• National Audit of Intermediate Care (NAIC)</td>
</tr>
<tr>
<td>• National Early Inflammatory Arthritis Audit</td>
</tr>
<tr>
<td>• National Clinical Audit of Anxiety and Depression (Core Audit)</td>
</tr>
<tr>
<td>• National Clinical Audit of Anxiety and Depression – Psychological Therapies (Spotlight)</td>
</tr>
<tr>
<td>• National Audit of Care at the End of Life</td>
</tr>
<tr>
<td>• National Audit of Psychosis – (EIP spotlight audit)</td>
</tr>
<tr>
<td>• POMH-UK Topic 16b: Rapid Tranquillisation</td>
</tr>
<tr>
<td>• POMH-UK Topic 18a: Use of clozapine</td>
</tr>
<tr>
<td>• POMH-UK Topic 6d: Assessment of the side effects of depot antipsychotics</td>
</tr>
<tr>
<td>• POMH-UK Topic 7f: Monitoring of patients prescribed lithium</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Confidential Enquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td>• National Confidential Inquiry into Suicide and Homicide by People with Mental Illness</td>
</tr>
<tr>
<td>• Long Term Ventilation in Children up to 25</td>
</tr>
</tbody>
</table>
The national clinical audits and national confidential enquiries that Midlands Partnership NHS Foundation Trust participated in during 2018/19 are as follows:

### National Audit

- National Diabetic Foot Care Audit (NDFA)
- The Falls and Fragility Fracture Audit Programme (FLS-DB) Clinical audit
- Sentinel Stroke National Audit Programme (SSNAP)
- In-Patient Falls Audit
- National Early Inflammatory Arthritis Audit
- National Clinical Audit of Anxiety and Depression – (Core Audit)
- National Clinical Audit of Anxiety and Depression – Psychological Therapies (Spotlight)
- National Audit of Care at the End of Life
- National Audit of Psychosis – (EIP spotlight audit)
- POMH-UK Topic 16b: Rapid Tranquillisation
- POMH-UK Topic 18a: Use of clozapine
- POMH-UK Topic 6d: Assessment of the side effects of depot antipsychotics
- POMH-UK Topic 7f: Monitoring of patients prescribed lithium

### National Confidential Enquiries

- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
- Long Term Ventilation in Children up to 25

The national clinical audits and national confidential enquiries that Midlands Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, 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>National Audit</th>
<th>% cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Diabetic Foot Care Audit (NDFA)</td>
<td>100% 176/176 eligible cases</td>
</tr>
<tr>
<td>The Falls and Fragility Fracture Audit Programme (FLS-DB) clinical audit</td>
<td>100% 1423/1423 eligible cases</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>100% 755/755 eligible cases</td>
</tr>
<tr>
<td>In-Patient Falls Audit</td>
<td>N/A (No cases met inclusion criteria for 18/19)</td>
</tr>
<tr>
<td>National Early Inflammatory Arthritis Audit</td>
<td>100% 489/489 eligible cases</td>
</tr>
</tbody>
</table>
The reports of 6 national clinical audits were reviewed by the provider in 2018/19 and Midlands Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

**Improve feedback to staff about performance**
- Share audit reports for learning and celebration through local and Trust groups

**Reorganise work flow / practice**
- Submit Business Case for Fracture Liaison Service in Stafford
- Develop Fracture Liaison Service (FLS) pathways with elderly care to refer inpatients

**Improve documentation to standardise processes and ensure best practice**
- Agree a local standard process for how National Diabetic Foot Ulcer (NDFA) data is entered onto the national database.
- Generic care plan template created for clinical teams to utilise when patients are prescribed high dose antipsychotics

**Improve communication with other agencies**
- Clarify podiatry referral process with commissioners to ensure that expected pathways are followed.

**Enhance Training and support for staff**
- Training of front line staff and raising awareness and need for inputting on NDFA.
- Communication to be sent to clinicians responsible for prescribing regarding best practice for prescribing high dose and combined antipsychotics
- Both Early Intervention teams now have a trained practitioner available to offer Cognitive Behavioural Therapy.
Supervision arrangements are in place following the appointment of a consultant clinical psychologist.

All Early Intervention teams practitioners in South Staffordshire are trained in Behavioural Family Therapy with further training planned for Shropshire.

Training of staff and engagement within stroke rehabilitation to ensure understanding of Sentinel Stroke National Audit Programme (SSNAP) and consistency of data collated and submitted.

The reports of 62 local clinical audits were reviewed by the provider in 2018/19 and Midlands Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

**Improve feedback to staff about performance**
- Share audit reports for learning and celebration through local and Trust groups.
- Wards can now access live information on their performance against the CQUIN and other physical health monitoring requirements.
- Shared learning across teams where behavioural therapy is being delivered effectively.
- Safeguarding team will ensure that safeguarding supervision is offered in all cases which will be monitored / reviewed monthly.

**Reorganise work flow/ practice**
- Protected time has been made available in the Health Advising rota to do chlamydia follow-up contact tracing via telephone and/or text.
- Epilepsy Care Pathway to be reviewed to better reflect the needs of the service user group and the service specification.
- Propose/develop a “drop off” service for patients requiring a ‘test of cure’ (TOC), providing an alternative to needing to book appointments and reducing DNA’s.
- Develop and implement a systematic approach to arranging CPA reviews, including the completion of physical health checks and sending the required correspondence (in support of CQUIN 3b).
- All wards to have an up to date list of authorised signatories for staff who can order medicines available on the ward. Dispensary Manager to produce a sheet that will be sent annually.

**Improved patient literature/ access to information**
- Easy Read leaflets for service users with epilepsy to be sourced or developed.
- Team Leaders to make sure melatonin information is readily available at clinics for clinicians to disseminate to patients and/or parents/carers.
- Increase number of insulin self-administrations through; roll out self-care plan; devise a patient leaflet; devise an animation of self-administration tutorial.

**Improve documentation to standardise processes and ensure best practice**
- Obesity care plan template to be developed and agreed for use within the service, to be used by key workers to formulate and individualise weight management care plans with patients.
- Guidelines on the management of gonorrhoea to be published on the shared drive, accessible by all staff.
- Profession specific care records guidance (Allied Health Professionals, Dental, Health Visiting and Nursing) has been updated and circulated to teams.
- Training and support will be provided to prescribers in relation to compliance with the Prescription Forms and Security Policy.
• New standard operating procedure for purchasing of new equipment is in development that includes detail around advice and support available from the Infection Control Team.
• Standardised handover tool to be agreed and rolled out across teams.
• Implement a new continence basic assessment form, including details of carer involvement, measurements and treatment plan.

**Improve communication with other agencies**
• Develop and implement standard processes for the production of discharge letters in inpatients to enhance communication with GPs.
• Devise a template for immediate communication to the GP for dissemination and use by paediatricians.
• Disseminate the referral criteria to referrers to the Infant Feeding Team, as an aid when completing Tongue Tie referrals.

**Enhance training and support for staff**
• Specific support will be provided to teams where required to deliver improvements in tobacco and alcohol, screening and interventions.
• Care planning workshops are being planned and are to be rolled out by the Clinical Education Team.
• Post incident support is included in the Trust’s ‘Restrictive Practices Strategy’. This will be included within the De-escalation Management Intervention (DMI) training and promoted through the DMI website.
• Allied Health Professional staff to attend the Recovery college confidentiality training, and invite Mental Health Act Department to deliver Advanced Directive training for teams.
• Infection Control Team to host on a study day in relation to sharps and sharps management.

**Clinical Research**

The number of patients receiving relevant health services provided or subcontracted by Midlands Partnership NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 2219.

**Commissioning for Quality and Innovation**

A proportion of Midlands Partnership NHS Foundation Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Midlands Partnership NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at: [https://www.mpft.nhs.uk/about-us/quality/cquins](https://www.mpft.nhs.uk/about-us/quality/cquins)

The monetary total for income in 2018/19 conditional upon achieving quality improvement and innovation goals was £3m and the monetary total for the associated payment in 2017/18 was £1.6m.
Registration with the Care Quality Commission

Midlands Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered. Midlands Partnership NHS Foundation Trust has the following conditions on registration: the registered provider must ensure that the regulated activity of personal care is managed by an individual who is registered as a manager in respect of that activity at or from all locations. The Care Quality Commission has not taken enforcement action against Midlands Partnership NHS Foundation Trust during 2018/19.

