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NHS Foundation Trust NHS

Quality Report 2014/15

Quarter 3

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Part 1. Statement on Quality from the Chief Executive

Introduction

This will be provided at year end 2014/15.

Part 2a. Looking ahead to 2015/16

Quality Priorities for Improvement 2015/16

We are currently collating the quality improvements for 2015/16 through feedback from stakeholders and also from organisational learning.

Part 2b. Statements relating to the Quality of NHS Services Provided

The following section will include responses to a nationally defined set of statements which are common across all Quality Accounts/Reports.

Information will be included in this section for the final year end Quality Report 2014/15.

Dependent on guidance published by Monitor it is anticipated that this will include:

1. A review of services;
2. Participation in national clinical audits and national confidential enquires;
3. Learning from local clinical audits;
4. Participation in clinical research.

Use of the Commissioning for Quality & Innovation (CQUIN) framework

The national contractual use of CQUINs is to support the essential focus upon quality improvement in the provision of services and incentivise through specific quality payments. Although the main focus of CQUINs is on quality improvements for our service users, a proportion of ²gether NHS Foundation Trust's income in 2014/15 is conditional on achieving quality improvement and innovation goals agreed between ²gether NHS Foundation Trust and Gloucestershire Clinical Commissioning Group, Herefordshire Clinical Commissioning Group and NHS South West Specialised Commissioning Group (for the provision of low secure mental health NHS services).

2014/15 CQUIN Goals

Gloucestershire

Goal Name	***Description***	***Goal weighting***	***Expected value***	***Quality Domain***
Personality Disorder Service Delivery	To improve services for people with personality disorders by ensuring service delivery that is consistent with regional strategy expectations for these patients.	20%	£330,000.00	User Experience
Patient Experience Survey feedback	This indicator asks four locally agreed questions relating to patient experience where improvement was identified as being required following the 2013/14 national MH survey results.	20%	£330,000.00	User Experience
Friends and Family Test (Staff)	Staff will have access to a quarterly questionnaire asking two questions. • Whether you would recommend the Trust to Friends and Family requiring treatment.	8%	£132,000.00	Effectiveness

Goal Name	Description	Goal weighting	Expected value	Quality Domain
	• Whether you would recommend the Trust as a place to work.			
Friends and Family Test	Early Implementation	6%	£99,000.00	User Experience
Friends and Family Test	Phased Expansion	6%	£99,000.00	User Experience
Cardiometabolic Assessment for Patients with Schizophrenia	Improving the Physical Healthcare of Patients with Schizophrenia	10%	£165,000.00	Effectiveness
Patients on CPA : Communication with General Practitioners	A local audit covering communication with Patients' GPs, to include care Plans and relevant content.	10%	£165,000.00	Effectiveness
NHS Safety Thermometer	To collect and report upon four elements of the NHS Safety Thermometer	20%	£330,000.00	Safety

Herefordshire

Goal Name	Description	Goal weighting	Expected value	Quality Domain
Friends and Family Test (Staff)	Staff will have access to a quarterly questionnaire asking two questions • Whether you would recommend the Trust to Friends and family requiring treatment • Whether you would recommend the Trust as a place to work	2%	£7,100.00	Effectiveness
Friends and Family Test	Early Implementation	2%	£7,100.00	User Experience
Friends and Family Test	Phased Intervention	2%	£7,100.00	User Experience
NHS Safety Thermometer	To collect and report upon four elements of the NHS Safety Thermometer	4%	£14,200.00	Safety
Cardiometabolic Assessment for Patients with Schizophrenia	Improving the physical healthcare of patients with Schizophrenia.	5%	£17,700.00	Effectiveness
Communication with General Practitioners	A local audit of communication with Patients' GPs covering Care Plans and their content.	5%	£17,700.00	Effectiveness
Children's and Young peoples transition to Adult Services	Local indicator to capture and act upon feedback from people in transitional phase from child Mental health services to adult Mental Health Services.	25%	£88,000.00	Effectiveness
Antipsychotic Prescribing	Indicator to ascertain the percentage of patients with Dementia who are prescribed Antipsychotics in a Community setting who are subject to regular review.	20%	£71,000.00	Safety
Harm Prevention	Falls Prevention and bone Health staff training	20%	£71,000.00	Effectiveness
Harm Prevention	Use of falls pathway and Risk Assessment Tool	15%	£53,300.00	Effectiveness

Low Secure Services

Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
Cardiometabolic Assessment for Patients with Schizophrenia	Improving the Physical Healthcare of Patients with Schizophrenia	10%	£4,800.00	Effectiveness
Friends and Family Test	Phased Expansion	10%	£4,800.00	Effectiveness
Specialised Services Quality Dashboard	Assurance that the Clinical dashboard is completed and used for monitoring purposes.	20%	£9,600.00	Efficiency
Collaborative Risk Assessments	The provision of an education Training package for Patients and qualified staff	30%	£14,400.00	User Experience
Supporting Carer Involvement	To support Carer involvement with relatives	30%	£14,400.00	User Experience

The total combined potential value of the income conditional on reaching the targets within the CQUINs during 2014/15 is £2,052,200.

In 2013/14, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,080,492 of which £2,080,292 was achieved.

Statements from the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS trusts have been legally required to register with the CQC. Registration is the licence to operate and to be registered, providers must, by law, demonstrate compliance with the requirements of the CQC (Registration) Regulations 2009.

²gether NHS Foundation Trust is required to register with the CQC and has no conditions on its registration. This means that the Trust has continued to demonstrate compliance with the regulations and we are registered to provide the following regulated activities:

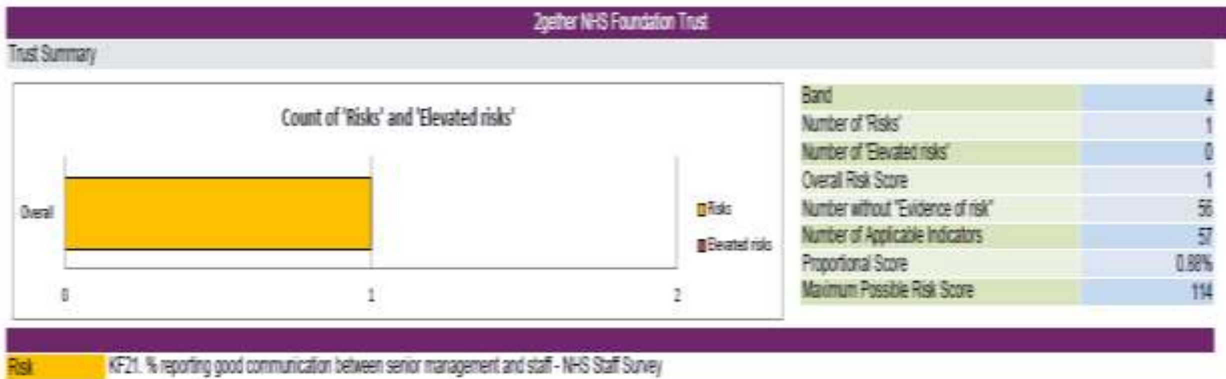
- Assessment or medical treatment to persons detained under the Mental Health act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The locations from which the Trust is registered to provide these regulated activities are confirmed on the CQC website www.cqc.org.uk .

The Care Quality Commission has not taken enforcement action against ²gether NHS Foundation during 2014/15 or the previous year 2013/14.

The CQC have moved away from publishing Quality Risk Profiles for Trusts and they are developing Intelligent Monitoring Report the first of which for all mental health organisations was published in November 2014. CQC intelligent monitoring of trusts that provide mental health services considers 59 different types of evidence, based on sources that include the NHS staff survey, bed occupancy rates, the national health outpatient survey and concerns raised by trust staff. These evidence sources are used to answer the five key questions that they ask of services – are they safe, effective, caring, responsive and well lead.

The first Intelligent Monitoring Report for ²gether NHS Foundation Trust shows 1 item as a risk from 57 indicators which placed the Trust in Band 4, which is the lowest banding of risk. The 1 risk indicator reported related to the NHS Staff Survey and showed that the % of staff who reported good communication between senior management and staff was less than expected. The summary report published is shown overleaf.



It is anticipated that the next Intelligent Monitoring Report will be published in May 2015.

CQC Inspections of our services

The Care Quality Commission (CQC) has not undertaken inspections of the Trust's services during 2014/15, and we do not anticipate undergoing a comprehensive inspection until July 2015 at the earliest. Inspections undertaken during 2013/14 are available on the CQC website under the location of each service.

http://www.cqc.org.uk/search/hospitals/2gether

Mental Health Act reviews

The Mental Health Act Commissioner (MHAC) visits the Trust's in-patient units to meet with detained patients and scrutinise the associated Mental Health Act paperwork and records – the process forms part of the Care Quality Commission monitoring system. The visits can be made at any time, are generally unannounced and can be either during normal working hours or out of hours.

During Quarter 2014/15 there have been MHAC visits to the Montpellier Unit, Westridge, Hollybrook, Priory Ward, Greyfriars PICU, Mortimer Ward and Chestnut Ward In response to these visits, the Trust has reviewed the following:

- Use of Extra Care Areas;
- Processes for documentation of S17 leave forms;
- Discharge planning processes;
- Documentation of Statutory Consultees discussions with Second Opinion Approved Doctors (SOADs);
- Patient involvement in care planning;
- Recording of Patients' Rights under Section 132 of the Mental Health Act Code of Practice;
- Processes to ensure that Sections are not allowed to "lapse" but should be ended in line with policy.

Safeguarding Children and Children in Care Special Review in Gloucestershire

2gether NHS Foundation Trust has participated in one CQC special review relating to Children Looked After and Safeguarding in Gloucestershire in March 2014, the report was published on 3 July 2014 The review followed the journey of the child, and covered all health settings including the Trust's Children and Young Peoples Service (CYPS) and adult mental health services.

