AGENDA

Culture and Conduct Protocol

We are a values-led Board. We place quality of care and safeguarding the needs of our patients at the heart of everything we do. We work consciously as a team to support and constructively challenge each other in the best interests of service users, their carers and families. We champion the interests of staff and acknowledge that they are working well in challenging times. We seek to ensure value for money at all times through efficient use of our resources in the delivery of services and achievement of standards. We welcome the rigour of debate with fellow Board members, drawing upon a range of different experiences and perspectives and applying the Nolan principles of Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Purpose</th>
<th>Board Lead</th>
<th>Format</th>
<th>Timings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Apologies:</td>
<td></td>
<td>Oral</td>
<td>12.30pm</td>
</tr>
<tr>
<td>2.</td>
<td>Declarations of Interests&lt;br&gt;For Board members to declare any relevant interests in items on the agenda.</td>
<td>Chair</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Quality Account 2017/18&lt;br&gt;External Audit Report &amp; Opinion</td>
<td>Approval&lt;br&gt;Assurance</td>
<td>Mrs Musson&lt;br&gt;Mrs Musson</td>
<td>Enc 1&lt;br&gt;Enc 2&lt;br&gt;(To follow)</td>
</tr>
<tr>
<td>4.</td>
<td>ANY OTHER BUSINESS</td>
<td></td>
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<tr>
<td>5.</td>
<td>DATE AND TIME OF THE NEXT MEETING</td>
<td></td>
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<td>1.00pm</td>
</tr>
</tbody>
</table>

Monday 2\textsuperscript{nd} July 2018, The Seminar Room, Bloxwich Hospital, Reeves Street, Bloxwich WS3 2JJ
Board Meeting Date: 22 June 2018

Agenda Item number: 3

Enclosure: 1

Report Title: Quality Account 2017/2018

Accountable Director: Rosie Musson, Acting Director of Nursing

Author (name & title): Rosie Musson, Acting Director of Nursing

David Miles – Quality Improvement Facilitator

Purpose of the report: To present the final draft report, including stakeholder comments to the Trust Audit Committee for recommendation to Trust Board for sign off.

Action required from the Board

<table>
<thead>
<tr>
<th>Decision / Approval</th>
<th>Gain assurance</th>
<th>Discussion</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

What other Trust Committee or Group has considered the key elements of this report?

Committee: Quality and Safety Committee and Audit Committee

Date reviewed: 13 June 2018

Key points or recommendations from Committee:

The Quality and Safety Committee approved the document for submission to the Audit Committee.

Feedback and a recommendation from the Audit Committee will be given at the meeting.

Is referral to Trust Board required?

Yes

If yes, for what purpose?

Formal sign off of the Quality Account

Strategic Objective(s) to which this paper relates:

<table>
<thead>
<tr>
<th>High quality services</th>
<th>Inclusive partnerships</th>
<th>Leadership culture</th>
<th>Responsible workforce</th>
<th>Supporting strategies</th>
<th>Effective/efficient resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

The CQC domains that this report relates to are:

<table>
<thead>
<tr>
<th>Caring</th>
<th>Responsive</th>
<th>Effective</th>
<th>Well-led</th>
<th>Safe</th>
</tr>
</thead>
</table>

Please give brief details:

(Improvements / Risks to current position)

The Quality Account is underpinned by all CREWS domains and provides an overarching annual report on key activity relating to quality.
**Title**

Quality Account 2017/2018

**Introduction**

The Trust is required to prepare annually a Quality Account for publication in accordance with National guidance. This report outlines the process in preparation of the account for 2017/18 and presents the draft Quality Account for discussion and approval to Trusts Board.

**Executive Summary of key points, issues, financial impact and risks**

**Summary of key points, issues**

- The Quality Account has been produced in line with National Guidance and has been subject to wide consultation.

- Following consultation with key stakeholders the main changes have related to format as opposed to content.

- Feedback from both Walsall and Dudley Commissioners has been included in the Quality Account.

- Feedback from Healthwatch in Walsall has been included in the account

- External audit are completing their audit processes, which will be presented at the extraordinary Audit Committee on 21 June 2018.

- Following the Audit Committee the Quality Account will be received by the Trust Board to consider the Audit Committee’s recommendation regarding the sign off of the Quality Account.

- Subject to the internal approval process the Quality Account needs to be published on NHS Choices website by the 30th June 2018 in line with National Guidance.

**Further detail**

A final draft of the Quality Account is appended to the report.

**Recommendation**

The Board will be asked to accept the Audit Committee’s recommendation regarding the adoption of the Quality Account 2017/18 for publication.
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Part 1: Chief Executive’s Statement

Welcome to the 2017-18 Quality Account for Dudley and Walsall Mental Health Partnership NHS Trust

I am pleased to introduce our Quality Accounts for 2017/18. The Trust has had another positive year with a continuing focus on delivering high quality services.

Our Quality Account for 2017/18 provides examples from across our services reflecting the range of work we have delivered and continue to deliver to ensure and improve the quality of care. We have set out where improvements have been made and how we will continue to work to ensure that quality is improved within the organisation.

The Trust is a multi-site provider (26 sites) of mental health and social care services serving the Black Country boroughs of Dudley and Walsall within the West Midlands. The Trust’s headquarters are situated in Dudley, approximately ten miles north-west of Birmingham. We employ around 1100 staff.

The Black Country region demonstrates cultural, economic and educational diversity. Walsall, along with Sandwell and Wolverhampton, experience high levels of multiple deprivation.

We are a relatively small yet flexible organisation, responding to change and challenge, quickly and effectively.

We are especially proud of our:

- Open and transparent culture
- Robust relationships with commissioners and excellent local health economy knowledge
- Reputation for good service quality and governance
- Good engagement with service users, carers, agencies and community groups
- Consistently high performance

In 2017/18, we continued to focus on maintaining the delivery of high quality services, evidenced by our performance against national and local indicators as well as feedback from our service users and carers. Below are some of the highlights from 2017/18.

- Continued to be rated GOOD by the CQC
- Our staff survey results were excellent and show that staff engagement remains high and we are one of the top performing trusts in many areas
- Leadership across the Trust at a senior management level have continued to develop a positive culture of leadership
- Improved the quality of clinical supervision and appraisals to support care delivery and practice
- Focused on clinical leadership and staff empowerment
- Continued to develop the role of Experts by Experience and widen the scope of their work in ensuring that service users and carers have a voice in service improvement
- Increased our capability in research and development as well as increasing patient involvement
• Strengthened clinical audit within the Trust and ensured alignment of clinical audit to Trust’s Quality Improvement Strategy
• Improvements to our clinical environments informed by feedback from a visit to Dimence in the Netherlands
• Embraced and embedded Duty of Candour at all levels
• Maintained Royal College of Psychiatrists Centre for Quality Improvement (CCQI) Accreditations
• Maintained Royal College of Psychiatrists Memory Services National Accreditation Programme (MSNAP) accreditation.
• Launched a new Transcranial Magnetic Stimulation service for the treatment of depression
• Expanded our Autism Spectrum Disorder ASD and Attention Deficit Hyperactivity Disorder ADHD diagnostic services to meet growing demand
• Introduced Peer Support Workers on our wards
• Received a national E-rostering award for effective safer staffing
• We achieved our highest ever uptake rate for flu vaccinations.

As Chief Executive of the Trust, I can confirm that, to the best of my knowledge, the information contained in this Quality Account is accurate. The Statement of Directors responsibilities summarises the steps taken to develop this Quality Account and external assurance is provided in the form of statements from our commissioners. The report of an external audit undertaken by Grant Thornton UK LLP is included in the Quality Account.

We are proud of the service we provide and hope you will take the time to read this Quality Account.

On behalf of the Board I am pleased to present this account to you.

Mark Axcell
Chief Executive
Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement
This is the forward-looking section of the Quality Account. It details the improvements planned for the next year and explains why the priorities have been chosen. When identifying the 2018/19 priorities, considerations were given against progress made since the last Quality Account which is detailed in Section 3 of this report.

During 2017/18, the Trust embraced an ambitious agenda for quality improvement which has been delivered through the Quality Improvement Strategy. The Trust will continue this journey during 2018/19, and has identified four quality improvement priorities through a process of reviewing services and working with stakeholders, and by looking at the Trust’s performance against national and local quality indicators.

These quality priorities are especially pertinent as barometers for service quality as they:
- Reflect the vision and current priorities for the organisation.
- Are distributed across the CQC domains: Caring, Responsive, Effective, Well-led, Safe
- Represent both local and national agendas
- Include priorities that are important to our service users and their carers
- Include priorities that are important to our staff
- Include priorities that are important to stakeholders and partners
- Are a mixture of new areas and those which build on key priorities from 2017/18 and are applicable to services being developed as part of the Trust’s vision.

For each of the quality priorities a delivery strategy has been developed to track the performance against improvement initiatives at all levels from ward to board. Progress against these priorities will take place through quarterly integrated ‘Quality Reports’ presented to the Quality and Safety Committee and Trust Board.

2.2 Our priorities for 2018/19

Priority One: Patient Safety First Approach

<table>
<thead>
<tr>
<th>Drivers</th>
<th>The Trust is committed to providing harm free care to patients; reducing and preventing any unintended or unexpected event that could lead to harm. This will be achieved through the Sign Up To Safety Pledges:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Putting safety first;</td>
</tr>
<tr>
<td></td>
<td>o Continually learning;</td>
</tr>
<tr>
<td></td>
<td>o Being honest;</td>
</tr>
<tr>
<td></td>
<td>o Collaborating;</td>
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<td></td>
<td>o Being supportive</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>We will continue to demonstrate an increase in incident reporting whilst reducing the level of harm caused to patients;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>We will reduce the incidence of disruptive and aggressive behaviours;</td>
</tr>
<tr>
<td></td>
<td>We will reduce the incidence of serious self-harming behaviours;</td>
</tr>
<tr>
<td></td>
<td>We will reduce the number of patient falls;</td>
</tr>
<tr>
<td></td>
<td>We will reduce the number of suicides of patients in our care;</td>
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<tr>
<td></td>
<td>We will ensure our Being Open – Duty of Candour Policy is fully embedded;</td>
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<tr>
<td></td>
<td>We will continue to publish our patient safety data;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Patient Safety metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benchmarking</td>
</tr>
<tr>
<td></td>
<td>Clinical Audit</td>
</tr>
</tbody>
</table>
### Priority Two: Using technology to improve care and recovery

**Drivers**
The Trust is committed to using technology and innovation to improve care and promote recovery. Working from the NHS Five Year Forward Plan the Trust will continue to realise and embed technology where possible to improve outcomes for service users and staff.

**Quality Indicator**
- We will implement through a staged approach a Trust wide patient record / EPR;
- We will assess the usefulness of Skype as a tool to improve communication with our service users;
- We will assess the viability of implementing an ePrescribing system;
- We will develop an annual Innovation in Informatics and IT focus group;
- We will continue to embed electronic rostering to improve safer staffing and staff experience.

