Agenda item 12.2

Report to:	[2]gether NHS Foundation Trust Board – 6th June 2019
Author:	Jane Stewart, Compliance Manager
Presented by:	John Trevains, Director of Quality

SUBJECT: **Quality Report for 2018-19**

Can this report be discussed at a public Board meeting?	Yes
If not, explain why	

This Report is provided for:			
Decision	**Endorsement**	Assurance	Information

EXECUTIVE SUMMARY

2018-19 Quality Report

- The Annual Quality Report summarises the progress made in achieving targets, objectives and initiatives identified, and has been collated following an extensive review of all associated information received from a variety of sources throughout the year. The Quality Report was signed off by the Audit Committee on 24th May 2019.

- The priorities for improvement during 2019-20 have been agreed in consultation with both internal and external stakeholders. These priorities were categorised under the three key dimensions of effectiveness; user experience and safety and included all initiative which were not achieved during 2018-19. It is the intention that all initiatives that were not achieved on 18–19 will be subject to scrutiny through out the year and the methods of reporting data will be analysed to ensure that a cumulative position is reflected rather than performance quarter to quarter.

- The draft Quality Report has been shared with commissioners in Herefordshire and Gloucestershire, and also both Healthwatch organisations and the Health and Community Care Overview and Scrutiny Committees (HCOSCs) in the two counties, in order for them to provide formal feedback which is published as part of the final report.

- The Committee should note the requirement that External Assurance on the Quality Report (provided by KPMG) must provide a limited assurance report on the content of Quality Reports produced by Foundation Trusts. In providing this assurance, KPMG have reviewed the draft report for consistency with the following:

1. Papers relating to the Quality Report reported to the Board over the year;
2. Feedback from commissioners;
3. Feedback from governors;

4. Feedback from Healthwatch organisations;
5. The trust" complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
6. Feedback from other named stakeholder(s) involved in the sign off of the Quality Report;
7. Latest national and local patient survey;
8. Latest national and local staff survey;
9. The Head of Internal Audit "annual opinion over the trust" control environment; and
10. Care Quality Commission data.

KMPG have also tested the following mandated indicators in line with the updated NHSI guidance:

1. *Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral.*
2. *Inappropriate out-of-area placements for adult mental health services.*

And the local indicator as requested by Trust Governors

3. *Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload.*

KPMG have issued an unqualified audit opinion which was received by the Audit Committee on 24 May 2019.

- Audit Committee formally ratified the Quality report on 24 May 2019 as mandated. Additionally, Part 1 on Page 4 (Statement on Quality from the Chief Executive) was signed off by the Deputy Chief Executive and Annex 2 of the Quality Report which describes Director's responsibilities in respect of the Quality Report was signed off formally by the Deputy Chair and Deputy Chief Executive.

- The Quality Report must be included as part of the Trust Annual Report and be submitted to NHSI by the end of May.

RECOMMENDATIONS

- The Board is asked to Note that the Audit Committee approved the Quality Report on 24 May 2019.
- Approve the Quality Report for submission to NHSI and wider publication.

Corporate Considerations	
Quality implications:	By the setting and monitoring of quality targets, the quality of the service we provide will improve.
Resource implications:	Collating the information does have resources implications for those providing the information and putting it into an accessible format
Equalities implications:	This is referenced in the report
Risk implications:	Specific initiatives that are not being achieved are highlighted in the report.

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	P
Ensuring Sustainability	P

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Seeing from a service user perspective			p
Excelling and improving	P	Inclusive open and honest	P
Responsive	P	Can do	P
Valuing and respectful	P	Efficient	P

Reviewed by:		
	Date	

Where in the Trust has this been discussed before?		
Governance Committee	Date	Quarterly
Council of Governors		Quarterly
Trust Board		Quarterly

What consultation has there been?		
Ongoing liaison with internal & external stakeholders, in particular commissioners, Healthwatch organisations & HCOSCs	Date	Quarterly

Explanation of acronyms used:	**HCOSC** = Health and Care Overview and Scrutiny Committee

1. CONTEXT

Every year the Trust is obliged by statute to produce a Quality Report, reporting on activities and targets from the previous year's Account, and setting new objectives for the following year. Guidance regarding the publication of the Quality Report is issued by NHSI (incorporating the Department of Health Guidance for Quality Accounts) and the Quality Report checked for consistency against the defined regulations.

The Audit Committee approved the areas for quality improvement in the forthcoming year following the period of consultation with stakeholders, and the content of the Quality Report in its entirety for presentation to the Trust Board.

Quality Report 2018/19

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

It is my pleasure, on behalf of [2]gether NHS Foundation Trust, to present our annual Quality Report for 2018/19. Quality and continuous improvement is at the centre of everything we do. We regularly review our performance against our quality indicators – those we set for ourselves, and those nationally mandated or agreed with our commissioners.

This year our main quality standards included:

- Measures focussed on improving the physical health of our service users;
- Improving the health and wellbeing of our staff, including increasing the uptake of flu vaccinations;
- Closer working with GPs and also with our acute hospitals on supporting people who attend A&E with mental health needs;
- Improved transitions for children and young people moving into adult services;
- Improving access to psychological therapies and initial waiting times for early intervention in psychosis;
- Improving patient safety, including reducing harm through patients going 'absent without leave' and reducing suicides among patients who have used our services;
- Reducing length of stay in inpatient services, planning more effectively for discharge and providing follow up within seven days of discharge;
- Providing healthy food for staff, visitors and patients; and
- Improving the experiences of people who use our services.

Many of these targets have been achieved. We are particularly pleased with the results of our flu vaccination programme, as well as the results of our Staff Survey, which show that 75.5% of Trust colleagues would recommend the Trust as a place for friends or relatives needing treatment.

We were also proud that service users who responded to the 2018 Community Mental Health Survey once again rated the care provided through [2]gether's services in the top 20% of mental health services in England. In 5 out of the 11 sections of the survey we score 'Better' than 80% of other Trusts who took part. Another source of particular pride for our Trust is our most recent PLACE assessment, which places us above the national average for Mental Health and Learning Disability settings in all six domains. Cleanliness, food, privacy, dignity, maintenance and other factors are all vitally important in helping people to get better and stay well, so we are very happy with these results.

Of course, we couldn't let this Quality Report pass without reflecting on our most recent CQC inspection. While the inspection took place in the previous financial year, the outcome was shared with us in early June. We were delighted to have retained our overall 'good' rating, with some improvements in particular areas:

- Wards for older people with mental health problems are now rated 'Outstanding' for being caring and 'Good' for safe.
- Community-based mental health services for older people are now rated 'Good' overall, 'Good' for being well-led and 'Good' for being effective.
- Wards for people with a learning disability or autism are now rated 'Good' for being responsive.

Our specialist community mental health services for children and young people retained their 'Good' rating across the board. None of the services inspected had their ratings downgraded.

We have not, however, achieved every target we set out to achieve this year - for a variety of reasons. These priorities will continue to be the focus of our attention in 2019/20.

Our main priorities will be:

- Reducing the proportion of patients in touch with our services who die by suicide;
- Increasing the use of supine restraint, as an alternative to prone restraint;
- Ensuring patients who become absent without leave do not come to serious harm;
- Ensuring the people who use our services, and their carers, will report feeling involved in their care;
- Improving the physical health of patients with a serious mental illness on Care Programme Approach;
- Ensuring services are informed by and involved in research and evaluation;
- Focus on patient involvement, crisis planning and community transitions. To be achieved through quality improvement approaches.
- To improve personalised discharge care planning in:
    a. Adult inpatient wards and;
    b. Older people's wards.
- To ensure that joint Care Programme Approach reviews occur for all service users who make the transition from children's to adult services.
- Focus on further development of a quality improvement led approach to robustly embed lessons learned following incidents.
- Making every contact count with approaches which prevent illness, promote health and encourage self-management; and
- Involving service users, family members and carers, and improving service user survey results.

Hand in hand with this will be our continued focus on our forthcoming merger with Gloucestershire Care Services NHS Trust – much of which is aimed at improving quality and patient outcomes.

The content of this report has been reviewed by the people who pay for our services (our commissioners), the Health and Care Scrutiny Committees of our local authorities and Healthwatch. Their views on this report are included on page 58. The report is also subject to review by our external auditor.

In preparing our Quality Report, we have used 'best endeavours' to ensure that the information presented is accurate and provides a fair reflection of our performance during the year. The Trust is not responsible, and does not have direct control for all of the systems from which the information is derived and collated. The provision of information by third parties introduces the possibility that there is some degree of error in our performance, although we have taken all reasonable steps to verify and validate such information.

As Chief Executive, I confirm that to the best of my knowledge the information within this document is accurate.

I will work with our Board, Governors, communities and partner organisations to strive for continued quality improvements during 2019/20 and look forward to updating you further the same time next year!

Paul Roberts
Chief Executive

Part 2.1: Looking ahead to 2019/20

Quality Priorities for Improvement 2019/20

This section of the report looks ahead to our priorities for quality improvement in 2019/20. We have developed our quality priorities under the three key dimensions of **effectiveness, user experience and safety** and these have been approved by the Trust Board following discussions with our key stakeholders.

Following feedback from service users, carers and staff, our Governors and commissioners as well as Herefordshire and Gloucestershire Healthwatch, we have identified 8 goals and **12** associated targets for 2019/20. These targets will be measured and monitored through reporting to the Trust Governance Committee with the period of time varying from monthly, quarterly or annually dependent upon what we measure, and the frequency of data collection.

How we prioritised our quality improvement initiatives

The quality improvements in each area were chosen by considering the requirements and recommendations from the following sources:

Documents and organisations:

- [2]gether 2019/20 Operational Plan;
- [2]gether Quality Strategy2018;
- NHS England: Five Year Forward View:
- NHS England: Implementing the Five Year Forward View for Mental Health. Updated July 2017;
- Care Quality Commission (via CQC Comprehensive Inspection at our sites in October 2015 and March 2018);
- NHS Outcomes Framework;
- Department of Health, with specific reference to 'No health, without mental health' (2011) and 'Mental health: priorities for change (January 2014);
- Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health 2015;
- NHS England: Commissioning for Quality & Innovation (CQUIN) Guidance for 2017-2019. November 2016; Commissioning for Quality & Innovation (CQUIN) Guidance for 2017-2019. March 2019.
- NHS Improvement. Single Oversight Framework November 2017;
- National Institute for Health & Care Excellence publications including their quality standards;
- Preventing suicide in England: Forth annual report on the cross-government outcomes strategy to save lives. Department of Health 2019;
- National Confidential Inquiry into Suicide and Safety in Mental Health: Annual Report 2018;
- Gloucestershire Sustainability Transformation Plan (STP);
- Herefordshire & Worcestershire STP.
- NHSE Long Term Plan 2019

The feedback and contributions have come from:

- Healthwatch Gloucestershire;
- Healthwatch Herefordshire;

- Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and Council colleagues;
- Herefordshire Overview and Scrutiny Committee and Council colleagues;
- Gloucestershire Clinical Commissioning Group;
- Herefordshire Clinical Commissioning Group;
- Internal assurance and audit reports;
- NHS South of England Mental Health Patient Safety Improvement Programme;
- Trust Governors;
- Trust clinicians and managers.

Effectiveness

Goal	Target	Drivers
Improving the physical health care for people with serious mental illness.	1.1 To improve the physical health of patients with a serious mental illness on CPA by a positive cardio metabolic health resource (Lester Tool). This will be used on all patients who meet the criteria within the inpatient setting and all community mental health teams. We aim to achieve 90% compliance for inpatients and early intervention teams and 75% compliance for all other community mental health teams.	To support NHS England's commitment to reduce the 15-20 year premature mortality in people with psychosis and improve their safety through improved assessment, treatment and communication between clinicians. We wish to continue to improve the physical health for those people in contact with our services. There is historical data available for year on year comparison.
Ensure that people are discharged from hospital with personalised care plans.	1.2 To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.	As we did not achieve this in 2018/19 we wish to ensure effective discharge from our inpatient services and enhance communication with both service users and primary care services. There is historical data available for year on year comparison.
	1.3	

Goal	Target	Drivers
Improve transition processes for child and young people who move into adult mental health services.	To ensure that joint Care Programme Approach (CPA) reviews occur for all service users who make the transition from children's to adult services. If a joint review does not take place, the reason must be recorded	We wish to continue to support this as a key quality priority during 2019/20 to further improve our transition processes. There is historical data available for year on year comparison.

User Experience

Goal	Target	Drivers
Improving the experience of service user in key areas. This will be measured though defined survey questions for both people in the community and inpatients.	2.1 Was someone close to you involved in your care as much as you wanted? > 72% **Target :** To achieve a response 'Yes' for more than 72**%** of the people surveyed.	Questions 2.2 – 2.4 are areas relating to patient experience where we wish to improve following the 2018 Care Quality Commission (CQC) national community mental health survey results.
	2.2 Have you had help and advice to find support to meet your physical health needs if you have needed it? > 54% **Target :** To achieve a response 'Yes' for more than 54**%** of the people surveyed.	
	2.3 Have you had help to keep work or carry on with everyday activities? >54% **Target :**	

Goal	Target	Drivers
	To achieve a response of 'Yes' for more than 5**4%** of the people surveyed.	
	2.4 Has information about your care been explained in a way that you can understand? > 84% **Target :** To achieve a response of 'Yes' for more than 84**%** of the people surveyed.	

Safety

Goal	Target	Drivers
Minimise the risk of suicide of people who use our services.	3.1 Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload.	Gloucestershire Suicide Prevention Strategy and Action Plan Preventing suicide in England: Third annual report on the cross-government outcomes strategy to save lives. National Confidential Inquiry into Suicide & Safety in Mental Health We have historical data available for year on year comparison.
Ensure the safety of people detained under the Mental Health Act.	3.2 Detained service users who are absent without leave (AWOL) will not come to serious harm or death. We will report against 3 categories of AWOL as follows; harm as a	NHS South of England Patient Safety Improvement Programme It is a high risk area with historical data available

Goal	Target	Drivers
	consequence of: 1. Absconded from escort 2. Failure to return from leave 3. Left the hospital (escaped)	for year on year comparison. We have historical data available for year on year comparison.
Minimise the risk of harm to service users within our inpatient services when we need to use physical interventions	3.3 To increase the use of supine restraint as an alternative to prone restraint. There will be a greater percentage of supine restraints compared to prone.	Positive and safereducing the need for restrictive interventions. April 2014. Mental Health Units (Use of Force) Act 2018: Seni's Law. We wish to continue to support this as a key quality priority during 2019/20 to minimise risk of harm. We have historical data available for year on year comparison.
	3.4 To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need. This aims to reduce the use of restrictive practices and will include primary and secondary prevention strategies.	Positive and safe: reducing the need for restrictive interventions. April 2014 We wish to continue this as a key quality priority during 2019/20 to minimise risk of harm and promote wellbeing. We have historical data available for year on year comparison.
Embedding Learning from Serious incidents	3.5 Focus on further development of quality improvement led approach to robustly embedding lessons learned following incidents.	We wish to develop, improve, and cascade learning from across the organisation in order to increase patient safety and minimise risk of harm. New indicator

Part 2.2: Statements relating to the Quality of NHS Services Provided

Review of Services

The purpose of this section of the report is to ensure we have considered the quality of care across all our services which we undertake through comprehensive reports on all services to the Governance Committee (a sub-committee of the Board).

During 2018/2019, the [2]gether NHS Foundation Trust provided and/or sub-contracted the following NHS services:

Gloucestershire
Our services are delivered through multidisciplinary and specialist teams. They are:

- One stop teams providing care to adults with mental health problems and those with a learning disability;
- Intermediate Care Mental Health Services (Primary Mental Health Services and Improving Access to Psychological Therapies);
- Specialist services including Early Intervention, Mental Health Acute Response Service, Crisis Resolution and Home Treatment, Assertive Outreach, Managing Memory, Children and Young People Services; Eating Disorders, Intensive Health Outcome Team and the Learning Disability Intensive Support Service;
- Inpatient care.

Herefordshire
We provide a comprehensive range of integrated mental health and social care services across the county. Our services include:

- Providing care to adults with mental health problems in Primary Care Mental Health Teams, Recovery Teams and Older People's Teams;
- Children and Adolescent Mental Health care;
- Specialist services including Early Intervention, Assertive Outreach and Crisis Resolution and Home Treatment;
- Inpatient care;
- Community Learning Disability Services;
- Improving Access to Psychological Therapies.

[2]gether NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the NHS services reviewed in 2018/19 represents 92.3 % of the total income generated from the provision of NHS services by [2]gether NHS Foundation Trust for 2018/19.

Participation in Clinical Audits and National Confidential Enquiries

During 2018/19 three national clinical audits and two national confidential enquiries covered NHS services that [2]gether NHS Foundation Trust provides.

During that period, [2]gether NHS Foundation Trust participated in 100% national clinical audits and 100% of confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that [2]gether NHS Foundation Trust was eligible and participated in during 2018/19 are as follows:

National Clinical Audits

Clinical Audits	Participated Yes/No	Reason for no participation
National Clinical Audit of Psychosis (NCAP)	Yes	N/A
National Clinical Audit of Anxiety and Depression (NCAAD) – Core Audit of Practice Guidance	Yes	N/A
National Clinical Audit of Anxiety and Depression (NCAAD) – Spotlight audit on psychological therapies	Yes	N/A

National Confidential Enquiries

National Confidential Enquiries	Participated Yes/No	Reason for no participation
National Confidential Inquiry into Suicide & Safety in Mental Health	Yes	N/A
Confidential Enquiry into Maternal Deaths	Yes	N/A

The national clinical audits and national confidential enquiries that [2]gether NHS Foundation Trust participated in, and for which data collection was completed during 2018/19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Topic	Trust Participation		National Participation	
	Teams	Submissions	Teams	Submissions
National Clinical Audit of Psychosis (NCAP)	All adult community mental health teams	Random sample of 100 service users	Information not available*	Information not available*
National Clinical Audit of Anxiety and Depression (NCAAD)	All adult inpatient services	Random sample of 83 service users	Information not available*	Information not

				available*
National Clinical Audit of Anxiety and Depression (NCAAD) – Spotlight audit on psychological therapies	All older people's mental health service All working age psychological services in mental health teams	Random sample of 61 service users	Information not available*	Information not available*

*This information has not been provided by the Royal College of Psychiatrists

The report of this national clinical audit is not yet available and [2]gether NHS Foundation Trust intends to take action to continue to improve the quality of healthcare provided based upon the information provided.