Feedback was generally favourable, recognising high standards of quality in service provision and due attention paid to safeguarding matters. Our Trust received 6 specific organisational recommendations which are listed as follows:

1. All CYPS practitioners receive regular, formal, safeguarding supervision in line with statutory guidance;
2. That all adult mental health workers undertake formal training in the “Think Family” approach and that this model is embedded in service delivery;
3. That adult mental health workers are engaged effectively in child in need and child protection processes, including attendance at common assessment framework (CAF) meetings;
4. That CYPS practitioners are supported to liaise effectively and work in partnership with out of area Tier 4 providers on a case by case basis;
5. That all young people who require specialist support have timely access to the specialist CYPS 3.5 service;
6. That practitioner in adult mental health services routinely document the impact of parental mental health on young people and include the child or young persons’ needs in care plans.

An action plan responding to the recommendations under the stewardship of Gloucestershire Clinical Commissioning Group (CCG) was completed ahead of the 31 July 2014 deadline. Good progress is being made, Think Family training is well attended; the Trust Safeguarding Named Nurse is facilitating specialist supervision sessions with the Named Doctor for Safeguarding and work is ongoing to improve systems to record parental mental health issues. Progress against the action plan is being monitored via Gloucestershire CCG to assure progress.

Changes in service registration

No requests to change our registration with the CQC have been this year, although a revised Statement of Purpose has been submitted.

Quality of Data

Statement on relevance of Data Quality and actions to improve Data Quality

This information will become available in the final year-end report.

Information Governance Toolkit

This information will become available in the final year-end report.

Clinical Coding Error Rate

This information will become available in the final year-end report.

Part 3. Looking Back: A Review of Quality during 2014/15

Introduction

The 2014/14 quality priorities were agreed in May 2014 and published in last year's Quality Report, and can be accessed through the following link:

http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=2769

The quality priorities were grouped under five broad areas of quality improvements. This section of the report outlines the achievements and progress made in each of the three areas of Effectiveness, User Experience and Safety to date. It also outlines key service developments which have positively impacted on the care we provide as it is important to us that we constantly strive to improve quality overall.

The table below provides a summary of our progress against these individual priorities. Each are subsequently explained in more detail throughout Part 3.

Summary Report on Quality Measures for 2014/2015

		2012-2013 Actual	2013-2014 Actual	2014 - 2015 Actual at Q3
Effectiveness				
1	90% of community patients with a serious mental illness will have had an annual physical health check. Gloucestershire Herefordshire	**-**	**86%** **47%**	**We cannot report on this exact target - so it is not met.**
2	The number of falls resulting in harm (fractures) will be maintained at **3** or less across all our inpatient units.	**4**	**3**	**3**
3	The proportion of people gate kept by the Crisis & Home Treatment Team prior to admission will be 95%. This will ensure appropriate access to inpatients services. Gloucestershire Herefordshire Combined	**89%** **70%**	**95%** **95%**	**99.3%** **100%** **99.4%**
User Experience				
4	Did 2gether Trust staff involve a member of your family or someone else close to you, as much as you would like in your care? < 53%	-	**50%**	**91%**
5	Did we organise the care and services that you need? <59%	-	**57%**	**94%**
6	Have you been given information on how you can contact your Care Co-ordinator or lead professional if you have a problem? <72%	-	**66%**	**93%**
7	Have you been offered a written or printed copy of your care plan? <41%	-	**40%**	**76%**
Safety				
8	Reduce the numbers of deaths relating to identified risk factors of people in contact with services when compared data from previous years.	**18**	**22**	**17**
9	Reduce the number of people who are absent without leave from inpatient units who are formally detained.	**53**	**110**	**94**
10	**95%** of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care.	**98.8%**	**99.1%**	**93%**

Effectiveness

In 2014/15 we remained committed to ensure that our services are as effective as possible for the people that we support. We set ourselves 3 targets against the goals of:

- Improving the physical health care for people with schizophrenia and other serious mental illnesses;
- Continuing to measure the effectiveness of the falls prevention work for in-patients;
- Ensure appropriate access to psychiatric inpatient care.

Target 1.1 90% of community patients with a serious mental illness will have had an annual physical health check

The target described above will not be met as the information has not been captured in exactly this way this year reflecting the national CQUIN reporting requirements; we are, therefore, reporting on the progress made overall in promoting physical health.

There is a long established association between physical comorbidity (the presence of multiple illnesses) and mental ill health. People with severe and enduring mental health conditions (Serious Mental Illness - SMI) experience worse physical health and reduced life expectancy compared to the general population. People with schizophrenia and bipolar disorder die an average 25 years earlier than the general population largely because of physical health problems. People with SMI are at increased risk of a range of physical illnesses and conditions, including coronary heart disease (CHD), diabetes, respiratory disease, greater levels of obesity and metabolic syndrome.

Last year we wanted to ensure that 70% of service users on our caseload who had a diagnosis of schizophrenia or bi-polar affective disorder (as these are the most at risk group of people) had an annual physical health check. To achieve this, we routinely undertook a physical health check for all services users with these diagnoses who were admitted to our inpatient units. For the majority of people living in the community this was more complicated, and involved our teams working closely with colleagues in primary care to identify service users and support them to attend their GP surgery for the health check. The results are seen in the table below

	Target	2013-14
Gloucestershire Services	>70%	86%
Herefordshire Services	>70%	47%

For 2014/15 this became a National CQUIN for all mental health services across England. In June 2014 the Royal College of Psychiatry, on behalf of NHS England, issued comprehensive guidance on how the national physical Care CQUIN will be delivered and audited. This necessitated a significant change in the way in which we anticipated collecting information and included marked changes from the original guidance focusing only on inpatients with a SMI diagnosis. Part 1 of the CQUIN focused on the delivery of a specialist cardiometabolic assessment tool for individuals with an SMI, this was called the LESTER Tool (see Figure 1.)

The Trust developed extensive plans and guidance to facilitate this work during the inpatient audit period. These plans were formulated to provide a sustainable ongoing solution that we can continue into the future, and we are exploring how to roll this out into community services in Quarter 4. The audit period was 1 August 2014 – 31 September 2014. This was administrated as a bespoke Royal College of Psychiatry audit outside of the National Audit of Schizophrenia which was the original platform for gathering data.

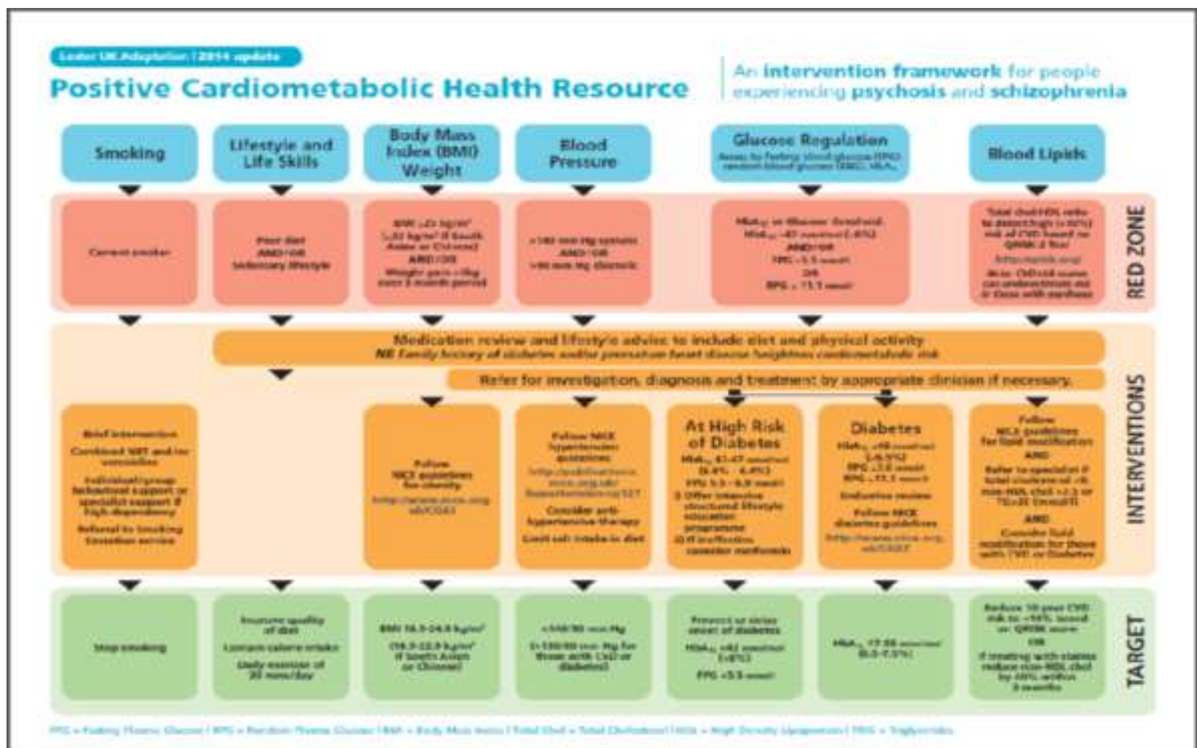


Figure.1

We are pleased to report that the implementation and delivery of Part 1 of this CQUIN was successful. **We achieved a Trust wide average of 95% compliance for screening and above 90% on average for interventions and onward referral for inpatients.** This work also allowed us to obtain clear data regarding the quality of future interventions. This will enable us to strengthen our approach in providing good quality physical health care for this vulnerable group.

The second part of the CQUIN focuses on sharing improved physical health information for people with an SMI who are cared for by our Trust as part of the Care Programme Approach (CPA). This programme will provide improved physical health information for General Practitioners; this will seek to enable primary care to improve physical care interventions and monitoring for people with an SMI in the community. The improved information set includes the following:

- Care Plan;
- Diagnosis specified;
- ICD 10 Diagnosis - inclusive of mental health and physical issues (if known);
- Medication list;
- Medication Monitoring;
- Physical health information;
- Physical Health Monitoring - completed or required.

We will be reporting our results on this programme at the end of Quarter 4 2014/15.

We are also pleased to report that we were successful in applying to NHS England's Improving Quality initiative to fund selected sites around the county to develop physical health care projects for services users. This project will run through 2014/15 and 15/16. Our project is to expand our successful inpatients programme to a wider cohort and incorporate the community teams in both Gloucestershire and Herefordshire within this. This project will expand the remit beyond the scope of the LESTER tool CQUIN and work to improve access to other physical health care such as sexual health and dental care, and include embedding a health check into primary care processes. Our successful bid has allowed us access to additional funding and national expertise.