**Measurement**
- EPR project milestones
- Service user feedback
- Staff feedback
- Evaluation of annual informatics innovation event
- Rostering metrics

### Priority Three: Improving inpatient care and experience

**Drivers**
The Trust is committed to improving the quality of inpatient service user care and experience. Following feedback from the CQC the Trust continues to undertake targeted work to improve the quality of inpatient services, to move the service towards a CQC rating of ‘Outstanding’.

**Quality Indicator**
- We will continue to make improvements to the physical environment through the Trust's capital programme;
- We will continue improve our annual PLACE scores;
- We will implement an electronic compliance monitoring system for the Estates and Facilities;
- We will introduce Smoke Free in line with national guidance;
- We will introduce a Therapeutic Hub to improve the Therapeutic Day and outcomes for service users;
- We will continue to achieve AIMs Accreditation for our inpatient wards.

**Measurement**
- Implementation of Capital Programme
- Annual PLACE report and benchmarking
- Performance against Estates compliance standards
- Smoke Free project milestones
- Service users feedback
- AIMs accreditation results.

### Priority Four: Making sure care pathways are person centred and effectively support recovery

**Drivers**
The Trust is committed to ensuring care pathways are person centred and effectively support recovery. The Trust will continue to improve its person centred approach to care pathways, which enhance communication and timely access to care.

**Quality Indicator**
- We will undertake a comprehensive mapping exercise of person centred approaches within our current pathways;
- We will undertake a gap analysis and identify areas of best practise;
- We will establish Trust wide standards for person centred care;
- We will implement an improvement plan;
- We will continue to implement the Trust's values and behavioural framework.

**Measurement**
- Completion of person centred mapping
- Completion of gap analysis
- Development and implementation of improvement plan
- Clinical Audit
How will we review and monitor these priorities?
Each quality improvement priority identified for 2018/19 will be delivered through the framework laid out on the Trust’s Quality Improvement Strategy. Progress will be monitored through the Trust’s quality governance framework and overseen by the Quality and Safety Committee. The Quality and Safety Committee and Trust Board will receive quarterly updates on progress and also any required exception reports.

2.3 Statements of Assurance
The aim of the following sections (2.4 – 2.10) is to provide information to the public which will be common across all Quality Accounts, thereby enabling people to gain a more informed and transparent view about what different healthcare organisations have reported. The statements in this section offer assurance from the Trust Board to that public that the Trust is:-

- Performing to essential standards
- Measuring our clinical processes and performance
- Involved in national projects and initiatives aimed at improving quality.

2.3.11 National Health Service Resolution (NHSR) Compliance

Following a change in approach the NHSR confirmed there were to be no further standard based assessments after March 2014; however the Trust is still committed to demonstrating compliance with these standards as they show an on-going commitment to the proactive management of risk within the organisation. Compliance with these standards and ensuring the on-going suitability of policies pertaining to NHSR standards continues to be overseen by both the Trust’s Policies and Procedures Focus Group and the Trust’s Quality and Safety Committee.

2.4 Reviewing the Quality of Trust Services

During 2017/18 the Trust delivered NHS services through four service lines:

- Early Intervention Services
- Urgent Care and Access Services
- Inpatient Services (Acute and Older Adults)
- Community Services

The Trust has reviewed the data available to them on the quality of care in these services and the overall view of the Trust is that the quality of services remains good.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by the NHS Trust for the reporting period 2017/18.

2.5 Clinical Audit

Clinical Audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring clinical practice in line with these standards, improving the quality of care and health outcomes. (HQIP ‘New Principles for Best Practice in Clinical Audit’ – Radcliffe Publishing, 2011).

As part of the Clinical Governance Agenda, the Trust has a comprehensive Clinical Audit programme that is delivered as part of the annual audit programme. This is monitored by the Quality and Safety Committee on behalf of the Trust Board. The Clinical Audit and
Effectiveness Committee provides support and guidance for Trust priority audits and promotes cooperation between service lines when developing and carrying out clinical audit within the organisation. The Committee also assists audit leads in developing action plans and recommendations for priority audits, such as those relating to NICE guidelines, national and Trust priorities.

2.5.1 National Clinical Audits and Confidential Enquiries

During April 2017 to March 2018 four National Clinical Audits and one National Confidential Enquiry covered NHS services that Dudley and Walsall Mental Health Partnership Trust provides.

During that period the Trust participated in 100% of National Clinical Audits and 100% of National Confidential Enquiries in which it was eligible to participate.

The National Clinical Audits and National Confidential Enquiries that the Trust was eligible to participate in during April 2017 to March 2018 were:-

- Prescribing Observatory for Mental Health (POMH) Use of Depot/LA Antipsychotic Injections for Relapse Prevention
- Prescribing Observatory for Mental Health (POMH) Prescribing Valproate for Bipolar Disorder
- Commissioning for Quality Innovation (CQUIN) Improving physical healthcare for to reduce premature mortality in people with severe mental illness (PSMI). Data collected and submitted through the National Clinical Audit of Psychosis (NCAP)
- Commissioning for Quality Innovation (CQUIN) Preventing ill health by risky behaviours – alcohol and tobacco
- National Confidential Enquiry into Homicide and Suicide.

The National Clinical Audits that Dudley and Walsall Mental Health Partnership NHS Trust participated in, and for which data collection was completed during April 2017 to March 2018 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases.

**Figure 1: National Clinical Audits**

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Participation</th>
<th>% Cases Submitted</th>
<th>Learning</th>
</tr>
</thead>
</table>
| POMH: Use of Depot/LA Antipsychotic Injections for Relapse Prevention      | Yes           | No set sample size 61 submitted | - Overall Trust compliance was good, with the Trust scoring in line with national average levels.  
- The Trust scored above national average levels in relation to patients having clinical plans should they default from treatment, the assessment of side effects and therapeutic responses.  
- The Trust will continue to embed this good practice through the Clinical Audit and Effectiveness Committee. |
| POMH: Prescribing Valproate for Bipolar Disorder                           | Yes           | No set sample size 137 submitted | - Trust compliance was in line with national average levels for most standards.  
- The Trust scored particularly well |
in relation to carrying out the necessary physical health checks in inpatient settings.

- There was one identified area of improvement relating to the consistent documentation of benefits/side effects of Valproate being discussed with the patient prior to commencing treatment.

<table>
<thead>
<tr>
<th>CQUIN: Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI). National Clinical Audit of Psychosis (NCAP)</th>
<th>Yes</th>
<th>100 cases submitted 100% of requested sample group</th>
<th>N/A. Results due June 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Confidential Enquiry into Homicide and Suicide</td>
<td>Yes</td>
<td>Criteria Met</td>
<td></td>
</tr>
</tbody>
</table>

### 2.5.2 Local Clinical Audits

The Trust’s own Quality Priority Audits for 2017/18 were derived from a number of key sources including trend analysis of incidents, complaints, commissioner requests, and national best practice guidelines (e.g. NICE). They were designed to give assurance with regards to newly embedded processes and to ensure embedded quality processes were safe and effective. A selection of audits commissioned to support these processes and the key findings or recommendation arising from these audits is detailed in the table below.
<table>
<thead>
<tr>
<th>Title of Audit</th>
<th>Summary of Actions / Recommendations</th>
</tr>
</thead>
</table>
| **Care Programme Approach (CPA) Audit** | CPA aims to ensure that robust arrangements are in place regarding discharge planning and aftercare of people with serious mental illness. The audit showed that the Trust continues to deliver standards in accordance with national requirements; however the audit demonstrated the following areas for improvement:-  
- Documented evidence that the service user has been involved in their risk assessment  
- Documented evidence of service user involvement in the development of care plans  
- Re-audit planned for 2018/19. |
| **Patient Searches** | The Trust continues to monitor compliance with the Search Policy to ensure that blanket restrictions are not in place and that all medical staff are acting within accordance with the 2015 Mental Health Act Code of Practice, and the Trust’s Search Policy when justifying the use of searches when patients return from community leave. Audit results showed improvement across all standards from the previous audit and continued assurance that patient searches were being carried out in accordance with Trust policy. The audit highlighted the following areas for improvement:-  
- Continue to review search documentation to address inconsistencies  
- Review guidance in relation to searching patients who have been on community leave and informal patients  
- Re-audit planned for 2018/19. |
| **Venous Thromboembolism (VTE) Audit** | This audit aims to identify whether VTE risk assessments for Older Adult patients are being carried out and documented in a timely manner. Audit results showed that VTE risk assessments were carried out and documented in line with Trust policy. The audit also highlighted the following areas for improvement:-  
- Increase the number of forms filled out within 24 hours of patient admission to Older Adults inpatient services  
- Address inconsistencies with completion of form to ensure all relevant information is recorded. |
| **Falls Prevention** | The Trust carries out monthly monitoring of patient falls to report to the relaunched Falls Forum. The audit aims to identify and document all patients who are at risk of a fall. It also aims to ensure that all falls incidents are reported. Audit results show a good level of compliance against all standards relating to documentation and reporting. The audit highlighted the following areas for improvement:-  
- Training to be delivered to Falls Champion on each ward  
- Ongoing monitoring and improvement in the documentation and reporting of patient falls. |
2.6 Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Dudley and Walsall Mental Health Partnership Trust in 2017/18 that were recruited to participate in research approved by a Research Ethics Committee was 372 participants as of the end of February 2018. Patients were offered the chance to take part in 17 large scale, high quality, national NIHR Portfolio research studies, seven of which were new studies opened during 2017/18, including randomised control trials, epidemiological research and genetic research, as displayed below. Participation in clinical research demonstrates the Trust’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. The Trust supports clinical staff to stay abreast of the latest treatment options through active participation in research.