Participation in National Confidential Enquiries

Confidential Enquiries	% cases submitted	
	[2]gether	National Average
National Confidential Inquiry into Suicide & Safety in Mental Health	98.8%	97%
Confidential Enquiry into Maternal Deaths	Information not published	Information Unavailable

Local Clinical Audit Activity

Clinical Audits	2017/18 audit programme	2018/19 audit programme
Total number of audits on the audit programme	158	160
Audits completed (at year end)	70	94
Audits that are progressing and will carry forward	40	21
Audits taken off the programme for specific reasons	48	45

The reports of 72 local clinical audits were reviewed by the provider in 2018/19 and [2]gether NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- With regard to the ongoing review of key clinical policies, ***Assessment and Care Management CPA***, the Trust has continued to implement and embed these principles into policies and practice. With this in mind, there has been a review of the electronic clinical record to ensure that this both appropriately captures clinical activity and continues to reflect service user's needs. Specifically, there has been a review of the core assessment structure to ensure that it is proportionate and more reflective of clinical practice across Trust services whilst at the same time streamlining the number of forms that staff are required to complete. Audits have continued to be carried out

throughout the year to provide assurance and associated actions plans were developed to support improvements in compliance. This action continues from last year and will remain an ongoing focus moving forward.

- The Trust continues to consider advanced decisions/wishes and preferences which is being taken forward to ensure that this continues to be reflected in sufficient detail within the care record of service users. Further ongoing audits will be carried out and there will remain an ongoing focus moving forward to ensure that advanced decisions, wishes and preferences are sufficiently detailed to be clear to all accessing a clinical record. The actions relating to this will be monitored and further action plans created to continue to improve the quality of entries.

Specific examples of change in practice that have resulted from clinical audits are:

- The national guidance for Delayed Transfer of Care (DTOC) classification was changed in October 2017 to improve reporting. The first audit was undertaken to cover Q1 (1st April 2018 – 30th June 2018) and compliance was recorded at 64%. The following actions were implemented:
  1) Ensure all medics and nursing staff who attend MDTs are made aware of the expected standards
  2) Record DTOC within inpatient management section and clinical progress notes for each individual patient who is considered a DTOC.

  Following implementation of these actions, compliance increased to 95% by the end of Q2. This was a robust result but it was acknowledged that compliance should be at 100% therefore communications regarding the practice notice were re-emailed and discussed at team meetings to remind staff of the expectations. By the end of Q3, compliance had reached the desired 100%.

- Assessing fitness to drive –medical professional's guidance from the Driver and Vehicle Licensing Agency (DVLA) states that people experiencing acute psychotic disorder, hypomania or mania must not drive during acute illness and must notify the DVLA. Within the Trust, this led to a clinician wishing to audit this to see whether clinicians were advising service user to contact the DVLA (where applicable). This audit was first undertaken in June 2017 and achieved a compliance rate of 45%. A detailed action plan was devised including the following action:

  1) Care coordinators to ensure that driving status and concerns about driving are regularly reviewed throughout the patient's care including risk assessments and care plan reviews.

  Following implementation of the action plan, data was collected over a period of six months (1st May 2018 – 31st October 2018) and the final audit has shown a 47% increase in compliance and compliance was recorded at 92% - a positive change occurring through clinical audit. There is still room for improvement to achieve the desired 100% compliance therefore the current actions have been devised to complete ahead of a re-audit in 2019:

  1) Ensure care coordinators continue to review driving with patients and document these discussions.
  2) Ensure completed DVLA medical information forms are uploaded to the patients RiO record.
  3) Raise awareness of the need to record driving status across the Trust – including encouraging inpatient units to document at admission and discharge.

4) Present the audit findings at relevant clinical forums to praise the hard work achieved so far and to ensure the momentum is continued.

Participation in Clinical Research

Research Activity in 2gether in 2018-19

The number of patients receiving relevant health services provided or subcontracted by 2gether NHS Foundation Trust in 2018/19 that were recruited during that period to participate in National Institute for Health Research Portfolio research approved by a research ethics committee was 422 against a target of 507. Not all activity undertaken in 2018/19 has been fully reported and it is expected that this target will rise further over the first few weeks of 2019/20 as reporting systems are updated.

This participation was from across **24** different studies[1] . This level of recruitment is slightly higher than the previous year's total of **386** participants (again from 24 studies), and reflects a fairly stable portfolio in 2018/19 compared to previous years' instability.

In 2018/19, the Trust registered and approved **29** studies. Of these studies, **21** were based in mental health services, **7** in dementia services and 1 in Learning Disabilities. Of the total number of studies **14** were Academic/Student projects, **13** were Non-Commercial Portfolio studies, **1** was a Commercially Sponsored Portfolio Study and **1** was a Non-Commercial, Non-Portfolio study. **6** of the studies were Service Evaluations.

Growing 2gether Research

Our research team continues to perform well in the national key performance indicator of recruiting to time and target (RTT) for open research studies, as well as supporting a number of activities that help to grow research across the counties of Gloucestershire and Herefordshire. In 2018/19 we were awarded a small financial bonus for performance in RTT by the Clinical Research Network West of England (CRNWoE). We continue to seek new ways to expand our service, and the Trust will be exploring opportunities to work more closely with Gloucestershire Care Services NHS Trust where the proposed merger of our respective organisations provides an opportunity for enhanced multi-disciplinary working and increased opportunities for service users to take part in research. The 2019/20 Annual Plan submitted to the CRNWoE includes a bid for additional funding to support the development of research across the new organisation.

Our partnership with Cobalt Health continues have been collaborating to carry out research with people who experience Alzheimer's disease and dementia. The pioneering programme between our Trust and the Cheltenham-based charity aims to ensure that research into the illness is undertaken in Gloucestershire and Herefordshire. The research results will contribute towards improving standards of care and treatment locally, and also to the wider research environment nationally and internationally. This year Cobalt has continued to fund two Research Nurse posts based at the Fritchie Centre, to exclusively support the development and opening of clinical trials for dementia. Further funding has been agreed to also support the development of Principal Investigators and to secure time for clinicians to support commercially sponsored research. The expansion of the local portfolio in this way will generate income for the Trust that can be reinvested in research that supports the aims of the Trust Research Strategy and the COBALT charity vision.

Budgets for 2019/20 have recently been announced and [2]gether NHS Foundation Trust is one of only 3 (out of 9) Trusts within the CRNWoE to have performed well enough to increase their budget over last year. Gloucestershire Care Services NHS Trust is one of the others and the team will explore opportunities for using these budgets to set up an infrastructure to work across both Trusts as we move towards a merged organisation.

Research [2]gether strategy

Our Research [2]gether Strategy 2016 – 2020 enters its fourth year and continues to work towards our vision to be a 'world class centre of practice-based research and development to help make life better'.

The Strategy Implementation Plan has been updated to recognise achievements to date and to outline plans for meeting further targets over the next 2 years.

Research Studies

A list of [2]gether studies recruiting in 2018/19 can be seen in table 1 below.

Table 1 – Studies Recruiting in [2]gether – 2018/19

Short Name	Managing Specialty	Status	Opening Date	Closure Date	Participants
An anonymous survey of mindfulness, self-compassion, wellbeing and mental health.	Mental Health	Closed	10/02/2017	31/03/2018	80
AD GENETICS	Dementias and Neurodegeneration	Open	01/06/2001	01/02/2020	52
VALID WPs 3/4: Pilot trial and RCT of COTiD-UK	Dementias and Neurodegeneration	Closed	24/09/2014	04/07/2017	42
FAM-Survey	Mental Health	Closed	24/11/2017	25/04/2018	40
Dementia Carers Instrument Development:DECIDE Psychometric evaluation	Dementias and Neurodegeneration	Closed	05/01/2016	25/01/2018	31
DPIM - bipolar disorder	Mental Health	Suspended	01/10/2010	31/12/2017	15
NCISH	Mental Health	Open	01/04/1997	04/01/2022	15
Tackling chronic depression (TACK) Phase 1	Mental Health	Open	23/05/2017	31/03/2019	15
The Adult Autism Spectrum Cohort - UK	Mental Health	Open	08/01/2015	01/09/2019	13
Caregiver obligations, preparedness and willingness to care	Dementias and Neurodegeneration	Closed	26/02/2016	27/03/2018	11
REACT Trial	Mental Health	Closed	22/04/2016	30/09/2017	10
The RADAR trial	Dementias and Neurodegeneration	Closed	01/04/2014	31/05/2018	8
Patient preferences for psychological help	Mental Health	Closed	03/10/2017	12/07/2018	8
Investigation of wellbeing interventions in NHS staff	Mental Health	Closed	20/02/2017	01/10/2018	8
PPiP2	Mental Health	Open	01/01/2015	30/08/2020	6
Evaluation of Memory Assessment Services: Main Study (phase 2) v1	Dementias and Neurodegeneration	Closed	12/10/2015	31/08/2017	6
everyBody Plus: Web-based self-help programme for BN, BED and OSFED	Mental Health	Closed	27/06/2017	13/07/2018	5
Voices Impact Scale (VIS): Evaluation	Mental Health	Closed	01/11/2016	06/04/2018	5
TRIANGLE: A novel patient and carer intervention for Anorexia Nervosa	Mental Health	Open	30/06/2017	31/03/2020	4
The effectiveness of perinatal mental health services	Mental Health	Closed	10/02/2015	06/03/2018	3
DPIM - schizophrenia	Mental Health	Suspended	01/10/2010	31/12/2017	2
Molecular Genetic Investigation	Mental Health	Open	01/04/2006	31/12/2019	2
Quality and Effectiveness of Supported Tenancies (QuEST) WP4	Mental Health	Closed	01/06/2015	30/09/2017	2
CREAD 2	Dementias and Neurodegeneration	Closed	23/06/2017	19/06/2018	1
Psychological Adjustment in Progressive Multiple Sclerosis	Neurological Disorders	Closed	12/01/2016	31/07/2017	1
BN29553 (Tau PET Longitudinal Substudy)	Dementias and Neurodegeneration	Closed	01/06/2017	02/06/2017	1

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

A proportion of 2gether NHS Foundation Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between 2gether NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at www.2gether.nhs.uk/cquin

2018/19 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	Description	Goal weighting	Expected value	Quality Domain
1a (a) National CQUIN – Staff health and wellbeing	To achieve a 5 percentage point improvement in 2 of the 3 NHS annual staff survey questions on Health and Wellbeing	0.3	£75133	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients		£75133	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff		£75133	Safety
2 National CQUIN - Improving Physical Healthcare 3a	- To reduce premature mortality by demonstrating cardio metabolic assessment and treatment for patients with psychoses.	0.3	£180320	Effectiveness
2 National CQUIN - Improving Physical Healthcare 3b	- To reduce premature mortality - Improved communication with GPs		£45080	Effectiveness
3. Improving Services for people with mental health needs who present to A & E.	Care and management for frequent attenders to Accident and Emergency	0.3	£225400	Safety
4. Transitions out of Children and Young People's Mental Health Services.	To improve the experience and outcomes for young people as they transition out of (CYPMHS)	0.3	£225400	Effectiveness
5.Preventing ill health by risky behaviours – Alcohol and Tobacco	To offer advice and interventions aimed at reducing risky behaviour in admitted patients	0.3	£225400	Effectiveness

Herefordshire

Herefordshire Goal Name	Description	Goal weighting	Expected value	Quality Domain
1a (a) National CQUIN – Staff health and wellbeing	To achieve a 5 percentage point improvement in 2 of the 3 NHS annual staff survey questions on Health and Wellbeing	0.3	£19066	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients		£19066	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff		£19066	Safety
2 National CQUIN - Improving Physical Healthcare 3a	- To reduce premature mortality by demonstrating cardio metabolic assessment and treatment for patients with psychoses.	0.3	£45760	Effectiveness
2 National CQUIN - Improving Physical Healthcare 3b	- To reduce premature mortality - Improved communication with GPs		£11440	Effectiveness
3. Improving Services for people with mental health needs who present to A & E.	Care and management for frequent attenders to Accident and Emergency	0.3	£57201	Safety
4. Transitions out of Children and Young People's Mental Health Services.	To improve the experience and outcomes for young people as they transition out of (CYPMHS)	0.3	£57201	Effectiveness
5.Preventing ill health by risky behaviours – Alcohol and Tobacco	To offer advice and interventions aimed at reducing risky behaviour in admitted patients	0.3	£57201	Effectiveness

Low Secure Services

Low Secure Goal Name	Description	Goal weighting	Expected value	Quality Domain
Reduction in length of stay	Aim to reduce lengths of stay of inpatient episodes and to optimise the care pathway. Providers to plan for discharge at the point of admission and to ensure mechanisms are in place to oversee the care pathway against estimated discharge dates.	2.5	£45000	Effectiveness

The total potential value of the income conditional on reaching the targets within the CQUINs during 2018/19 is £2,440,000. Of which £2,440,000.00 was achieved.

In 2017/18, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,282,000 of which £2,282,000 was achieved.

2019/20 CQUIN Goals

The CQUIN goals for 2019/20 reflect the nationally agreed schemes and are intended to deliver clinical quality improvements and drive transformational change in line with the Five Year Forward View and NHS Mandate. These include:

National CQUINs applicable to Gloucestershire and Herefordshire mental health services:

- Staff Flu Vaccinations
- Alcohol and Tobacco Screening and Brief Advice
- 72 hour follow up Post Discharge: Routine Submission to MHSDS
- Mental Health Data Quality: MHSDS Data Quality Maturity Index and Mental Health Data Quality Interventions: Submission to MHSDS
- Use of Anxiety Disorder Specific Measures in IAPT: Routine submission to IAPT Data Set.

Low Secure Services

- Healthy Weight in Adult Secure Mental Health Services.

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.

[2]gether NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 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.

[2]gether NHS Foundation Trust has no conditions on its registration.

The CQC has not taken enforcement action against [2]gether NHS Foundation during 2018/19 or the previous year 2017/18.

[2]gether NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

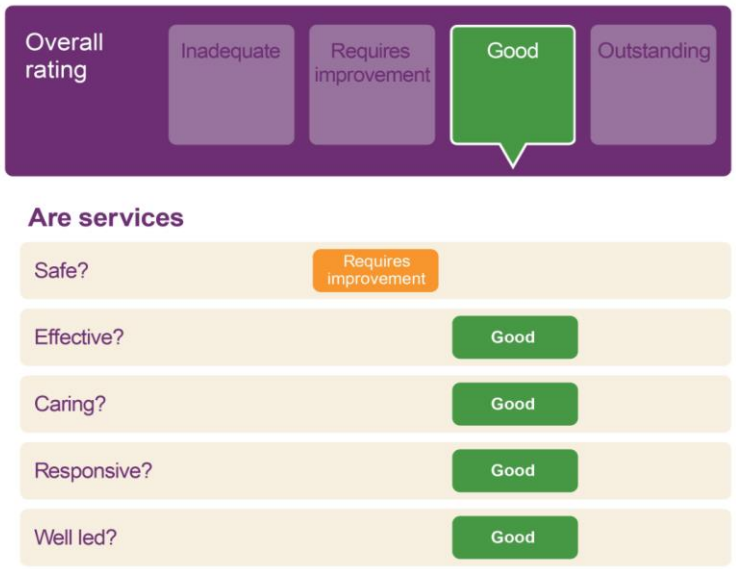
CQC Inspections of our services

The CQC have moved away from the previous Comprehensive Inspection model to one which consists of an annual Well Led review which is announced, and unannounced inspections of specific services. The CQC undertook the following inspections during the period: 12th February to 29th March 2018.

1. Unannounced inspection of community based mental health services for older people
2. Unannounced inspection of wards for older people with mental health problems
3. Unannounced inspection of wards for people with learning disabilities or autism
4. Unannounced inspection of specialist community mental health services for children and young people
5. Well Led Review

New Ratings from latest review

The overall Trust rating remains GOOD and the CQC recognised that there have been many improvements made since the last inspection in 2015.



The inspection found that there were some aspects of care and treatment in some services that needed improvements to be made to ensure patients were kept safe. However, the vast majority of services were delivering effective care and treatment. The Trust has developed an action plan in response to the 11 “must do” recommendations, and the 23 “should do” recommendations identified by the inspection and has managed the actions through to their completion.

In 2019/20 we are contributing to the CQC National review of seclusion and Long term segregation.

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Outstanding ☆	Good	Good	Good	Outstanding ☆	Outstanding ☆
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Requires improvement	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Forensic inpatient/secure wards	Good	Good	Good	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Outstanding ☆	Good	Good	Good
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

A full copy of the Comprehensive Inspection Report can be seen here.

Quality of Data

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

Good quality data underpins the effective provision of care and treatment and is essential to enabling improvements in care. [2]gether NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data (Month 10 data is reported below, as this was the only available information at the date of publication).