Midlands Partnership NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas 2018/19; Local System Review of health and social care in Staffordshire during 22\textsuperscript{nd}-26\textsuperscript{th} October 2018, Local System Review of health and social care in Stoke on Trent (progress report) during 21\textsuperscript{st}-22\textsuperscript{nd} November 2018. The reviews identified key areas for improvement for the Staffordshire health and social care system and for the Stoke on Trent health and social care system and Midlands Partnership NHS Foundation Trust has made progress by 31\textsuperscript{st} March 2019 in taking such action as a system partner. The reports are available at [https://www.cqc.org.uk/sites/default/files/20181214_local_system_review_staffordshire.pdf](https://www.cqc.org.uk/sites/default/files/20181214_local_system_review_staffordshire.pdf) [https://www.cqc.org.uk/sites/default/files/20181221_stoke_LSR.pdf](https://www.cqc.org.uk/sites/default/files/20181221_stoke_LSR.pdf)

Quality of Data

Midlands Partnership NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in latest published data.

The percentage of records in the published data:

Which included the patient’s valid NHS number was:

- 99.8\% for admitted patient care;
- 100\% for out-patient care.

Which included the patient’s valid General Medical Practice Code was:

- 100\% for admitted patient care;
- 100\% for out-patient care.

‘Midlands Partnership Foundation Trust successfully completed the Data Security and Protection toolkit submission for 2018-19. The Trust was compliant in all areas with the exception of Mandatory Training and completion of a recent Psuedonimysation Audit, ‘NHS digital’ has accepted the action plans to remedy these outstanding metrics

Midlands Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.
Learning from Deaths

During 2018/19 380 of Midlands Partnership NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 92 in the first quarter (former South Staffordshire & Shropshire Healthcare NHS Foundation Trust);
- 106 in the second quarter;
- 82 in the third quarter;
- 100 in the fourth quarter.

By 31st March 2019, 150 case record reviews and 192 investigations have been carried out in relation to 341 of the deaths included in the paragraph above.

In 7 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 95 in the first quarter;
- 109 in the second quarter;
- 82 in the third quarter;
- 56 in the fourth quarter

0 representing 0% of patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter;

These numbers have been estimated using the outcome from the Root Cause analysis review for unexpected deaths and the outcome of the mortality review for death by natural cause.

Summary of Learning From case record reviews and investigations conducted in relation to the deaths identified

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Learning</th>
</tr>
</thead>
</table>
| Mental Health Services      | • The importance of carrying mental health physical annual reviews within the required time-frame
                                    • An emerging theme has been identified regarding diagnostic over-shadowing when service users with mental health conditions access physical health services
                                    • The importance of conducting medication reviews as part of annual physical health reviews
                                    • Did Not Attend Policy to be adhered to at all times to ensure involvement and engagement is maximised
                                    • The importance of clinical teams / wards obtaining GP summaries as soon after referral / admission as possible |
The importance of timely entries on the clinical electronic record system
The importance of reviewing observation and engagement levels following periods of self-harming

### Inclusion Services
- The importance of recording the actual units of alcohol consumption: to have a standard method of reporting alcohol use
- Where a Safeguarding need has been identified, follow-up actions need to be clearly documented
- Service users presenting as high risk need to have wrap around services involved in reviews and agree a joint contingency plan
- Positive learning identified whereby Inclusion workers have supported service users to attend physical health appointments

### Prison Services
- Access to information regarding annual physical health reviews to inform prescribing and ongoing interventions
- The need to signpost/referral to relevant agencies where bereavement issues have been identified
- Positive learning identified regarding joint working between primary care prison staff and mental health workers.

### Community (Physical Health)/Community Hospitals
- The importance of assessing clinical risk at the point of referral for social care assessment
- It has been noted on a number of occasions that palliative care requirements and frailty have not been identified by partner agencies referring for social care only elements of Home First
- Positive learning identified from a number of joint worked cases between local acute hospital and community hospital

### Learning Disability Services
- The need to review the role of Community Learning Disability Nurses with regard to carry out physical health assessments
- There have been a number of cases reviewed by Trust Mortality Review Panel where a late diagnosis on cancer has been made
- The Trust Mortality Review Panel has noted a number of deaths that have not been considered for a full LeDeR despite having complex health needs

### Forensic Services
- Care Planning and risk assessment to reflect the physical health needs

### Description of the actions taken in 2018/19 as a consequence of the learning and the impact of these actions

<table>
<thead>
<tr>
<th>Action Taken</th>
<th>Impact of Action</th>
</tr>
</thead>
</table>
| The establishment of a multi partner strategic collaborative to reduce mortality for those with psychosis | Improved understanding of those individuals who require an annual physical health assessment  
New model of joint working agreed so that going forward service users will have a combined physical health review and mental health review, coordinated by a primary care nurse and a mental health practitioner |
| Delivery of physical health reviews in line with the national CQUIN requirements | Increase in the number of individuals who have participated in an annual physical health review and a greater understanding of their physical health and lifestyle needs |
| Review and implementation of the Trust Did Not Attend Policy                  | Greater clarity for staff regarding follow up arrangements after a service user does not attend
More assertive follow up for those service users who do not attend but are considered to be at significant risk |
| The recruitment of a Family Liaison                                          | Improved the liaison with families following a death
Bereavement support offered to families and signposting to specialist |
| Officer to work with families following a death | support agencies
Increased involvement of families in Serious Incident investigations
Richness of learning for clinical staff viewed from the family perspective |
| Sharing of internal mortality review reports with LeDeR to enhance multi-agency learning | Learning has fed into local LeDeR learning bulletins and has also been fed into national themes via LeDeR local area contacts |
| Focus on physical health checks in forensic services | More staff trained in taking bloods and performing ECG which give more availability and choice for service users (e.g. if a service user prefers a male we are better able to accommodate this)
The self-referral process to the clinic has allowed service users greater access to health promotion opportunities - they can come and get support and advice out of choice and when they feel ready
Feedback from service users is that they feel that the interventions offered in the clinic means they feel that their physical health is being given priority and the appointment based system allows for greater structure
The development of a multi-profession physical health team that includes, Nursing staff, Dietetics and Sports Instructors is allowing for a more holistic approach to health and well-being |

0 case record reviews and 40 investigations completed after 31st March 2018 which related to deaths which took place before the start of the reporting period.
0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the outcome from the Root Cause analysis review for unexpected deaths and the outcome of the mortality review for death by natural cause.

0 representing 0% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.
Reporting Against Core Indicators

The NHS (Quality Accounts) Amendment Regulation 2012 sets out a core set of quality indicators, which Trusts are required to report against in their Quality Accounts. The inclusion of these mandated indicators enables the Trust to provide data that is benchmarked against the national average performance of other mental health trusts. We have reviewed these indicators and are pleased to provide you with our position against all relevant indicators for the last two reporting periods (years).

*Please note that the CPA 7 day follow up and delayed transfer of care figures for quarter 4 2017/18 differ from those published in our 2017/18 Quality Accounts. This is due to a refresh in data published by the NHS Digital Indicator portal*

CPA 7 day follow-up

The data made available to the Trust by the NHS Digital Indicator Portal with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period. The data presented in line with the standard national definition which can be found within the Standard Definitions section of this report on page 60.