Figure 3: Number of portfolio research studies 2017/18

<table>
<thead>
<tr>
<th>Research Study Title</th>
<th>Topic</th>
<th>Service Line</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>EO AD Genetics – Detecting susceptibility genes for early onset Alzheimer’s Disease</td>
<td>Alzheimer’s Disease</td>
<td>Older Adult Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>LO AD Genetics – Detecting susceptibility genes for late onset Alzheimer’s Disease</td>
<td>Alzheimer’s Disease</td>
<td>Older Adult Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>ALOIS – Prospective non-interventional study of patients with mild to moderate Alzheimer’s Disease and their caregivers in four European Countries</td>
<td>Alzheimer’s Disease</td>
<td>Older Adult Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>ASC – UK – Learning about the lives of adults on the autism spectrum and their relatives</td>
<td>Autism Spectrum Disorder in Adults</td>
<td>Adult Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>OPNT Bulimia Nervosa Naloxone Spray - Randomised, double-blind, placebo controlled trial evaluating the effects of naloxone hydrochloride nasal spray on eating behaviours in bulimia nervosa</td>
<td>Eating Disorders</td>
<td>Adult Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>CoACTION: Cultural adaptations in clinical interactions</td>
<td>R&amp;I Service Delivery</td>
<td>Ethnic Minority service users and Clinicians</td>
<td>Open</td>
</tr>
<tr>
<td>A Survey of mindfulness and self-compassion in IAPT - An anonymous survey of mindfulness, self-compassion, wellbeing and mental health</td>
<td>IAPT Service Delivery</td>
<td>Adult Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>MOLGEN - Molecular Genetics of Adverse Drug Reactions (Clozapine)</td>
<td>Genetics</td>
<td>Adult Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>PPPH- Patient Preferences for Psychological Help</td>
<td>Schizophrenia</td>
<td>Adult Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>REQOL- questionnaire to help understand and monitor progress of recovery and quality of life</td>
<td>All Service Users</td>
<td>Adult Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>VIS- Voice impact Scale</td>
<td>Psychosis/Schizophrenia</td>
<td>Adult Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>BI-425809- Clinical trial of BI 425809 (name of drug) effect on cognition and functional capacity in schizophrenia.</td>
<td>Schizophrenia</td>
<td>Adult mental Health</td>
<td>In Set Up</td>
</tr>
<tr>
<td>Study title</td>
<td>Focus Area</td>
<td>Stage</td>
<td>Status</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>---------------------------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>N-CAT - National survey of Child Anxiety and Treatment access</strong></td>
<td>Anxiety disorders</td>
<td>Schools</td>
<td>Closed</td>
</tr>
<tr>
<td><strong>Tiga Cub – Feasibility study of child psychotherapy vs usual treatment for children with difficult behaviour.</strong></td>
<td>Conduct disorder</td>
<td>Child and Adolescent Mental Health</td>
<td>Closed</td>
</tr>
<tr>
<td><strong>DPIM Schizophrenia – DNA Polymorphism in Mental Health illness</strong></td>
<td>Schizophrenia</td>
<td>Adult Mental Health</td>
<td>Closed</td>
</tr>
<tr>
<td><strong>FemNAT - Understanding gender differences in disruptive behaviour in children and teenagers</strong></td>
<td>Conduct Disorder</td>
<td>Child &amp; Adolescent Mental Health</td>
<td>Closed</td>
</tr>
<tr>
<td><strong>PRONIA – Personalised prognostic tools for early psychosis management</strong></td>
<td>First Episode Psychosis and Depression</td>
<td>Adult Mental Health</td>
<td>Closed</td>
</tr>
</tbody>
</table>
2.7 CQUIN (Commissioning for Quality and Innovation)

A proportion of the Trust’s income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Dudley and Walsall Mental Health Partnership Trust and the commissioners through the Commissioning for Quality and Innovation (CQUIN) framework. CQUIN is a national initiative which aims to embed demonstrable quality improvements within the commissioning cycle for NHS healthcare.

2017/18 marks the first year of the CQUIN schemes being split over a two year period (2017/19). During this period, the Trust will participate in five national schemes with a total value of £1.34m. The schemes cover a range of services.

The CQUIN scheme indicators, financial values and performance for the past three years are summarised below.

Figure 4: Historical CQUIN Performance 2015/16 – 2017/18

<table>
<thead>
<tr>
<th>Year</th>
<th>Scheme Title</th>
<th>National / Local</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>6 Schemes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Dementia Pain Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Physical Health Check</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Urgent Emergency Care – Reducing MH &amp; A&amp;E Attendances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Medicines Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Enhanced Carers Support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. DW-ROM</td>
<td></td>
</tr>
<tr>
<td>2016/17</td>
<td>8 Schemes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Improving Physical Health Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Improving Health and Wellbeing of NHS Staff Medicines Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Management Voluntary Sector Working</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. DW-ROM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Mental Health MDT Pilot</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Avoidable MHA Admissions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. John’s Dementia Campaign</td>
<td></td>
</tr>
<tr>
<td>2017/18</td>
<td>5 Schemes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Improving staff health and wellbeing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Improving physical healthcare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Improving services for those who present to A&amp;E</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Transitions out of children and young people’s mental health services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Preventing ill health by risky behaviours</td>
<td></td>
</tr>
</tbody>
</table>

Financial Value

| Year     | Value: £1.39m | Achieved: £1.365m | Value: £1.35m | Achieved: £1.23m | Value: £1.34m | Achieved: |

Further details for the reporting period and the following twelve months can be obtained from communications@dwmh.nhs.uk

Figure 5: 2017/18 -2018/19

<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>National / Local</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improving staff health and wellbeing</td>
<td>National</td>
</tr>
<tr>
<td>2. Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI)</td>
<td>National</td>
</tr>
<tr>
<td>3. Improving services for people with mental health needs who present to A&amp;E</td>
<td>National</td>
</tr>
<tr>
<td>4. Transitions out of Children and Young People’s Mental Health Services (CYPMHS)</td>
<td>National</td>
</tr>
<tr>
<td>5. Preventing ill health by risky behaviors – alcohol and tobacco</td>
<td>National</td>
</tr>
</tbody>
</table>

Further details for the reporting period and the following twelve months can be obtained from communication@dwmh.nhs.uk
2.8 What others say about the Trust?

As a provider of NHS services, the Trust is monitored and regulated by a variety of external bodies and arrangements. This regulatory framework helps to ensure that the Trust provides services which are of the highest quality, well-managed and make appropriate use of resources.

Statements from the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission and the Trust has no conditions attached to its registration. Through the Trust’s quality governance processes the Trust responds to guidance issued by the Secretary of State for Health relating to Part 1, Chapter 2 of the Health Act 2009 in respect of the Quality Accounts.

In November 2016 the Trust received a formal CQC assessment against the CQC’s assessment framework. The Trust’s report from this visit was published on the 28th March 2017 and has seen the Trust move from an overall rating of “requires improvement” to an overall rating for the Trust of “good”. The assessment noted that the Trust had made improvements to:-

- The documentation of long-term segregation and the management of blanket restrictions on adult acute wards
- Reducing waiting times for specialist community services for children and young people
- Ensure that staff were displaying a dedicated and caring attitude towards service users
- Provide core services that were responsive to the needs of the people who used them
- Develop a new positive culture of leadership at senior management level/Allowing for good staff morale and staff who felt supported in carrying out their roles effectively.

Figure 5: March 2017 CQC Findings
Dudley and Walsall Mental Health Partnership NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2017/18.

The Trust participated in a thematic review for children’s mental health in Walsall during October 2017. The review involved tracking of cases, interviews, focus groups, meetings with service users and carers, and our partner services in learning disabilities, private and the voluntary sector. Initial verbal feedback included positive comments on the service provided, including iCAMHS, FLASH, the Early Help Service that is commissioned through the CAMHS Transformation Plan. The reviewers felt that CAMHS were proactive in safeguarding and in listening to the voice of the child.

Royal College of Psychiatrists Centre for Quality Improvement (CCQI) Accreditations

During 2017/18 the Trust has continued to participate in CCQI National Quality Improvement projects managed by the Royal College of Psychiatrists. This is a voluntary national improvement and development programme which aims to raise the standards of care in mental health services. CCQI accreditation is a nationally recognised indicator of high quality services which support continuous quality improvement.

The Trust has retained its CCQI accreditation for:-
- All of its working age adult inpatient wards via the Accreditation for Inpatient Mental Health Services programme.
- Its Electro-Convulsive Treatment (ECT) Services via the Electro-Convulsive Therapy Accreditation Scheme
- Memory Services National Accreditation Programme

The Trust has also received three peer reviews in relation to three of its four older peoples ward via the Accreditation for Inpatient Mental Health Services. The peer review assessment into all 3 wards has led to the development of an action plan which requires implementation to ensure that these wards remain accredited

2.9 Data Quality

Good quality information underpins the effective delivery of care and is essential for measuring and monitoring improvements in quality and performance. The Trust has made significant improvements to its performance management and reporting framework, and has taken a number of actions to improve data quality.

The Trust has a well-established Contract Activity Review Meeting (CARM). This meeting is held at the start of each month to discuss and review the previous month’s data, before it is presented to the Finance and Performance Committee, to commissioners at the Contract Review, Clinical Quality Review Meetings and then at Board. CARM is now an established governance mechanism for the Trust that involves operational and information staff.

The function of CARM has been further developed during 2017/18 to help raise the profile of information in the Trust and to drive data quality improvements.

In particular, this forum has been extended and is now used to:
- Monitor progress against the Data Quality Improvement Plan
- Review all submitted reports to monitor performance against target
• Co-ordinate exception reports and remedial action plans to achieve operational service compliance
• Authorise submission of performance related data to any external organisations
• Standardise data definitions
• Explore emerging performance challenges
• Commission work covering more detailed analysis and forecasting
• Help managers understand the financial impact and implications of changes in the level of activity.

In 2017/18 the Trust refreshed its Data Quality Improvement Plan (DQIP) which aims to ensure that all strategic, operational and clinical decisions are made on the basis of good information drawn from robust data.

The DQIP was endorsed by Senior Management Executive Team and the Finance and Performance Committee, and implementation has continued throughout 2017/18.

New processes have been put in place to track and monitor all data quality checks and exercises. The scope and purpose of each data quality process is agreed centrally and the results are documented to ensure that a clear audit trail of checks and changes is maintained.

The Performance Department monitors other Data Quality Reports. These include Blank Team Referrals, Floating Referrals, Duplicate Referrals, Appointments with no Outcomes, Daily Demographic checks, Monthly Batch Trace files cross referencing GP Practices and Deceased Records.

2.10 NHS Number and General Practice Code Validity

The Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data (month eleven) which included the patient’s valid NHS number was:
- 99.7% for Admitted Patient Care (national 99.4%)
- 100% for Outpatient Care (national 99.6%)

The percentage of records in the published data which included the patient’s valid General Practice medical code:
- 99.4% for Admitted Patient Care (national 99.9%)
- 99.8% for Outpatient Care (national 99.8%)

2.10.1 Information Governance Toolkit Attainment Levels

Information Governance (IG) refers to the systems and processes the Trust has in place to safely and effectively manage all types of information. The NHS Digital IG Toolkit (IGT) is an online system which allows NHS organisations and partners to assess themselves against NHS Digital’s Information Governance policies and standards. It also allows members of the public to view participating organisations. Trusts are required to assess themselves annually against the standards in the toolkit.

Dudley and Walsall Mental Health Partnership NHS Trust Information Governance Assessment Report provides an overall score of 68% and 95% of all staff received IG
training during 2017/18. In accordance with the IG Toolkit, the Trust is rated Satisfactory and has a green RAG rating.

The score was lower than in the previous year. This was due to the timetabling of work to support Information Governance standardisation linked to the proposed TCT integration with two other NHS trusts, but which did not ultimately take place.

There was one significant incident reported in 2017/18 to the Information Commissioner.