- The patient's valid NHS number was: **99.4%** for admitted patient care (**99.4%** national); and **100**% for outpatient care (**99.6**% national);

- The patient's valid General Practitioner Registration Code was: **100%** for admitted patient care (**99.9%** national); and **100%** for outpatient care (**99.6%** national).

[2]gether NHS Foundation Trust has taken the following action to improve data quality building on its existing clinical data quality arrangements:

- During 2018/19 the Trust has continued to progress data quality improvement. Based on the work undertaken in previous years to provide automated reports, we have continued the early warning reports for senior managers so they are alerted to any identified gaps;

- The trust continued to monitor and review all areas of the Trust data quality within the Operational Performance Network educating managers and staff how to use the Business Inelegance tools available. This method enables effective management of data quality through awareness, training and support and moves away from the labour intensive data quality management through list generation;

- "Team Sites" a platform that brings many data sources together into one place has been rolled out to all inpatient and community teams which enables staff to manage their individual and team data quality more effectively;

- "Patient Tracking List" this tool provides an overview off all clients within the service detailing waiting times from the referral to treatment and then waiting times between appointments. There has been an intensive review of all cased throughout 2018/19 to ensure the accuracy of the clinical record.

- 'Deep Dives' have continued throughout 2018/19 and will continue throughout coming years, reviewing all aspects of service performance and data quality focusing on Service Specific Reporting" and "Demand and Capacity".

Information Governance

2018/19 was the first year in which the Trust was required to complete the Data Security and Protection Toolkit, the Information Governance Toolkit having been withdrawn at the end of 2017/18. The Trust published its DSPT assessment in March 2019, and exceeded the required standards.

The Trust's efforts will remain focussed on maintaining the current level of compliance during 2019/20 and ensuring that the relevant evidence is up to date and reflective of best practice as currently understood, and that good information governance is promoted and embedded in the Trust through the work of the Information Governance Committee and Trust managers and staff.

The Trust acquired Cyber Essentials Plus accreditation in 2018/19, and is committed to retaining that accreditation in future years.

The Trust's Internal Auditor completed a review in 2018/19 of the Trust's preparations for the introduction of the General Data Protection Regulation. This review produced a classification of 'Low Risk' A further audit is planned for 21019/20 which will review the DSPT submission, and Information Governance in general.

Clinical Coding

[2]gether NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/2019 by the Audit Commission.

Learning from Deaths

During 1 April 2018 – 31 March 2019 663 patients of [2]gether NHS Foundation Trust died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

211 in the first quarter;
155 in the second quarter;
169 in the third quarter;
128 in the fourth quarter.

The terminology used to describe the stages of Mortality Review changed in December 2018 following publication of the Royal College of Psychiatrists' Structured Judgement Review documentation. [2]gether adopted this methodology in January 2019 following discussion and agreement at Mortality Review Committee (MoReC). Mortality Review Committees have convened regularly since November 2018. However, whilst learning from these reviews is limited, the active review of patient deaths does provide assurance that End of Life Care and the care provided to our patients is of an excellent quality which seldom results in unexpected deaths, natural or otherwise.

Following discussion at Mortality Review Committee (MoReC) in and at countywide Mortality Steering Groups in both Gloucestershire and Herefordshire, it was agreed to exclude from active review those open for ACI Monitoring only and those with a primary diagnosis of dementia who are over 70 years old. MoReC had become very aware that older people with dementia die as a natural consequence of the illness process resulting in limited learning from this cohort of patients. There will be a continued focus on those 70 years and under.

By 31 March 2019, 33 RCPsych Structured Judgement Reviews (SJRs) and 19 Serious Incident (SI) Investigations have been carried out in relation to 663 of the deaths included above.

In 0 cases a death was subjected to both a case record review and investigation

The number of deaths in each quarter for which a Structured Judgement Review, Clinical Incident Review or a Serious Incident investigation was carried out was:

16 in the first quarter
13 in the second quarter
18 in the third quarter
5 in the fourth quarter

The above figures do not include current open SJRs and SI Investigations from 2018/19.

0 deaths representing 0.0% of the 663 patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided [2]gether NHS Foundation Trust to the patient. In relation to each quarter, this consisted of:

0 representing 0% for the first quarter;
0 representing 0.0% for the second quarter;
0 representing 0% for the third quarter;
0 representing 0% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review Methodology developed by the RCPsych

The trust identified that:

- In some cases there does not appear to have been early dialogue between mental health services, social services and health visiting, with regard to both child care and wider

support. This could have improved the knowledge of all services involved and potentially provided a more collaborative package of care.
- There was a lack of clarity between the teams involved regarding referral pathways for families to access Local Authority Children's Services support/Social Services (other than for safeguarding purposes) and benefits to support children with disabilities.
- On occasion, informal admissions have not achievable due to the lack of available beds in the hospital chosen.
- On occasion, the initial referral from the GP had been downgraded from 'urgent' to 'routine' without attempting to discuss this with the referrer (GP) as per policy.

In response to the above learning points the trust has:

- Undertaken a review of the pathways by which Trust clinical teams communicate with external agencies/providers such as social care. A clear process has been established and implemented to enable early communication across all agencies involved in patient care or the care of dependents within a household.
- Undertaken a review of the system for notifying the teams of bed availability outside of office hours; and improving the system for ensuring that the Bed State is checked regularly when supporting patients who are waiting for admissions.
- The Contact Centre Manager is now actively monitoring the communication with General Practitioners when triaging referrals and for the Referrer Information sheet to clearly explain the criteria for an "Emergency", "Urgent" and "Routine" response.

The trust believes that by implementing the above actions, patient safety and quality of care has improved.

0 SJRs and 7 investigations completed after 31 March 2018 related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structured Judgement Review Methodology developed by the RCPsych.

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

As a Trust we are committed to the National Quality Boards (2017) Learning from Deaths guidance. The Trust ensures that it seeks to actively learn and implement changes in practice identified from reviews of death. The Trust is a an active supporter of the Learning Disabilities Premature Mortality Review programme (LeDeR) in Gloucestershire and Herefordshire

All our staff are required to notify, using the Datix system, the deaths of all Trust patients. This comprises anyone open to a Trust caseload at the time of their death and who dies within 30 days of receiving care from ^{2}gether. Deaths recorded on Datix are collated for discussion at the monthly Mortality Review Committee Meeting chaired by the lead Clinical Directors. All deaths of patients with a learning disability will be also reported through the appropriate Learning Disabilities Mortality Review Program (LeDeR) process, and deaths of people under the age of 18 will be reported through the current child death reporting methodology.

Learning from Deaths continues to provide vital guidance. As a Trust we are fully committed to recognising the need to improve services following learning from events both nationally and locally such as Gosport, Mid Staffordshire and the Learning Disabilities Premature Mortality Review (LeDeR), alongside our own local serious incidents.

From 1st January 2017 up until 31st March 2019 Gloucestershire. 109 LeDeR referrals had been received, 61 have had an initial review completed (56% review completed), 47 are open (26 remain unable to be allocated due to reviewer capacity). 44% of people died in their usual place

of residence, with Gloucestershire Royal Hospital second place to die at 31%. 66% of the deaths were males (33% female and 1% other) compared with a national average of 58% male.

Table 2 - Status of reviews by year:

	CLOSED	OPEN	Grand Total	% completed
2017	**41**	**5**	**46**	**89%**
2018	**18**	**31**	**49**	**37%**
2019	**2**	**12**	**14**	**17%**
Grand Total	**61**	**47**	**109**	**56%**

Learning Themes from LeDeR:

- Communications and support to access primary care Learning Disability Annual Health Checks
- Reasonable adjustments made to access to mainstream healthy lifestyles preventative services e.g. smoking cessation, weight management and eating well
- Suitable reasonable adjustments being put in place in mainstream health services is inconsistent particularly around meeting communication needs.
- Utilisation and documentation of the Mental Capacity Act by mainstream health services is inconsistent
- Treatment escalation practices particularly in relation to end of life protocols for those individuals who are considered to be frail.

Part 2.3: Mandated Core Indicators 2018/19

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 2017-18	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19
[2]gether NHS Foundation Trust	99.6%	98.4%	97.6%	98.4%	97.7%
National Average	95.4%	95.5%	95.8%	95.7%	95.5%
Lowest Trust	69.2%	87.2%	73.4%	88.3%	81.6%
Highest Trust	100%	100%	100%	100.%	100%

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- During 2015/16 we reviewed our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services, the changes were introduced in 2016/17. This has strengthened and continues to support the patient safety aspects of our follow up contacts.

[2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Clearly documenting follow up arrangements from Day 1 post discharge in RiO;
- Continuing to ensure that service users are followed up within 48 hours of discharge from an inpatient unit whenever possible.

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

	Quarter 3 2017-18	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19
[2]gether NHS Foundation Trust	99.5%	98.6%	99.4%	99.4%	98.9%
National Average	98.5%	98.7%	98.1%	98.4%	97.8%
Lowest Trust	84.3%	93.7%	85.1%	81.4%	78.8%
Highest Trust	100%	100%	100.00%	100.00%	100%

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- Staff respond to individual service user need and help to support them at home wherever possible unless admission is clearly indicated;

[2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Continuing to remind clinicians who input information into the clinical system (RiO) to both complete the 'Method of Admission' field with the appropriate option when admissions are made via the Crisis Team and ensure that all clinical interventions are recorded appropriately in RiO within the client diary.

3. **The percentage of patients aged 0-15 & 16 and over, readmitted to hospital, which forms part of the Trust, within 28 days of being discharged from a hospital which forms part of the trust, during the reporting period**

	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19	Quarter 4 2018-19
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	5.8%	6.2%	6.1%	7.8%	5.6%

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust does not have child and adolescent inpatient beds;
- Service users with serious mental illness are readmitted hospital to maximize their safety and promote recovery;
- Service users on Community Treatment Orders (CTOs) can recalled to hospital if there is deterioration in their presentation.

[2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Continuing to promote a recovery model for people in contact with services;
- Supporting people at home wherever possible by the Crisis Resolution and Home Treatment Teams.

4. **The percentage of staff employed by, or under contract to, the Trust during the reporting period who responded positively to " if a friend or relative needed treatment I would be happy with the standard of care provided by the Organisation"**

	NHS Staff Survey 2015	NHS Staff Survey 2016	NHS Staff Survey 2017	NHS Staff Survey 2018
[2]gether NHS Foundation Trust Score	65.5%	72.6%	74.2%	74.5%
National Average Score	59.4%	58.9%	61.2%	61.3%
Worst Trust Score	38.4%	44.1%	41.6%	38.2%
Best Trust Score	83.6%	82.2%	86.5%	80.8%

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- For the third year running, all staff in post were invited to take part in the survey. Previously the survey had only been sent to a random sample of staff. The overall response rate in the most recent survey was **40.55%** (reduced from 44% the previous year). This equated with **863** staff taking the time to contribute their views. The survey provides a rich and accurate picture of the staff views on the Trust's services to date.

[2]gether NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by taking steps to:

- Improve response rates
- Improve further staff engagement
- Improve the quality of appraisals
- Improve our Safe Environment by reducing Bullying and Harassment
- Improving our Quality of Care

5. "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 2015	NHS Community Mental Health Survey 2016	NHS Community Mental Health Survey 2017	NHS Community Mental Health Survey 2018
[2]gether NHS Foundation Trust Score	7.9	8.0	8.0	7.7
National Average Score	Not available	Not available	Not available	Not available
Lowest Score	6.8	6.9	6.4	5.9
Highest Score	8.2	8.1	8.1	7.6

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- [2]gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 11 domains and 'about the same' as the majority of other mental health Trusts in the remaining 6 domains.

[2]gether NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Supporting people at times of crisis;
- Involving people in planning and reviewing their care;
- Involving family members or someone close, as much as the person would like;

- Giving people information about getting support from people with experience of the same mental health needs as them;
- Helping people with their physical health needs and to take part in an activity locally;
- Providing help and advice for finding support with finances, benefits and employment.

6. 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.

	1 October 2017-31 March 2018				1 April 2018-30 September 2018			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	2901	83.69	2	28	2385	68.2	2	14
National	166787	-	569	1331	3414	54.17	10.74	25.21
Lowest Trust	1	14.88	0	0	1747	24.9	7	20
Highest Trust	8134	96.72	121	138	4634	114.3	8	28

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

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- NRLS data is published 6 months in arrears; therefore data for severe harm and death will not correspond with the serious incident information shown in the Quality Report.

[2]gether NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services, by:

- Continuing to hold a Datix User Group to improve the processes in place for the timely review, approval of, response to and learning from reported patient safety incidents;

- Creating an additional part time Datix Administrator post to enhance data quality checks and further promote timeliness of reporting. This post commenced in 2017/18 and we have added some further support hours.

- Developing a suite of reports and Dashboards to aid monitoring of incidents on wards to assist staff in identifying themes and trends plus hot spots.

Part 3: Looking Back: A Review of Quality during 2018/19

Introduction

The 2018/19 quality priorities were agreed in May 2018.

The quality priorities were grouped under the three areas of Effectiveness, User Experience and Safety.

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 2018/2019

Effectiveness		2016 - 2017	2017 - 2018	2018- 2019
1.1	To improve the physical health of patients with a serious mental illness on CPA by a positive cardio metabolic health resource (Lester Tool).	**Achieved**	**Achieved**	**Achieved**
1.2	To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.	**Achieved**	**Not achieved**	**Not Achieved**
1.3	To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.	**Not achieved**	**Not achieved**	**Achieved**
User Experience				
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 84%**	**Achieved**	**Not achieved**	**Achieved**
2.2	Do you know who to contact out of office hours if you have a crisis? **>71%**	**Achieved**	**Achieved**	**Achieved**
2.3	Has someone given you advice about taking part in activities that are important to you? **> 64%**	**Achieved**	**Achieved**	**Achieved**
2.4	Have you had help and advice to find support to meet your physical health needs if you needed it? **> 73%**	**Achieved**	**Achieved**	**Achieved**
Safety				
3.1	Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload.	**Not achieved**	**Not achieved**	**Achieved**
3.2	Detained service users who are absent without leave (AWOL) will not come to serious harm or death. We will report against 3 categories of AWOL as follows; harm as a consequence of: 1. Absconded from escort 2. Failure to return from leave 3. Left the hospital (escaped)	**Not measured**	**Achieved**	**Achieved**
3.3	To increase the use of supine restraint as an alternative to prone restraint	**Not Measured**	**Not Measured**	**Not achieved**
3.4	To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need.	**Not measured**	**Not measured**	**Achieved**

Easy Read Report on Quality Measures for 2018/2019

Quality Report 	This report looks at the quality of [2]gether's services. We agreed with our Commissioners the areas that would be looked at.	
Physical health 	We increased physical health tests and treatment for people using our services. We met the target.	
Discharge Care Plans 	Less people had all parts of their discharge care plan completed at the end of the year than previously. There is improvement being made though. We have not met the target.	
Care (CPA) Review 	All people moving from children's to adult services had a care review. We met the target.	
Care Plans 	85% of people said they felt involved in their care plan. This is more than the target (84%). We met the target.	
Crisis 	81% of people said they know who to contact if they have a crisis. This is more than the target (71%). We met the target.	

Activity 	76% of people said they had advice about taking part in activities. This is more than the target (64%). We met the target.	↑
Physical Health 	82% of people said they had advice about their physical health This is more than the target (73%). We met the target.	↑
Suicide 	There were fewer suicides compared to this time last year. We met the target	↑
AWOL 	In patients who were absent without leave did not come to serious harm or death. We met the target.	↑
Face down restraint 	We have reduced the number of face-down restraints this year but we are still doing more of these than face up restraints. We are doing lots of work to get better at this but did not quite meet the target at the end of the year.	↓
Physical Intervention Care Plans 	Everyone at Berkley House has one of these. We met the target.	↑

Effectiveness

In 2018/19 we remain committed to ensure that our services are as effective as possible for the people that we support. For the second consecutive year we set ourselves 3 targets against the goals of:

- Improving the physical health care for people with schizophrenia and other serious mental illnesses;
- Ensuring that people are discharged from hospital with personalised care plans;
- Improving transition processes for child and young people who move into adult mental health services.

Target 1.1 To increase the number of service users (all inpatients and all SMI/CPA service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment

The 2018/19 Physical Health CQUIN includes all service users with an active diagnosis of Psychosis (using the CQUIN specified ICD-10 codes) who are either an inpatient or who have access to community services including; Assertive Outreach Team (AOT), Recovery Teams, Community Learning Disability Teams (CLDT's), Older Age Services (OP's) and Children and Young Persons Services (CYPS). The sample group for this year includes patients from both counties.

The Trust is awaiting the results of the national CQUIN (part a) audit across inpatient and community mental health services and the Early Intervention Service (EIP) self assessment scheme to be published. The audit specifically looked at ensuring service users have a thorough Cardio Metabolic assessment and treatment if necessary. The Trust internal audit of the data submitted nationally notes that the CQUIN targets compliance of 90% for inpatient and Early Intervention services, and 75% for community mental health services have been achieved. Results of the internal audit of the national CQUIN (part b), which looked at collaboration with primary care clinicians, proved successful again. We have achieved our CQUIN target of over 90% of patients audited during the period, GP's have been provided with an up to date copy of the patients' care plan/CPA review letter or discharge summary.

Whilst this is the final year of the 'Improving Physical Healthcare to reduce premature mortality in people with a Serious Mental Illness' CQUIN there are robust systems in place with staff trained to continue implementing this as 'business as usual'. There are plans to add further health checks for patients to include oral health, national screening awareness and sexual health. Changes will be made to the Health & Lifestyle form on the electronic patient record, and training will be rolled out to staff Trust wide.

