QUALITY ACCOUNT

2013/14

Pennine Care NHS
NHS Foundation Trust

CONTENTS

QUALITY ACCOUNT

Whilst financial pressures persist, providing quality care must and will remain our priority.

"We have shown our commitment in providing quality care, with a focus on positive patient experience."

Part 1:

Statement on Quality from the Chief Executive of the NHS Foundation Trust

As the recently appointed Chief Executive of the Trust it gives me great pleasure to introduce you to this year's Quality Account.

This has been another exciting and productive year for the Trust, our members and partners, we have continued to develop services in response to the changing face of the health care system and have seen the organisation continuing to grow, welcoming Community Services from Trafford.

As a Trust, like other NHS organisations across the country, we have had to respond to a number of ongoing financial and other challenges, and in response to these challenges we have demonstrated a resolve and flexibility as to how we provide services. We have shown our commitment in providing quality care, with a focus on positive patient experience. This year, and in the years to come, providing quality care across all our Community and Mental Health Services will always remain central to our aims and goals as an organisation.

Our Quality Account for 2013/14 details quality improvement projects initiated in, and implemented throughout, the year across our Mental Health and Community Services and also sets out some of our key priorities for quality improvement as we move into 2014/15. The priorities for quality improvement have been chosen from the core areas of safety, clinical effectiveness and patient experience, reflecting emergent themes arising from consultation with clinical and operational staff, service users, carers, the Foundation Trust membership and the Council of Governors.

In addition to the quality initiatives detailed within the Quality Account we have initiated numerous additional service improvement projects throughout the year. We have worked closely with service users and carers to improve patient experience as part of the 'Triangle of Care' project. We are improving clinical effectiveness by introducing an improved

integrated health record system ‘PARIS’. Under the direction of the Director of Nursing and Allied Health Professionals we have worked closely with all our staff to consider and act upon recommendations resulting from the Francis report to improve patient safety.

I and all our staff are committed to ensure that Quality will always be at the centre of the care we provide, and in partnership with our service users, carers, Commissioners and local communities, we will make sure that this continues to drive all service improvements.

To the best of my knowledge, the information in this document is accurate.

Michael McCourt
Chief Executive
28 May 2014

Part 2:

Priorities for Improvement and Statements of Assurance from the Board relating to the Quality of Services Provided

Performance in 2013/14 against Quality Indicators identified in the 2012/13 Quality Report

The Trust identified the following quality priorities in 2012/13 which were detailed in last year’s Quality Report.

Priority 1: Rapid Assessment Interface Discharge (RAID, Year 2) Alcohol – Patient Safety

Priority 2: Telehealth – Patient Experience

Priority 3: Physical Health, Community Mental Health – Clinical Effectiveness

The Trust’s performance against each of these indicators in 2013/14 is indicated below.

Further details of our performance in each of these indicators, and a selection of others, is available in Part three of this report.

The priorities as listed above were chosen to represent quality indicators across both Mental Health and Community Services.

Priority 1 above (RAID, year 2 Alcohol – Patient Safety) builds upon the RAID priority and priority 2, Telehealth (patient experience) builds on work commenced as part of the Hospital in the Community initiative, both of which were outlined in last year’s Quality Account. There is no comparative data to report as the priorities examine different aspects of the original projects. Priority 3 was set as a new priority last year and as such no comparison data is available.

We are also pleased that our Council of Governors were again able to choose a performance indicator to be audited by our external auditor. The Council of Governors have chosen ‘patient experience – community mental health indicator score with regard to a patient’s experience of contact with a health or social care worker’ and as a result our processes relating to this indicator will be audited.

The Trust is confident that a high level of quality assurance in our 2013/14 priorities can be achieved through internal governance structures and processes, external auditor scrutiny and joint working with our community and mental health Commissioners.

Performance in 2013/14

Priority 1: RAID (Year 2) Alcohol – Patient Safety

The overarching aim of this priority is to reduce the attendances to hospital Accident and Emergency (A&E) departments and hospital admissions where alcohol is a key factor, in addition, to develop systems and processes to ensure patients are engaged in appropriate mainstream alcohol services i.e. NHS or 3rd sector.

In order to deliver on this indicator, a dedicated alcohol liaison function consisting of qualified and unqualified alcohol practitioners has been developed as part of the RAID project. These practitioners have worked with a small cohort of people who are high users of unscheduled hospital care, primarily as a result of alcohol dependency, in order to reduce high rates of alcohol-related hospital attendances and admissions.