2.10.2 Clinical Coding Error Rate

Clinical coding compliance applies to inpatient records to ensure that diagnosis and procedures are coded correctly and consistently across the Trust. Clinical coding is part of the Information Governance (IG) Toolkit requirements where the accuracy of coding must be maintained at a given level to achieve level two or three within the Toolkit.

The Trust continues to meet national requirements in this area.
Part 3: Review of Quality Performance

This section provides information related to the quality performance of the Trust’s services. External sources of data have been used to provide the public with as much benchmarking information as possible.

This part of the Quality Account is presented in four sections:

1. Part 3A – Performance against Department of Health (DOH) Mandatory Indicators, which Trusts are required to report against in their Quality Accounts for 2017/18
2. Part 3B – Performance against 2017/18 Quality Improvement Priorities
3. Part 3C - Performance against additional Quality Performance Indicators chosen by the Trust including National and Contractual KPIs
4. Part 3D - Statement from the Trust’s key stakeholders.

Part 3A: Department of Health Mandatory Indicators

The NHS (Quality Account) Amendments regulations (2012) defined a set of core quality indicators, which Trusts are required to report against for their Quality Accounts from 2013/14 onwards. The Trust’s position against all relevant indicators for the last two years is shown in the following sections.

3.1 Preventing People from Dying Prematurely – 7 Day Follow-up

The Trust has utilised the information available from NHS Digital and the Trust considers that the data is as described for the following reasons:-

- Staff are aware of their responsibilities regarding data quality through regular communications and team meetings. In addition, all national, local and internal quality indicators are reviewed and data validated at the Contracted Activity Reporting Meeting (CARM) with representation from all Trust areas
- Robust data quality monitoring and validation processes and procedures are in place and embedded along with clear guidance on the requirements to record data accurately
- The Trust has taken the following actions to improve this percentage, and the quality of its services, by:-
  - holding a series of awareness sessions
  - Issuing daily specific exception reports to operational managers
  - Strong leadership provided by senior operational staff to ensure that the clinical importance of this indicator was understood
This continued to be an important area for the Trust in 2017/18. The Trust has performed strongly throughout 2017/18 and managed to achieve 96.1%.

The table below provides the percentage achievement for the last three years.

**Figure 9: 7 Day Follow Up**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Full Year 2015/16</th>
<th>Full Year 2016/17</th>
<th>Full Year 2017/18</th>
<th>National Average 2017/18</th>
<th>Highest 2017/18</th>
<th>Lowest 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Day Follow Up</td>
<td>95%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>97.7%</td>
<td>73%</td>
</tr>
</tbody>
</table>

The graph below provides the monthly percentage achievement in 2017/18.

**Figure 10: Seven Day Follow Up in 2017/18**

### 3.2 Enhancing the Quality of Life for People with Long Term Conditions

The Trust has utilised the information available from NHS Digital and the Trust considers that the data is accurate for the following reasons:

- Staff are aware of their responsibilities regarding data quality through regular communications and team meetings. In addition, all national, local and internal quality indicators are reviewed and data validated at the Contracted Activity Reporting Meeting with representation from all Trust areas.
- Robust data quality monitoring and validation processes and procedures are embedded with clear guidance on the requirements to record data accurately.
The Trust has taken the following action to increase access to the CRHT team and so the quality of its services by:–
  • Issuing monthly exception reports to operational staff
  • Strong leadership provided by senior operational staff to ensure that the clinical importance of this indicator was understood. This continued to be an important area for the Trust in 2017/18.

The information provided by NHS Digital showed numerators, denominators and percentages for all admissions to acute inpatient services and how many were gate-kept by the CRHT Team.

This has been an area of consistent strong performance throughout 2017/18 with 100% inpatient admissions being gate-kept in 2017/18.

The table below provides the percentage achievement for the last three years.

**Figure 11: Crisis Gatekeeping**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Full Year 2015/16</th>
<th>Full Year 2016/17</th>
<th>Full Year 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gate keeping of Inpatient Admissions by CRHT</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The graph below provides the monthly percentage achievement 2017/18.

**Figure 12: Gatekeeping Achievement Rates**
3.3 Ensuring that people have a positive experience of care – staff survey

The official sample size in respect of the National Staff Survey for Dudley and Walsall Mental Health Partnership NHS Trust was 1061. 541 completed questionnaires were returned from this sample. The response rate was therefore 52.3%.

Similar organisations surveyed by Quality Health had a mean overall response rate of 44%.

Figure 13: Staff Survey

<table>
<thead>
<tr>
<th>Survey Year</th>
<th>Question</th>
<th>Trust</th>
<th>MH/LD Trust Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Question 22b - ‘If a friend or relative needed treatment I would be happy with the standard of care provided by this Trust’</td>
<td>55%</td>
<td>59%</td>
</tr>
<tr>
<td>2012</td>
<td>Question 12d - ‘If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation’</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>2013</td>
<td>Question 12d - ‘If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation’</td>
<td>60%</td>
<td>59%</td>
</tr>
<tr>
<td>2014</td>
<td>Question 12d - ‘If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation’</td>
<td>62%</td>
<td>60%</td>
</tr>
<tr>
<td>2015</td>
<td>Question 21d - ‘If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation’</td>
<td>65%</td>
<td>59%</td>
</tr>
<tr>
<td>2016</td>
<td>Question 21d - ‘Agreed that they would be happy with standard of care for friend / relative’</td>
<td>66%</td>
<td>59%</td>
</tr>
<tr>
<td>2017</td>
<td>Question 21d - ‘Agreed that they would be happy with standard of care for friend / relative’</td>
<td>66%</td>
<td>63%</td>
</tr>
</tbody>
</table>

The Trust considers that these percentages are as accurate for the following reason:-

- As previously recommended, the Trust used an independent approved contractor to run the staff survey on behalf of the Trust in 2011-2017. Approved contractors provide external assurance of the process
- In 2017, the Trust has continued to use the same independent approved contractor to run the staff survey
- In 2017 the Trust employed a permanent substantive Staff Engagement Lead in a combined role encompassing the new Freedom To Speak Up Guardian post. They will continue to promote the Staff Survey as well as leading the Staff Friends and Family Test, work with Staff Engagement Champions and managers to support initiatives to further drive staff engagement and standards of care
- In 2017 we continued to offer eligible staff both traditional paper surveys and electronic versions which were offered to all staff to complete rather than just a
The Trust has taken the following actions to improve this percentage, and so the quality of the services provided:-

- The Trust has held focus groups and in particular utilises the staff Engagement Champions drawn from a variety of locations and services during 2017, to help understand any issues, and to seek staff feedback on possible solutions/remedies. These are planned to continue for 2018
- Staff Engagement Lead is working with the Workforce Committee and Heads of Service to review Staff Survey results by Service Line to enable a more detailed understanding of the challenges and opportunities specific to their areas, and will be working with them to create bespoke action plans
- Senior management continue to attend areas outside of their usual remit, to improve the visibility to staff on the ground and to enhance engagement and communication Trust-wide

The Trust will be taking the following actions to improve this percentage, and so the quality of the services provided:-

- Outputs/recommendations from the focus groups and staff engagement sessions and work with Heads of Service will be included in action plans, as appropriate
- The Trust launched the Staff Friends and Family Test via its intranet, in May 2014, and have monitored these throughout the year, drilling down into the free text comments as to why people answered the way they did. This has seen staff continuing to state that they would recommend the Trust as a place for treatment/care to friends and family, maintaining a score above 80% in the latest SFFT in February 2018 with a result of 82%

3.4 Helping people to recover from episodes of ill health during injury

Readmission rates
The Trust has used information from the Trust’s information system (OASIS) as the information was not accessible from NHS Digital to enable meaningful comparison.

The Trust considers that the data is accurate for the following reasons:-

- Staff are aware of their responsibilities regarding data quality through regular communications and team meetings. In addition, all national, local and internal quality indicators are reviewed and data validated at the Contracted Activity Reporting Meeting with representation from all Trust areas
- Robust data quality monitoring and validation processes and procedures are in place and embedded along with clear guidance on the requirements to record data accurately.

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

- Developing processes and procedures, to agreed parameters, with clinical staff to ensure validated readmissions figures were reported internally and externally
- Establishing robust reporting through the Trust’s data warehouse dashboard to enable services to view the level of readmissions
- Strong leadership provided by senior operational staff to ensure that the clinical importance of this indicator was understood. The Trust has closely monitored this indicator and year end results show a rate at 9.4% against an aspirational Trust target of 10%.
The table below provides the percentage achievement for the last three years.

**Figure 14: Readmission Rates**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Full Year 2015/16</th>
<th>Full Year 2016/17</th>
<th>Full Year 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission Rate</td>
<td>&lt;10%</td>
<td>8.2%</td>
<td>10.9%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

The graph below provides the monthly percentage achievement 2017/18.

**Figure 15: Trust Readmission Rate in 2017/18**

3.5 **Ensuring people have a positive experience of care – national survey**

The Trust has utilised the information available from the Information Centre in relation to the 2013, 2014 and 2015 and 2017 Community Patient Survey. To determine the Trust’s performance against this indicator, the mean score achieved against the following three questions has been calculated from the 2017 survey of people who use community mental health services:

*Extract from survey – Section Health and Social Care Workers:*

1. Did the person or people you saw listen carefully to you?
2. Were you given enough time to discuss your needs and treatment?
3. Did the person or people you saw understand how your mental health needs affect other areas of life?
Figure 16: Patient Experience

<table>
<thead>
<tr>
<th>Performance</th>
<th>Experience of Care 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dudley and Walsall Mental Health Partnership NHS Trust</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Figure 17: Survey Overall Experience

Health and social care workers

![Survey Results]

Figure 18: Benchmarking against other Trusts

<table>
<thead>
<tr>
<th>How this score compares with other Trusts</th>
<th>Based on patients’ responses to the survey, this</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.9/10 Listening for the person or people seen most recently listening carefully to them</td>
<td>About the same</td>
</tr>
<tr>
<td>7.3/10 Time for being given enough time to discuss their needs and treatment</td>
<td>About the same</td>
</tr>
<tr>
<td>7.0/10 Understanding for the person or people seen most recently understanding how their mental health needs affect other areas of their life</td>
<td>About the same</td>
</tr>
</tbody>
</table>

The overall score is the average of the domain scores, which is taken as the experience of care score.

We consider the percentages are as described for the following reasons:-
- The Trust used an independent approved contractor to run the Community Patient Survey on behalf of the Trust in 2011-2017
- 2017 figures for the lowest and highest scoring Trust are provided by the CQC.

We have taken the following actions to improve this score further, and the quality of our services:-
- Improved the visibility of our Service Experience Desk (PALS and Complaints) to
better support service uses, carers and staff

- Patient Reported Experience Measures (PREMS) survey has been developed and is currently being deployed across all teams. The survey has been developed for benchmarking teams and service lines against CREWS standards. PREMS are used to understand patients’ views on their experience while receiving care.