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Bench-mark</th>
<th>Total number of patients on CPA discharged from psychiatric inpatient care</th>
<th>Number of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care</th>
<th>Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Apr 2017 – 30th Jun 2017</td>
<td>Trust</td>
<td>336</td>
<td>331</td>
<td>98.5%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>16,372</td>
<td>15,824</td>
<td>96.7%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>124</td>
<td>124</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>7</td>
<td>5</td>
<td>71.4%</td>
</tr>
<tr>
<td>1st Jul 2017 – 30th Sept 2017</td>
<td>Trust</td>
<td>321</td>
<td>310</td>
<td>96.6%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>16,347</td>
<td>15,814</td>
<td>96.7%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>141</td>
<td>141</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>8</td>
<td>7</td>
<td>87.5%</td>
</tr>
<tr>
<td>1st Oct 2017 – 31st Dec 2017</td>
<td>Trust</td>
<td>378</td>
<td>362</td>
<td>95.8%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>16,790</td>
<td>16,017</td>
<td>95.4%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>141</td>
<td>141</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>351</td>
<td>243</td>
<td>69.2%</td>
</tr>
<tr>
<td>1st Jan 2018 – 31st Mar 2018</td>
<td>Trust</td>
<td>408</td>
<td>396</td>
<td>97.1%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>19,795</td>
<td>16,040</td>
<td>95.5%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>1,154</td>
<td>1,006</td>
<td>87.2%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
</tbody>
</table>
**2018/19**

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Bench-mark</th>
<th>Total number of patients on CPA discharged from psychiatric inpatient care</th>
<th>Number of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care</th>
<th>Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Apr 2018 – 30th Jun 2018</td>
<td>Trust</td>
<td>415</td>
<td>396</td>
<td>95.4%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>17,329</td>
<td>16,594</td>
<td>95.8%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>1,104</td>
<td>1,200</td>
<td>92.0%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>1st Jul 2018 – 30th Sept 2018</td>
<td>Trust</td>
<td>400</td>
<td>382</td>
<td>95.5%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>17,080</td>
<td>16350</td>
<td>95.7%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>1,272</td>
<td>1,149</td>
<td>95.7%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>1st Oct 2018 – 31st Dec 2018</td>
<td>Trust</td>
<td>379</td>
<td>363</td>
<td>95.8%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>16,104</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>16,860</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>1,282</td>
<td>1,146</td>
<td>89.4%</td>
</tr>
<tr>
<td>1st Jan 2019 – 31st Mar 2019</td>
<td>Trust</td>
<td>368</td>
<td>359</td>
<td>97.6%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

*National benchmarking data for the period 1st January 2019 to 31st March 2019 is yet to be released by the NHS Digital Indicator Portal.*

Midlands Partnership NHS Foundation Trust considers that this data is as described for the following reasons.

- Our staff understand the clinical evidence underpinning this target and are committed to maintaining a high level of compliance
- We have well established mechanisms in place for monitoring and validating data quality relating to CPA.

Midlands Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Continuing to raise awareness with clinical staff regarding their responsibility for providing 7 day follow-up
- Conducting clinical audits to identify areas that require targeted improvement.
Admission to Acute Wards via Crisis Resolution Home Treatment

The data made available to the Trust by the NHS Digital Indicator Portal with regard to the percentage of admissions to acute wards for which Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period. The data presented is in line with the standard national definition which can be found within the Standard Definitions section of this report on page 60.

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Benchmark</th>
<th>Proportion of admissions to acute wards that were gate kept by the CRHT teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>1\textsuperscript{st} Apr 2017 – 30\textsuperscript{th} Jun 2017</td>
<td>Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>98.7%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>88.9%</td>
</tr>
<tr>
<td>1\textsuperscript{st} Jul 2017 – 30\textsuperscript{th} Sept 2017</td>
<td>Trust</td>
<td>99.2%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>98.6%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>94%</td>
</tr>
<tr>
<td>1\textsuperscript{st} Oct 2017 – 31\textsuperscript{st} Dec 2017</td>
<td>Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>98.5%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>84.3%</td>
</tr>
<tr>
<td>1\textsuperscript{st} Jan 2018 – 31\textsuperscript{st} Mar 2018</td>
<td>Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>98.7%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>88.7%</td>
</tr>
<tr>
<td>1\textsuperscript{st} Apr 2018 – 30\textsuperscript{th} Jun 2018</td>
<td>Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>98.1%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>85.1%</td>
</tr>
<tr>
<td>1\textsuperscript{st} Jul 2018 – 30\textsuperscript{th} Sept 2018</td>
<td>Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>98.4%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>81.1%</td>
</tr>
<tr>
<td>1\textsuperscript{st} Oct 2018 – 31\textsuperscript{st} Dec 2018</td>
<td>Trust</td>
<td>99.6%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>97.8%</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>78.8%</td>
</tr>
<tr>
<td>1\textsuperscript{st} Jan 2019 – 31\textsuperscript{st} Mar 2019</td>
<td>Trust</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Highest reporting Trust</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Lowest reporting Trust</td>
<td>*</td>
</tr>
</tbody>
</table>

*National benchmarking data for the period 1\textsuperscript{st} January 2019 to 31\textsuperscript{st} March 2019 is yet to be released by the NHS Digital Indicator Portal.

Midlands Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

- Our staff understand the clinical evidence underpinning this target and are committed to maintaining a high level of compliance

Midlands Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:-

- Continuing to reinforce to clinical staff the importance of gatekeeping admissions to hospital
Readmission to Hospital within 28 Days of Discharge

The percentage of patients aged 16 and over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period (please note there were no admissions of patients aged 0-15 during the reporting period)

Please note that this data is not made available to the NHS Digital Indicator Portal as it is not a requirement for mental health trusts. The data to support this indicator has been taken from RiO the Trust clinical electronic record system. Therefore no national benchmarking data is available.

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Benchmark</th>
<th>% of patients aged 16 and over readmitted to hospital within 28 days of discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Apr 2017 – 30th Jun 2017</td>
<td>Trust</td>
<td>11.1%</td>
</tr>
<tr>
<td>1st Jul 2017 – 30th Sept 2017</td>
<td>Trust</td>
<td>6.5%</td>
</tr>
<tr>
<td>1st Oct 2017 – 31st Dec 2017</td>
<td>Trust</td>
<td>10.4%</td>
</tr>
<tr>
<td>1st Jan 2018 – 31st Mar 2018</td>
<td>Trust</td>
<td>12.7%</td>
</tr>
<tr>
<td>1st Apr 2018 – 30th Jun 2018</td>
<td>Trust</td>
<td>9.0%</td>
</tr>
<tr>
<td>1st Jul 2018 – 30th Sept 2018</td>
<td>Trust</td>
<td>13.0%</td>
</tr>
<tr>
<td>1st Oct 2018 – 31st Dec 2018</td>
<td>Trust</td>
<td>11.5%</td>
</tr>
<tr>
<td>1st Jan 2019 – 31st Mar 2019</td>
<td>Trust</td>
<td>10.1%</td>
</tr>
</tbody>
</table>

Midlands Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

- We have well established mechanisms for following up people who are discharged from inpatient services and for monitoring and validating data quality relating to 28 day readmission rates

Midlands Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by

- Continuing to reinforce to clinical staff the importance of timely and appropriate follow up
- Continuing to monitor and validate data in line with Standard Operating Procedures
Patient Experience of Community Mental Health Services

The data made available to the Trust by the Care Quality Commission with regard to the Trust’s “Patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period.

To determine our performance against this indicator we have referred to the section score (mean score) for the Health and Social Care Workers section of the CQC Community Mental Health Survey. This section is made up of three areas as follows:

- **Listening**: for the person or people seen most recently *listening carefully to them*
- **Time**: being given *enough time* to discuss their needs and treatment
- **Understanding**: for the person or people seen most recently understanding how their mental health needs affect other areas of their life

<table>
<thead>
<tr>
<th>Performance</th>
<th>Experience of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017 Survey</td>
</tr>
<tr>
<td>Midlands Partnership NHS Foundation Trust</td>
<td>8.1</td>
</tr>
<tr>
<td>Lowest Reporting Trust Score</td>
<td>6.4</td>
</tr>
<tr>
<td>Highest Reporting Trust Score</td>
<td>8.2</td>
</tr>
</tbody>
</table>

*Data source: Care Quality Commission Community Mental Health Survey’s 2017 and 2018

Midlands Partnership NHS Foundation Trust considers that this data is as described for the following reasons.

- That the Trust continues to drive engagement and responsiveness to individual service users’ needs
- That the data has been compiled and validated by the Picker Institute

Midlands Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by

- Sharing the outcomes of the 2018 Patient Survey across the Trust
- Comparing the scores with our real-time service users experience measures
- Identifying local actions to be taken
- Monitoring progress through our care group governance forums
Patient Safety Incidents

The data made available to the Trust by NHS Improvement with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. The data presented is in line with the standard national definition which can be found within the Standard Definitions section of this report on page 60.

We are unable to provide national benchmarking data for this indicator for the full two year data period, as the latest National Reporting and Learning Service Patient Safety Incident Report release (by NHS Improvement) was for the period 01/04/2018 – 30/09/2018. On 1 June 2018 South Staffordshire and Shropshire Healthcare NHS Foundation Trust (RRE; mental health cluster) acquired Staffordshire and Stoke on Trent NHS Trust (R1E; community cluster) and changed to Midlands Partnership NHS Foundation Trust. The Midlands Partnership NHS Foundation Trust has been placed within the Community Trust cluster for the latest incident report release and comparisons. We have provided a full two year comparison of Trust data for Community and Mental Health Clusters. Total number of incidents by degree of harm is not published by NHS Improvement therefore the data included within the accounts is Trust data only.