This has been achieved through targeted support for identified frequent attenders including;

- Increasing the successful engagement of alcohol dependent patients who place most demand on urgent care resources into community-based treatment and recovery
- Improving engagement of this group of patients with community-based, assertive outreach, treatment and support approaches
- Increasing confidence of clinicians to discharge from hospital
- Providing intensive support to clients, to improve chances of successful treatment and recovery in the community.

Across our four boroughs with A&E departments, the team has undertaken assertive community outreach work with people who are recognised as 'frequent flyers' to the A&E department and people who have had a number of acute hospital admissions as a consequence of their alcohol dependency.

The quality outcomes are demonstrable through this case study:

Sam

(N.B this case study uses name changes to ensure confidentiality)

Sam is a 40 year old single man, living in supported accommodation for people with mental health problems. He experiences auditory and visual hallucinations and has developed anxiety as a result; this increases if he needs to go out on his own in busy public places.

Sam reported that both his mother and grandfather had problems with alcohol. His grandfather's death was directly attributable to alcohol misuse and Sam was always exposed to alcohol from a young age. As a child he also suffered incidents of abuse from a relative which he believes have impacted on his mental health and memories of this are a trigger for his drinking.

Sam was referred to the RAID Alcohol team in October 2012 via the RAID A&E team.

Sam had called an ambulance after self-harming whilst intoxicated. At that time Sam reported that he had no knowledge of taking himself to hospital, let alone any memory of the incident in question, until he woke up in a hospital bed the morning after. He then discharged himself.

The RAID practitioner started to meet with Sam on a regular basis. Engagement in the first instance was difficult, however after a period of time a relationship of trust developed and Sam became increasingly keen to participate and address his issues.

Sam reported an 8 year history of binge drinking but disclosed that from December 2011 his drinking pattern has increased and had started to get out of control.

Since December 2011 Sam reported that he had presented to A&E with alcohol related issues approximately 182 times. This was later confirmed by hospital staff.

From hospital records it was reported that Sam was attending A&E sometimes twice daily. Sam's Care Coordinator was not always aware of his A&E presentations, however this communication improved as a consequence of consistent mental health practitioners being present in A&E through the RAID A&E team. Presentations would be similar in nature characterised by intoxication and overdoses. Sam would always be admitted to the Medical Assessment Unit (MAU) overnight but when he had sobered-up would discharge himself.

Sam initially made light of the constant presentations and did not appear to consider his actions risky. When discussing risks to himself, Sam always denied intending to harm himself and would say that he never had any recollection of any of the incidents.

The RAID practitioner worked intensively with Sam over a number of weeks and jointly they discussed various methods for reducing alcohol consumption, addressing his mental health issues and discussed methods for filling his day and occupying his time more productively. With support from the RAID practitioner, Sam started to access social activities and started to consider options around employment.

As Sam was fully occupied, alcohol consumption reduced to a minimum, only consuming the occasional drink at weekends. Hospital presentations also stopped and Sam did not make any presentations to A&E for the 3 months he was with the RAID team.

Since working with the team, Sam has accessed counselling for the abuse he experienced as a child. Prior to this, Sam had never felt ready to talk about it.

Sam now has a peer mentor to support his on-going recovery and he has now been discharged from the RAID service.

Cost savings (patient level example)

January 2012 to October 2012 (excluding overnight admissions)	182 presentations to A&E	**£16,380**
October 2012 to September 2013	36 presentations to A&E	**£3,240**
Cost saving		**£13,140**

Overall, the RAID team has had 3430 contacts in 2013/14. This resulted in over 2100 hours of engagement. 1199 referrals were made to the team with 29% (347) of these referrals being signposted or referred on to other teams etc. This is broken down by quarter in the table below:

Measure	Q1	Q2	Q3	Q4	Total during 2013/14
Total number of referrals made to RAID team	347	333	281	238	**1,199**
Number of Referrals who were signposted or referred into other services	113	107	71	56	**347**

Priority 2: Telehealth – Patient Experience

A key priority for 2013/14 was to increase the use of Telehealth within Pennine Care NHS Foundation Trust, in order to improve the quality of care provided to patients, their clinical outcomes, and their experience. This was enabled primarily through the Hospital in the Community (HinC) project, whereby introduction of new technology (to remotely monitor vital signs) was introduced for patients with long-term conditions, and a robust evaluation framework to demonstrate the benefits was set up. Different models of implementation were progressed, for example, in Bury patients with Heart Failure benefited, in Oldham patients with Chronic Obstructive Pulmonary Disease were selected, and in Heywood, Middleton and Rochdale (HMR) patients under the care of the integrated nursing service were able to access Telehealth.