3.6 Patient Safety Related Incidents

The Trust has obtained data from NHS Digital which utilises data from the National Reporting and Learning System (NRLS) from which national benchmarking data is then scrutinised by the Trust to monitor performance.

The figures below are taken from the last four half yearly feedback reports from the NRLS who collect information regarding all patient safety related incidents within the Trust and offer a comparison against similar organisations. As a mental health provider we are placed into a cluster group alongside 56 other mental health organisations.

**Figure 19:** Patient Safety Related incidents Submitted to the NRLS

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Number of Incidents per 1000 bed days</th>
<th>Median – per 1000 bed days</th>
<th>Percentile of 56 other reporters within mental health cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st October 2015 – 31st March 2016</td>
<td>31.96</td>
<td>37.54</td>
<td>Middle 50%</td>
</tr>
<tr>
<td>1st April 2016 – 30th September 2016</td>
<td>36.82</td>
<td>42.45</td>
<td>Middle 50%</td>
</tr>
<tr>
<td>1st October 2016 – 31st March 2017</td>
<td>44.33</td>
<td>44.33</td>
<td>Middle 50%</td>
</tr>
<tr>
<td>1st April 2017 – 30th September 2017</td>
<td>63.29</td>
<td>42.66</td>
<td>Middle 50%</td>
</tr>
</tbody>
</table>

**Figure 20:** Patient Safety related incidents

<table>
<thead>
<tr>
<th>Date Range</th>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st October 2015 – 31st March 2016</td>
<td>470</td>
<td>407</td>
<td>8</td>
<td>0</td>
<td>5</td>
<td>890</td>
</tr>
<tr>
<td></td>
<td>52.8%</td>
<td>45.7%</td>
<td>0.9%</td>
<td>0.0%</td>
<td>0.6%</td>
<td></td>
</tr>
<tr>
<td>1st April 2016 – 30th September 2016</td>
<td>555</td>
<td>467</td>
<td>17</td>
<td>1</td>
<td>3</td>
<td>1043</td>
</tr>
<tr>
<td></td>
<td>53.2%</td>
<td>44.8%</td>
<td>1.6%</td>
<td>0.1%</td>
<td>0.3%</td>
<td></td>
</tr>
<tr>
<td>1st October 2016 – 31st March 2017</td>
<td>738</td>
<td>464</td>
<td>19</td>
<td>0</td>
<td>9</td>
<td>1230</td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>37.7%</td>
<td>1.5%</td>
<td>0</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>1st April 2017 – 30th September 2017</td>
<td>961</td>
<td>660</td>
<td>36</td>
<td>2</td>
<td>9</td>
<td>1668</td>
</tr>
<tr>
<td></td>
<td>57.6%</td>
<td>39.6%</td>
<td>2.2%</td>
<td>0.1%</td>
<td>0.5%</td>
<td></td>
</tr>
</tbody>
</table>
3.7 Serious Incidents

The Trust takes a very rigorous approach to serious incident (SI) reporting and has a fully embedded reporting culture across the organisation. The Trust is fully committed to learning from serious incidents and has a robust embedding lessons procedure in operation to ensure that all actions identified through the investigation of serious incidents are fully implemented.

During the year the Trust has reviewed and made improvements to the Serious Incident Processes. The planned benefits of the new process are:-

- Improved terms of reference that aim to provide robust areas of investigation
- Full executive knowledge of ongoing Serious Incidents
- Increased commissioner engagement and support
- Faster turnaround of SI reports
- Improved investigation outcomes, root cause and contributing factors leading to identified areas for improvement / Areas for learning leading to better healthcare provision
- Timely feedback to relatives / patients of outcomes
- Assurance to Trust Board
- Open and transparent investigation process.

Figure 21: Reported Incident 2017/18

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

- Incident reporting is a central component to risk management within the Trust. All incidents have been managed according to the Trusts ‘Incident, Near Miss and Serious Incident Reporting Policy’
- All incidents are recorded on ‘Safeguard’ which is the Trust’s Integrated Risk Management System, for which staff receive training and on-going support
- The Trust is considered to have a good reporting culture and that all incidents are reported in a timely manner, with regular training provided to all staff and managers.
The organisation also recognises the importance of having robust process for the investigation of incidents, complaints and claims. This is done through the use of root cause analysis techniques that can be used to identify any key areas of learning for the organisation and identifies any systems failures, key events, human errors and areas for improvement.

The Trust submits its quality report to the Commissioner Quality Review meeting on a monthly basis for external scrutiny. This process acts as an independent scrutiny check.

### 3.8 Learning from Deaths

During reporting period 2017/18, 138 Dudley and Walsall Mental Health Partnership NHS Trust patients died. The deaths occurred in the following timeframe:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>25</td>
</tr>
<tr>
<td>Q2</td>
<td>38</td>
</tr>
<tr>
<td>Q3</td>
<td>48</td>
</tr>
<tr>
<td>Q4</td>
<td>27</td>
</tr>
</tbody>
</table>

Of the 138 reported deaths, the Trust undertook a serious incident investigation into 27 of these cases (These were the cases that met the requirements of the National Serious Incident Framework). These investigations aimed to determine what problems (if any) there were in the care provided. Investigations were undertaken for each quarter of that reporting period as follows:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Investigations Undertaken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>4</td>
</tr>
<tr>
<td>Q2</td>
<td>5</td>
</tr>
<tr>
<td>Q3</td>
<td>9</td>
</tr>
<tr>
<td>Q4</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
</tr>
</tbody>
</table>

From the 27 cases that were investigated by the Trust, 8 cases (representing 5.8% of the patient deaths during the reporting period) were assessed as 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:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of completed investigations highlighting care problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>2</td>
</tr>
<tr>
<td>Q2</td>
<td>3</td>
</tr>
<tr>
<td>Q3</td>
<td>3</td>
</tr>
<tr>
<td>Q4</td>
<td>0</td>
</tr>
</tbody>
</table>
These numbers have been calculated using the National Guidance on Learning from Deaths which is used within the Trust alongside the Serious Investigation Process.

**Summary of Learnings**

The 8 investigations that have identified potential issues in the care provided to patients have highlighted some key areas / themes of learning.

- To ensure that clinical staff fully consider the extent of the impact that relationship breakdowns, drug and alcohol addictions, social factors and financial stressors can potentially have upon a patient’s mental health.

- To ensure that there is effective communication pathways between the Trust and patient’s GP’s, with particular focus on the Trust Discharge Summary highlighting any known key risks and signposting to key support services

- To ensure that patient’s treatment plans are produced in line with expected Trust standards.

- To ensure that there is joined up care relating to a patient’s pain management and physical health care requirement which is fully aligned with their mental health treatment plans.

**Summary of Specific Actions and Assessment of Impact**

<table>
<thead>
<tr>
<th>Action Taken</th>
<th>Assessment of Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In all cases of suicide, Investigation findings are linked to the Trust Suicide Prevention Strategy.</strong></td>
<td>The effectiveness of the Trusts suicide prevention strategy is continually overseen by the Trusts suicide prevention group and interfaces with work being complete by the local CCGs in relation to the development of borough wide suicide prevention strategies.</td>
</tr>
<tr>
<td><strong>DNA Processes</strong> – Further review of Trust policy and assurances that practice is embedded across Trust.</td>
<td>The effectiveness of changes to the Trusts DNA processes will assessed through a future clinical audit.</td>
</tr>
<tr>
<td><strong>Signposting</strong> – A review of the statutory and voluntary information available to staff to provide to patients has been undertaken.</td>
<td>The effectiveness of the review of statutory and voluntary information available to be provided to patients will be assessed by the Trusts program of supportive visits, which looks at the availability of information and leaflets as part of this work.</td>
</tr>
<tr>
<td><strong>Suicide Prevention Training / Staff skills</strong> – The Trust has undertaken a formal review of training provided to staff, ensuring that lessons from incidents are incorporated into the training material with a Training Needs Analysis being utilised to ensure the training is delivered to all appropriate staff.</td>
<td>Suicide prevention training is monitored through the Trusts learning and development team, through the Trusts training data. The Trust has also conducted a survey of the effectiveness suicide prevention training using a survey on the Trust intranet.</td>
</tr>
</tbody>
</table>
• **Supporting patients social care needs, Housing support, Family Intervention** - The Trust is working in partnership to ensure that processes are in place with the Local Authority and voluntary organisations i.e. CAB to address patient’s holistic needs.

• **The implementation and effectiveness of this action will be reviewed as part of the Trusts embedding lessons processes.**

• **Relationship Breakdowns / Financial Stressors** – The Trust is working to ensure that staff are aware of impact on patients mental health / depression risk factors as part of Suicide Prevention training.

• **The Trust has also conducted a survey of the effectiveness suicide prevention training using a survey on the Trust intranet.**

• **Medicines Management** – The Trust has amended processes to ensure GP’s are informed of any potential or actual overdose via discharge letter in line with the Coroner’s Regulation 28 ruling.

• **The effectiveness of revised processes will be monitored through CQRM meetings with commissioners and monitoring of reported clinical incidents.**

• **Partnership Working** – The Trust continues to attend and support regional and local Suicide Prevention Groups.

• **The effectiveness of this will be overseen as part of the development of each CCGs suicide prevention strategy**

• **Helium / Gas Inhalation** – The Trust has raised awareness of this issue with Public Health / and has also included this risk factor in Suicide Prevention training for its staff.

• **The effectiveness of this action will be overseen by the Trusts suicide prevention group who will continue to scrutinise serious incident investigations.**

• **Criminal Justice** - Counselling and support is to be offered to patients who are experiencing stress as a result of any criminal justice / legal proceedings being pursued against them.

• **The implementation of this action will be overseen by the Trusts embedding lessons process.**

• **Family involvement** – a review of the Trust’s Triangle of Care process has been undertaken.

• **Triangle of Care information is reviewed as part of the Trusts program of supportive visits, as such effectiveness of this action will be assessed through this piece of work.**

• **Personality Disorder (PD) support** – The Trust has developed a new PD strategy.

• **The new implementation of the new PD strategy will be continually reviewed as part of its implementation.**

There were a total of 4 incidents that occurred prior to 01/04/17 whose investigations were subsequently completed within the 2017/18 reporting timeframe.

During reporting period 2016/17 154 Dudley and Walsall Mental Health Partnership NHS Trust patients died. Of the reported 154 deaths the Trust undertook serious incident investigations into 10 of these cases.

From the 10 cases investigated by the Trust, 5 cases (representing 3.2% of the patient deaths during the reporting period) were assessed to be more likely than not to have been due to problems in the care provided to the patients.

These numbers have been calculated using the National Guidance on Learning from Deaths which is used within the Trust alongside the Serious Investigation Process.
3.9 Duty of Candour

In the wake of the Francis Inquiry into the failings at Mid Staffordshire NHS Foundation Trust, the Department of Health introduced a contractual Duty of Candour that requires NHS organisations to be open and honest with patients and their families about patient safety incidents.