Mental Health Cluster NRLS Reportng 1st April 2017 – 31st March 2018

<table>
<thead>
<tr>
<th>Degree of Harm</th>
<th>All Mental Health Trusts</th>
<th>MPFT (SSSFT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>93.6%</td>
<td>65.7%</td>
</tr>
<tr>
<td>Low</td>
<td>28.7%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Moderate</td>
<td>4.6%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Severe</td>
<td>0.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Death</td>
<td>0.7%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Trust Total reported incidents by degree of harm Mental Health
01/04/2017 – 30/09/2017

<table>
<thead>
<tr>
<th>Degree of Harm</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2109</td>
</tr>
<tr>
<td>Low</td>
<td>124</td>
</tr>
<tr>
<td>Moderate</td>
<td>19</td>
</tr>
<tr>
<td>Severe</td>
<td>0</td>
</tr>
<tr>
<td>Death</td>
<td>1</td>
</tr>
</tbody>
</table>
Trust Total reported incidents by degree of harm Mental Health
01/10/2017 – 31/03/2018

<table>
<thead>
<tr>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>1737</td>
<td>51</td>
<td>18</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Community Health Cluster NRLS Reportng 1st April 2017 – 31st March 2018

Trust Total reported incidents by degree of harm Community Health
01/04/2017 – 30/09/2017

<table>
<thead>
<tr>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>2791</td>
<td>3384</td>
<td>534</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>
Trust Total reported incidents by degree of harm Community Health
01/10/2017 – 31/03/2018

<table>
<thead>
<tr>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>2844</td>
<td>4064</td>
<td>619</td>
<td>9</td>
<td>2</td>
</tr>
</tbody>
</table>

Midlands Partnership NHS Foundation Trust Community Cluster NRLS Reporting 1st April 2018 – 30th September 2018

Trust Total reported incidents by degree of harm Community Health Cluster
01/04/2018 – 30/09/2018

<table>
<thead>
<tr>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>4673</td>
<td>4724</td>
<td>420</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>
Trust Incident Data by Degree of Harm 2017/18 - 2018/19

### Trust Total Reported Incidents by Degree of Harm 2017/18 – 2018/19

<table>
<thead>
<tr>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>7255</td>
<td>5179</td>
<td>429</td>
<td>3</td>
</tr>
<tr>
<td>2018/19</td>
<td>6799</td>
<td>6520</td>
<td>352</td>
<td>0</td>
</tr>
</tbody>
</table>

### Trust Total Reported Incidents by % Degree of Harm 2017/18 – 2018/19

<table>
<thead>
<tr>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>56.37%</td>
<td>40.24%</td>
<td>3.33%</td>
<td>0.02%</td>
</tr>
<tr>
<td>2018/19</td>
<td>49.73%</td>
<td>47.69%</td>
<td>2.57%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Midlands Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

- Robust risk management is central to the effective running of our organisation and therefore all managers and staff throughout the Trust take responsibility for the reporting of and learning from incidents

Midlands Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by

- Continuing to improve our processes for reporting and learning from incidents whilst ensuring that we continue to examine incident trends and clusters taking action to minimise future risk.
In part 3 of this Quality Accounts report we provide an overview of the quality of care provided by Midlands Partnership NHS Foundation Trust during 2018/19 against a range of local quality indicators. These indicators have been agreed by the Trust Board of Directors following a period of consultation with key stakeholders. The indicator set for each year spans the three domains of quality; patient safety, clinical effectiveness and experience and suggestions for priorities are drawn from a number of sources, including; Commissioning for Quality and Innovation (CQUIN) goals, feedback themes from real-time service user experience, recommendations from national reviews, quality improvement areas identified from our internal thematic reviews, Trust’s review of its quality performance, for example incident data and complaints and stakeholder feedback, both external and from internal engagement forums.

Our local quality indicators that we intend to report upon for 2019/20 are set out below. As well as new goals we will also be as taking forward our improvement priorities from 2018/19.

### Patient Safety

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rationale for Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three high impact actions to prevent hospital falls (community Hospitals)</td>
<td>Taking the three key actions below as part of a comprehensive multidisciplinary falls intervention will result in fewer falls, bringing length of stay improvements and reduced treatment costs</td>
</tr>
<tr>
<td>Reducing harm from medication incidents</td>
<td>We did not meet our proposed pledge to reduce harm from medication incidents during 2018/19 and therefore will continue to focus on this key quality area and report back in our 2019/20 accounts.</td>
</tr>
<tr>
<td>Reducing restrictive practices within adult low and medium secure services</td>
<td>This was one of our improvement priorities for 2018/19 and we want to continue to monitor and report progress against this key quality area</td>
</tr>
</tbody>
</table>

### Clinical Effectiveness Measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rationale for Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving staff health and wellbeing</td>
<td>We did not make our desired improvement goal last year and therefore we want to continue our focus on this key quality priority</td>
</tr>
<tr>
<td>Effective communication between MPFT clinicians and primary care clinicians for patients with severe mental illness</td>
<td>This was one of our improvement priorities for 2018/19 and we want to continue to monitor and report progress against this key quality area</td>
</tr>
<tr>
<td>Healthy weight for adult secure mental health services</td>
<td>Providing healthy service environments and healthy lifestyle choices has a positive impact on wellbeing and weight management. There is also a consequential cost saving for health and social care systems if obesity rates are addressed.</td>
</tr>
</tbody>
</table>

### Service User / Carer Experience

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rationale for Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery college for medium and low secure patients</td>
<td>Although we have made progress with this initiative we have an ambition to further improve participation in recovery college courses and therefore will report back on this in our 2019/20 accounts.</td>
</tr>
<tr>
<td>Healthy food for NHS patients, visitors and staff</td>
<td>This was one of our improvement priorities for 2018/19 and we want to continue to monitor and report progress against this key quality area</td>
</tr>
<tr>
<td>Engaging meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death</td>
<td>We have invested in this area through the recruitment of our Family Liaison Officer but we realise there is still improvement work to be done we therefore want to continue to monitor the progress in this important area</td>
</tr>
</tbody>
</table>
Our Local Quality Indicators 2018/19

This section of the report provides details of our performance against our local indicator set. The indicators were chosen following a period of consultation with our key stakeholders and subsequent agreement by our Trust Board. Comparison is made between 2017/18 performance and 2018/19 performance and is Trust comparison as national benchmarking data is not available. Please note the data to support compliance with these local indicators is taken from Trust clinical electronic record systems and incident reporting system.

### Patient Safety Measures

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Rationale</th>
<th>Data Source</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing ill health by risky behaviours – total number of unique admitted patients with a tobacco screen</td>
<td>This was one of our improvement priorities for 2017/18 and a CQUIN scheme for 2017-2019. We wanted to continue to monitor and report progress against this key quality area</td>
<td>Rio – Trust Clinical Electronic Record system Quarter 4 results</td>
<td>Green (Met)</td>
</tr>
<tr>
<td>Reducing harm from medication incidents</td>
<td>This is one of our key Sign up to Safety pledges</td>
<td>Safeguard – Trust incident reporting system</td>
<td>Yellow (Not Met)</td>
</tr>
</tbody>
</table>

#### Performance 2017/18 vs 2018/19

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing ill health by risky behaviours – total number of unique admitted patients with a tobacco screen</td>
<td>89% (Mental Health Inpatient Wards)</td>
<td>98% (Mental Health Inpatient Wards)</td>
</tr>
<tr>
<td>Reducing harm from medication incidents</td>
<td>100% (Community Hospitals)</td>
<td>100% (Community Hospitals)</td>
</tr>
</tbody>
</table>

We are pleased that our community hospitals have maintained their excellent performance and that our mental health wards have further improved their performance by 9%.