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We did not meet this target.

Target 1.2 The number of falls resulting in harm (fractures) will be maintained at 3 or less across all our inpatient units.

In 2012/13 the Trust had an agreed quality target to reduce serious harm from falls by 50% from the baseline established in March 2010; this was part of an initiative for mental health providers entitled Leading Improvements in Patient Safety. A 33% reduction was achieved at that time, and subsequently all wards have achieved a 50% reduction in the number of falls at times, and levels of harm are generally reported as consistently low. This initiative is now maintained through a mental health collaborative, the NHS South of England Mental Health Patient Safety Improvement Programme.

In terms of absolute numbers of falls resulting in fractures, Figure 2 below shows these incidents from 2010/11 to the end of Quarter 3 2014/15.

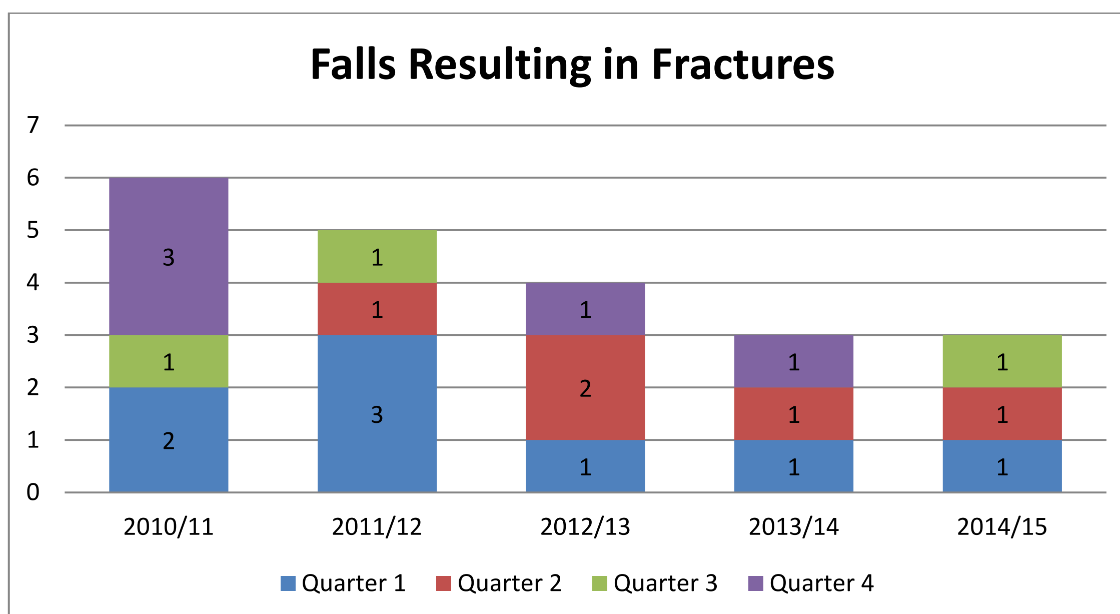

Figure 2

In this year, one fall resulting in a fracture occurred on Chestnut Ward, Charlton Lane Centre during May 2014, one fall resulting in a fracture happened on Willow Ward, Charlton Lane Centre in July 2014 and one fall resulting in a fracture, and subsequently death on Mulberry Ward, Charlton Lane Centre in December 2014.

Cantilupe Ward, Stonebow Unit and Mulberry Ward, Charlton Lane Centre have reported low levels of harm from falls, with no moderate or severe harm incidents reported. Willow Ward, Charlton Lane Centre has been consistently reducing the number of falls over time. Jenny Lind Ward, Stonebow Unit has achieved both a reduction in the number of falls and the levels of harm overall.

Implementation of the following interventions continues to assist with minimising the risk of fractures:

- Preparation of the physical environment – There are new red anti-ligature hand rails fitted on Willow Ward and also in the therapy corridor. It has been agreed that, due to high bed usage, red anti-ligature hand rails will also be funded and fitted to Cantilupe, Jenny Lind, Mulberry and Chestnut wards;
- Night light plug-ins are used;
- Communication of risk - Safety crosses are used to log falls locally and use as a prompt at handover, and indicators on Patient Safety Boards are in place;

- The Falls Pathway has been revised and post falls interventions, including use of hip protectors where the need is identified, multi-disciplinary team review, medication review, functional assessment and the promotion and use of mobility and standing aids;
- Falls alert magnets on the patient status whiteboards;
- All inpatients are assessed for falls risks on admission. In Wotton Lawn Hospital and Charlton Lane Hospital this is completed by a physiotherapist. At Stonebow unit, a different level of therapist provision is provided and therefore nurses complete the assessment;
- Visual prompts in the form of pictures of mobility aids are used to remind both patients and staff of what is required to promote individual patient safety;
- E-learning education on falls prevention;
- Red walking frames have been tested on a small scale and have proved successful in raising both staff and patient's awareness of the need to use a walking aid, therefore, vigilance has been heightened;
- By using improvement methodology, a Falls Information leaflet for patients/carers/family has been tested out by our physiotherapy team at Charlton Lane Hospital with service user/family involvement. This has been successful in providing both information and a safety briefing regarding falls and action post falls. The leaflet is now available for use and also in Easy Read format. At the Stonebow Unit, the Hereford Team have met and amended the leaflet to reflect local provision, as this differs from Gloucestershire. This is yet to be finalised for use.
- Intentional Rounding has been revisited and is being tested out currently on Mulberry and Jenny Lind Wards.
- A "rummage box" is being tested out on Willow Ward, as a distraction technique.
- Induction at Charlton Lane Hospital for new staff now includes training on falls and risk levels. All other staff receives twice yearly updates.

Our current focus is to continue to share the learning from tests of change across both Gloucestershire and Herefordshire, and indeed across the wider NHS via the Patient Safety Improvement Programme. The graph overleaf (Figure 3) which is used by the Patient Safety Improvement Programme, summarises numbers of falls, any associated harm, the wards involved and the dates of implementing interventions since April 2011 until December 2014 (where falls are coded/reported against a specific ward). When interpreting the levels of harm for falls, the following definitions are applied.

Low harm = no harm
Minor harm = bruising
Medium harm = fracture requiring surgery
High harm = permanent harm which cannot be corrected by surgery

This target is currently being maintained.

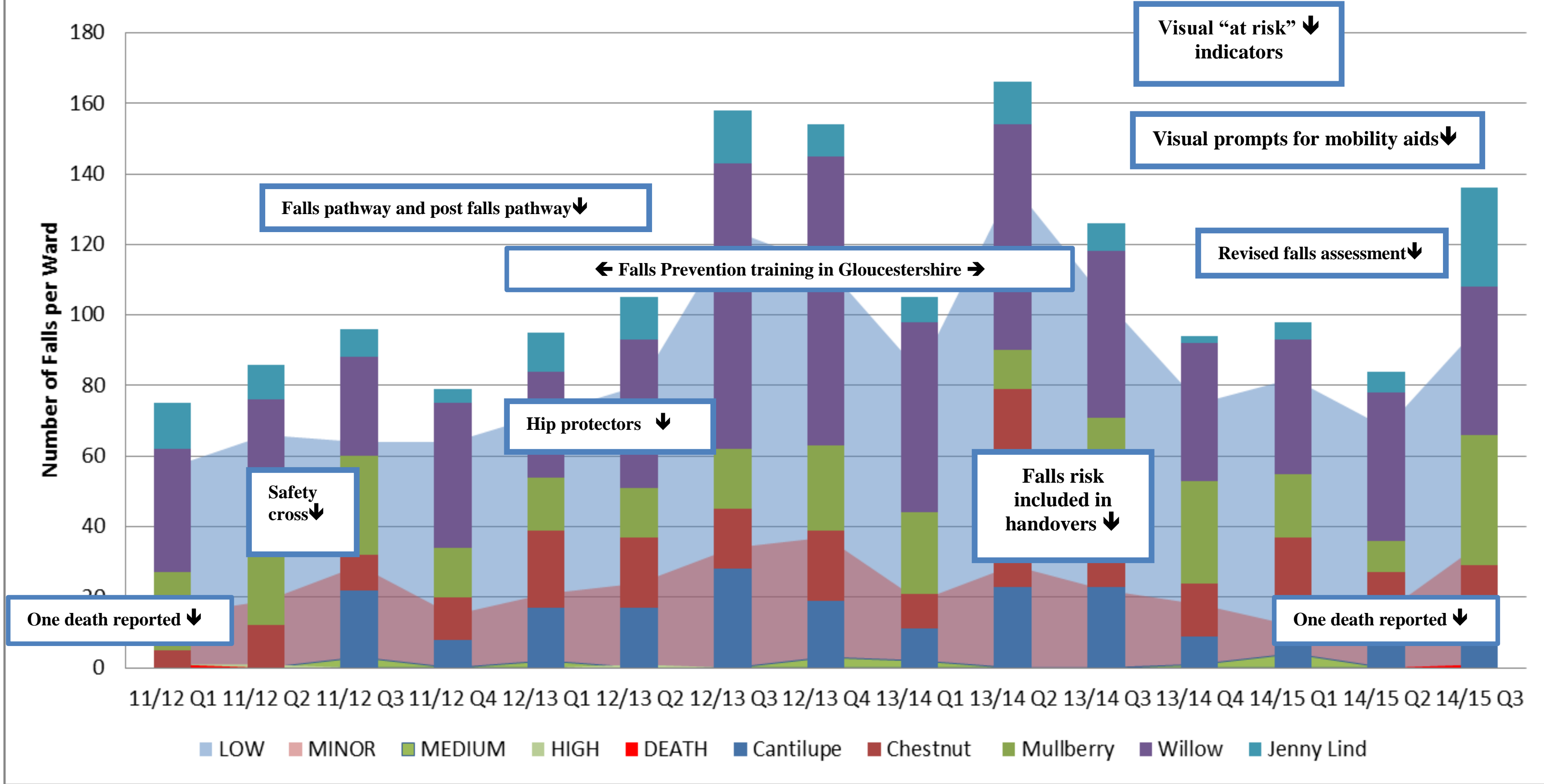

Figure 3

Target 1.3 The proportion of people gate kept by the Crisis & Home Treatment Team prior to admission will be 95%. This will ensure appropriate access to inpatients services.