All incidents that are rated moderate and above have been reviewed further to confirm the level of harm sustained and the level of contact the service user had at the time with Trust services.

There were ten cases during 2017/18 where the process for Duty of Candour has been applied.

**Figure 22: Number of Trust Incidents / Complaints where the Duty of Candour process has been followed**

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>May</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jun</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Jul</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Aug</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sep</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oct</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nov</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dec</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Jan</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Feb</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mar</td>
<td>10</td>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>
Part 3B: Performance against Quality Improvement Priorities
This section of the Quality Account demonstrates the significant improvements made against the five Quality Improvement Priorities for 2017/18.

The progress against the priorities and the associated action plans were monitored by the Quality and Safety Committee and the Trust Board.

3.10 Progress against 2017/18 Priorities

Priority 1: Smoke Free (continued from 2016/17)

Drivers Smoking is the largest single preventable cause of morbidity. People with mental health problems smoke significantly more, with levels about three times of those observed in the general public. The Trust is committed to supporting individuals to stop smoking whilst receiving NHS Care as this is seen as a significant opportunity to support individuals and reduce smoking. The Trust recognises that by prioritising smoking cessation it will be supporting people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.

Progress
- Steering group well established good engagement and representation from all key stakeholders, including public health Dudley and Walsall, Human Resources, Experts by Experience, Pharmacy, Finance, Staff engagement champions, Communications
- Draft implementation plan developed and presented to Management Executive Committee. Management Executive Committee will oversee the project, full business case under development
- Learning from early implementers and scoping of evidence based practice
- Smoke Free Trust policy developed
- Smoke free date of December 2018 in principle agreed.

Priority 2: Person Centred Care / Care Planning

Drivers People who use mental health services should have the opportunity to make informed decisions about their care and treatment, in partnership with their health and social care practitioners. Putting person centered values into practice means that you are providing care that is focused on the individual. It demonstrates to the individual that you want to care for and support their recovery.

The CQC report and internal monitoring show that whist progress continues to be made further work is required to improve the quality and consistency of person centered care planning.

Progress
- Care plan checks added to Trust supportive visits
- Care plan re-audit completed across all wards
- Mapping exercise scheduled to gather evidence of person centred care and care planning across all Trust services and teams.
### Priority 3: Improving the quality of our record keeping

**Drivers**

Through feedback from the CQC, internal clinical audits and feedback from service users it has been identified that improvements need to be made to the quality of record keeping to enable greater consistency. The Trust currently has a mix of electronic and paper records, which creates challenges to consistency, however as the trust moves towards an electronic single patient record further work is required to ensure the quality of record keeping is maintained and improved.

**Progress**

- Guidance on best practice record keeping standards re-issued to staff
- Clear guidance on record keeping standards given to managers and included in ward audit activity
- Spot-checks on the standards of documentation added to Trust supportive visits.

---

### Priority 4: Ensure organisational learning is embedded and sustained

**Drivers**

Learning is identified through complaints, claims, audit and third party inspections. If learning is embedded in practice and sustained over time, the likelihood of repeated incidents and other events which can cause harm are reduced. Through feedback from the CQC Inspection and internal quality governance processes it has been identified further work is required to improve embedding lessons process to ensure effective triangulation of information, monitoring of actions taken and ensuring improvements are embedded in practice.

**Progress**

- Trust Embedding Lessons Group re-launched with new membership and terms of reference
- Creation of a centralised database and SharePoint system to allow different service areas to triangulate actions and develop themes
- Monthly and quarterly Lessons Learnt bulletin produced for all Trust staff.

---

### Priority 5: Refocus / Recovery Model

**Drivers**

Recovery is a concept that recognises people can be in control of their lives despite mental health problems, and can regain a meaningful life despite a mental illness. Refocus is a specific approach to recovery that works with both individual and team attitudes towards recovery practices.

**Progress**

- Initial round of Refocus training delivered to staff
- Wrekin ward staff trained in use of DWROM need to explain what DWROM stands for recovery model with Wrekin ward chosen as a pilot for DWROM use on selected service users
- Attendance of three Refocus events
- DWROM now fully implemented to assist care planning on Wrekin ward.
Part 3C: Trust performance against additional quality performance indicators

This section of the Quality Account aims to provide a selection of indicators chosen by the Trust to demonstrate a holistic view of quality across the services provided. The Trust has included contractual and national key quality indicators and a selection of quality indicators the Trust uses to monitor the quality of the services provided.

3.11 Contractual Quality Requirement Goals agreed with Commissioners

For 2017/18, the Trust monitored 27 contractual Key Performance Indicators (KPIs) set by Dudley and Walsall CCG. These KPIs were largely rolled-over from the previous year and were in line with national reporting requirements.

The table below shows the performance levels achieved for the KPIs where thresholds were finalised in the year.

**Figure 23: Contractual KPI’s Performance in 2017/18**

<table>
<thead>
<tr>
<th>Contractual KPIs</th>
<th>Target</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Referral to Treatment Time – Incomplete</td>
<td>&gt;92%</td>
<td>98.1%</td>
</tr>
<tr>
<td>2 7 day follow up on Inpatient Admissions</td>
<td>&gt;95%</td>
<td>96.1%</td>
</tr>
<tr>
<td>3 Delayed Transfers of Care (All Reasons)</td>
<td>&lt;7.5%</td>
<td>4.1%</td>
</tr>
<tr>
<td>4 Completion of NHS Number on MHSDS</td>
<td>&gt;99%</td>
<td>99.3%</td>
</tr>
<tr>
<td>5 Completion of Ethnicity Code on MHSDS</td>
<td>&gt;90%</td>
<td>99.3%</td>
</tr>
<tr>
<td>6 Copies of Care Plans (CPA caseload)</td>
<td>&gt;95%</td>
<td>95.5%</td>
</tr>
<tr>
<td>7 Percentage of people experiencing a first episode of psychosis</td>
<td>&gt;50%</td>
<td>100%</td>
</tr>
<tr>
<td>8 The proportion of people that wait six weeks or less from referral to their first IAPT treatment appointment</td>
<td>&gt;75%</td>
<td>98.4%</td>
</tr>
<tr>
<td>9 The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment</td>
<td>&gt;95%</td>
<td>99.9%</td>
</tr>
<tr>
<td>10 Completion of IAPT Minimum Data Set outcome data</td>
<td>&gt;90%</td>
<td>97.6%</td>
</tr>
<tr>
<td>11 The proportion of users on CPA who have had a review within the last 12 months</td>
<td>&gt;95%</td>
<td>97.6%</td>
</tr>
<tr>
<td>12 Proportion of in-scope patients assigned to a cluster</td>
<td>Walsall&gt;95%</td>
<td>95.6%</td>
</tr>
<tr>
<td>13 IAPT – People who receive psychological therapies – attending one session only</td>
<td>Dudley&gt;5724</td>
<td>Dudley - 4093</td>
</tr>
<tr>
<td></td>
<td>Walsall&gt;4848</td>
<td>Walsall - 3271</td>
</tr>
<tr>
<td>14 IAPT – people who have successfully completed treatment</td>
<td>&gt;50%</td>
<td>Dudley - 55.5%</td>
</tr>
<tr>
<td></td>
<td>Walsall - 57.1%</td>
<td></td>
</tr>
<tr>
<td>15 CRS - proportion of patients seen within 6 weeks.</td>
<td>Dudley&gt;75%</td>
<td>88.2%</td>
</tr>
<tr>
<td>16 PT Hub - proportion of patients seen within 18 weeks.</td>
<td>Dudley&gt;95%</td>
<td>98%</td>
</tr>
<tr>
<td>17 Eating Disorders - % of children &amp; young people who receive treatment within four weeks of referral for routine cases</td>
<td>Walsall&gt;95%</td>
<td>100%</td>
</tr>
<tr>
<td>18 Eating Disorders - % of children &amp; young people who receive treatment within one week of referral for urgent cases.</td>
<td>Walsall&gt;95%</td>
<td>100%</td>
</tr>
<tr>
<td>19 PLT - number of patients seen on the wards within 24 hours.</td>
<td>Dudley&gt;85%</td>
<td>100%</td>
</tr>
</tbody>
</table>
The Trust’s overall performance against the commissioners’ KPIs is very positive and has improved throughout the year.

Significant improvements have been made in data quality and the Trust meets regularly with commissioners to discuss performance and quality. The Trust is fully aware of areas it needs to improve and is working closely with commissioners to achieve this.
3.12 Patient Environment

According to NHS England, “Good environments matter”. The expectation is that every NHS patient should be cared for with compassion and dignity in a clean and safe environment and that if patients believe that standards fall short then they should be able to hold the service and its management to account.

The annual Patient Led Assessment of the Care Environment (PLACE) was introduced in early 2013 and replaced PEAT (Patient Environment Action Team).

The Trust PLACE 2017 assessments were completed on all hospital sites between March and May 2017. This information, along with all other PLACE assessment data was subsequently collated together to create the PLACE 2017 Action Plan.

Summary Results

The table below shows the Trust’s scores against national results from 2015-2017. For one domain the Trust scored above the national average level. Five domains indicate that improvements are required; Cleanliness, Condition, Appearance and Maintenance, Food and Hydration and Disability. Further discussion regarding the Trust actions need to take place in the context of the Trust’s overarching capital programme and priorities.

**Figure 24: National PLACE Scores vs Trust Results 2017**

<table>
<thead>
<tr>
<th>Domains</th>
<th>National Average</th>
<th>Trust Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>97.60%</td>
<td>98.05%</td>
</tr>
<tr>
<td>Condition Appearance and Maintenance</td>
<td>90.10%</td>
<td>93.34%</td>
</tr>
<tr>
<td>Privacy, Dignity and Wellbeing</td>
<td>86.00%</td>
<td>84.20%</td>
</tr>
<tr>
<td>Food and Hydration</td>
<td>88.50%</td>
<td>88.19%</td>
</tr>
<tr>
<td>Dementia</td>
<td>74.51%</td>
<td>75.22%</td>
</tr>
<tr>
<td>Disability</td>
<td>78.83%</td>
<td>82.50%</td>
</tr>
</tbody>
</table>

Comments: Below in two domains, Below in four domains, Below in five domains.