Successful physical health clinics continue to run at Pullman Place and 27a St Owen Street, providing service users in the community access to physical health checks in an environment with staff who are familiar to them. Such is the success of the physical health clinics, it is hoped to employ a Physical Health nurse for one day a week to take a lead on developing the clinics further within Pullman Place.

The Trust has agreed to purchase ECG machines for the community hubs. This will provide the opportunity for routine ECG screening for possible cardiac anomalies for patients who are at an increased cardio metabolic risk, largely due to medication side effects and lifestyle factors. Training for staff to take ECG's will be provided by the Physical Health Facilitator, and refresher training for medics to interpret ECG's will be held internally by the Trust own Medical team.

Alongside the CQUIN work, [2]gether continues to increase access to physical health treatment for service users. Work around a Quality Improvement initiative 'Well Woman Wednesdays' at Wotton Lawn Hospital, where ladies are offered a full range of advice and success to cervical screening in house, has been recognised nationally with further work planned to expand the initiative.

[2]gether has continued to work with "Equally Well" which is a national collaborative to support the physical health of people with a mental illness. The Trust have been approached by the RCN to collaborate with a parity of esteem/lived experience project where experts by experience have been involved, this will be presented in London in May 2019.

We have met this target.

Target 1.2 To improve personalised discharge care planning in:
a) Adult inpatient wards and
b) Older people's wards.

Discharge from inpatient units to the community can pose a time of increased risk to service users. During 2016/17 we focused on making improvements to discharge care planning to ensure that service users are actively involved in shared decision making for their discharge and the self-management care planning process. Identical criteria are being used in the services across both counties as follows:

1. Has a Risk Summary been completed?
2. Has the Clustering Assessment and Allocation been completed?
3. Has the Pre-Discharge Planning Form been completed?
4. Have the inpatient care plans been closed within 7 days of discharge?
5. Has the patient been discharged from the bed?
6. Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?
7. Has the 48 hour follow up been completed?

Trust wide compliance for each of the individual criteria assessed is outlined in the table below. For future audits, services will focus on the criteria scoring an **AMBER** or **RED** RAG rating to promote improvement.

		Year End Compliance (2017/18)	Year End Compliance (2018/19)	Direction of travel
1.	Has a Risk Summary been completed?	100%	100%	⇔
2.	Has the Clustering Assessment and Allocation been completed?	83%	92%	⇧
3.	Has HEF been completed? (LD only)	38%	83%	⇧
4.	Has the Pre-Discharge Planning Form been completed?	32%	31%	⇩
5.	Have the inpatient care plans been closed within 7 days of discharge?	29%	14%	⇩
6.	Has the patient been discharged from bed?	100%	100%	⇔
7.	Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?	89%	88%	⇩
8.	Has the 48 hour follow up been completed if the Community Team are not doing it?	92%	70%	⇩

For year end 2018/19, of the eight individual criteria assessed, compliance has remained the same for two criteria, increased for two criteria and decreased for 4 criteria compared to the year end data for 2017/18.

It is recommended that the focus remains on the following two criteria as these are consistently showing poor compliance:

- Has the Pre-Discharge Planning Form been completed?
- Have the inpatient care plans been closed within 7 days of discharge?

We will also be looking to ensure that discharges summaries and medication information for service users discharged from hospital are sent to their GP within 48 hours of Discharge.

We are also including discharge care planning information from within our Recovery Units, as they too discharge people back into the community.

These targets are reviewed on a quarterly basis and in year we were pleased to note that in 2018/19 there had been an overall improvement at the end of quarter 3 over quarter 2 data and this was reported as a welcome achievement. However, the year end compliance figure is lowered due to the performances in Q1 and Q2.

Year end results from the audits against these standards are seen below.

Gloucestershire Services

Criterion	Year End Compliance (2015/16)	Year End Compliance (2016/17)	Year End Compliance (2017/18)	Year End Compliance (2018/19)	Direction of Travel (comparing 2018/19 to 2017/18)
Overall Average Compliance	**69%**	**72%**	**73%**	**69%**	⇩
Chestnut Ward	84%	85%	83%	**84%**	⇧
Mulberry Ward	75%	79%	73%	**70%**	⇩
Willow Ward	59%	71%	69%	**69%**	⇔
Abbey Ward	72%	75%	78%	**70%**	⇩
Dean Ward	79%	73%	73%	**71%**	⇩
Greyfriars PICU	50%	62%	64%	**58%**	⇩
Kingsholm Ward	75%	72%	72%	**72%**	⇔
Priory Ward	80%	80%	80%	**76%**	⇩
Montpellier Unit	50%	57%	64%	**61%**	⇩
Honeybourne	N/A	70%	65%	**64%**	⇩
Laurel House	N/A	65%	81%	**71%**	⇩
Berkeley House	N/A	N/A	N/A	**63%**	N/A

Year-end overall average compliance in Gloucester for these standards during this year is **69%** which is a 4% decrease on the 73% achieved in 2017/18, it is noted that 9 of the 12 inpatient areas have decreased in compliance. There will be an increased focus on ensuring that these standards are met throughout next year.

Herefordshire Services

Criterion	Year End compliance (2015/16)	Year End Compliance 2016/17)	Year End Compliance (2017/18)	Year End Compliance (2018/19)	Direction of Travel (comparing 2018/19 to 2017/18)
Overall Average Compliance	**N/A**	**74%**	**71%**	**71%**	⇔
Cantilupe Ward	**N/A**	85%	82%	**78%**	⇩
Jenny Lind Ward	**N/A**	71%	68%	**70%**	⇧
Mortimer Ward	**N/A**	69%	65%	**66%**	⇧
Oak House	**N/A**	70%	68%	**65%**	⇩

Year-end overall average compliance in Herefordshire for these standards during this year is **71%** which is consistent with the 2017/18 compliance. There will be an increased focus on ensuring that these standards are met throughout next year.

This target has not been met for year end 2018/19.

Target 1.3 To ensure that joint Care Programme Approach reviews occur for all service users who make the transition from children's to adult services.

The period of transition from children and young people's services (CYPS) to adult mental health services is often daunting for both the young person involved and their family or carers. We want to ensure that this experience is as positive as it can be by undertaking joint Care Programme Approach (CPA) reviews between children's and adult services every time a young person transitions to adult services.

Results from 2017-18 transitions are also included below so that historical comparative information is available.

2017-18 Results

Gloucestershire Services

Criterion	Compliance Quarter 1 (2017/18)	Compliance Quarter 2 (2017/18)	Compliance Quarter 3 (2017/18)	Compliance Quarter 4 (2017/18)
Joint CPA Review	100%	100%	100%	75%

Herefordshire Services

Criterion	Compliance Quarter 1 (2017/18)	Compliance Quarter 2 (2017/18)	Compliance Quarter 3 (2017/18)	Compliance Quarter 4 (2017/18)
Joint CPA Review	100%	100%	Not applicable	Not applicable

2018-19 Results

Gloucestershire Services

Criterion	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018/19)	Compliance Quarter 4 (2018/19)
Joint CPA Review	100%	100%	100%	100%

Herefordshire Services

Criterion	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018/19)	Compliance Quarter 4 (2018/19)
Joint CPA Review	100%	Not applicable	100%	100%

We are pleased to report that during 2018/19 all young people who transitioned into adult services had a joint CPA review. This is an improvement on our last year's performance.

To improve our practice and documentation in relation to this target, a number of measures were developed and implemented during 2018-19 as follows:

- Transition to adult services for any young person will be included as a standard agenda item for teams, to provide the opportunity to discuss transition cases;
- Transition will be included as a standard agenda item in caseload management to identify emerging cases;
- Teams are encouraged to contact adult mental health services to discuss potential referrals;
- There is a data base which identifies cases for transition;
- SharePoint report identifies those young people who are 17.5 years open to teams. Team Managers then monitor those who are coming up to transition discuss them with care coordinators in caseload management to see whether transition is clinically indicated.

These measures will continue to be used to promote good practice into 2019/20.

We have met this target.

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 users in key areas. This was measured though defined survey questions for both people in community and inpatient settings.

The Trust's **How did we do?** survey combines the NHS Friends and Family Test and our local Quality Survey. The Quality Survey questions encourage people to provide feedback on key aspects of their care and treatment.

The two elements of the **How did we do?** survey will continue to be reported separately as Friends and Family Test and Quality Survey responses by county. A combined total percentage

for both counties is also provided to mirror the methodology used by the CQC Community Mental Health Survey.

Data for Quality Survey (Quarter 4 2018/19 – January to March 2019) results:

Target 2.1 Were you involved as much as you wanted to be in agreeing the care you will receive? < 84%

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	227 (191 positive)	85% TARGET 84%
	Herefordshire	58 (50 positive)	
	Total	285 (241 positive)	

This target has been met.

Target 2.2 Have you been given information about who to contact outside of office hours if you have a crisis? > 71%

Question	County	Number of responses	Target Met?
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	89 (74 positive)	81% TARGET 71%
	Herefordshire	14 (9 positive)	
	Total	103 (83 positive)	

This target has been met.

Target 2.3 Have you had help and advice about taking part in activities that are important to you? > 64%

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	81 (63 positive)	76% TARGET 64%
	Herefordshire	13 (8 positive)	
	Total	94 (71 positive)	

This target has been met.

Target 2.4 Have you had help and advice to find support for physical health needs if you have needed it? > 73%

Question	County	Number of responses	Target Met?

Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	79 (67 positive)	82% **TARGET 73%**
	Herefordshire	11 (7 positive)	
	Total	90 (74 positive)	

This target has been met.

Feedback from the Quality survey along with the National Community Mental Health survey results helped us to identify the need to increase the involvement of people in the development of their care plans. This is the focus of our work to implement an Always Event as part of the NHS England campaign.

Although response rates for the survey have increased over time the level of response continues to be lower than we would like. During Quarter 4 we have introduced a new system to capture survey feedback with aim to increase the number of response we receive to both aspects of the How did we do? survey.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 4, 2018/19

The FFT involves service users being asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*"

Our Trust played a key role in the development of an easy read version of the FFT. Roll out of this version ensures that everybody is supported to provide feedback.

The table below details the number of combined total responses received by the Trust each month in Quarter 4. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. These figures are submitted for national reporting.

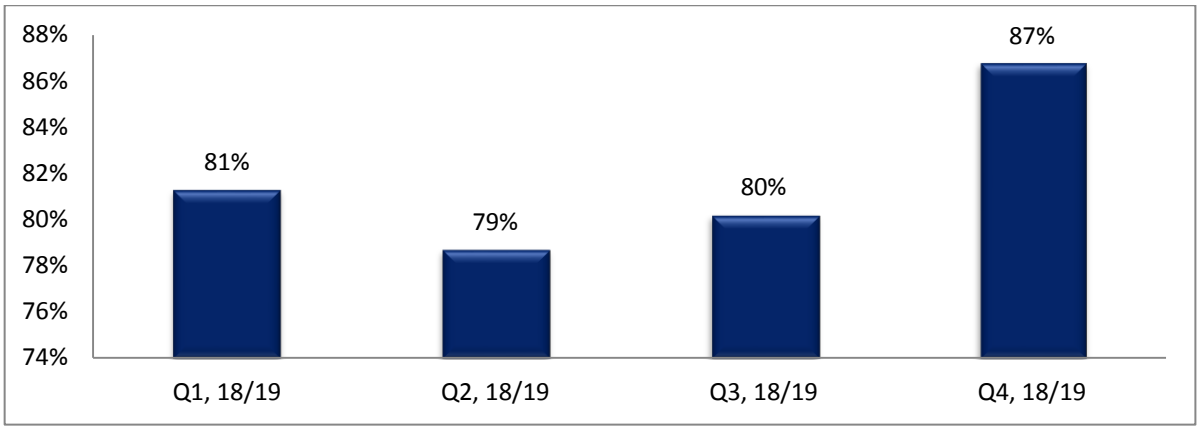
	Number of responses	FFT Score (%)
January 2019	55 (53 positive)	96%
February 2019	196 (168 positive)	86%
March 2019	203 (173 positive)	85%
Total	454 (394 positive) **(last quarter = 1046)**	**87%** **(Last quarter = 80%)**

The FFT score for our Trust this quarter has increased, which suggests that those who responded to our survey experienced a high level of satisfaction with the services that we provide. This is encouraging news as previous quarters of this year have shown a downward trend in levels of satisfaction. Although the number of responses is lower than we would like and it is hoped that the new system implemented during Quarter 4 to capture survey feedback will enable us reach the wider population of the people who we serve.

The Service Experience Department (SED) have undertaken further analysis of this quarter's FFT scores to review for any areas that are influencing decreased scores and are sharing with operational colleagues for further follow up and action.

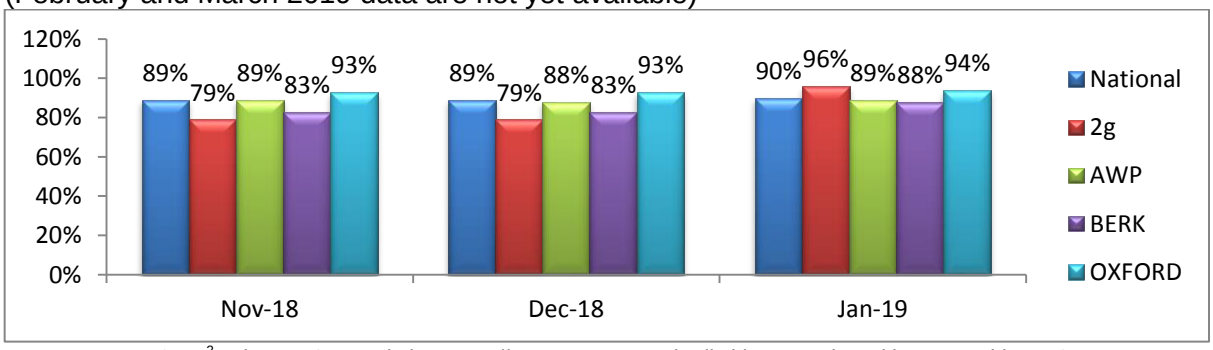
FFT Scores for ^{2}gether NHS Foundation Trust for the past year

The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust generally receives mostly positive feedback.



Friends and Family Test Scores – comparison between [2]gether Trust and other Mental Health Trusts across England

The chart below shows the FFT scores for November 2018, December 2018, and January 2019 (the most recent data available) compared to other Mental Health Trusts in our region and the national average. Our Trust consistently receives a high percentage of recommendation although we have achieved lower scores than other Trusts in our region in recent quarters. This is a reversal from previous years and does not triangulate with our positive National Survey scores. (February and March 2019 data are not yet available)



2g – [2]gether NHS Foundation Trust // AWP – Avon and Wiltshire Mental Health Partnership NHS Trust
BERK – Berkshire Healthcare NHS Foundation Trust // OXFORD – Oxford Health NHS Foundation Trust

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 users in key areas. This was measured though defined survey questions for both people in community and inpatient settings.

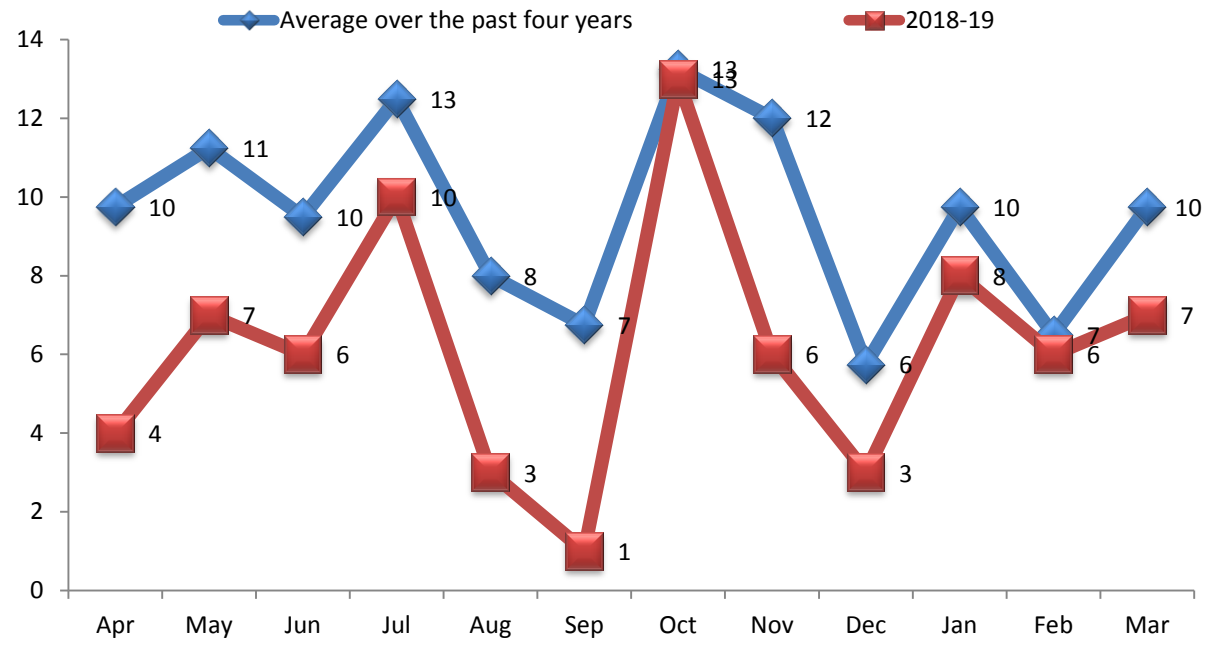
The Trust's **How did we do?** Survey combines the NHS Friends and Family Test and the Quality Survey. The Quality Survey questions encourage people to provide feedback on key aspects of their care and treatment.