Crisis Resolution and Home Treatment Teams provide a 24-hour service to people in their own homes to avoid hospital admissions where possible and provide the maximum opportunity to resolve individual crises. Their role in mental health services is to ensure that individuals experiencing severe mental distress are supported in the least restrictive environment and as close to home as possible, thereby avoiding the potential for an unnecessary admission to hospital.

When an admission to hospital is needed, the Crisis Resolution & Home Treatment Teams will arrange this, working closely with inpatient staff to ensure continuity of care, and then will also help service users to return home as quickly as possible, supporting them after discharge.

The national target is that 95% of people admitted to acute mental health wards will be "gate kept" by the Crisis Resolution & Home Treatment Teams[1]. An admission has been "gate kept" by a Crisis Resolution & Home Treatment Teams if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission.

Trust performance against this target is detailed in Figure 4 below, and it is seen that we have consistently exceeded the requirement over a 2 year period. At the end of Quarter 3 2014/15, it was reported that 99.4% of people admitted our inpatient units were "gate kept" by Crisis Resolution & Home Treatment Teams. **We are currently meeting this target.**

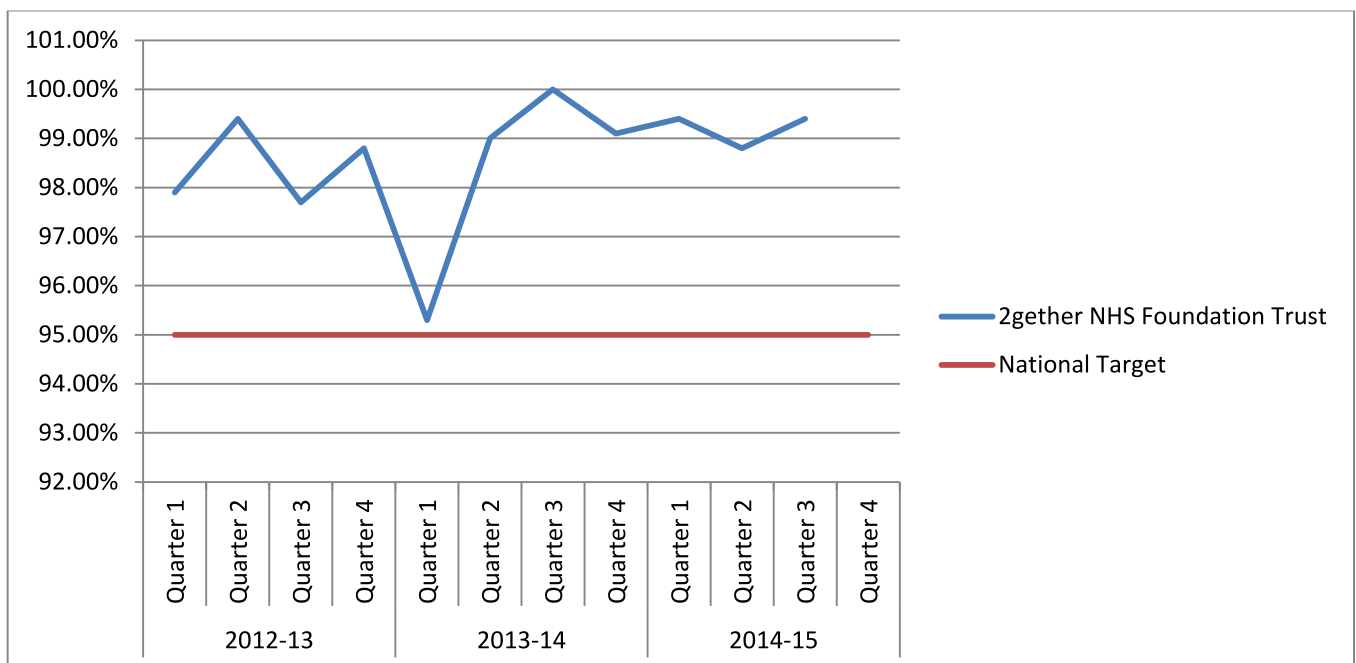

Figure 4

[1] Detailed requirements for quality reports 2013/14: Monitor, February 2014

User Experience

In this domain, we have set ourselves 1 goal of improving service user experience and carer experience with 4 associated targets.

- Improving the experience of service user in key areas. This will be measure though defined survey questions for both people in the community and inpatients

Below are the responses to the returned service user questionnaires during Quarter 3.

Target 2.1 Did 2gether Trust staff involve a member of your family or someone else close to you, as much as you would like in your care? > 53%

Questions	Treatment setting	Sample size Glos	No. of 'yes' Glos	% 'yes' Glos	Sample size Hfd	No of 'yes' Hfd	% 'yes' Hfd	Total % giving 'yes' answer in Glos+Hfd
Question 1 Did [2]gether Trust staff involve a member of your family or someone close to you as much as you would like in your care?	Inpatient	56	54	96%	28	28	100%	**91%**
	Community	323	279	86%	208	198	95%	
	Total Responses	**379**	**333**	**88%**	**236**	**226**	**96%**	

We are currently meeting this target.

Target 2.2 Did we organise the care and services that you need? >59%

Questions	Treatment setting	Sample size Glos	No. of 'yes' Glos	% 'yes' Glos	Sample size Hfd	No of 'yes' Hfd	% 'yes' Hfd	Total % giving 'yes' answer in Glos+Hfd
Question 2 Did we organise the care and services that you need?	Inpatient	56	49	88%	28	28	100%	**94%**
	Community	323	297	92%	208	205	99%	
	Total Responses	**379**	**346**	**91%**	**236**	**233**	**99%**	

We are currently meeting this target.

Target 2.3 Have you been given information on how you can contact your Care Co-ordinator or lead professional if you have a problem? >72%

Questions	Treatment setting	Sample size Glos	No. of 'yes' Glos	% 'yes' Glos	Sample size Hfd	No of 'yes' Hfd	% 'yes' Hfd	Total % giving 'yes' answer in Glos+Hfd
Question 3 Have you been given information on how you can contact your care coordinator or lead professional if you have a problem?	Inpatient	56	49	88%	28	28	100%	**94%**
	Community	323	297	92%	208	205	99%	
	Total Responses	**379**	**346**	**91%**	**236**	**233**	**99%**	

We are currently meeting this target.

Target 2.4 Have you been offered a written or printed copy of your care plan? >41%

Questions	Treatment setting	Sample size Glos	No. of 'yes' Glos	% 'yes' Glos	Sample size Hfd	No of 'yes' Hfd	% 'yes' Hfd	Total % giving 'yes' answer in Glos+Hfd
Question 4 Have you been offered a written copy of your care plan?	Inpatient	56	42	75%	28	23	82%	**76%**
	Community	323	241	75%	208	164	79%	
	Total Responses	**379**	**283**	**75%**	**236**	**187**	**79%**	

We are currently meeting this target.

The scores suggest that of the people who responded to the survey, their experiences were generally positive. In all areas the scores have further improved since Quarter 2 suggesting that practice development activity is having a positive impact.

Friends and Family Test

Work has been carried out to develop further ways of ensuring that the Friends and Family Test is made available to all service users. This question asks people who have used the service whether they would recommend the service should their friends or family require care.

The following six-point response scale is used to answer the question:
1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don't know

The standard way to report the findings is by calculating the percentage of people who state that they would either be 'Extremely Likely' or 'Likely' to recommend the services of the Trust. This figure is reported routinely in the Trust's Service Experience report.

Quarter 3 Results – [2]gether overall Friends and Family Test

798 people took part in the standard Friends and Family Test this quarter. Data were gathered using multiple sources including text messaging, iPad and paper systems.

Trust Area	Number of responses	Number Likely to recommend	% number likely to recommend
Overall	798	690	86%
Herefordshire In-patient	28	21	75%
Gloucestershire In-patient	56	43	77%
Herefordshire Community	208	185	89%
Gloucestershire Community	506*	441	87%

* The sample size for Gloucestershire community is higher than the responses in the 4 questions above as it included text messaging responses.

The results reveal that overall the number of people who would recommend the Trust's services is slightly higher than last quarter. The results also suggest that people using [2]gether's Herefordshire and Gloucestershire services were nearly equally likely to recommend [2]gether's services in Quarter 3. In both counties, more people were slightly more likely to recommend the Trust's Community services rather than the In-patient Units.

Adjusted version of the Friends and Family Test for People with Learning Disabilities in Herefordshire

[2]gether NHS Foundation Trust has continued to offer Easy Read Friends and Family Test for people with learning disabilities. The results below are reported for Q3 from the Community Team for People with Learning Disabilities in Herefordshire and illustrate a return of 13. This response rate is significantly lower than the number of responses received in Quarter 2 (n=54) so caution should be taken in the generalisation of the results. We remain committed to offering people the option to complete an easy read version of the survey.

Reporting Period: October – December 2014 Number of forms received: 13					
Questions	% Yes	Yes	Maybe	No	Don't Know / N/A
1. Would you want your Friends and Family to come here if they were ill?	92.3%	12	1	0	0
2. Did the staff explain things well?	92.3%	12	0	0	
3. Were staff friendly and helpful to you?	100%	13	0	0	
4. Did the staff listen to you?	100%	13	0	0	
5. Did the staff listen to your carer or family?	100%	13	0	0	0
6. Were you given easy to understand information about your visit?	76.9%	10	2	1	
7. Did the staff explain what will happen with your healthcare when you leave?	92.3%	12	0	1	

Survey of Gloucestershire Children and Young People

The Experience of Service Questionnaire (CHI ESQ) is a national questionnaire and part of the CYP IAPT national dataset specifically for community services and includes questionnaires for different groups including:

- Carer/Parent
- Service Users Age 9-11
- Service Users Age 12-18

Children and Young People (CYP) in Gloucestershire are asked to complete the Experience of Service Questionnaire at 6 month review or at a discharge meeting. The data is collected via paper forms or hand held devices.