<table>
<thead>
<tr>
<th>Year Data</th>
<th>Trust Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 Data</td>
<td></td>
</tr>
<tr>
<td>2016 Data</td>
<td></td>
</tr>
<tr>
<td>2017 Data</td>
<td></td>
</tr>
</tbody>
</table>
Figure 25: National PLACE Scores 2017 vs Trust Average (by site)

<table>
<thead>
<tr>
<th>Results are provided for four domains:</th>
<th>Cleanliness</th>
<th>Condition, Appearance and Maintenance</th>
<th>Privacy, Dignity and Well-being</th>
<th>Food</th>
<th>Dementia</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Average</td>
<td>98.40%</td>
<td>94.02%</td>
<td>83.70%</td>
<td>89.70%</td>
<td>76.70%</td>
<td>82.50%</td>
</tr>
<tr>
<td>Trust Average</td>
<td>95.13%</td>
<td>87.58%</td>
<td>82.62%</td>
<td>85.95%</td>
<td>78.12%</td>
<td>74.13%</td>
</tr>
<tr>
<td>BLX</td>
<td>96.22%</td>
<td>77.62%</td>
<td>81.90%</td>
<td>81.96%</td>
<td>84.83%</td>
<td>79.75%</td>
</tr>
<tr>
<td>DPH</td>
<td>90.87%</td>
<td>84.31%</td>
<td>79.37%</td>
<td>81.59%</td>
<td>64.14%</td>
<td>67.92%</td>
</tr>
<tr>
<td>BFH</td>
<td>97.83%</td>
<td>92.58%</td>
<td>84.33%</td>
<td>89.25%</td>
<td>81.61%</td>
<td>75.04%</td>
</tr>
</tbody>
</table>

Following publication of the yearly PLACE results, the Trust has put in place an action plan to address areas for improvement. Actions taken to improve the Trust’s PLACE score have been allocated against the six PLACE domains and will be monitored through the Infection Prevention and Control Committee.

3.13 Service Experience

3.13.1 Friends and Family Test – Net Promoter

Introduced in April 2012, the Friends and Family Test (FFT) asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. This means patients are able to give feedback on their experience of our services, giving us a better understanding of the needs of our patients and enabling improvements.

The Trust implemented this test in 2013 as part of a CQUIN scheme. People being discharged from community services were asked “How likely is it that you would recommend this service?”

In 2017/18 of the 2038 people asked, 72% responded with ‘likely’ or ‘extremely’ likely. The full results are shown below. The full results are shown below.
3.13.2 Community Mental Health Survey 2017 Overall Satisfaction Score

The Annual Community Mental Health Survey 2017 was conducted independently for the Trust by Quality Health and a questionnaire was sent out to c. 850 people who received community mental health services. The response rate was 27% (229 usable responses received from a basic sample of 850).

Some of the results are shown below.

**Figure 27: Patient experience**

<table>
<thead>
<tr>
<th>Performance</th>
<th>Experience of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dudley and Walsall Mental Health Partnership NHS Trust</td>
<td>7.4 – Is the mean average score of the main three questions as shown below</td>
</tr>
</tbody>
</table>

Mostly the Trust rated within the intermediate 60% of the 52 trusts surveyed, there are two in the top 20% for service users know who to contact out of hours if they have a crisis, and for service users feeling that decision making was carried out jointly with them. In addition,
seven scores are in the lower 20%, and these relate to Changes in Who People See, Treatments, Support and Wellbeing and Overall. Service users' scores on care experience with Dudley and Walsall Mental Health Partnership NHS Trust has an overall rating of 69.1%, with service users rating their experience of our services overall as ‘good’ or ‘very good’.

**Figure 28: Benchmarking against other Trusts**

<table>
<thead>
<tr>
<th>How this score compares with other Trusts</th>
<th>Based on patients’ responses to the survey, this Trust scored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening for the person or people seen most recently listening carefully to them</td>
<td>About the same</td>
</tr>
<tr>
<td>Time for being given enough time to discuss their needs and treatment</td>
<td>About the same</td>
</tr>
<tr>
<td>Understanding for the person or people seen most recently understanding how their mental health needs affect other areas of their life</td>
<td>About the same</td>
</tr>
</tbody>
</table>

Areas for action focus on maintaining the positive feedback and in addressing some areas for improvement such as in the coordination of care, monitoring the effects of medication, crisis care and receiving additional support and triangulating these findings with other patient experience methods to identify key themes.

### 3.13.3 Inpatient Mental Health Survey 2016 Overall Satisfaction Score

The Annual Mental Health Inpatient Survey 2016 was conducted independently for the Trust by Quality Health and a questionnaire was sent out to c.362 people who received inpatient mental health services. The response rate was 27% (91 usable responses from a usable sample of 333).

Overall out of the 40 scored questions the Trust was rated mainly within middle 60% of all 19 trusts surveyed in 2016 by Quality Health. The Trust scored within the upper 20% of trusts for service users saying that they were always listened to carefully by their psychiatrists. The Trust has seen an improvement in scores around service users feeling that staff took their family/home situation into account when planning their discharge and around delays in discharge.

However the Trust does fall into the lower 20% of scores on just under a third (twelve) of the questions. Areas identified where improvements can be made relate to food; provision of talking therapy; activities; care of physical health problems; contact following discharge and. The Trust is using feedback from the survey to inform quality improvements.

### 3.13.4 Compliments and Complaints

In addition to our focus on quality, we recognise that sometimes people’s experience of our services is not always as positive as we would hope. In October 2007, the Health Service Ombudsman published ‘Principles for Remedy’ as an overall good practice guide for public bodies in dealing with complaints. Our complaints policy is based around these principles which are:-
In response to the Francis inquiry into the failings of Mid-Staffordshire NHS Foundation Trust, the Parliamentary and Health Service Ombudsman, Local Government Ombudsman and Healthwatch England committed to developing a user-led “vision” of the complaints system and produced a report entitled “My Expectations for Raising Concerns”. This report sets down the vision/framework that was created and the findings of the primary research with patients, service users, frontline staff and stakeholders that lay behind it. There are five main areas to the framework which the Trust aims to follow and achieve which is incorporated into the Service Experience Desk induction programme, complaints training and promoted throughout the Trust.

During the period April 2017 to March 2018, we received a total of 139 formal complaints, 26 of which were withdrawn or closed. We responded to 46 cases within the target timescale; 33 cases remain open, 26 of which were still within target at the time of writing.

The number of complaints received is relatively small compared to the number of patients we see and treat each year.

**Figure 29: Compliments and Complaints data**

![Compliments & Complaints 2017/18](chart.png)
Over the last twelve months we are pleased to say we have received a large number of compliments (402) from people who have accessed our services, highlighting cases where the quality of our services has been recognised and appreciated.

The Service Experience Desk (SED) feature “On a Happy Note” highlights the positive comments made by service users about their care by posting a selection of experiences from service users on the Trust Intranet every month.

Some examples of what people have said about our services are demonstrated below:

- **Thank you for everything you have done for me and your patience. I really appreciate your time and your effort and most importantly your patience with me. You have brought me to a stage in my life where I have never been before. My anxiety and self-control have never been so good and I can’t thank you enough for that.**

- **We found the support and advice we received from the staff member invaluable. He provided support not only to my mum during her time she suffered but provided excellent support the family and gave advice on how best so support mum. An excellent service!**

- **Staff go above and beyond to make everyone feel cared for, which is exactly what people with bipolar personality disorder needs. They sent me a card when I was feeling too low to come to the group and even tried to put a note through my door when they could not get me on the phone. I just wanted to let you know how amazing they are.**

- **I know there is an awful long way to go for my daughter and sometimes I feel as if I’m on automatic pilot but I thank you wholeheartedly, because I know I can say with my hand on my heart that if it weren’t for you she wouldn’t be here today.**
I cannot thank all the staff enough for the help and kindness they have showed me. Nothing was too much trouble. The nursing staff, doctors and health care assistants were very helpful and caring. If you needed to talk or were upset they were there to listen whatever time it was. I am celiac so staff made sure I had gluten and what free meals, bread and biscuits and sandwiches were always available. Everyone made my stay very comfortable and I would like to say a very big thank you. The dedication to the job they do is 100%.

Couldn’t wish to meet two nicer people. Since meeting them both they have made me feel more confident in myself and achieved massive goals. Not only have I met two great support workers I’ve met two extremely kind and caring friends.

I have been a patient for a number of years. I was seen by the same doctor up until my recent discharge. I would like to express a sincere thank you to him for the care and support I have received. My recovery and hopes for the future would not have been possible without this. He is kind, caring and understanding and I have been treated with the utmost respect. If in the future I need help or advice, I know that I will be treated with an excellent level of care – I would highly recommend.

The job you do is so valuable, you change peoples’ lives and you’ve changed mine in a few months, thank you for changing my thoughts from negative to positive

3.14 Feedback from Service Users and Carers

Over the past twelve months our eight Experts by Experience (EBEs) have been involved in raising awareness of Trust activities and gaining valuable feedback from service users and carers. We have also gained essential and valuable feedback via informal concerns and comments from the Service Experience Desk and patient surveys. Here are a sample of the selected actions that have been carried out as a result of feedback from those who use our services, their relatives and carers.

<table>
<thead>
<tr>
<th>You Said:</th>
<th>We Did:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service users accessing the STEPPS programme would like to be able to continue supporting and meeting with each other following completion of the programme.</td>
<td>A patient experience action plan has been developed and a forum is under development for patients after they have completed the 20 week course, to share experiences, to look at support for service users post intervention and to create of volunteer opportunities and support for service users post intervention.</td>
</tr>
<tr>
<td>The wording on the Psychological Therapies Hub leaflet could put people off attending therapeutic courses and wording could be taken as condescending</td>
<td>Wording was changed to ensure that the leaflet was more motivating but also now highlights the importance of commitment to any interventions offered and how this will enable a patient to better understand their difficulties and overcome their problems.</td>
</tr>
<tr>
<td>Patients complained about the lack of activities on the ward and access to the activity cupboard</td>
<td>An Activity Lead Nurse has been allocated to the ward and activities that are being carried are going to be monitored.</td>
</tr>
<tr>
<td>Patients felt that the ward needed a revised timetable and would like more choice of</td>
<td>A timetable has been developed and now includes walking groups, relaxation</td>
</tr>
</tbody>
</table>
activities sessions and cooking. Each patient now has their own activity planner so that they can choose what activities to participate in and these are raised at the Ward Community Meeting. Patients can now cook their own breakfast or lunch and this is facilitated by the Occupational Therapist.

Patients feel that reviews would be better in the morning as when it's review day they become anxious and agitated waiting around all day.

Groups such as relaxation are now taking place at the start of the day so that patients have a purpose for the day and are using distraction techniques to cope with anxiety about reviews.

The care plan/treatment plan was very lengthy.

We have now condensed the care plan into one document, as it was previously two separate documents.

In order to ensure that sessions are kept confidential so that patients feel comfortable in talking about sensitive issues, a suggestion was made to have music playing the waiting room.

A TV has been put in the waiting area and plays a range of DVDs that are child friendly.

Patients and parents accessing the CAMHs service felt the forms that need to be completed at first appointment were too lengthy and the waiting room is often busy and distracting which makes it harder to complete them. A suggestion was made to send forms out prior to appointment.

Forms are now being sent out to parents prior to appointment as well as having forms available at base in case patients/parents or carers forget to bring them.