### Medication Incidents by Degree of Harm 2017 - 2019

<table>
<thead>
<tr>
<th>Degree of Harm</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near Miss</td>
<td>6.30%</td>
<td>15.43%</td>
</tr>
<tr>
<td>No Harm</td>
<td>89.48%</td>
<td>74.36%</td>
</tr>
<tr>
<td>Minor Harm</td>
<td>4.03%</td>
<td>9.90%</td>
</tr>
<tr>
<td>Moderate Harm</td>
<td>0.16%</td>
<td>0.26%</td>
</tr>
<tr>
<td>Major Harm</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Our Risk Management Team has been working across clinical services to promote the importance of reporting near miss events. This allows us to identify themes and take action to reduce the risk of near miss incidents becoming incidents that cause harm. We have not met our ambition to reduce incidents that cause harm and although it is positive to see that there were no major harm incidents, and that incident that cause moderate and minor harm are low, we need to continue our focus on this pledge and report back next year on progress.
<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Rationale</th>
<th>Data Source</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uptake of the flu vaccine by front line staff</td>
<td>This was a CQUIN indicator for 2017/19. Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months. Influenza is a highly transmissible infection and patients found in hospital are much more vulnerable to severe effects. Uptake of the flu vaccine is therefore important to reduce transmission of the virus to vulnerable patient groups.</td>
<td>IMMFORM – Public Health data base for flu vaccination data</td>
<td>![Green Light]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance 2017/18</th>
<th>Performance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>70.8%</strong> (Former South Staffordshire &amp; Shropshire Healthcare NHS Foundation Trust)</td>
<td><strong>76.3%</strong> (Compliance for Midlands Partnership NHS Foundation Trust)</td>
</tr>
<tr>
<td><strong>70.2%</strong> (Former Staffordshire &amp; Stoke on Trent Partnership Trust)</td>
<td></td>
</tr>
</tbody>
</table>

The national CQUIN target for 2017/18 was 70%  

The national CQUIN target for 2018/19 was 75%
### Clinical Effectiveness Measures

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Rationale</th>
<th>Data Source</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving staff health and wellbeing</td>
<td>This was one of our improvement priorities for 2017/18 and we wanted to</td>
<td>NHS Staff Survey 2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td>continue to monitor and report progress against this key quality area</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance 2017/18</th>
<th>Performance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Staff Survey Question</strong></td>
<td><strong>2017 Results</strong></td>
</tr>
<tr>
<td>Does your organisation take positive action on health and well-being</td>
<td>35% (definitely)</td>
</tr>
<tr>
<td>In the last 12 months have you experienced musculoskeletal problems as a result of work activities</td>
<td>20%</td>
</tr>
<tr>
<td>During the last 12 months have you felt unwell as a result of work related stress</td>
<td>38%</td>
</tr>
</tbody>
</table>

Given the organisational context, specifically in relation to merger and the impact that this has had on how staff are feeling about change, and also considering research evidence regarding the negative impact of mergers. We need to continue to monitor staff experience around these areas and we will report back on this in our next quality accounts.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Rationale</th>
<th>Data Source</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardisation of falls assessment tools</td>
<td>During 2017/18 a thematic review was undertaken regarding the assessment and management of falls across the former SSSFT. The review recommended that the Trust needs to develop and implement a standardised approach to assessing the risk of falls</td>
<td>RiO – Trust electronic record system</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance 2017/18</th>
<th>Performance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The thematic review undertaken in the former South Staffordshire & Shropshire Healthcare NHS Foundation Trust identified that a number of falls assessment and checklists were being used across older peoples inpatient areas. The review found that in some areas a checklist was being completed and in others a checklist and FRASE risk assessment were used. The appropriate tools were only in use in 20% of inpatient areas.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Rationale</th>
<th>Data Source</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-disciplinary care plans for all service users open to learning disability services</td>
<td>Care planning was an area for improvement in learning disability services identified during our comprehensive CQC inspection in 2016. Initially the focus for improvement was on improving the quality of care plans within each professional group. Having achieved this our focus is now on implementing a single multi-disciplinary care plan.</td>
<td>Clinical audit</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance 2016-17</th>
<th>Performance 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>% compliance</td>
<td></td>
</tr>
<tr>
<td>% of service users with a care plan in place</td>
<td>89% 98% 99%</td>
</tr>
<tr>
<td>% with care plan completed appropriately (personalised &amp; in line with assessment)</td>
<td>79% 95% 97%</td>
</tr>
</tbody>
</table>
Service User Experience Measures

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Rationale</th>
<th>Data Source</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery college for medium and low secure patients</td>
<td>This was one of our improvement priorities for 2017/18 and we want to continue to monitor and report progress against this key quality area</td>
<td>CQUIN data submission</td>
<td>Green</td>
</tr>
</tbody>
</table>

**Performance 2017/18** | **Performance 2018/19**

<table>
<thead>
<tr>
<th>Enrolment and participation by quarter</th>
<th>Service users eligible*</th>
<th>Participation</th>
<th>Enrolment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017-2018</td>
<td>Number*</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Q4</td>
<td>75*</td>
<td>32</td>
<td>42.7%</td>
</tr>
<tr>
<td>2018-2019</td>
<td>Number*</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Q4</td>
<td>82</td>
<td>37</td>
<td>45.1%</td>
</tr>
</tbody>
</table>

* Protocol for Multi Disciplinary Team rating of service user eligibility introduced for Q3 2017-18

There has been a gradual increase in the number of service users participating in recovery college courses across medium and low secure services. We do however want to continue to focus on this key quality improvement area and report back progress in our next quality accounts.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Rationale</th>
<th>Data Source</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing our patient experience response rate in mental health services</td>
<td>The Trust’s current patient experience response rate in mental health services is low and therefore we are unable to use this feedback as a reliable temperature gauge of patient experience. We will focus on improving our methodologies for gathering patient feedback during 2018/19</td>
<td>Trust mental health patient experience system responses</td>
<td>Green</td>
</tr>
</tbody>
</table>

**Performance 2017/18** | **Performance 2018/19**

3679 surveys completed | 4743 survey completed

There was a 29% increase in survey returns during 2018/19. This is a positive step towards us being able to improve services based on the views of our services users. We recognise though that surveys are not everyone’s preferred route for providing feedback and we are therefore going to be looking at feedback mechanisms as one of our key quality priorities for 2019/20.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Rationale</th>
<th>Data Source</th>
<th>Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaging meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death</td>
<td>This was a key recommendation from the National Guidance on Learning from Deaths released by the National Quality Board in March 2017. This was a local indicator for us in 2017/18 and we want to continue to monitor of progress in this important area</td>
<td>National Quality Board – Learning from Deaths guidelines</td>
<td>Green</td>
</tr>
</tbody>
</table>

**Performance 2018/19**

In response to the publication of the National Quality Board guidance the Trust has implemented a number of improvements to engage more meaningfully with families following a death. These changes include:

- The recruitment of a Family Liaison Officer
- Producing an information leaflet that offers advice and signposting on bereavement services and more specialist counselling.
- Working with bereaved families to identify improved approaches to engaging families when service users do not give consent
- Changing the letters we write to families to make them more personal
Performance Against Mandated National Measures

We are committed to delivering all relevant national priorities and targets. Our performance against the access targets and outcome measures as set out in Appendices 1 and 3 of the Single Oversight Framework are detailed below, this excludes those indicators that we have reported elsewhere within this set of accounts:

<table>
<thead>
<tr>
<th>National Targets &amp; Regulatory Requirements</th>
<th>Threshold</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention in Psychosis (EIP). People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral. (A)</td>
<td>50%</td>
<td>44%</td>
<td>89.5%</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Proportion of people completing treatment who move to recovery (from IAPT dataset)</td>
<td>50%</td>
<td>52%</td>
<td>53%</td>
</tr>
<tr>
<td>b) Waiting time to begin treatment (from IAPT minimum dataset)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Within 6 weeks of referral</td>
<td>75%</td>
<td>86%</td>
<td>88%</td>
</tr>
<tr>
<td>ii) Within 18 weeks of referral</td>
<td>95%</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>Admissions to adult facilities of patients under 16 years old</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inappropriate out-of-area placements for adult mental health services (A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Inpatient wards</td>
<td>90%</td>
<td>80%</td>
<td>98%</td>
</tr>
<tr>
<td>b) Early intervention in psychosis services</td>
<td>90%</td>
<td>70%</td>
<td>80%</td>
</tr>
<tr>
<td>c) Community mental health services (people on care programme approach)</td>
<td>65%</td>
<td>35%</td>
<td>78%</td>
</tr>
</tbody>
</table>
ANNEX 1

Statements from Commissioners, Local Healthwatch and Scrutiny Committees

Staffordshire & Stoke-on-Trent Clinical Commissioning Groups (CCGs) are pleased to comment on this Quality Account 2018/2019.