The results from Quarter 3 2014-2015 (Figure 5) were generally positive and also highlight areas for improvement. The lowest scoring responses in quarter 3 are consistent with those of quarter 2 and were the convenience of appointments and their location. The highest scoring response of quarter 3 are consistent with those in quarter 2 and reflect that young people are happy with the quality of treatment they receive, such as they feel they are being listened to, find it easy to talk and view treatment as being helpful.

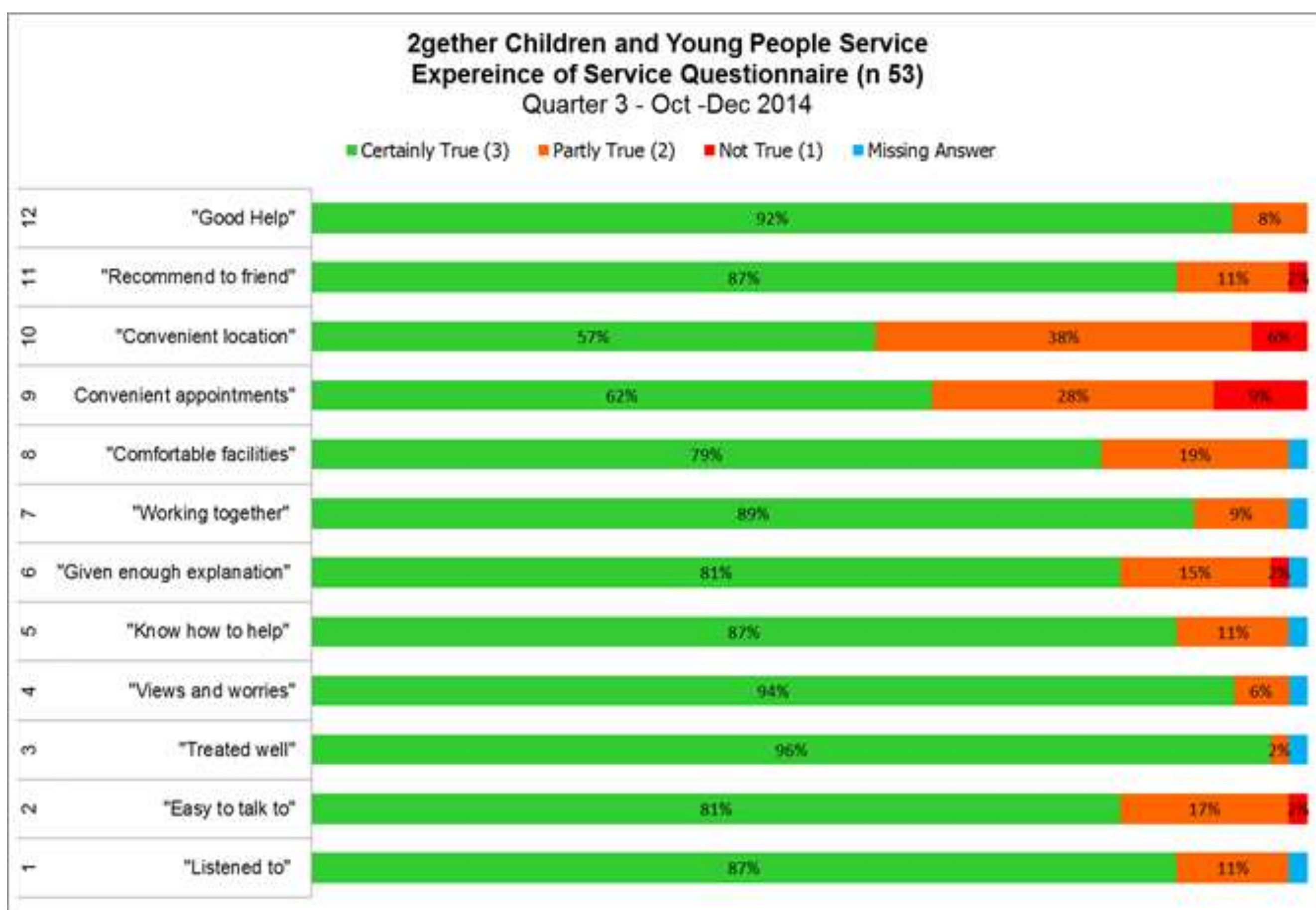

Figure 5

Safety

Protecting service users from further harm whilst they are in our care is a fundamental requirement. We seek to ensure we assess the safety of those who use our services as well as providing a safe environment for service users, staff and everyone else that comes into contact with us. In this domain, we have set ourselves 3 goals to:

- Minimise the risk of suicide of people who use our services;
- Ensure the safety of people detained under the Mental Health Act;
- Ensure we follow people up when they leave our inpatient units within 48 hours to reduce risk of harm.

There are 3 associated targets.

Target 3.1 Reduce the numbers of deaths relating to identified risk factors of people in contact with services when compared data from previous years.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14 we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams. Last year we reported 22 suspected suicides, which was 4 more than in 2012/13 and did not met the target.

Figure 6 below shows the number of reported suspected suicides of people in contact with our services over a 4 year period. During Quarter 3 2014/15 we reported 6 suspected suicides, with a cumulative year to date total of 17, which is lower than the comparable time period in the previous year. **We are currently meeting this target.**

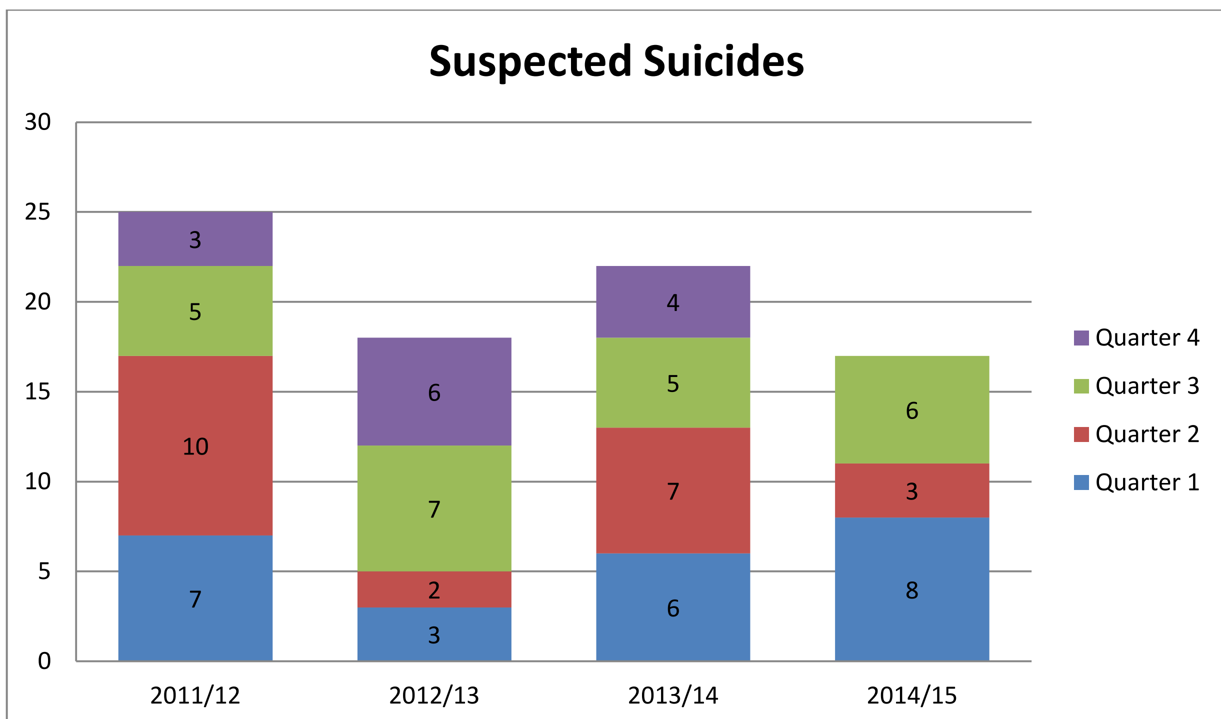

Figure 6

It should be noted that the Quarter 2 Quality Report identified 4 reported suspected suicides during Quarter 2. This figure has been amended to 3 as a police investigation determined that one of these was, in fact, a domestic homicide.

Whilst we report all deaths which appear to be as a consequence of self-harm as suspected suicide, ultimately it is the coroner who determines how a person came by their death. Figure 7 provides the number of suicide, open and narrative conclusions following an inquest being heard for the same cohort of service users.