The two elements of the **How did we do?** Survey will continue to be reported separately as Friends and Family Test and Quality Survey responses by county. A combined total percentage for both counties is also provided to mirror the methodology used by the CQC Community Mental Health Survey.

Complaints

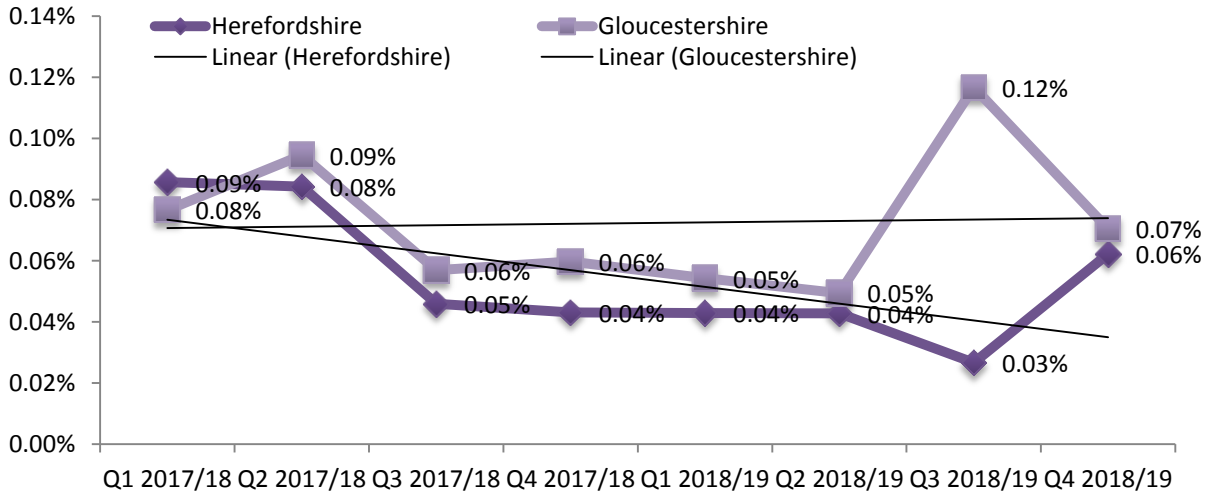
Between 1 April 2018 and 31 March 2019 the Trust received **74** formal complaints, an increase in actual number from the previous year which was 65 formal complaints. However, Figure 1 below (the numbers of complaints received by [2]gether in 2018/19 by month compared to the average over preceding 4 years) provides a trend line suggesting that the numbers of complaints received has been relatively consistent in relation to the number of people seen over a period of two years.

Figure 1



When the numbers of complaints are measured against the number of individual contacts within our services the percentage of complaints is very low (trend line shown for 2017/18 and 2018/19 in Figure 2).

Figure 2



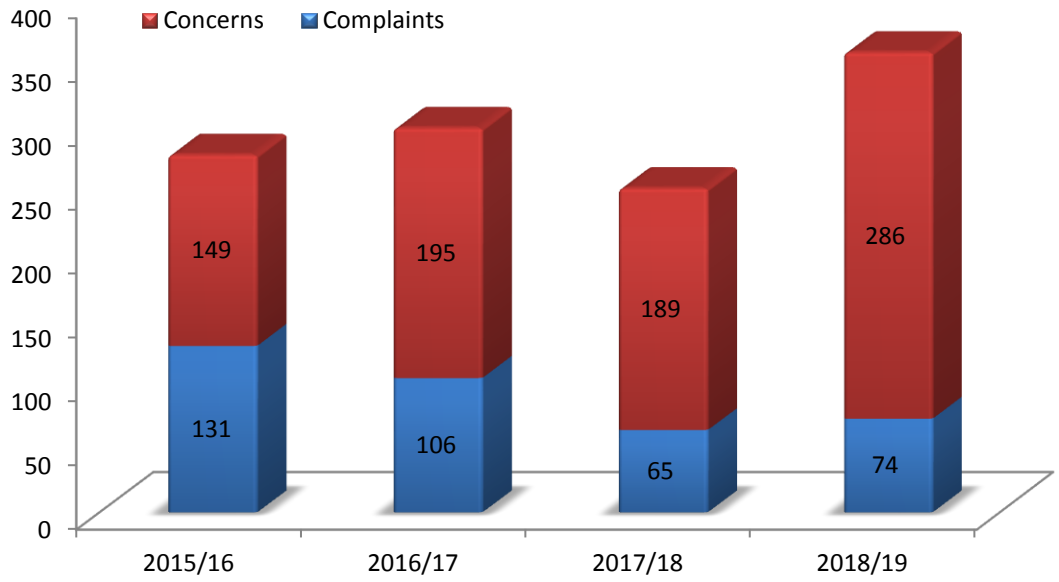
People who contact our Service Experience Department (SED) should receive a response within three working days. The SED will seek to resolve any concerns in the most timely and proportionate manner. Those who wish to pursue a formal complaint will have their complaint issues clarified and sent to them in writing for confirmation – this is known as the acknowledgement of complaint process.

A continuous high level of the written acknowledgement of complaints within the expected three day timeframe has been demonstrated throughout this year with **97%** (**72 of 74**) of complaints acknowledged within the three day time standard.

During 2018/19 a greater proportion of concerns raised with the Service Experience Department were supported through the management of 'concerns' process.

Analysis of this information for 2018/19 shows that there has been a 14% increase in the number of formal complaints (n=74), the number of concerns has increased by 51% (n=286) (Figure 3).

Figure 3



There has been 43% increase in the combined number of complaints and concerns reported to the Service Experience Department during 2018/19. It is important to acknowledge that the SED also record additional contacts made directly with the department and these are categorised as requiring advice or signposting and also recorded on Datix.

During 2017/18 there were 273 contacts for advice or signposting recorded. This type of contact has increased by 44% in 2018/19 with a total of 393 advice and signposting contacts recorded.

During 2017/18 there were, in total, 527 recorded direct contacts with SED, which increased by 43% to 756 contacts in 2018/19 *(These numbers do not include contacts relating to compliments as these are obtained from a variety of sources other than direct contact between individuals and the SED).*

People are encouraged to seek an independent investigation of their complaint via an external review by the Parliamentary Health Services Ombudsman (PHSO), Local Government Ombudsman (LGO) or the Care Quality Commission (CQC) if they are not satisfied with the outcome of [2]gether's investigation or if they feel that their concern remains unresolved.

The table below summarises the contact that external review agencies have had with our Trust throughout 2018/19.

The data includes complaints raised and investigated by our Trust over previous years and due to this the totals do not correlate with the total number of initial requests made in 2018/19.

Table 3

	PHSO	LGO	CQC	Total
Number of requests for initial information about individual complaints during 2018/19	**7**	**0**	**0**	**7**
Number of complaints closed following initial review of information with no further action.	**1**	**0**	**0**	**1**
Number of complaints where intention to investigate has been confirmed	**3**	**1**	**0**	**4**
Number of complaints currently under investigation	**2**	**1**	**0**	**3**
Number of complaints closed following investigation	**3**	**0**	**0**	**3**
Number of complaints upheld following investigation	**0**	**0**	**0**	**0**

The quarterly Service Experience Report to the Trust Board outlines in detail the themes of complaints, the learning and the actions that have been taken. Learning from complaints, concerns, compliments and comments is essential to the continuous improvement of our services.

Safety

Protecting service users from further harm whilst they are in our care is a fundamental requirement. We seek to ensure that 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;
- Reduce the number of prone restraints used in our adult inpatient services:

There are 3 associated targets.

Target 3.1 **Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload**.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14, during which year we reported **22** suspected suicides, we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams and we have continued with this important target each year. Sadly the number increased and during 2016/17 we reported **26** suspected suicides and in 2017/18 the number of reported suspected suicides increased to **28.** We are pleased to report that by the end of 2018/19 the number had reduced and that we reported **25** suspected suicides. This is seen in Figure 4.

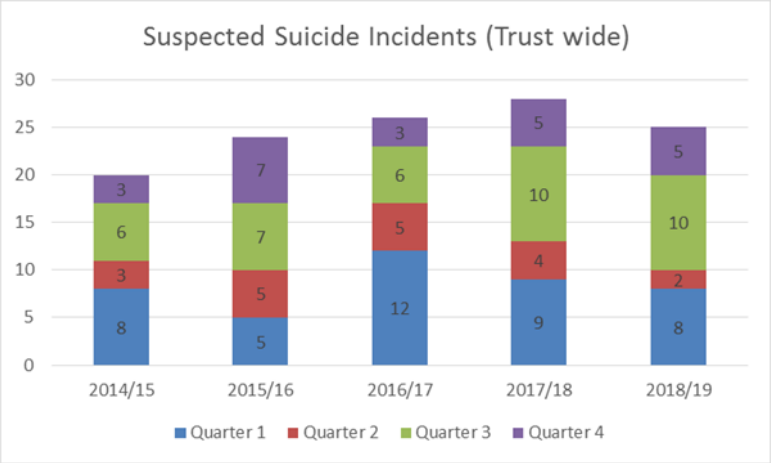


Figure 4

What we also know is that we are seeing more and more service users on our caseload year on year, so we measured this important target differently this year. This is also reported as a rate per 1000 service users on the Trust caseload. The graph in Figure 5 shows this rate from 2014/15 onwards for all Trust services covering Herefordshire and Gloucestershire, and we are aiming to see the median value (green line) get smaller. During 2015/16, 2016/17 and 2017/18 the median value was 0.09. By the end of 2018/19 the median value has fallen to 0.06.

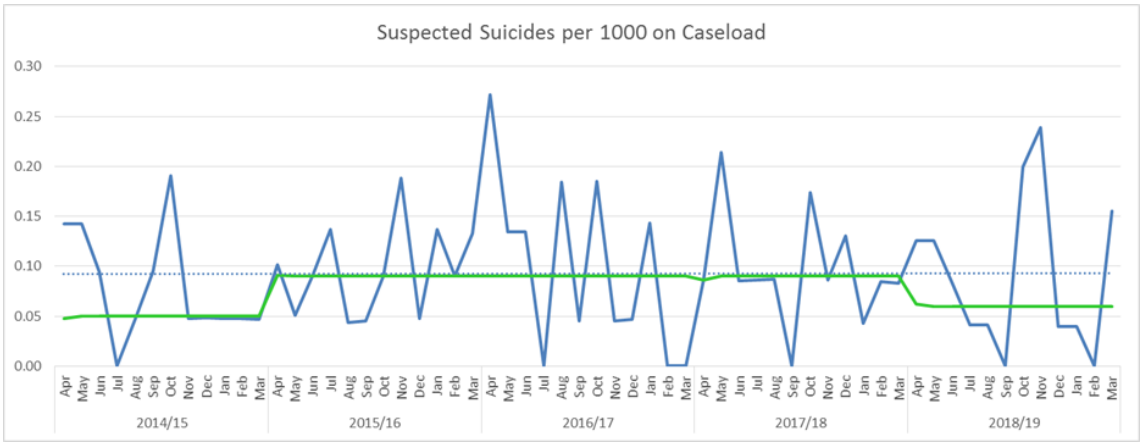
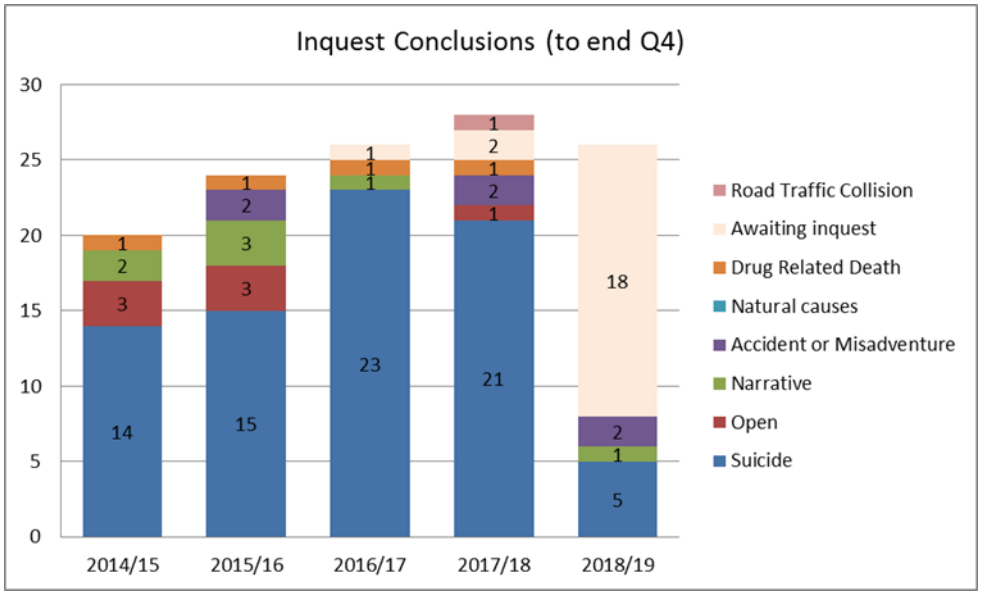


Figure 5

In terms of the inquest conclusions, these are shown in Figure 6 below. It is seen that the majority of reported suspected suicides are determined as such by the Coroner.



Information is provided below in Figures 7 & 8 for both Gloucestershire and Herefordshire services separately. It is seen that greater numbers of suspected suicides are reported in Gloucestershire services. There is no clear indication of why the difference between the two counties is so marked, but it is noted that the population of people in contact with mental health services in Gloucestershire is greater, and the overall population of Gloucestershire is a little over three times that of Herefordshire (based on mid -2015 population estimates).

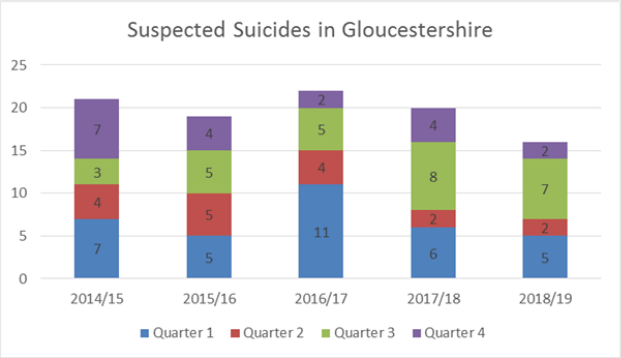


Figure 7

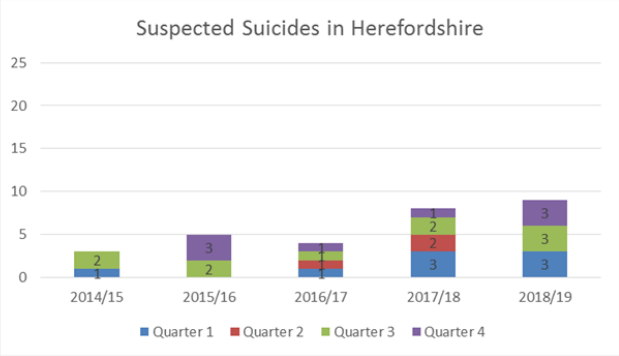


Figure 8

We will continue to work hard to identify and support those people experiencing suicidal ideation and aim to establish the interventions that will make the most impact for individuals. We launched the StayAlive App during 2017/18; this is a pocket suicide prevention resource for both people who are having thoughts of suicide and those who are concerned about someone else who may be considering suicide. This is available on AppStore and Google Play and may have had some role in reducing the suicide numbers seen this year.

In 2019/20 we are working with partners in our ICS and Public health to further improve suicide reduction approaches such as the “zero Inpatient Suicide initiative”

GRASSROOTS SUICIDE PREVENTION
Thinking about suicide? #StayAlive
prevent-suicide.org.uk

We are currently meeting this target.

Target 3.2 Detained service users who are absent without leave (AWOL) will not come to serious harm or death.

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 Patient Safety and Quality Improvement Mental Health Collaborative. AWOL reporting includes those service users who:

1. Abscond from a ward,
2. Do not return from a period of agreed leave,
3. Abscond from an escort.

What we want to ensure is that no detained service users who are AWOL come to serious harm or death, so this year we are measuring the level of harm that people come to when absent.

In **2016/17** we reported **211** occurrences of AWOL (162 in Gloucestershire and 49 in Herefordshire detailed in the table below). There are a number of factors which influence this, including open wards, increased numbers of detained patients in our inpatient units, increased

acuity, and on occasion, service users who leave the hospital without permission multiple times. **170** occurrences were reported during **2017/18.**

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	95	49	18	**162**
Herefordshire	40	4	5	**49**
Total	**135**	**53**	**23**	**211**

None of these incidents led to serious harm or death.

At the end of **2017/18** the following occurrences of AWOL were reported

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	72	59	11	**142**
Herefordshire	20	3	5	**28**
Total	**92**	**62**	**16**	**170**

None of these incidents led to serious harm or death.

At the end of **2018/19** the following occurrences of AWOL have been reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	62	66	16	**144**
Herefordshire	46	0	0	**46**
Total	**108**	**66**	**16**	**190**

None of these incidents led to serious harm or death.

.

We are meeting this target

Target 3.3 To increase the use of supine restraint as an alternative to prone restraint (on all adult wards & PICU)

The use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, however it is also a response that has potential to cause harm to an individual. As a Trust we want to minimise the use of this wherever possible through therapeutic engagement and occupation in the inpatient environment; alongside effective de-escalation techniques and alternatives to prone restraint.

During 2015/16, the Trust developed an action plan to reduce the use of prone restraint by 5% year on year. At the end of 2016/17, **211** instances of prone restraint were used which was an overall increase on the prior year. At the end of 2017/18, **229** instances of prone restraint were used so this was also an increase in the use of this type of restraint seen the following year.