The quality assurance framework that Commissioners use reviews information on quality, safety, patient experience, outcomes and performance, in line with national and local contractual requirements. The CCG Quality representatives meet with the Trust on a monthly basis to seek assurance on the quality of services provided. The CCGs work closely with the Trust and undertake continuous dialogue as issues arise and conduct quality visits to clinical areas to experience the clinical environment and listen to the views of patients and front line staff.

The CCGs acknowledge the hard work involved in bringing two organisations together and note the positive results in the NHS Staff Survey 2018.

The CCG would like to recognise the Trust’s commitment to improving quality as demonstrated by the following achievements:

- Commissioners wish to celebrate the recognition of staff’s hard work for nomination and success at national awards including both the HSJ and Nursing Times Awards.
- The CQC inspected community health services for adults and end of life care in April 2018 and awarded the services an overall rating of ‘Good’. In their reports the CQC recognised that significant improvements had been made in these services which are a result of the hard work of staff. The Trust has recently been through a comprehensive CQC well led inspection and the CCGs look forward to receiving the outcome report.
- Outcomes and learning from the Trust’s quality improvement tools were recognised within two CQC publications in September 2018; “Quality improvement in hospital trusts - Sharing learning from trusts on a journey of QI” and ‘Sexual Safety on Mental Health Wards’.
- The Trust is continuing with their collaborative work across the health economy to enhance physical health assessments for people with mental illness to support holistic assessment and reduce health inequalities.
- In 2018, the CCGs commissioned an independent review of CAMHS and Autism services, the CAMHS element of which related to MPFT. A number of recommendations for action and improvement have been agreed and we look forward to continuing to work with the Trust to drive improvements.

Priorities for 2019/20

Commissioners welcome the priorities for 2019/20. In particular the 72 hour follow up for people discharged from inpatient mental health wards which supports the Suicide Prevention agenda.

We recognise that the numbers, calibre, skill mix and continuity of staff are fundamental to providing/sustaining quality care. Commissioners closely monitor workforce in relation to recruitment and retention. We are excited by the opportunity to work with the Trust to enhance community nursing reporting to change the emphasis from workforce to caseload skill mix in line with National publications.

Commissioners are pleased that the Trust continues to be an active partner within the Staffordshire Sustainability and Transformation Partnership where integrated care remains a key priority in improving patient outcomes.

We look forward to working together with the Trust to ensure continued improvement over the coming year.

Marcus Warnes
Accountable Officer

Heather Johnstone
Executive Director of Nursing & Quality

Trust’s response to feedback from Staffordshire & Stoke on Trent CCG

We thank the CCG for their feedback. We have taken note of the feedback received and are pleased with the recognition of the Trust’s achievements
Feedback from Telford and Wrekin CCG

Telford and Wrekin CCG acknowledges the progress that Midlands Partnership Foundation Trust has made since the official launch on 1st June 2018. Bringing together mental health, learning disability, specialist children’s services and wider regional and national specialist services with community physical health services.

The key achievements are outlined in the Quality Account, and TW CCG representatives recognise the work that has been undertaken to continue to deliver Telford and Wrekin CCG’s commissioned services.

The CCG congratulates MPFT on its key achievements over the last twelve months which include:

The 2018 NHS Staff Survey results which reflect MPFT’s commitment to engaging the workforce. Participating in the NHS staff survey for the first time as Midlands Partnership NHS Foundation Trust, the survey results showed that MPFT scored better than average across five of the key themes and average in the remaining five, which is excellent for a newly integrated trust with staff who have experienced major change.

Verbal reports from CQC inspectors stated how impressed they have been with the level of enthusiasm demonstrated by everyone they met during the CQC inspection of core services in February and March 2019.

MPFT Freedom to Speak up Team was shortlisted in the ‘Creating a Supportive Staff Culture’ category at the 2018 HSJ Awards.

MPFT’s innovative partnership between two Trusts’ and a private healthcare provider, which aims to bring patients who are currently in secure care outside of the West Midlands closer to home, was “highly commended” at the 2018 HSJ Awards.

MPFT Tissue Viability Service and Community Nurses were victorious at the 2018 Nursing Times Awards in the Innovation in Chronic Wound Management category. The award recognises the work the service has carried out to improve timely, accurate assessment and diagnosis of lower limb wounds, which has resulted in patients wounds healing quicker. Although not specific to TWCCG commissioned services, evidence of increased knowledge and understanding of tissue viability have been seen during Quality Assurance visits to mental health services.

The Trust’s focus on quality improvements has been profiled in the CQC national report “Quality improvement in hospital trusts – sharing learning from trusts on a journey of QI”.

MPFT Quality Framework Priorities 2018/19

MPFT five key proprieties for delivering our strategic quality objective:

- People who use MPFT services will be happy about the way they are treated and will have genuine opportunities to make an impact on service improvements
- Teams will be supported to make continuous quality improvements the norm
- MPFT will learn from mistakes and take steps to reduce future errors
- MPFT CQC rating will not fall below an overall rating of ‘Good’ and the CQC will see evidence of outstanding practice in an increasing number of services
- MPFT will engage in a comprehensive programme of research to enable practice to be built on the best available evidence

The Priorities for 2018/19 have been reviewed and monitored via the CCG Clinical Quality Review Meetings and contracts meetings. The 2019/20 outcomes will also be reviewed and monitored be via these same forums.

Telford and Wrekin CCG state that to the best of their knowledge, the data and information contained within the 2018/19 Quality Account is accurate.

Christine Morris
Executive Nurse, Lead for Quality & Safety
Healthwatch Shropshire

MPFT Quality Accounts

We welcome the opportunity to respond to the draft Quality Accounts of the Midlands Partnership Foundation Trust. Healthwatch Shropshire (HWS) welcomes MPFT’s commitment to include service users and carers in the development of services and the emphasis given to outcomes. It would be useful to see some examples of the impact that this engagement has had.

The trust achieved the highest response rate for the staff survey in their benchmark group of trusts which is to be commended as is their commitment to focus on staff feedback.

Priorities for 2018/19

Priority 1- Reducing restrictive practices within adult low and medium secure services inpatients

- The large increase in restrictive practices is concerning. Some of the reasons given for the increase lack clarity. However if the rise in cases is due to increased reporting following the focus on this area it is welcomed and we look forward to hearing how the improvement measures will impact on the current levels over the coming year.

Priority 2- Effective communication between Trust clinicians and primary care clinicians for patients with severe mental illness

- The Trust is to be congratulated on the improvements shown and we welcome the continued focus especially as Shropshire is still somewhat off the target compared with South Staffordshire. It is really helpful for the figures to be presented with a geographical breakdown so Shropshire residents can see how services are being developed locally.

Priority 3- Healthy food for NHS patients, visitors and staff

- It is noted that although the priority target has been met that the Trust will continue to monitor this area as one of the Local Quality Indicators.

We welcome the three priorities for 2019/20 but would have liked to see some focus on the BeeU service in Shropshire within the Quality Accounts. The feedback we have received around the service during this year has been overwhelmingly negative. This has been shared with the Trust and the Trust response has been published with the report.

We would welcome the opportunity to be involved in future stakeholder consultations around priorities for improvement. We would also be very willing to work with the Trust to improve feedback response in Shropshire.

It is concerning that patient experience of care, as measured by the CQC Community Mental Health Survey, has fallen, although it is noted that the trust remains ‘Better’ when compared with other Trusts and the rates have fallen for both the highest and lowest rated Trusts.

HWS is pleased to see the progress the trust has made on its Local Quality Indicators and commend the Trust for its commitment to continue to work on the areas where improvement has either not been achieved or not achieved to the level hoped for.

Trust’s response to feedback from Healthwatch Shropshire

We thank Healthwatch Shropshire for their feedback. We have taken note of the feedback received and are pleased with the recognition of the Trust’s achievements. We acknowledge that Healthwatch Shropshire would like to have seen more focus on the BeeU service and will consider this in our 2019/20 Quality Accounts.
Staffordshire Health Scrutiny commentary

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.

We have 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 have 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.

Our approach has been to review the Trust’s draft Account and make comments for them to consider in finalising the publication. Our comments are as follows:

We note that the trust was formed during the course of the year and this may have affected the trusts performance and income projections.

Introduction. A statement, signed by the CEO is present in the account but it is not signed by the Chairman, however we do acknowledge that he has signed the Statement of Directors Responsibilities at the end of the document.

The Trusts vision and a list of the services the new Trust provides are not included.