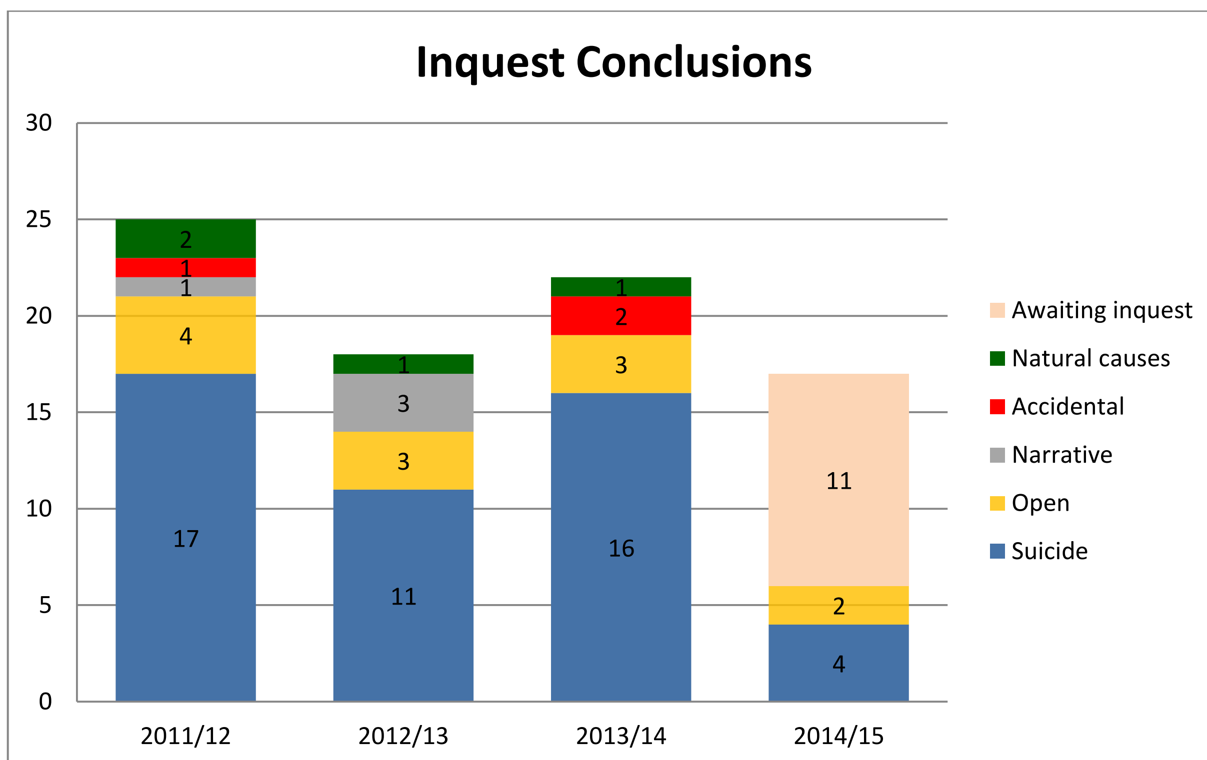

Figure 7

The first report on the National Suicide Prevention strategy[2] notes that sadly for the first time since 2007 the national suicide rate has risen. The findings within the Trust are consistent with the national picture. The report details 6 key areas for local services to work together to promote suicide prevention, namely:

1) Implement NICE guidelines on self-harm, and support additional psychosocial and physiological interventions;
2) Work collaboratively to support service users facing debt, housing problems and unemployment;
3) Increased focus on support for people bereaved by suicide;
4) Increased focus on understanding and addressing the factors associated with suicide in males;
5) Improve access to psychological therapies for children and young people;
6) Work closely and collaboratively with coroners.

Our teams are mindful of these recommendations and continue to work closely with service users who are at risk of suicide to support them through times of crisis. Initiatives such as the implementation of the inpatient and community suicide prevention toolkit, annual ligature assessments within our inpatient services, undertaking follow up within 48 hours post discharge from inpatient units, and the provision of Applied Suicide Intervention Skills Training (ASIST) during 2013/14 have helped to improve staff awareness of issues associated with suicide.

[2] Preventing suicide in England: One year on. First annual report on the cross-government outcomes strategy to save lives. January 2014.

Target 3.2 Reduce the number of people who are absent without leave from inpatient units who are formally detained.

Much work has been done to understand the context in which detained service users are absent without leave (AWOL) via the NHS South of England Mental Health Patient Safety Improvement Programme. AWOL reporting includes those who abscond from the ward, those who fail to return from a period of agreed leave, and a third category of those who escape whilst on escort.

To date, we have not been able to identify which interventions are most effective. Our current focus is to identify which interventions are being used consistently by teams across both Gloucestershire and Herefordshire, and which of those are making a difference to reducing AWOLS. The following interventions have been tested and implemented:

- Rule Clarity regarding leaving the ward, although different methods may be used;
- The profile of the person most likely to abscond is known through research, and this has been supported by the revised Trust Risk Assessment and Management Policy;
- Data/charts are shared with wards as a source progress against the aim to reduce AWOLs;
- Pre admission work with Crisis Resolution & Home Treatment Teams;
- Gym use and activities on offer;
- Access to Pay as you Go phones;
- Measurement and reporting continues. Safewards[3] is being implemented - 3 interventions per ward at Wotton Lawn Hospital. This is evident and visual within the ward environments and service users are engaged. It aims to impact on reducing AWOL through increased service user engagement.

Variation exists between Gloucestershire and Herefordshire due to commissioning arrangements and this includes difference in therapy input/provision which impacts on structured activity.

We have tested out a variety of interventions on specific adult inpatient wards as means of making improvements using a developmental approach. For example, we know that Rule Clarity for patients has been established on wards but different implementation methods are be used. The profile of the person most likely to abscond is known but we also need to know that this is applied consistently. Therefore identifying the specifics of which interventions have made a difference can be complex and there is ongoing work to determine 'reliability' of interventions. For example, a plan is in place to address how we will know if giving out Leave Cards is effective and is reliable. We want to know if this happens 95% of the time and so the recording of such is important. A test of change completed in October 2014 by the Mortimer Ward team, showed that this happens 75% of the time.

The total number of detained patients reported as being absent without leave during 2013/14 was **110** and whilst we did not meet our target, the reported incidents did not lead to patient harm. The number of reported incidents during Quarter 3 2014/15 was **35**, bringing the total this year to **94** which is more than the same period in 2013/14.

	2013/14	2014/15 Q1
Quarter 1	23	20
Quarter 2	25	39
Quarter 3	24	35
Quarter 4	38	
Totals for year	**110**	**94**

We are not, therefore, meeting this target.

[3] Safewards: the empirical basis of the model and a critical appraisal. Len Bowers. 2013

The graph overleaf (Figure 9) which is used by the Patient Safety Improvement Programme, summarises numbers of AWOLS, any associated harm, the wards involved and the dates of implementing interventions since September 2012 until December 2014. (where AWOLS are coded/reported against a specific ward. We are aware that a large number of AWOLS, whilst being reported and included in the table above, are coded to a location defined as "other". This is why these do not show in Figure 9).

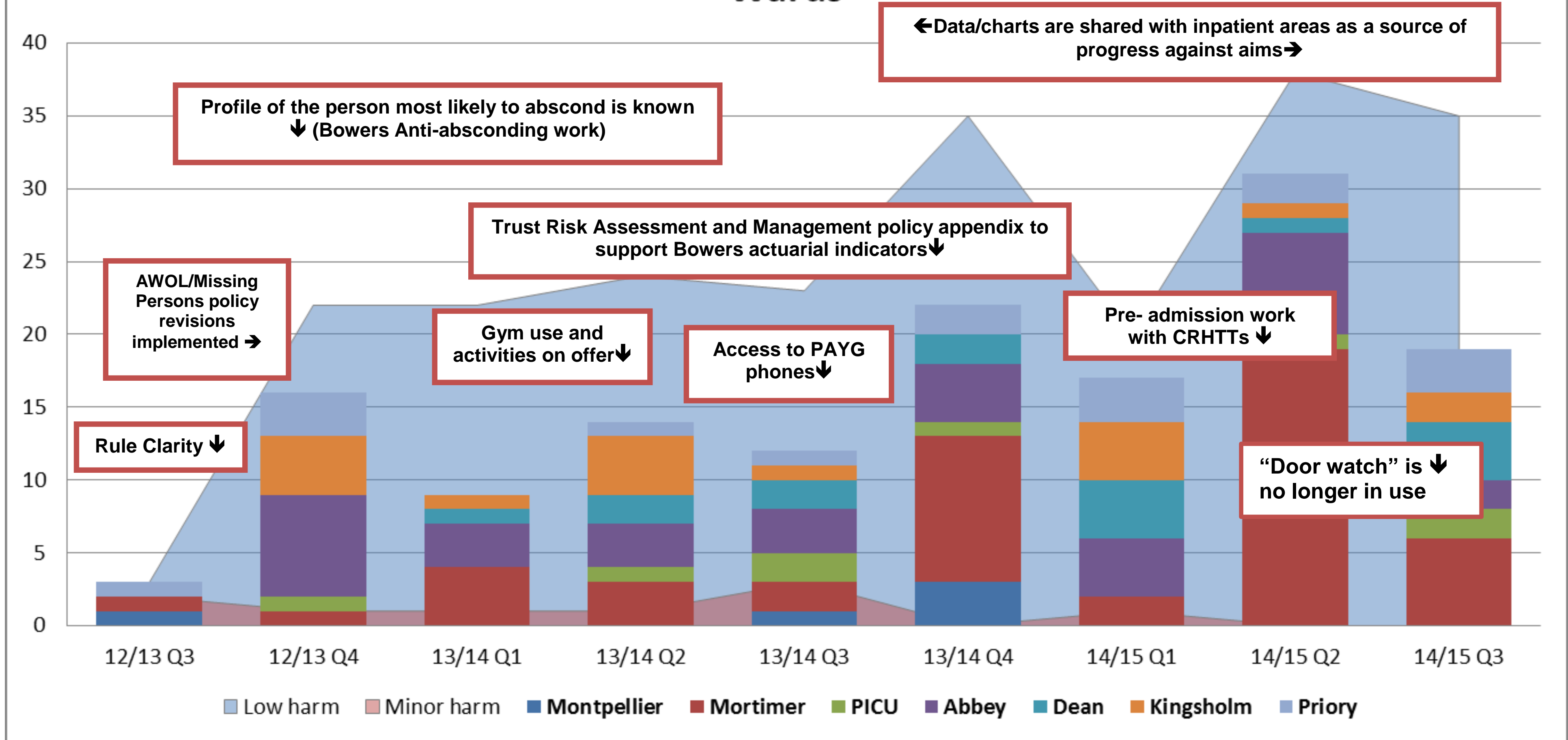

Figure 7

Target 3.3 95% of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care

This is a local target and one which we first established as a quality target in 2012/13. The national target is that 95% of CPA service users receive follow up within 7 days[4].

Discharge from inpatient units to community settings can pose a time of increased risk of self-harm for service users. The National Confidential Inquiry into Suicides and Homicides[5] recommended that *'All discharged service users who have severe mental illness or a recent (less than three months) history of self-harm should be followed up within one week'*

One of the particular requirements for preventing suicide among people suffering severe mental illness is to ensure that follow up of those discharged from inpatient care is treated as a priority and that care plans include follow up on discharge. Although the national target for following up service users on CPA is within 7 days, in recognition that people may be at their most vulnerable within the first 48 hours, we aim to follow up 95% of people within these 2 days. This has been an organisational target for two years, and the cumulative figures for each year end are seen in the table below.

During Quarter 3, Herefordshire services have followed up 86% of people discharged from inpatient care and Gloucestershire services have followed up 95%, this gives an organisational compliance figure of 93%. Teams will be reviewing their performance against this target in efforts to ensure that 95% of people discharged from hospital during 2014/15 will have been achieved by year end.