The Trust promotes accurate and good quality recording of restraint procedures being utilised, so while we are disappointed that we have not seen the level of reduction required we are confident that we are accurately recording this procedure.

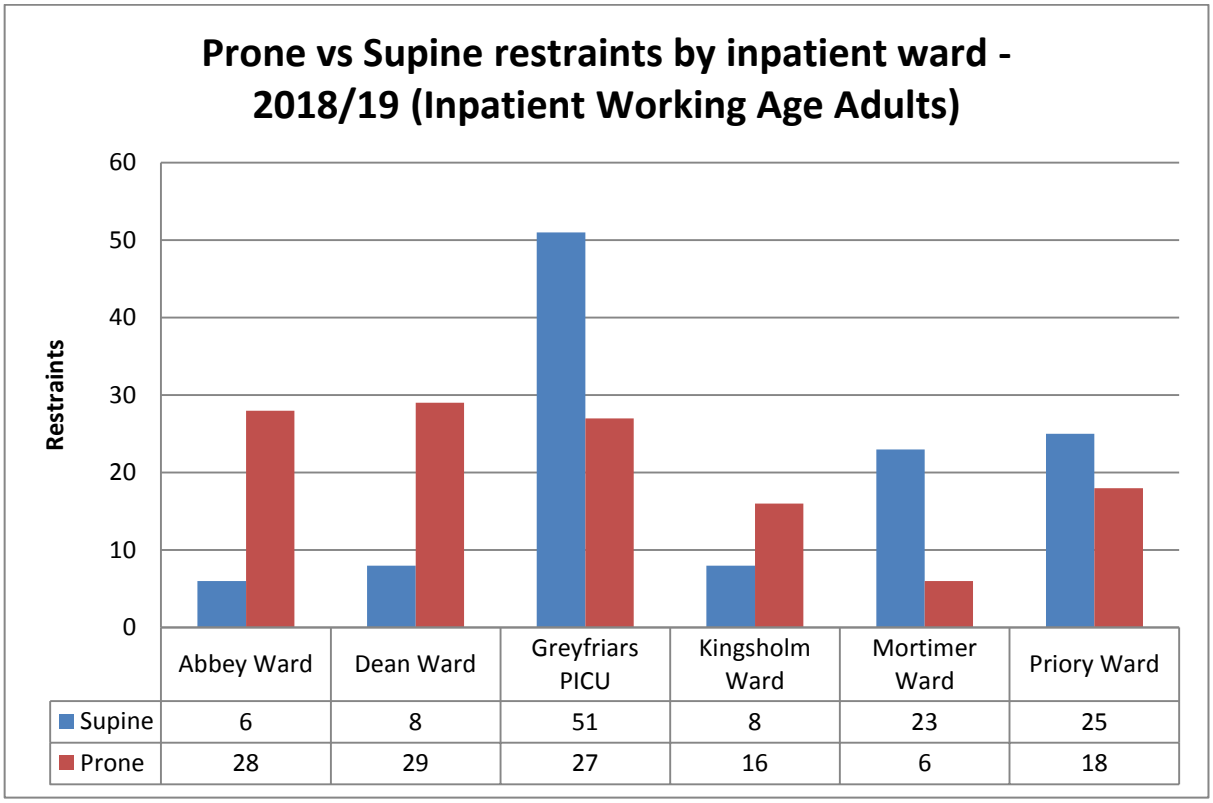
The Trust has a sub group focused on reducing physical restraint, in line with national guidance, reporting into our Trust Governance Committee. From reviewing our restraint data in detail over the past 3 years, we have seen a reduction in physical restraint and a positive increase in the use of supine restraint as an appropriate and safer alternative to prone restraint. This is due to active promotion of techniques used.

In 2018/19 our quality aim was to see a continued increase in the use of supine restraint as an alternative to prone restraint. In 2017/18 there were 215 (adjusted from 229 with exclusions) prone and 183 supine restraints on Working Age Adults wards, a difference of 32 more prone restraints. This compares to the 2018/19 figures where there were 124 prone restraints and 121 supine restraints, a difference of 3 more prone restraints.

It is encouraging to note that overall prone restraint was down from 215 restraints in 2017/18 to 124 restraints in 2018/19, which is a 42.3% decrease.

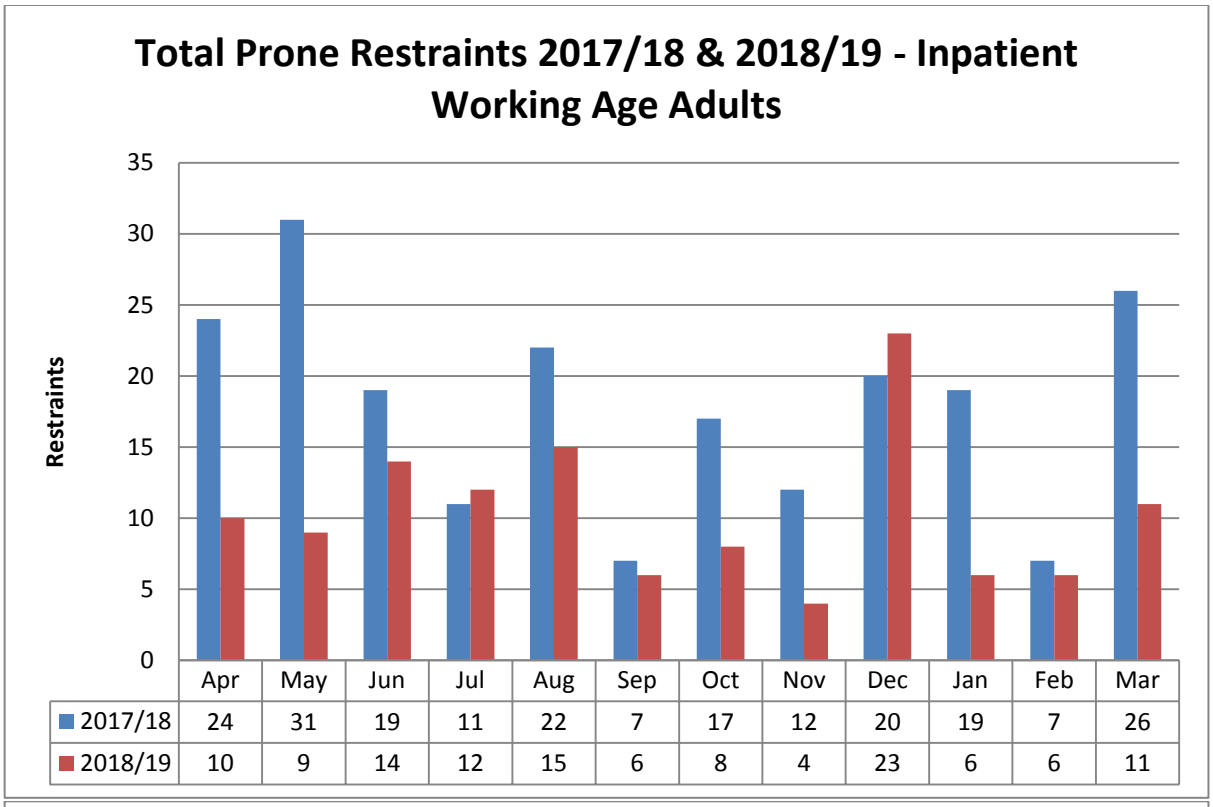
We missed our 2018/19 quality improvement target for prone restraints to be lower than supine restraints by a difference of 3 prone restraints over supine. However, clinical staff have made good progress in this area and our analysis of the challenge has indicated where clinical exceptions have led to the use of prone restraint over supine.

In 2019/20 we will be doing further work to address this including additional work on training staff in alternative injection sites, the development of new approaches to alternatives to prone restraint and of course ongoing work to reduce all forms of restraint in inpatient services.

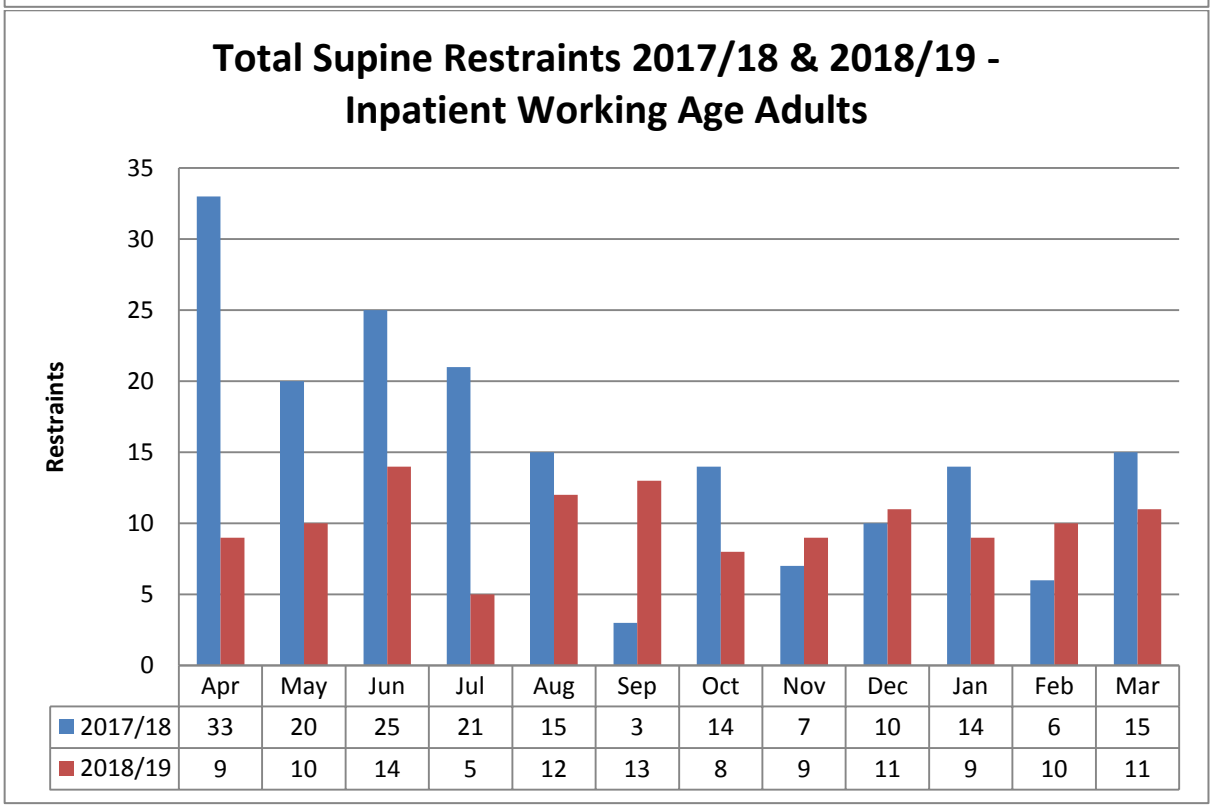


	Abbey Ward	Dean Ward	Greyfriars PICU	Kingsholm Ward	Mortimer Ward	Priory Ward
Supine	6	8	51	8	23	25
Prone	28	29	27	16	6	18

Fig 9



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	24	31	19	11	22	7	17	12	20	19	7	26
2018/19	10	9	14	12	15	6	8	4	23	6	6	11



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	33	20	25	21	15	3	14	7	10	14	6	15
2018/19	9	10	14	5	12	13	8	9	11	9	10	11

Fig 10 and 11

We have not met this target.

Target 3.4 **To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need.**

Berkeley House currently has 7 patients all of whom have specific care plans for Positive Behaviour Management (PBM) interventions; these care plans are on RiO and a copy of an accessible care plan is available for the patient.

They also have Positive Behavioural Support (PBS) plans which contain detailed information regarding primary, secondary and tertiary strategies for each person. Within these plans are functional assessments of behaviours that individuals may display. These include what a good day looks like and individualised strategies to manage behaviours when a patient begins to show signs of distress.

Primary prevention strategies aim to enhance the service users' quality of life and meet their unique needs thereby reducing the likelihood of behavioural disturbances.

Secondary prevention strategies focus on the recognition of early warning signs of impending behavioural disturbance and how to respond in order to encourage the patient to be calm.

Tertiary strategies guide the responses required to manage behavioural disturbance and acknowledge that the use of proportionate restrictive interventions may be required to minimise harm.

Alongside these strategies patients have activity care plans providing information on preferred activities, likes and dislikes and implementation of these activities for each individual. All patients also have a Health Action Plan and health and wellbeing care plan that gives information on health issues thus minimising possible influences pain may have an individual's behaviour.

All these plans are written following assessment and advice obtained from PBM trainers about any patient specific interventions (1 staff member at Berkeley House is also a PBM trainer). Also included in these plans are sensory interventions formulated by an occupational therapist which are implemented at associated primary and secondary phases appropriate for each individual.

All patients have a bespoke PBM assessment and care plan, this is written in conjunction with the Behaviour Support & Training Team, the PBM trainer we have within the staffing establishment at Berkeley House and the wider Multidisciplinary team. These plans include sensory interventions formulated by an occupational therapist. The PBM assessment (Individual Patient Physical Intervention Technique Checklist) clearly identifies techniques to be implemented for each individual as and when proportional to the risk to self and others.

Patients are physically monitored following all physical interventions to ensure that any concerns of physical harm or distress are acted upon within a timely manner. Where appropriate debriefs would be offered to patients post incident.

There are staff debriefs after any incidents of intervention, during which they are able to reassess and evaluate interactions and change care plans accordingly to better meet patient needs. Incidents are logged and discussed at MDT each week and interventions reviewed.

We have met this target.

Serious Incidents reported during 2018/19

By the end of Quarter 4 2018/19, 3**8** serious incidents were reported by the Trust; the types of these incidents reported are seen below in Figure 12.

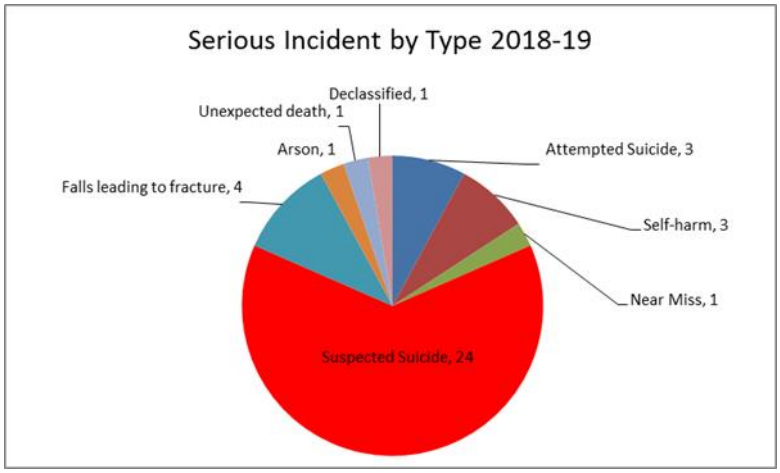


Figure 12

Figure 14 shows a 4 year comparison of reported serious incidents. The most frequently reported serious incidents are “suspected suicide” and attempted suicide which is why we continue to focus on suicide prevention activities in partnership with stakeholders. All serious incidents were investigated by senior members of staff, all of whom have been trained in root cause analysis techniques. To further improve consistency of our serious incident investigations we appointed a whole time equivalent Lead Investigator commenced this important work in May 2017, and 2 further dedicated Investigating Officers are now available via the Trust’s Staff Bank.

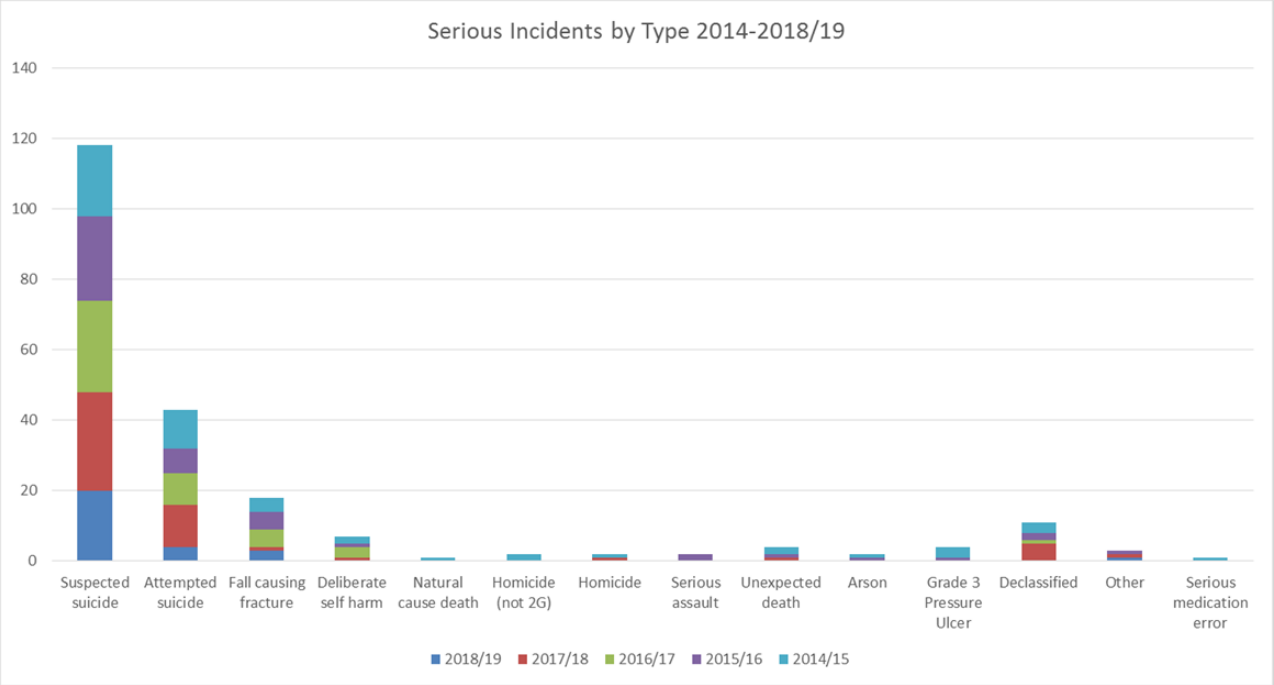


Figure 13

Wherever possible, we include service users and their families/carers to ensure that their views are central to the investigation, we then provide feedback to them on conclusion and copies of our investigation reports. During 2018/19 we continued to develop processes to provide improved support to people bereaved by suicide and in May 2018 18 staff were trained in Postvention techniques by the charity Suicide Bereavement UK. These trained staff now act voluntarily as Family Liaison Officers (FLOs) and are allocated to support families of service users on our caseload who have died by suspected suicide.