Priorities. We note that the 2018/19 priorities had been chosen by the previous trusts, South Staffordshire and Shropshire and the former Staffordshire and Stoke on Trent Partnership Trust and those chosen by the current Midlands Partnership Trust are for 2019/20.

The Priorities are well detailed and include next steps. Links to the Care Quality Commission registration and recent inspection reports are included.

Statements of Assurance. The number of services reviewed is present and the explanation and detail of how it is intended to measure progress and monitor the delivery of clinical services is welcomed.

Evidence of participation in local and national clinical audits and subsequent outcomes are explained. We are of the opinion that the actions to improve section was useful however, more statistical comparison information would be useful along with the number of patients taking part in the research.

There is no mention in the document of Income and little mention of the CQUIN other than a link to an equally brief web page. More detail in the report would have been useful.

The learning from deaths section is informative but we presume that some of the data is missing and that the data will be available for the final document to enable the section to be more useful.

Review of quality performance. There is information about specific services and specialities. Core Indicators and evidence from complaints, patient and staff surveys, inspection benchmarking is present together with performance against key quality and mandatory Indicators.

The Glossary of Technical Terms and Standard Definitions is present and a useful addition to the document.

In relation to the general format and layout of the document, some of the data presented in table form may have been easier to understand if it had been presented in different formats. It is appreciated that the draft quality account is as it suggests draft, however, there were gaps in the data that made it difficult to scrutinise appropriately.

Trust’s response to feedback from Healthwatch Shropshire

We thank Staffordshire Health Scrutiny Committee for their feedback. We have taken note of the feedback received and are pleased with the recognition of the Trust’s achievements. We acknowledge the comment made regarding list of services, vision and more detail regarding income. These areas can all be found in the Trust Annual Report of which this document forms a part. CQUIN’s do however form a part of this document as our key priorities for improvement are all CQUIN schemes. Learning from deaths data within the document is complete and accurate for the whole financial year.
ANNEX 2

Statement of Directors’ Responsibilities

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

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

• the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19
• the content of the Quality Report is not inconsistent with internal and external sources of information including:
  o board minutes and papers for the period April 2018 to May 2019
  o papers relating to quality reported to the board over the period April 2018 to May 2019
  o feedback from commissioners dated 20/05/2019
  o feedback from governors dated 11/03/2019
  o feedback from local Healthwatch organisations dated 20/05/2019
  o feedback from Overview and Scrutiny Committee dated 20/05/2019
  o the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/11/2018
  o the 2017 community mental health national patient survey 22/11/2018
  o the 2017 national staff survey 26/02/2019
  o the Head of Internal Audit’s annual opinion of the trust’s control environment dated 24/05/2019
  o CQC inspection report dated 12/07/2016
• the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered
• the performance information reported in the Quality Report is reliable and accurate
• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
• the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
• the Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

• The reported indicator performance throughout this report has been calculated based on all mental health performance identified in line with NHS Improvement and NHS England guidance. Completeness of this information is therefore dependent on the complete and accurate entry of data. Information identified within the population will therefore not be included in the indicator calculation. We believe the data included in the indicator calculations to be complete and accurate. Specific completeness considerations for externally assured indicators can be found in the Standard Definitions section of this report on page 53.

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

By order of the Board.

24/05/2019

[Signature]

Chairman

24/05/2019

[Signature]

Chief Executive

mpft.nhs.uk
External Auditor’s Opinion

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Midlands Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of Midlands Partnership NHS Foundation Trust’s Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- early intervention in psychosis (EIP); people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) - approved care package within two weeks of referral; and

- inappropriate out-of-area placements for adult mental health services.

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;

- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2018/19 ('the Guidance'); and

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes and papers for the period April 2018 to May 2019;

- papers relating to quality reported to the board over the period April 2018 to May 2019;

- feedback from commissioners, dated 20 May 2019;

- feedback from governors, dated 11 March 2019;

- feedback from local Healthwatch organisations, dated 20 May 2019;

- feedback from Overview and Scrutiny Committee, dated 20 May 2019;

- the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;

- the 2017 community mental health national patient survey, dated 22/11 2018;
the 2018 national staff survey, dated 22/02/2019;

- Care Quality Commission Inspection, dated 12/07/2016;

- the 2018/19 Head of Internal Audit’s annual opinion over the trust’s control environment, dated 24 May 2019; and

- any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Midlands Partnership NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Midlands Partnership NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;

- making enquiries of management;

- testing key management controls;

- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and

- reading the documents.

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

Limitations

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

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

The scope of our assurance work has not included governance over quality or the non-
mandated indicator, which was determined locally by Midlands Partnership NHS Foundation 
Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to 
believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out 
in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified 
in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been 
reasonably stated in all material respects in accordance with the NHS Foundation Trust 
Annual Reporting Manual and the six dimensions of data quality set out in the 
Guidance.

KPMG LLP
Chartered Accountants
Birmingham

30 May 2019
**GLOSSARY**

**Glossary of Technical Terms**

**AHP** – healthcare professionals that include Occupational Therapist, Physiotherapist and Speech and Language Therapists

**Big Conversation** - As an organisation we want to make sure that Service Users and Carers are getting the best possible service from us. As part of this process we are asking our staff wherever possible to engage in a conversation with Service Users and Carers.

**Care Programme Approach (CPA)** - the process of how mental health services assess users' needs, plan ways to meet them and check that they are being met

**Cardio Metabolic** - describes a person's chances of damaging their heart and blood vessels when one or more risk factors are present

**CQC** - Care Quality Commission checks all hospitals in England to ensure they are meeting government standards, and shares their findings with the public

**CQUIN** - The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers’ income to the achievement of local quality improvement goals

**Daily Lean Leadership** - is the system that allows you to deliver customer value through proper support and leadership to those who are closest to the process (customers and process owners)

**Diagnostic Overshadowing** - a process where health professionals wrongly presume that present physical symptoms are a consequence of their patient's mental illness

**DNA** – did not attend an appointment

**ECG** - Electrocardiogram: A recording of the electrical activity of the heart.

**First Steps in QI** - Available to all staff who, as part of the training, will identify a small improvement project in their team whilst using basic elements of evidence based quality improvement methodology.

**FRASE** – is a specific falls risk assessment tool

**Freedom to Speak up Guardian** – helps to protect patient safety and the quality of care, improve the experience of the workforce and promote learning and improvement

**IM&T** – information management and technology

**Listening into Action** – is about re-engaging with employees and unlock their potential so they can get on and contribute to the success of your organisation, in a way that makes them feel proud.

**Medicines Optimisation Committee** – is the Trust medicines committee that ensures safe, effective patient centred use of medications

**Mental Capacity Act** - is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

**Mortality Review** – a process for reviewing deaths to help improve the overall quality of patient care
Naloxone - blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness. An opioid is sometimes called a narcotic. Naloxone is used to treat a narcotic overdose in an emergency situation.

NHS Digital Indicator Portal - The NHS Information Centre is England's central, authoritative source of health and social care information for frontline decision makers. Their aim is to revolutionise the use of information to improve decision making, deliver better care and realise increased productivity.

NICE (National Institute for Health and Care Excellence) - provides national guidance and advice to improve health and social care.

NRLS – National Reporting and Learning System.

Olanzapine - is an antipsychotic medication used to treat schizophrenia and bipolar disorder. It is usually classed with the atypical antipsychotics, the newer generation of antipsychotics.

Pathology - is a medical specialty that is concerned with the diagnosis of disease based on the laboratory analysis of bodily fluids such as blood and urine, as well as tissues, using the tools of chemistry, clinical microbiology, haematology and molecular pathology.

Physical Observations – using a set of clinical skills to monitor a patient such as pulse, temperature and blood pressure.

Picker Institute – A international charity in the field of person centred care. They have a rich history of supporting those working across health and social care systems measuring patient experience to drive quality improvement in healthcare.

POMH (Prescribing Observatory for Mental Health) - helps specialist mental health Trusts improve their prescribing practice by identifying specific topics within mental health prescribing and developing audit-based Quality Improvement Programmes (QIPs). Organisations’ are able to benchmark their performance against one another and identify where their prescribing practice meets nationally agreed standards.

Rapid Process Improvement Workshop (RPIW) - an improvement process that brings together a team of staff from either various departments or a single department to examine a problem, eliminate wastes, propose solutions, and implement changes.

Recovery - the concept of recovery is about service users staying in control of their life despite experiencing a mental health problem. Professionals in the mental health sector often refer to the ‘recovery model’ to describe this way of thinking. Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms.