	Target	2012-13	2013-14	2014-15 Q3
Gloucestershire Services	>95%	89%	95%	95% (Q2 : 93.6%)
Herefordshire Services	>95%	70%	95%	86% (Q2 : 98.3%)

We are not, therefore, meeting this target.

Serious Incidents Reported during 2014-15

At the end of Quarter 3, 37 serious incidents were reported by the Trust, and the types of incidents reported are seen in Figure 9. The number of reported incidents this year is the same as that reported for the same time period in 2013-14. However, the 2 incidents indicated as "Domestic Homicide*" have been "declassified" as NHS serious incidents as the perpetrators were not in receipt of care bringing the actual total of serious incidents to 35. The Trust will be participating in the associated Domestic Homicide Reviews.

The most frequently reported serious incidents are "suspected suicide" and attempted suicide. Figure 10 shows a 4 year comparison of reported serious incidents. There was one homicide reported during Quarter 2, in which a member of staff working in our Gloucestershire inpatient services was fatally stabbed by a service user. A Health & Safety Executive investigation continues due to this being a death in the work place, and there will also be an NHS Independent Homicide Inquiry in 2015/16.

There have been no Department of Health defined "Never Events" within the Trust during 2014-15. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

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[4] Detailed requirements for quality reports 2013/14: Monitor, February 2014

[5] Five year report of National Confidential Inquiry into Suicide and Homicide by people with mental illness Department of Health – 2001

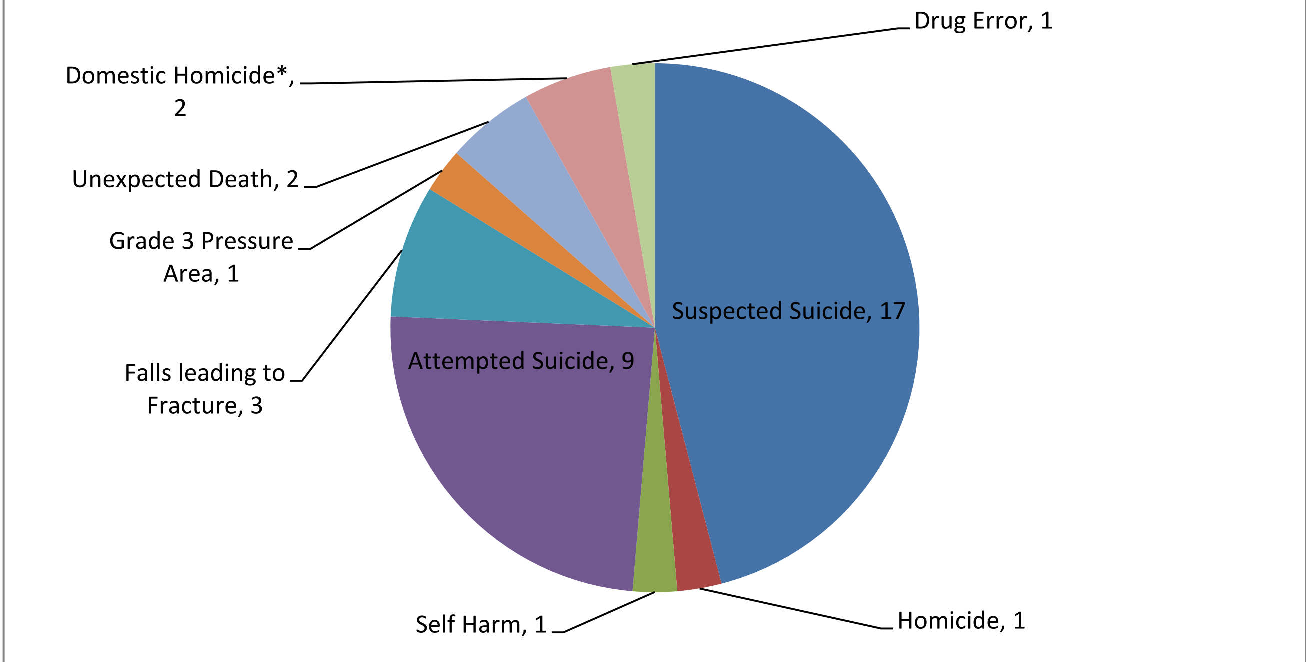

Figure 9

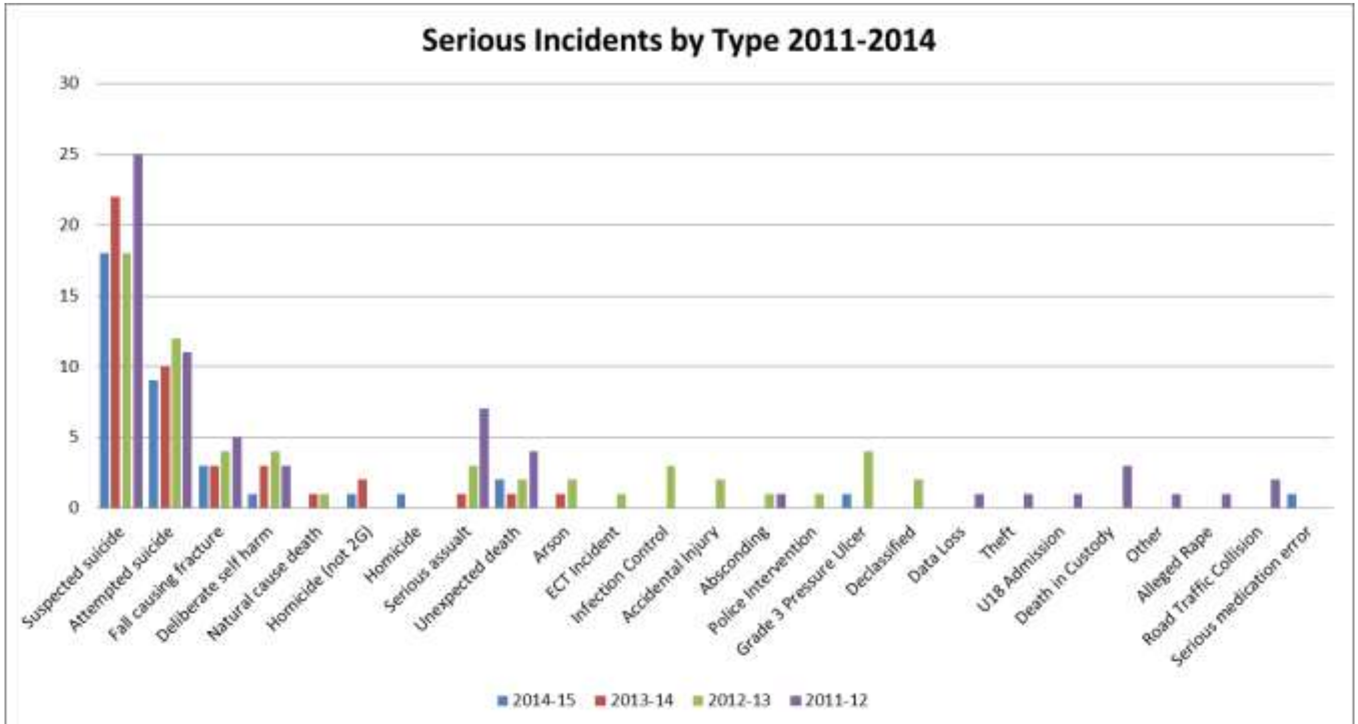

Figure 10

Organisational Learning

To ensure that appropriate organisational learning occurs, an Aggregated Learning Sub-Committee of the Trust Governance Committee has been formed. This meets quarterly to ensure that learning from incidents, inquests, complaints, service experience, claims, clinical audit and external inspection reports (where appropriate) occurs through thematic analysis.

This Sub-Committee produces aggregated learning reports which are cascaded through each of the Trust locality services, and it also ensures that the learning summaries which are completed following our reviews of serious incidents, are made available to staff.

The areas of learning we have identified during the year are:

1. Involving families and sharing information remains a theme in complaints received, and there have been serious incidents in which communication with service users and carers in regard of harm sustained could have been improved or explained sooner. This identified a need to raise the profile of the Duty of Candour.

2. Learning from medication incidents must be improved; there have been incidents in which medicines management could have been improved in the context of patient safety.

3. There was one serious incident and inquest which identified that interface between police and the NHS be improved.

4. Data Quality in DATIX in regard of including Person Identifiable Information (for the person harmed) must be improved.

5. There have been a number of complaints and serious incidents in which crisis management plans and/or identification of relapse indicators were not recorded/documented or shared.

6. Safeguarding supervision and recording of safeguarding decision making and formulation on RiO has been identified through both serious incident reviews and safeguarding meetings.

7. Physical health competences for nursing staff should be reviewed and provision of appropriate support and access to relevant training.

8. Families and carers must have appropriate support from ward/unit staff to understand what a mental health or learning disability service inpatient environment is like at the point of a service user being admitted.

9. Processes for undertaking and documenting environmental risk assessments, including fire and security must be reviewed.

Indicators & Thresholds for 2014/2015

The following table shows the 10 metrics that are monitored during 2014/15. These are the indicators and thresholds from Monitor and follow the standard Department of Health national definitions. Note that some are also the Trust Quality targets, and some may have more stretching targets than Monitor require as a threshold.

		2012-2013 Actual	2013-2014 Actual	National Threshold	2014-2015 Q3
1	Clostridium Difficile objective	1	1	0	**2**
2	MRSA bacteraemia objective	0	0	0	**0**
3	7 day CPA follow-up after discharge	98.6%	99.1%	95%	**97.9%**
4	CPA formal review within 12 months	95.1%	96.4%	95%	**97.1%**
5	Delayed transfer of care	0.9%	0.9%	≤7.5%	**1%**
6	Admissions gate kept by Crisis resolution/home treatment services	98.8%	99.1%	95%	**99.4%**
7	Serving new psychosis cases by early intervention teams	100%	100%	95%	**100%**
8	MHMDS data completeness: identifiers	99.7%	99.7%	97%	**99.7%**
9	MHMDS data completeness: CPA outcomes	79.7%	80.6%	50%	**97.2%**
10	Learning Disability – six criteria	6	6	6	**6**

Mandated Quality Indicators 2014-2015

There are a number of mandated Quality Indicators which organisations providing mental health services are required to report on, and these are detailed below. The comparisons with the national average and both the lowest and highest performing trusts are benchmarked against other mental health service providers.

1. Percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care

	Quarter 3 2013-14	Quarter 4 2013-14	Quarter 1 2014-15	Quarter 2* 2014-15	Quarter 3* 2014-15
^{2}gether NHS Foundation Trust	97.7%	98.5%	97.1%	97.2%	99.3%
National Average	96.7%	97.4%	97.4%	97.3%	97.3%
Lowest Trust	77.2%	93.3%	93%	91.5%	90%
Highest Trust	100%	100%	100%	100%	100%

2. Proportion of admissions to psychiatric inpatient care that were gate kept by Crisis Teams

	Quarter 3 2013-14	Quarter 4 2013-14	Quarter 1 2014-15	Quarter 2* 2014-15	Quarter 3* 2014-15
^{2}gether NHS Foundation Trust	100%	99.5%	99.4%	98.8%	100%
National Average	98.6%	98.3%	97.9%	98.5%	97.8%
Lowest Trust	85.5%	75.2%	33.3%	93%	73%
Highest Trust	100%	100%	100%	100%	100%

* Activity published on NHS England website via the NHS IC Portal is revised throughout the year following data quality checks. Activity shown for Quarters 2 & 3 has not yet been revised and may change. This is of particular relevance to Target 1.3, where internal Trust data shows 99.4% at Quarter 3 for Proportion of admissions to psychiatric inpatient care that were gate kept by Crisis Teams rather than 100% as shown above.

3. **The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends**

	NHS Staff Survey 2012	NHS Staff Survey 2013	NHS Staff Survey 2014
2gether NHS Foundation Trust Score	3.19	3.46	Not yet available
National Median Score	3.54	3.55	Not yet available
Lowest Trust Score	3.06	3.01	Not yet available
Highest Trust Score	4.06	4.04	Not yet available

4. **"Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.**

	NHS Community Mental Health Survey 2012	NHS Community Mental Health Survey 2013	NHS Community Mental Health Survey 2014
2gether NHS Foundation Trust Score	8.4	8.7	8.2
National Average Score	Not available	Not available	Not available
Lowest Score	8.2	8.0	7.3
Highest Score	9.1	9.0	8.4

5. **The number and rate* of patient safety incidents reported within the Trust during the reporting period and the number and percentage of such patient safety incidents that resulted in severe harm or death.**

	April 2013-September 2013				October 2013-March 2014			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
2gether NHS Foundation Trust	1,500	33.16	2	13	1,601	35.39	0	10
National	122,523	-	442	1,106	122,667	-	450	920
Lowest Trust	0	0	0	0	16	9	0	0
Highest Trust	6,609	67.06	36	76	5,906	58.69	36	57

* Rate is the number of incidents reported per 1000 bed days.

Community Survey 2014

The CQC published results of an independent survey taken in 2014 that tested the experience of service users who use 2gether's community services. The published results compare ratings about 2gether's services with the results of other mental health trusts.

2gether NHS Foundation Trust received one of the highest percentage response rates in the country to the questionnaire at 35% returned. Full details of this survey questions and results can be found on the CQC website http://www.cqc.org.uk/provider/RTQ/survey/6. No significant differences were noted between the results for Herefordshire and Gloucestershire.

Across most of the nine domains in the survey our scores were reported as 'About the Same' as other trusts. In the domain named 'Other aspects of life' service users rated 2gether's services as 'Better' than

others. The results are tabulated below together with the scores out of 10 for [2]gether Trust calculated by the CQC.

Table 3: [2]gether's scores compared with scores of other trusts

Score (out of 10)	Domain of questions	How the score relates to other trusts
8.2	Health and Social Care workers	Same as others
8.8	Organising Care	Same as others
7.4	Planning care	Same as others
7.9	Reviewing Care	Same as others
6.8	Changes in who people see	Same as others
6.6	Crisis care	Same as others
7.7	Treatment	Same as others
5.9	Other aspects of life	Better
7.7	Overall	Same as others

The questions asked in the 2014 survey were slightly different from previous years which makes direct comparison challenging. However, the CQC named [2]gether NHS Foundation Trust as one of the overall top performing Trusts as rated by participants of the survey this year.

In six out of the 33 evaluative questions, [2]gether received particularly favourable results compared with other Trusts rated in the CQC Survey. These questions include:

Q no.	Question
Q05	Did the person or people that you saw listen carefully to you?
Q07	Did the person or people you saw understand how your mental health needs affect other areas of your life?
Q11	How well does his person organise the care and services you need?
Q13	Were you involved as much as you wanted to be in agreeing what care you will receive?
Q34	In the last 12 months, did NHS mental health services give you any help or advice with finding support for or finding or keeping work?
Q43	Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS Mental Health services?

The results have been considered further for areas where improvements could be made. These include:

1. Further attention to asking people what's important to them for their recovery
2. Ensuring that all service users have a formal yet collaborative meeting, at least annually to discuss their care.
3. Further work to ensure that service users are provided with information about contact points out of office hours if they need support in a crisis.
4. Greater routine emphasis to support people to access help for physical health needs; benefits advice; employment opportunities and everyday activities.
5. Information provision regarding getting support from people who have experience of similar mental health needs.
6. Further practice development to ensure that our service ethos offers and emphasizes hope.

Staff Survey 2014

This information will be provided when it is published nationally.

PLACE Assessment Results 2014/15

In April 2013, Patient Led Assessments of the Care Environment (PLACE) were introduced in England, it is the new system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care

The final 2014 PLACE results for the Trust demonstrate considerable improvements across all areas in comparison to the 2013 PLACE scores. Results demonstrate a high level of compliance which compare favourably in comparison to National Average results.

	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance
National 2013	96%	85%	89%	89%
[2]gether 2013	98.3%	82.3%	88.3%	87.5%
National 2014	97%	89%	88%	92%
[2]gether 2014	98.9%	95.1%	96.5%	97.5%

A further analysis of the data in terms of each unit, in comparison to national average is presented below. Green indicates national average or above.

Site Name	Site Type	Cleanliness	Food Overall	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance
Hollybrook	Learning Disabilities	98.94%	93.71%	100.00%	98.31%
Westridge	Learning Disabilities	99.51%	96.40%	90.33%	97.50%
Charlton Lane	Mental Health only	99.33%	95.85%	98.51%	99.17%
Wotton Lawn	Mental Health only	99.28%	96.38%	97.55%	96.84%
Honeybourne, Cheltenham	Mental Health only	100.00%	96.59%	89.66%	99.18%
Laurel House, Cheltenham	Mental Health only	97.22%	97.04%	93.33%	96.55%
Stonebow Unit	Mental Health only	97.51%	90.03%	97.35%	99.21%
Oak House	Mental Health only	100.00%	N/A	87.10%	86.89%

The one area that scored below national average results was Oak House in Herefordshire, and we continue to work closely with commissioners to find more suitable premises for the services.

Annex 1 Glossary

BME	Black & Minority Ethnic
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CORC	CAMHS Outcomes Research Consortium (CORC)
CPA	Care Programme Approach: a system of delivering community service to those with mental illness
CQC	Care Quality Commission – the Government body that regulates the quality of services from all providers of NHS care.
CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
GriP	Gloucestershire Recovery in Psychosis (GriP) is 2gether's specialist early intervention team working with people aged 14-35 who have first episode psychosis.
HoNOS	Health of the Nation Outcome Scales – this is the most widely used routine Measure of clinical outcome used by English mental health services.
IAPT	Improving Access to Psychological Therapies
Information Governance (IG) Toolkit	The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against a list of 45 Department of Health Information Governance policies and standards.
MHMDS	The Mental Health Minimum Data Set is a series of key personal information that should be recorded on the records of every service user
Monitor	Monitor is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant
NHS	The National Health Service refers to one or more of the four publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom.

NICE	The National Institute for Health and Care Excellence (previously National Institute for Health and Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
NIHR	The National Institute for Health Research supports a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
NPSA	The National Patient Safety Agency is a body that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
PDSA	Plan Do Study Act is a suggested method for quality improvement in healthcare.
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.
QRP	The Quality and Risk Profile is a monthly compilation by the CQC of all the evidence about a trust they have in order to judge the level of risk that the trust carries to fulfil its obligations of care
RiO	This is the name of the electronic system for recording service user care notes and related information within ²gether NHS Foundation Trust. In a major exercise, it has been implemented across almost all the Trust's areas of operation during 2010.
ROMs	Routine Outcome Monitoring (ROMs)
SIRI	Serious Incident Requiring Investigation, previously known as a "Serious Untoward Incident". A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Report, we use the standard definition of a Serious Incident given by the NPSA
SWEBS	The Shortened Warwick-Edinburgh Well-being Scale is a scale for assessing a population´s mental wellbeing.
VTE	Venous thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 2 How to Contact Us

About this report

If you have any questions or comments concerning the contents of this report or have any other questions about the Trust and how it operates, please write to:

Mr Shaun Clee
Chief Executive Officer
2gether NHS Foundation Trust
Rikenel
Montpellier
Gloucester
GL1 1LY

Or email him at: shaun.clee@glos.nhs.uk

Alternatively, you may telephone on 01452 894000 or fax on 01452 894001.

Other Comments, Concerns, Complaints and Compliments

Your views and suggestions are important us. They help us to improve the services we provide.

You can give us feedback about our services by:

- Speaking to a member of staff directly
- Telephoning us on 01452 894673
- Completing our Online Feedback Form at www.2gether.nhs.uk
- Completing our Comment, Concern, Complaint, Compliment Leaflet, available from any of our Trust sites or from our website www.2gether.nhs.uk
- Using one of the feedback screens at selected Trust sites
- Contacting the Patient Advice and Liaison Service (PALS) Advisor on 01452 894072
- Writing to the appropriate service manager or the Trust's Chief Executive

Alternative Formats

If you would like a copy of this report in large print, Braille, audio cassette tape or another language, please telephone us on 01452 894000 or fax on 01452 894001.