We have plans for 2019/20 to train more staff in working positively with families.

The Trust also shares copies of our investigation reports regarding “suspected suicides” with the Coroners in both Herefordshire and Gloucestershire to assist with the Coronial investigations.

There have been no Department of Health defined “Never Events” within the Trust during 2018/19. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Duty of Candour

The Duty of Candour is a statutory regulation to ensure that providers of healthcare are open and honest with services users when things go wrong with their care and treatment. The Duty of Candour was one of the recommendations made by Robert Francis to help ensure that NHS organisations report and investigate incidents (that have led to moderate harm or death) properly and ensure that service users are told about this.

The Duty of Candour is considered in all our serious incident investigations, and as indicated in our section above regarding serious incidents, we include service users and their families/carers in this process to ensure their perspective is taken into account, and we provide feedback to them on conclusion of an investigation. Additionally, we review all reported incidents in our Datix System (incident reporting system) to ensure that any incidents of moderate harm or death are identified and appropriately investigated.

To support staff in understanding the Duty of Candour, we have historically provided training sessions through our Quality Forums and given all staff leaflets regarding this. There is also a poster regarding this on every staff notice board. During the CQC comprehensive inspection of our services in 2015, they reviewed how the Duty of Candour was being implemented across the Trust and provided the following comments in their report dated 27 January 2016.

“Staff across the trust understood the importance of being candid when things went wrong including the need to explain errors, apologise to patients and to keep patients informed.”

“We saw how duty of candour considerations had been incorporated into relevant processes such as the serious investigation framework and complaints procedures. Staff across the trust were aware of the duty of candour requirements in relation to their role.”

Our upgraded Incident Reporting System (Datix) has been configured to ensure that any incidents graded moderate or above are flagged to the relevant senior manager/clinician, who in turn can investigate the incident and identify if the Duty of Candour has been triggered. Only the designated senior manager/clinician can “sign off” these incidents.

Freedom To Speak Up – Quality Account Statement

[2]gether NHS Foundation Trust have fully integrated the need for staff to speak up in line with the recommendations from the Robert Francis report following the Mid Staffordshire enquiry and also subsequent enquiries that have highlighted the need for staff to have various pathways through which to raise concerns. These have been integrated into the Trusts ‘Speaking up at Work Policy’ which describes the various routes that staff can employ in order to raise concerns. The following information outlines the current provision within the Trust in regard to how staff can raise concerns freely and without suffering detriment from doing so.

In October 2016 [2]gether NHS Foundation Trust appointed a Freedom to Speak up Guardian whose role is to help:

- protect patient safety and the quality of care

- improve the experience of workers
- promote learning and improvement

The Freedom to Speak up Guardian does this by ensuring that staff are supported in speaking up and that barriers to speaking up are addressed. They also help to ensure that a positive culture of speaking up is fostered and that any issues raised are used as opportunities for learning and improvement. To enhance the role, Freedom to Speak Up advocates have also been appointed who assist individuals to consider the available options to raise concerns and to identify appropriate routes to do so.

The Trusts 'Speaking up at Work Policy' clearly states that staff who genuinely raise a concern will not be at risk of losing their job or suffering any form of detriment or retribution as a result. Provided that they are acting in good faith, it does not matter if they are mistaken or if there is a genuine explanation for their concerns. It goes on to describe how, should any individual subject an employee to victimisation or harassment due to making a qualified disclosure, this would be seen and treated as a serious disciplinary offence.

Other options available to staff within the Trust include:

Dignity at Work Officers – A Dignity at Work officer is a member of staff who undertakes this role in addition to their day to day job. They have been identified as someone who has the skills, understanding and empathy that makes them approachable to other staff. They are volunteers. Their role is to provide support and guidance to anyone who feels that they are a victim of harassment or bullying in the workplace. They will provide unbiased and confidential independent advice as to the options available and try to help you gain an insight into what can be done about a situation. During 2018, we recruited and trained additional Dignity at Work Officers.

Speak in Confidence – Speak In Confidence is a web-based system enabling staff to have an anonymous and confidential dialogue about issues that you may be concerned about, with a manager of your choice (there is a list of managers to choose from on the system which also includes the Trusts Freedom to Speak up Guardian to enable anonymous reporting to occur) Speak In Confidence has been introduced primarily to support staff who are subjected to inappropriate behaviour but who do not feel able to raise the issue through existing channels. The need for an alternative method of reporting issues was highlighted by the 2014 Staff Survey. Additionally, the Trust is now working in partnership with Gloucestershire Care Service NHS Trust to train and support Freedom to Speak Up Advocates. These are staff members who are provided with training and a network to improve further how staff can access advice and be signposted appropriately.

Rota Gaps – Safe Working

The Trust has a Consultant and Guardian of Safe Working Hours who provides the Trust Board with quarterly reports about the Trust's performance on junior doctors' rotas and rest periods. These quarterly Board reports summarise all exception reports, work schedule reviews and rota gaps, and provides assurance on compliance with safe working hours by both the Trust and doctors in approved training programmes. The purpose of the regular reports is to give assurance to the Board that doctors in training are safely rostered and their working hours are complaint with the Terms and Conditions of Service.

A summary of exception reporting and rota gaps for the year 1 April 2018 to 31 March 2019 is as follows:

Date	No. of reports	Resolutions
April 2018	14	6 - Time in lieu agreed

		8 - Compensation agreed
May 2018 to July 2018	16	1 – No further action 9 - Time in lieu agreed 5 - Overtime payment agreed 1 - Meeting with Educational Supervisor 5 - Work schedule reviews required
August 2018 to October 2018	13	2 – No further action 8 - Time in lieu agreed 3 – Meeting with Educational Supervisor
November 2018 to January 2019	11	4 - Compensation agreed 3 - Time in lieu agreed 3 - No further action 1 - Meeting with Educational Supervisor
February 2019 to March 2019	4	1 - Request for further information 1 - Time in lieu agree 2 - Meeting with Educational supervisor

Both junior doctors and their supervisors need to be more disciplined in meeting and resolving issues highlighted through the exception reports. The Guardian of Safe Working continues to support junior doctors and supervisors in resolving these issues.

Since changing the rota in Gloucestershire to working “waking nights”, there has been a significant decline in the number of exception reports from the rota. Reports from Gloucestershire have mainly related to inpatient jobs. They are not related to night shifts but mainly due to daytime workload which resulted in doctors staying beyond their contracted hours. There is a need for improvement in medical cover arrangements in Wotton Lawn Hospital, Gloucester, and significant work has been done to address this. This is being looked at as a priority for 2019/20.

There has been significant improvement in the number of reports from Herefordshire since adjusting the time allocated to average working hours during on calls. Work schedules of Herefordshire trainees were updated twice during this time period, following data received from exception reports and discussions at Junior Doctors Forums.

Based on Guardian of Safe Working reports and recommendations, the Trust has taken constructive steps to reduce the number of locum and agency doctors. For example, specific advertising ventures have been organised to attract more trainees to occupy the training posts entirely with some positive outcome. During much of the time period of 1 April 2018 to 31 March 2019, the Trust employed two Clinical Fellows to help with the gaps on the junior doctor rota. One Clinical Fellow has been employed in Gloucester and one Clinical Fellow employed in Hereford. They supported with daytime cover, but were also included on the junior doctor on-call rota as normal. Similarly, the Trust also employed a Specialty Doctor in Hereford who participated on the junior on-call rota.

Sign up to Safety Campaign – Listen, Learn and Act (SUP2S)

[2]gether NHS Foundation Trust has continued to build on the work previously reported under the umbrella of "Sign up to Safety". Sign up to Safety has evolved since its launch in 2014 and over time has narrowed its mission to focus on safety culture. The Patient Safety and Quality improvement initiatives are ongoing and some embedded as part of the way we do things here, demonstrating how a safety culture is in development. Monitoring is ongoing but reported every 6 months via the Trust Governance Committee. An example of this is the Trust's ongoing commitment to the South of England Mental Health Collaborative and the work developing around sharing the learning from deaths in mental health where an expert by experience is working in partnership with clinicians to understand ligature risks and ultimately learn together to improve safety.

NHSI Indicators 2018/2019

The following table shows the NHSI mental health metrics that were monitored by the Trust during 2018/19.

		2016-2017 Actual	National Threshold	2017-2018 Actual	2018-2019 Actual
1	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	**71.3%**	50%	**70%**	**72%**
2	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas: -inpatient wards -early intervention in psychosis services -community mental health services (people on CPA)	 - - -		 **95%** **92%** **90%**	 90% 92% 78%
3	Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database) Waiting time to begin treatment (from IAPT minimum dataset - treated within 6 weeks of referral - treated within 18 weeks of referral	**-** **37.8%**	50% 75% 95%	**50%** **67%** **85%**	**52%** **96%** **96%**
4	Admissions to adult facilities of patients under 16 years old.	**-**		**1**	**0**
5	Inappropriate out-of area placements for adult mental health services	**-**		**24**	**52**

Community Survey 2018

The Care Quality Commission (CQC) requires that all mental health Trusts in England undertake an annual survey of patient feedback. [2]gether NHS Foundation Trust has, for several years, commissioned Quality Health to undertake this work.

The 2018 survey of people who use community mental health services involved 56 providers in England. The data collection was undertaken between February and June 2018 using a standard postal survey method. The sample was generated at random using the agreed national protocol for all clients on the CPA and Non-CPA Register seen between 1st September and 30th November 2017. [2]gether NHS Foundation Trust received one of the highest percentage response rates at 36% (national average of 28%).

Full details of this survey questions and results can be found on the following website:
www.nhssurveys.org/Filestore/MH18/MH18_RTQ.pdf

²gether was the only mental health Trust in England to achieve a 'better than expected' rating for the survey results in both 2017 and 2018. ²gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 11 domains and 'about the same' in the remaining 6 domains. The results are tabulated below with the scores out of 10 for ²gether NHS Foundation Trust calculated by the CQC.

²gether's scores and comparison with other Trusts

Score (out of 10)	Domain of questions	How the score relates to other trusts
7.7	Health and social care workers	Better than others
8.9	Organising Care	Better than others
7.4	Planning care	Better than others
7.9	Reviewing care	Same as others
7.0	Changes in who people see	Same as others
7.4	Crisis care	Same as others
7.5	Medicines	Same as others
7.7	NHS Therapies	Same as others
5.2	Support and Wellbeing	Same as others
7.7	Overall view of care and services	Better than others
7.3	Overall experience	Better than others

²gether NHS Foundation Trust obtained the highest score achieved by **any** Trust on 3 of the 28 evaluative questions:

- *Were you given enough time to discuss your needs and treatment?*
- *In the last 12 months, did NHS mental health services give you any help or advice with finding or keeping work?*
- *In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?*

Next Steps

²gether scored well overall by comparison to other Trusts, being one of only four English Mental Health Trusts classed as 'better than expected'. It would appear from our CQC 2018 scores and information from a range of other service experience information (reported to Board quarterly) that actions being taken to enhance service experience over recent years are having a positive impact and that learning from feedback is being embedded into practice.

There are areas where further development and continued effort would enhance the experience of people in contact with our services. The priority areas to undertake further work have been identified by considering where the scores suggest a lower degree of satisfaction overall. As such the following areas for further practice development are proposed and an action plan has been developed alongside the relevant locality, corporate and professional leads.

- Giving people information about getting support from people with experience of the same mental health needs as them;
- Helping people to find support for their physical health needs;
- Involving family members or someone close, as much as the person would like;
- Helping people to join a group or take part in an activity;
- Providing help or advice for finding support with finances or benefits.

The 2018 results have been provided for all colleagues through a global email which celebrates our successes and thanks them for their dedication. Further cascade has been undertaken through Team Talk across Herefordshire and Gloucestershire. The results have been sent to Service Directors for sharing with teams and for generating ideas for continued practice

development. An infographic has been developed to share the local results in a more accessible format.

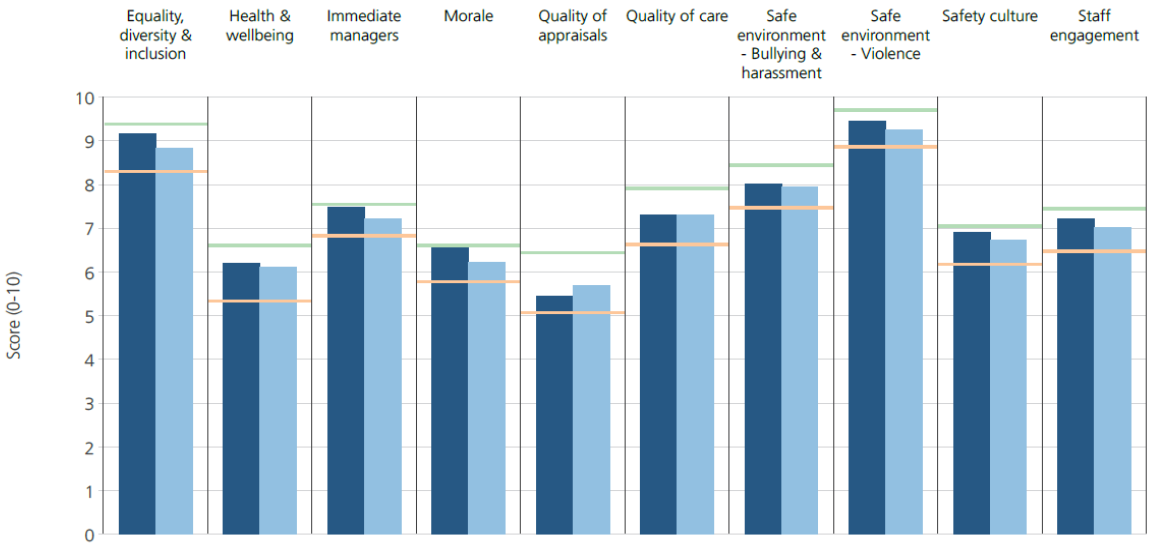
Staff Survey 2018

Staff Survey 2018
The Trust participates in the annual NHS Staff Survey alongside quarterly Staff Friends and Family Tests (FFT). While staff also have a wide variety of other ways to feed back their views and experiences of work, such as focus groups, Pulse surveys, and Speak In Confidence, the Staff Survey provides the most in-depth analysis of how staff view the Trust as an employer and as a provider of mental health and learning disability services.

The responses to each of the questions asked are now grouped into 10 “Themes”, progress against which can be measured year on year. These Themes and the questions within the survey are set nationally. These ten Themes cover the following areas:

- Equality, diversity and inclusion
- Health and wellbeing
- Immediate managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment – Bullying and harassment
- Safe environment – Violence
- Safety Culture
- Staff engagement

For the 2018 survey staff rated the Trust on the following basis for each of the Themes.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.5	6.6	6.4	7.9	8.4	9.7	7.0	7.4
Your org	9.2	6.2	7.5	6.6	5.4	7.3	8.0	9.4	6.9	7.2
Average	8.8	6.1	7.2	6.2	5.7	7.3	7.9	9.3	6.7	7.0
Worst	8.3	5.3	6.8	5.8	5.1	6.6	7.5	8.9	6.2	6.5
No. responses	851	855	857	845	741	672	849	845	852	862

There were no statistically significant improvements or reductions in any of the Trust’s scores for the 10 Themes. Staff scored the Trust better than average in 8 and below average in 2 of the Themes.

“Morale” and “Support from Immediate Managers” were two Themes which scored the best in the Mental Health / Learning Disabilities Trust class. Similarly, “Equality and Diversity” and “Safe Environment – Violence” also scored highly. Overall staff engagement has remained steady with staff rating the Trust at 7.2 consistently for the past four years. This benchmarks well against the comparator Trusts’ average score of 7.0.

The lowest scored theme for the Trust was the Quality of Appraisals. It is encouraging to note that the number of staff recommending the organisation as a place to work or receive treatment has again increased and was higher than the national average.

Recommending the Trust as a place to work has increased from 68.4% in 2017 to **71.8%** in 2018. (Well above the average benchmarking score of 61.1%). Recommending the Trust as a place for a friend or relative needing treatment, has increased from 74.2% in 2017 to **75.5%** in 2018.
For the third year running, all staff in post were invited to take part in the survey. Previously the survey had only been sent to a random sample of staff. The overall response rate in the most recent survey was **40.5%** (reduced by 4% over last year’s response rate and the same response rate as 2016). This equated with **863** staff taking the time to contribute their views making it a rich and accurate picture of the staff views about the Trust.

The Survey results are also used to inform progress against the Workforce Race Equality Standard (WRES), introduced in 2014. Key WRES indicators are taken from the survey. Staff rated the Trust as above average for all four Equality, diversity & inclusion questions.
Nationally within the NHS, levels of bullying and harassment remain high and as a Trust we continue to work to eliminate this. We continue to recruit and train Dignity at Work Officers alongside Freedom to Speak Up advocates. Similarly, we have continued to promote Speaking Up alongside the use of our confidential dialogue system known as Speak in Confidence as part of the wider suite of measures introduced to offer support to staff.