Restrictive Practice – are deliberate acts on the part of other person(s) that restrict a patient’s movement, liberty and/or freedom to act independently in order to: Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and end or reduce significantly the danger to the patient or others’. (MHA, CoP 2015).

Rio – an electronic clinical information and patient administration system. There is a clinical record for each individual, including assessment forms, care planning, diagnosis and progress notes; as well as caseload management, inpatient bed management and appointment booking tools.

Senates - a group of clinical leaders that provide strategic advice and guidance.

SMI – refers to people who have a severe mental illness.

Standard Operating Procedure – a document that describes a procedure, usually brief and including a flow chart or the process to be followed.
Tissue Viability - is a growing speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration.

Virginia Mason Production System – In 2002, Virginia Mason embarked on an ambitious, system-wide program to change the way it delivers health care and in the process improve patient safety and quality. It did so by adopting the basic tenets of the Toyota Production System (TPS), calling it the Virginia Mason Production System, or VMPS. This quality improvement system is one we use in the Trust.

136 Suite - is a place of safety for those who have been detained under Section 136 of the Mental Health Act by the police following concerns that they are suffering from a mental disorder.

Standard Definitions

Below are the standard definitions of those indicators detailed in Section 2 and 3 of this report (Core & Mandated Indicators):

Core Indicators:

CPA 7 Day Follow up (page 37)
The technical definition is as described in the “Department of Health Mental Health Community Teams Activity Return (MHRPRVCOM) Data Definitions August 2012 – Mental Health Performance Framework: Guidance UNIFY2 Collection”

The definition is as follows:

Detailed Definition:
The number of patients who were followed up either by face to face contact or by a phone discussion within 7 days of discharge from psychiatric in-patient care.

All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team.

Exemption:

- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of a patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CAMHS (child and adolescent mental health services) are not included.

The seven-day period should be measured in days, not hours, and should start on the day after the discharge.

Admission to Acute Wards via Crisis Resolution Home Treatment (page 39)
The technical definition is as described in the “Department of Health Mental Health Community Teams Activity Return (MHPHPRVCOM) Data Definitions August 2012 – Mental Health Performance Framework: Guidance UNIFY2 Collection”

The definition is as follows:

Detailed Definition:

The number of admissions to the trust's acute wards that were gate-kept by crisis resolution home treatment teams.
A crisis resolution home treatment (CRHT) team provides intensive support for people in mental health crises in their own home. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. Teams are required to meet all of the fidelity criteria including gatekeeping all admissions to psychiatry inpatients wards and facilitate early discharge of service users.

An admission has been gate kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission.

Total Exemption to CR/HT Gatekeeping:

- Patients recalled on Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admissions for psychiatric care from specialist units such as eating disorder units are excluded.

Partial exemption:

- Admissions from out of the trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local area. CR team should assure themselves that gatekeeping was carried out. This can be recorded as gatekept by CR teams.

**Patient Safety Incidents (page 42)**


The definition is as follows:

**Detailed Definition:**

**No harm:**
Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.

Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.

**Low:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.

**Moderate:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

**Severe:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
Death: Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

Criteria for the local indicator:
Multi-disciplinary care plans for all service users open to learning disability services (page 49)
The definition is as described in the 2018 clinical audit report
The definition is as follows:

Detailed Definition

“The Trust must ensure staff consistently and regularly review and update care plans. They must ensure all care planning documentation is personalised and addresses the needs identified in the assessment.”

In relation to those care plans, to establish:

- What percentage of people on our caseloads have a care plan in place.
- What percentage of these care plans are populated appropriately (i.e. are in line with assessment data, personalised etc.)
- What percentage of care plans are up to date/within agreed review date.

Mandated Indicators:

Inappropriate out of-area placements for adult mental health services (page 51)

The definition is as follows:

Detailed Definition:

An ‘out of area placement’ for acute mental health in-patient care happens when:

A person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services.

By this, we mean an inpatient unit that does not usually admit people living in the catchment of the person’s local community mental health service and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning.

Patients should be treated in a location which helps them to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as possible with the local environment.

Sending providers are to determine if a placement is classed as an OAP. The definition necessarily allows providers to apply knowledge of local catchment arrangements and the patient’s circumstances in taking a decision if a placement is an OAP. OAPs can occur within one NHS provider, in other NHS providers, or independent sector providers (ISPs).

Placement may occasionally be considered appropriate. Possible reasons have been outlined below.
Total number of bed days patients have spent inappropriately out of area. In Detailed requirements for quality reports it is specified that the indicator should be stated as a monthly average.

Early Intervention in Psychosis (page 51)
The technical definition is described in NHS England Guidance for reporting against access and waiting times standards: Children and Young People with an Eating Disorder & Early Intervention Psychosis

The definition is as follows:

Detailed Definition:

Clock Starts
The waiting time clock for the EIP and CYP ED standards starts when:
i) A referral request is received for an assessment for a child or young person with a suspected ED or person with suspected first episode psychosis (FEP), or is recognised as such upon receipt.
ii) The primary reason for referral should be CYP with suspected ED or suspected FEP. The clock start date is defined as the date referral received – this must be recorded accurately so the referral can be tracked.
iii) Where pathways start with an interface service, such as clinical triage, assessment centre, single point of access, the clock start date is the date the interface service receives the referral – not the date the referral is passed onto the relevant clinical team.
iv) Where a service accepts direct referrals (no interface service), the clock will start from the date the referral is received by that service.
v) Where a primary reason for referral is not recorded as suspected FEP or ED, but this is identified during triage/single point of access, the clock start date is the date of initial referral. If this is not suspected during triage but at a subsequent assessment then the date the clock starts is when suspicion is first raised.
vi) If a person is already in contact with mental health services (including acute hospital liaison) the clock starts when suspicion of FEP or ED is first raised (not backdated to their initial contact with the mental health service). Protocols should be in place so that staff can make timely referrals to the relevant specialist service for assessment and treatment.

Referral sources
Referrals may come from any source and the clock will start regardless of the agency making the request. Referrals may therefore be internal to provider organisations (e.g. a children and young people’s mental health service, a CMHT, inpatient ward or forensic mental health service) or external (e.g. a GP, carer, school or self-referral). The clock also starts regardless of any comorbidities, such as learning disabilities, substance misuse, personality disorder or autism.
It is therefore important that staff within provider organisations are trained and aware so they can make timely referrals to the relevant specialist service for assessment and treatment. Referrals could be in person, telephone, email, letter, or online.

Vetting referrals
Timely, clinically-led vetting of referrals will ensure referrals are appropriate and can assist in identifying if an alternative pathway may be more suitable. Vetting of urgent referrals should be prioritised and ideally be completed on the day of referral or the morning of the following day. Vetting can be carried out by an appropriately trained team of staff which should help minimise delays. Staff should follow clear protocols and be subject to continuous monitoring and audit. The vetting process should not delay clock start.

Recording clock start in the MHSDS
Clock start is recorded in the MHS101 Table and all the required fields should be completed in line with the data standard. The following will identify referrals to be assessed for the Mental Health AWT standards and the date of the clock start.
<table>
<thead>
<tr>
<th>MHSDS Table</th>
<th>MHSDS data Item name</th>
<th>National code</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHS101 – Service or Team Referral</td>
<td>Primary reason for referral</td>
<td>01: (Suspected) First Episode Psychosis</td>
<td>Identifies EIP referrals</td>
</tr>
<tr>
<td>MHS101 Service or Team Referral’</td>
<td>Referral request received date</td>
<td>Date received</td>
<td>Clock start date</td>
</tr>
</tbody>
</table>

**Externally assured indicator completeness considerations**

Below are the specific completeness considerations for those indicators that are externally assured by the Trust External Auditors:

**Early Intervention in Psychosis:** "The reported indicator performance has been calculated based on all patients being accurately recorded as having been referred to Early Intervention Services. Completeness of this information is therefore dependent on the complete and accurate entry of data at source. Patients who have not been identified within the population will therefore not be included in the indicator calculation. To the best of our knowledge the data used for the indicator calculation is complete."

**Out of Area Placements:** "The reported indicator performance has been calculated based on accurate recording of all mental health patients identified as requiring an acute inpatient admission and being correctly recorded as occupying an out of area bed. Completeness of this information is therefore dependent on the complete and accurate entry of data. Beds or patients not identified within the population will therefore not be included in the indicator calculation. To the best of our knowledge the data used for the indicator calculation is complete."