3.15 Feedback from Staff: Staff Survey

The Trust values staff feedback and recognises that the annual Staff Survey is the largest and most comprehensive means of understanding what is working well and what opportunities for improvement and development there are.

Quality Health (QH) acts independently on our behalf to undertake the Trust’s Staff Survey which is sent to all permanent staff. To offer the widest opportunity for completion approximately half of the staff received paper survey documents and about a half received the survey electronically. 1061 surveys were sent out, after excluding respondents that were later known to be ineligible, a usable sample of 1,034 remained of which 541 completed the survey yielding a response rate of 52.3%, an increase on the 51% response rate of 2016, and at the higher end of NHS trust response rates, the QH average for 2017 being 44%.

QH concluded:-
“The Staff Survey results for Dudley and Walsall Mental Health Partnership NHS Trust show a positive picture, the Trust is performing well & this is reflected in the views of staff.”

Our overall Engagement Score has increased from 3.79 to 3.94 (scored out of five). This is
against a 3.79 mental health sector average score for 2017 which places the Trust second out of 26 trusts in the mental health/learning disability sector and ninth out of 235 English NHS Trusts.

Key Findings:
For ease of analysis the 87 individual Staff Survey questions are condensed into 32 Key Findings (KF) where several questions are used to compile one overall score (% or out of five) in a given area. These results exemplify the success DWMH has achieved.

Compared to all 235 NHS England Trusts, DWMH had the highest score in two Key Findings
  o Key Finding Seven. Percentage of staff able to contribute towards improvements at work
  o Key Finding Ten. Support from immediate managers

Compared to 26 Specialist NHS England Mental Health and Learning Disability Trusts, the Trust had the highest score in a further ten Key Findings; overall the Trust is ranked as second amongst specialist Mental Health Trusts in England for all criteria.
  o Key Finding Two. Staff satisfaction with the quality of work and care they are able to deliver
  o Key Finding Three. Percentage of staff agreeing that their role makes a difference to patients/service users
  o Key Finding Four. Staff motivation at work
  o Key Finding Eight. Staff satisfaction with level of responsibility and involvement
  o Key Finding Nine. Effective team working
  o Key Finding Twelve. Quality of appraisals
  o Key Finding 14. Staff satisfaction with resourcing and support
  o Key Finding 19. Organisation and management interest in and action on health and wellbeing
  o Key Finding 20. Percentage of staff experiencing discrimination at work in the last twelve months
  o Key Finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents.

The Trust scores in the top five of responses for 26 out of 32 of the Key Findings and in the top eight for all responses across all 32 Key Findings.

DWMH's performance against the mental health sector Key Findings is impressive and show that in nine KFs (28%) the Trust scored significantly better than sector; in 23 (72%) there is no significant variation and in no instances did the Trust perform significantly worse than the sector.

Alongside 2017 sector comparisons it is also important to compare our performance against our 2016 results, and the Trust managed to improve in a number areas over those positive results. Compared to 2016 the Trust has improved significantly against one KF (3%) and has no significant variations in the remaining 31 (97%) Key Findings.

There are only two questions out of 87 where results have significantly slipped back against 2016, and only one of those is significantly lower than the sector scores (Q. 8a)

Q. 8a. I know who the senior managers are here. 80% (85%)
Q. 11c. 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? 94% (97%)
This leaves the Trust in the enviable position of only having these two areas of urgent focus, enabling a choice of which other priorities to select.

Whilst harassment, bullying and abuse (HBA) scores are well within NHS norms the Trust will continue to focus on these areas as any staff experiencing HBA at work from colleagues, managers, patients or members of the public is unacceptable.

In recognition of the challenging working conditions we will also be focusing on staff health and well-being and stress. Whilst our scores are good in terms of the NHS in general, they remain areas where the Trust would like to improve further in 2018/19 and will form part of our action plans working with senior managers and service lines.

3.16 Staff Health and Wellbeing

The wellbeing of our staff continues to be of paramount importance to us as we recognise that this has a direct impact on clinical outcomes and the experience of patients. It is therefore important that our staff are energised, motivated and healthy.

The Trust has a well-established Health and Wellbeing Committee who meet bi-monthly to discuss and plan operational health and wellbeing activities and programmes for staff. The group consists of Human Resources, operational managers, Occupational Health and the Trust’s Freedom to Speak Up Guardian/Staff Engagement Lead. This group reports directly to the Trust’s workforce committee and also monitors CQUIN targets and associated action plans.

Last year the Trust held two health and wellbeing events. The first was a specific health and wellbeing day, held in both Dudley and Walsall in January 2017. This took the form of a ‘market stall’ approach with exercise taster sessions, free massages, mindfulness taster session, free health checks and free nutritional food samples. The second event was a health and wellbeing week held in September 2017. Free goody bags were given out to staff across all sites along with different activities such as free health checks, organised walks and targeted communications throughout the week around different subject areas concerning health and wellbeing. The week focused more specifically on resilience, stress management and musculoskeletal conditions as our top reasons for sickness absence within the Trust.

For the coming year the group plans to focus on a year-long programme of events and activities with a different focus each month linked to national awareness days alongside the redesign of the Trust’s intranet pages concerning staff health and wellbeing.
Part 3D: Statements from the Trust’s key stakeholders

We approached the following stakeholders to comment on the Quality Account:
- Dudley CCG
- Walsall CCG
- Dudley Healthwatch
- Walsall Healthwatch
- Dudley Health and Wellbeing Board
- Walsall Health and Wellbeing Board
- Dudley Health Overview and Scrutiny Committee
- Walsall Health Overview and Scrutiny Committee

The Trust is pleased to have received the following commissioner feedback responses:
- Dudley CCG
- Walsall CCG
- Walsall Healthwatch

The Trust will endeavour to incorporate the comments into on-going quality improvements and welcomes opportunities for continued partnership working. The full responses are detailed below.
Dudley Clinical Commissioning Group and Walsall Clinical Commissioning Group provided the following joint feedback:

RESPONSE TO DUDLEY & WALSALL MENTAL HEALTH TRUST QUALITY ACCOUNT 2017/18

Walsall and Dudley Clinical Commissioning Groups (CCG) welcome the opportunity to comment jointly on Dudley and Walsall Mental Health Trust Quality Account.

It is encouraging to note the Trust had embraced an ambitious agenda for continued quality improvement which has been delivered through the Quality Improvement Strategy.

The Trust during 2017/18 have been working with partners towards Transforming Care Together (TCT) which featured a partnership agreement with Birmingham Community Healthcare Trust. Both CCGs recognised the project faced a number of challenges and had multiple complexities. Ultimately the decision was taken not to proceed however we know that moving forward valuable lessons have been learnt that will benefit the organisation and improve patient care.

It is pleasing to note that despite this challenging time the staff survey reflected a positive culture with the Trust being identified as one of the top performing Trusts in the country. Furthermore the Trust has committed to ongoing work to improve staff wellbeing.

Patient safety is of paramount importance to both CCGs and as such we are pleased that during 2017/18 the Trust has developed greater rigor in its approach to serious incident management. This has led to more lessons learnt which underpin improvements in patient care and avoidance of future harm. The CCGs are pleased to note the Trust has prioritised participating in clinical audits and research again offering important learning which can be taken forward and embedded to improve services.

The Trust priorities for 18/19 will need to focus on developing the work being delivered within community teams to support primary care. This work would aim to reduce the stigma related to mental health issues; manage risk and encouraging patients to access services closer to home. The Trust will also need to work to improve the Patient Led Environment Scores (Place) thereby offering an opportunity to enhance patient experience.

Both CCGs recognise that 2018/19 will be a year of development and consolidation firming up existing systems and processes to maintain safe and high quality care for patients.

Yours sincerely

Mr Paul Maubach
Chief Executive Officer for Dudley and Walsall CCGs
Walsall Healthwatch provided the following feedback:

**Healthwatch Walsall's response to Dudley and Walsall Mental Health Trust Quality Accounts 2017/18.**

Healthwatch Walsall are pleased to comment on the quality accounts 2017/18. It is positive that the Trust has continued with its CQC rating as good and that improvements are being made across the Trust. The quality accounts give a fair indication that the Trust is clear on its direction of travel for further improvements.

One of our priorities has been to assess access to CAMHS and the support for children into adolescence. Our report is in preparation and will be shared shortly.

One area which has been clearly identified is the difficulties accessing transitional services and support for young people and young adults with Autism. Healthwatch Walsall have met with several stakeholders around this issue.

It is a positive that the Trust continues maintaining delivery of high quality services and that work is continuing to improve the delivery of Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder diagnostic services in adults.

The quality accounts indicate that the Trust are using several methods to gather patient experiences such as the ‘friends and family’ test, the PLACE results, and experts by experience. We welcome that there it’s a commitment to capturing patient experiences by the Trust.

Healthwatch Walsall over the year have been contacted by patients in relation to information regarding the complaints advocacy service. We have been working with the Trust to ensure that the information has been updated and that patients are made clearer about the process.

Whilst it is positive to see that the quality accounts identify several clinical research studies, that look at improving patient’s quality of lives, we would welcome where possible information on success and learning from such trials and how they have made improvements to patients’ lives and the longer term impacts of these studies.

There is still work to do around the patient environment. Noted within the National PLACE scores in most areas, such as: cleanliness, condition, appearance, privacy, dignity, food, and disability, all show below national average results to date. It is disappointing to see these below targets in the 3 supporting hospitals.

Healthwatch Walsall would like to see that the Trusts action plan around PLACE scores is robust enough to see clear improvements within the next financial year.

The quality accounts report highlights detail of recording and monitoring around patient safety. Healthwatch Walsall asked the question “why there had been a year on year increase in Patient Safety related incidents”. We have been informed that the Trust has developed a robust culture of incident recording at all levels, and also a fair number of these incidents have been relating to patients with dementia.

The report details a great deal of information to satisfy statutory requirements. It highlights a clear understanding of the Trusts commitment to improving the quality, safety and efficiency of patient care.

It is also evident that the Trust is utilising several (including independent) performance and quality indicators to monitor the quality of care and that there are robust structures around clinical governance.
Healthwatch Walsall meets with the Trust’s Chief Executive on a quarterly basis and we welcome a closer working relation to share intelligence and experiences to improve the quality of patient care. Since the TCT merger has not been undertaken Healthwatch Walsall feels that it is positive that the Trust is making steps towards a much closer collaboration with Black Country Partnership NHS Foundation Trust.

May - June 2018
Part 4: Conclusion

This is the Trusts sixth Quality Account and it is designed to present an open and transparent view of the quality of service provided by the Trust. It describes the progress we have made in relation to our Quality Improvement Priorities and sets out further local Quality Improvement Priorities for 2018/19.

The Trust is extremely grateful for the input and continued support of key stakeholders and partners in developing this document. We are fully committed to maintaining and strengthening this dialogue through the coming year.