Following internal reviews and discussions of the findings, the Trust will focus on five priority areas corporately over the coming year. These include:

- Response rates
- Engagement
- Quality of Appraisals
- Safe Environment – Bullying and Harassment
- Quality of Care

Each Locality has also been asked to review their local ratings and are required to agree and report on priority areas and actions to focus on in the coming year.

More recently, in quarter 4 at the end of 2018/19, the Trust ran its 16th Staff Friends and Family Test with staff rating the Trust on the following basis:

- **86.24%** of staff would recommend the Trust as place to receive treatment – this compares to 75.5% for the Q3 18/19 test. This maintains our strong position well above the Q3 NHS average Mental Health and Learning Disabilities Trusts’ benchmarking score of 61.3%
- **71%** of staff would recommend the Trust as a place to work – this compares to 71.8% for the Q3 18/19 test, maintaining our position well above the Q3 NHS average Mental Health and Learning Disabilities Trusts’ benchmarking score of 61.1%.

While these scores are encouraging, the Trust will need to continue to work with staff and managers towards achieving further longer term improvements in staff experience and engagement.

PLACE Assessment 2018

Site Name	Cleanliness	Food Overall	Organisational Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Overall 2gether Trust Score: (taken from Organisation Average)	**99.64%**	**94.60%**	**92.43%**	**98.37%**	**93.11%**	**99.20%**	**90.18%**	**91.19%**
BERKELEY HOUSE	**100.00%**	**94.66%**	**90.79%**	**99.45%**	**100.00%**	**99.45%**	**N/A**	**93.77%**
CHARLTON LANE	**100.00%**	**96.55%**	**94.51%**	**100.00%**	**94.53%**	**99.84%**	**99.02%**	**92.69%**
WOTTON LAWN	**99.94%**	**95.04%**	**92.80%**	**100.00%**	**93.75%**	**99.88%**	**N/A**	**89.52%**
HONEYBOURNE	**99.13%**	**94.89%**	**91.10%**	**100.00%**	**94.53%**	**99.59%**	**N/A**	**92.43%**
LAUREL HOUSE	**100.00%**	**94.34%**	**88.87%**	**100.00%**	**94.53%**	**99.64%**	**N/A**	**95.92%**
STONEBOW UNIT	**98.62%**	**91.93%**	**91.20%**	**92.93%**	**89.49%**	**97.59%**	**81.53%**	**91.77%**
OAK HOUSE	**100.00%**	**N/A**	**N/A**	**N/A**	**90.32%**	**96.88%**	**N/A**	**86.67%**
National Average MH/LD	98.40%	90.60%	88.80%	92.30%	91.00%	95.40%	88.30%	87.70%
National Average	98.50%	90.20%	90.00%	90.50%	84.20%	94.30%	78.90%	84.20%
lowest	74.80%	60.70%	49.50%	48.10%	53.90%	68.80%	45.60%	50.20%
highest	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Key

At or above MH/LD National Average	
Below England MH/LD average	

These results are very positive and for the first time since PLACE began the Trust is above the national average for Mental Health and Learning Disability settings in all six domains. The overall results clearly demonstrate how as a Trust we are improving the quality of the non-clinical services provided to our patients.

Cleanliness performed really well this year and the Trust overall score was over 1% higher than the National average, with four of the seven sites assessed scoring 100%.

The Food assessment scored well this year and the Trust overall score was 4% higher than the National average. The ward 'food tasting' scored particularly well this year with four out of six sites scoring 100% for taste, texture, temperature and appearance.

In comparison with our local healthcare partners in Gloucestershire we achieved a higher average domain score than GCS and GHT in all domains.

In terms of individual site ranking Charlton Lane achieved the highest site average score of 97.14 followed closely by Berkeley House who achieved 96.87%

Annex 1: Statements from our partners on the Quality Report

NHS Gloucestershire CCG Comments in Response to 2gether NHS Foundation Trust Quality Report 2018/19

NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by 2gether NHS Foundation Trust (2gNHSFT) for 2018/19 in line with NHS Improvement guidance '*Detailed requirements for quality reports 2017/18*' published January 2018.

The report clearly identifies how the Trust performed against the agreed quality priorities for improvement for 2018/19 and also outlines their priorities for improvement in 2019/20. The CCG endorses the quality priorities included in the report whilst acknowledging the financial and workforce challenges 2gNHSFT have to address over the coming year. We also recognise the impact of managing the current merger with Gloucestershire Care Services (GCS) whilst continuing to deliver safe, high quality and clinically effective care. We will continue to work with the Trust where targets have not been met.

2gNHSFT had a comprehensive CQC inspection during February and March 2018 and we are pleased to note that the outcome of that inspection was that the overall Trust rating remains Good and the CQC recognition that there have been many improvements made since the Trust's last inspection in 2015. The CCG note the good progress made on the implementation of identified actions within the Trust's CQC action plan, and that the action plan has now been closed and any remaining actions will be mainstreamed into the relevant areas of business as usual and included in the 2gNHSFT Organisational Total Quality Improvement (OTI) Action Plan. The CCG will continue to work with the Trust to monitor the implementation of the OTI Action Plan in 2019/20.

We are pleased to note that the Trust achieved many of their targets in 2018/19 and are to be commended on the continued focus on supporting service users to improve their physical health, and reducing the number of suicides of patients in contact with their services. Once again the Trust has achieved the target for the number of frontline staff vaccinated against flu, and of being amongst the top 20% of mental health services nationally in the CQC's community mental health survey for 2018. The CCG are also pleased to note the results of the Trust Staff Survey, which demonstrates that 75.5% of Trust colleagues would recommend the Trust as a place for friends or relatives needing treatment, and their achievement in the Trust's most recent Patient Led Assessments of the Care Environment (PLACE) assessment, which places them above the national average for Mental Health and Learning Disability settings in all six domains. However, 2gNHSFT did not achieve some of the national targets and the CCG will work with the Trust to ensure these priorities will continue to be a focus for achievement in 2019/20.

We wish to acknowledge the extensive work undertaken by the Trust and progress to date against the Gloucestershire Improving Access to Psychological Therapies (IAPT) recovery plans. This continues to remain a high priority for the CCG, and we will continue to work with 2gNHSFT in 2019/20 to improving access to IAPT services to meet national targets.

2gNHSFT were compliant in meeting the CQUIN requirements and achieved targets in 2018/19, with the exception of Improving Services for people with mental health needs

who present to A&E. However, once again this was due to circumstances outside the control of 2gNHSFT and this has been acknowledged by the CCG. We will continue to work with the Trust on the achievement of their CQUIN goals for 2019/20 and delivery of clinical improvements and transformational change as set out in the Five Year Forward View and NHS Mandate.

The CCG are pleased to note the Trust's focus on continuing improvement in identified priorities for effectiveness, service user experience and safety in 2018/19. We note achievement of some of the targets in 2018/19, and whilst there are a number of areas where targets were partially or not achieved, the CCG are content that the Quality Report provides a balanced view.

The CCG acknowledge the Trust's commitment to Learning from Deaths; Identification of learning and actions have been put in place to improve patient safety and the quality of care for service users. 2gNHSFT has continued to engage in partnership working with other provider organisations to share this learning across the wider healthcare system in Gloucestershire. The CCG will continue to work with the Trust to monitor progress against these requirements in 2019/20.

The CCG also acknowledge the Trust's continued focus on service user and carer experience and quality of caring, and whilst not all targets were met, the Trust continues to receive a high percentage of positive responses. We note that the Trust consistently receives a high percentage of recommendation although they have achieved lower scores than other Trusts in the region in recent quarters. Whilst this is a reversal from previous years and does not triangulate with their positive National Survey scores, we recognise that the latest data was not available to the Trust at the time of developing their Quality Report and the CCG will continue to work with the Trust to monitor progress against this target in 2019/20.

We were pleased to note there continues to be a high level of clinical participation in local clinical audits, and also a positive increase in activity in relation to Clinical Research.

The CCG will continue to work with 2gNHSFT during the current merger with Gloucestershire Care Services (GCS) and resulting organisational change to ensure the trust is in a strong position to manage both present and future challenges in delivering mental health and learning disabilities services that provide best value with a clear focus on providing high quality, safe and effective care for the people of Gloucestershire.

Gloucestershire CCG confirm that to the best of our knowledge we consider that the 2018/19 Quality Report contains accurate information in relation to the quality of services provided by 2gNHSFT. During 2019/20 the CCG will continue to work with 2gNHSFT, all stakeholders and the people of Gloucestershire, to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the mental health and learning disability services provided to the residents of Gloucestershire and beyond.

Dr Marion Andrews-Evans
Executive Nurse & Quality Lead
NHS Gloucestershire CCG

Herefordshire CCG response to 2gether NHS Foundation Trust Quality Accounts

Herefordshire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by 2gether NHS Foundation Trust (2gNHSFT) for 2018/19.

The report is well written, concise and easy to understand.

The CCG acknowledge 2gNHSFT's continuing focus on patient and carer experience and the delivery of comprehensive high quality of care across a range of integrated health and social care services across the county, which underpins all clinical work delivered by the Trust.
The 2018/19 Quality Report demonstrates commitment to addressing challenges and concerns. Herefordshire CCG continues to engage with the trust and receives feedback from the Trust Quality Committee meetings and at the Contract Quality Review Forum and contacting meetings.

The CCG reviews 2gNHSFT's incident responses on a regular basis and find robust systems and processes in place with evidence of duty of candour has been undertaken in each report and evidence that learning is embedded within the wider Trust workforce.

The CCG is pleased to see that the Trust has taken action to

• Minimise the risk of suicide of people who use our services.
• Minimise the risk of harm to service users within inpatient services when the need to use physical interventions arises.

The CCG notes the work that is being undertaken with regard to the Trusts Suicide Prevention strategy and would seek to ensure Herefordshire patients are included within any evaluation and for this to be continued focus for the year ahead.

Of the mandated Quality Indicators required for reporting, all were above the national average with the exception of two indicators where the national percentage was not available

The CCG is pleased to note that patient feedback was consistently good and the Trust scored better that better than average in 10 themes of the staff survey.

Of the 4 safety targets, they are being met with exception of restraint which just marginally missed the target the CCG would be pleased to see a continued focus on this in the year ahead.

The CCG note the trust did not achieve its improvement for people discharged from hospital with personalised care plans. CCG would be pleased to see a continued focus on this in the year ahead. The CCG would like to see specific improvement relation to EMI services in Herefordshire.

The CCG notes the work that is being undertaken with regard to LeDER and would seek to ensure Herefordshire patients are included within any evaluation and for this to be continued focus for the year ahead.

We were pleased to note there continues to be a high level of 2gNHSFT engagement in both national and local clinical audits and research.

The CCG endorses all 2gNHSFT's priorities for improvement as contained in this report in the expectation that they will lead to improved delivery against effectiveness, service user experience and safety, supporting improved outcomes for service users.
Following a review of the information presented within this report, coupled with commissioner led reviews of quality across all providers, the CCG is satisfied with the accuracy of the report.

Helen Richardson
Chief Nursing Officer

Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health and Care Overview and Scrutiny Committee I welcome the opportunity to comment on the 2gether NHS Foundation Trust Quality Account 2018/19.

This has been a significant and challenging year for the Trust which is on its journey to integration with Gloucestershire Care Services NHS Trust. The Committee support the aim of the merger to improve patient outcomes and look forward to examining the detail in future meetings.

Members were pleased to note the recent CQC inspection where the Trust retained the overall 'good' rating'. The fact that wards for older people with mental health problems are now rated 'outstanding' for being caring and 'good' for safe is particularly pleasing.

With regards to the quality measures detailed in the report, members note that less people had all parts of their discharge care plan completed at the end of the year than previously but understand improvement is being made.

With regards to User Experience, Members are pleased to see the details of the Trust's 'How did we do?' survey which indicates targets are being met in this area. It is right, though, that this also allows identification of where improvement can be made such as a increased involvement of people in the development of their care plans.

This is an open and honest account of the Trust's position and it clearly has patient and staff wellbeing at its centre.

I would particularly like to thank the Trust for its work with the committee, in particular Ingrid Barker and Paul Roberts

Cllr Carole Allaway Martin
Chairman
Health and Care Scrutiny Committee

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8th May 2019

Healthwatch Herefordshire: Response to 2gether NHS Trust Quality Account 2018/19

Healthwatch Herefordshire thanks the Trust for the opportunity to comment on this year's annual quality report.

Firstly, we congratulate the Trust on its latest positive CQC inspection report which shows improvement from the previous 'good' rating. This is not an easy achievement and demonstrates real commitment by the board and staff. We also are pleased with the high ratings in the national patient survey.

We strongly support the Trust's plans to prioritise improvements to the physical health care of service users, to improve discharge care planning and transitional arrangements from children to adult care. We have expressed concern about the two latter topics over recent years as a result of feedback from services users with whom we have contact.

We are also very supportive of the need for a stronger approach to suicide avoidance in Herefordshire. This is a worrying risk in a very rural county with a large number of agricultural workers which seems to be a particularly vulnerable group.

The need to strengthen procedures and staff compliance with procedures for acute inpatients is vital to avoid deaths amongst this extremely vulnerable group and we look forward to urgent action being taken to address this. Similarly, the minimisation of inappropriate restraint techniques is vital to avoid unnecessary harm and loss of dignity amongst inpatients.

We also look forward to improvement in the access to IAPT in the county and in the outcomes of this service. We strongly support the benefit of early intervention to prevent the development of more serious problems later. We would like to see developments of further early intervention programmes for young people. In association with this Healthwatch Herefordshire is carrying out a major project on the mental health service needs of young people and we will share the outcomes of this as soon as they are available.

On a positive note for Herefordshire we note that there seems to have been a significant improvement in the Camps provision which had been problematic in the past.

In this report the prioritisation of the merger between 2gether and the Gloucestershire community health service is a serious concern for Healthwatch Herefordshire. Herefordshire county will now be a significantly smaller proportion of the total new organisation than of 2g. We believe that this factor plus the need to concentrate on implementing the merger

could lead to the loss of focus on mental health services in Herefordshire. This is not a development which we believe is helpful.

Finally, we would like to record how helpful our links with Dr Jane Melton have been over recent years. Jane has always been extremely open and collaborative, and we have developed a very positive relationship with her. We wish her well in the next stages of her career and personal life.

Ian Stead

healthwatch Gloucestershire
local health and care shaped by you

Healthwatch Gloucestershire's Response to 2gether NHS Foundation Trust Quality Statement 2018/19

Healthwatch Gloucestershire welcomes the opportunity to comment on 2gether NHS Foundation Trust's quality account for 2018/19. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we welcome the opportunity to comment. Over the past year we have continued to work with 2gether NHS Foundation Trust to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously.

We are pleased to see that the Trust continues include the involvement of service users, families and carers as a priority to help services improve. We welcome the priority which focuses on children and young people moving to adult services. This is a priority that is shared by Healthwatch Gloucestershire over 2019/20 and therefore, we would be happy to share with the Trust, any relevant, anonymous feedback that we gather during our engagement.

It is encouraging to note that the waiting times for patients who are waiting to begin IAPT treatment has improved.

We note that the Trust highlights areas of discharge care planning where targets have not been met this year, but that this will be a focus for 2019/20. Figures for this improved on a quarterly basis and Healthwatch Gloucestershire would be interested in the evaluation of this in the next year and the impact that this has on patients.

We understand that the number of prone restraints has increased slightly but welcome the new approaches to reduce this number in the year ahead.

The Trust has continued to actively engage with and build on its existing relationship with local Healthwatch in 2018/19.

We acknowledge the Trust's continued commitment to patient and public engagement and their efforts to build on relationships with local Healthwatch and look forward to working with the Trust over the coming year.

Annex 2: Statement of Directors' Responsibilities in respect of the Quality Report

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

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

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2018 to March 2019
    - papers relating to Quality reported to the Board over the period April 2018 to April 2019
    - feedback from Gloucestershire commissioners dated May 2019
    - feedback from Herefordshire commissioners dated May 2019
    - feedback Governors dated 17 March 2019
    - feedback from Herefordshire Healthwatch dated May 2019
    - feedback from Gloucestershire Healthwatch dated May 2019
    - feedback from Gloucestershire Health and Care Overview and Scrutiny Committee dated May 2019
    - feedback from Herefordshire Overview and Scrutiny Committee dated May 2019
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2019
    - the 2018 national patient survey
    - the 2018 national staff survey
    - the Head of Internal Audit's annual opinion over the trust's control environment dated May 2019
    - CQC inspection report dated 1st June 2018

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with MHs Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

….....Date.....Deputy Chair

.....Date.....Deputy Chief Executive

Annex 3: Glossary

ADHD	Attention Deficit Hyperactivity Disorder
BMI	Body Mass Index
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
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
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk register.
GriP	Gloucestershire Recovery in Psychosis (GriP) is ^{2}gether'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.
MCA	Mental Capacity Act
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
NHSI	NHSI 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
MUST	The Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
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.
PBM	Positive Behaviour Management
PHSO	Parliamentary Health Service Ombudsman
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.
PMVA	Prevention and Management of Violence and Aggression
RiO	This is the name of the electronic system for recording service user care notes and related information within ^{2}gether NHS Foundation Trust.
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
SMI	Serious mental illness

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 4: 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:

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Chief Executive
2gether NHS Foundation Trust
Edward Jenner Court
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Gloucester Business Park
Brockworth
Gloucester
GL3 4AW

Telephone: 0300 421 8100 Email: 2gnft.comms@nhs.net

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 0300 421 7146.