In order to deliver the outcomes of this indicator, a monthly Telehealth Implementation Group was formed, to support the borough clinicians in the development of this new technology, and the requirement to redesign care pathways to take into account the new ways of working. The overall HinC project was reported through to senior executives via the Service Development Group, and latterly the Integrated Business Planning Group.

Throughout the year, clinical teams have become much more confident in the selection of appropriate patients who could benefits from Telehealth, and the evaluation demonstrates benefits across a range of factors, in all the three boroughs measured (Bury, Oldham, and HMR). Two workshops have taken place enabling the clinical teams to share their experiences and good practice. The evaluation document is now being used by the Service Directors within each borough, as an evidence base to discuss further spread of the existing Telehealth technology, in addition to exploring other technologies that could support self-management and improved outcomes and experience.

Quality outcomes evidence by the evaluation

Overall there has been positive reporting, of patient satisfaction with the technology itself, confidence in their ability to manage their own condition effectively, and reports of increased knowledge and patient reassurance, as exampled by the feedback below:-

- 'It helps monitor my condition. Feel more confident, less anxious about condition. Able to carry on with normal life'
- 'Loved to read my observations, gave me confidence'

- ‘Gives me a sense that because I am on my own someone was monitoring my health’
- ‘More of a view of how my oxygen levels are and therefore reassures me’
- ‘Provided reassurance, helped me to manage my condition’

(Feedback received via patient survey returns)

Carers reported feeling very strongly about the benefits of Telehealth with many or all reporting satisfaction in relation to peace of mind, assisting condition management and helping both patient and clinician to understand changes in the patient’s condition.

GPs were also very positive regarding the benefits of Telehealth with 91% (out of a total of 46 GPs) reporting they felt the technology had enabled early detection and intervention in exacerbations in the patient’s condition. The majority of GPs also reported that Telehealth offered peace of mind for the patients and encouraged better self-management of their condition.

Since implementation, the project has benefitted patients by achieving a 34% (215 to 142) reduction in hospital admissions, a 20% (883 to 710 days) reduction in lengths of stay, and 21% (157 to 124) less A&E attendances. Associated with this deflection from secondary care, to date the project has evidenced savings of £136,393 (£440,366 to £303,973) against hospital admissions and £3,301 (£17,560 to £14,259) in A&E attendances (reductions of 31% and 19% respectively). As the evaluation data only considers nine months of clinical data and there is less data for some patients, the estimated figure for the full year should be approximately £180,000 cost savings, in addition to improved, patient experience and outcomes.

Additionally, it is important to realise that Long Term Condition (LTC) patients experience natural disease progression and deteriorating health. Therefore the savings currently evidenced under-represent the true figure and further financial benefits can be evidenced by considering this. Indeed, interrogation of the data for this patient cohort, prior to any Telehealth intervention, reveals that patients undergo a number of hospital admissions and A&E attendances and crucially that, in a one year period, the frequency of admissions increases by 20% and the frequency of A&E attendances increases by 15%. Thus, in addition the project improves patient experience and outcome, whilst remaining financially viable.

Priority 3: Physical Health, Community Mental Health – Clinical Effectiveness

The following work has been undertaken to deliver this objective:

Information sharing with patients

Pennine Care in collaboration with a local user and carer group developed a standardised letter for service users explaining the importance of good physical health, the link between physical and mental health and also encouraging attendance at their GP practice for an annual physical health check. Care coordinators have the responsibility to distribute this letter to all service users at an appointment or review to facilitate further discussion, address issues and any anxieties and to offer support to the service user to attend the physical health check appointment at the GP surgery.

What we will do next

A physical health leaflet has been developed and will be distributed, this leaflet provides detailed information on what to expect at the annual physical health check and why it is beneficial to attend. The leaflet will be made available to all secondary care community based mental health services, including Early Intervention and Review and Recovery.

Medication monitoring

Pennine Care has developed and implemented a medication specific monitoring tool to be implemented for all service users who are on newly prescribed or changed antipsychotic medication. The medication monitoring tool will be accompanied with medication specific information sheets available from the Choice and Medication website.

A review of the implementation of the medication care plan was undertaken, however identifying the cohort of patients who had either commenced or changed antipsychotic medication during the audit sample period was problematic. The patient cohort was unobtainable via electronic systems and a number of methods were explored to identify the cohort including working with pharmacy colleagues.

What we will do next:

We will carry out a sample audit across our community mental health teams to evidence:

- Medication management care planning
- Provision of a Physical Health letter

This will be feedback to our Commissioners as part of the CQUIN and we will take forward any resultant improvement action plans as a result of this.

We have taken into account staff feedback that medication and medication side effect monitoring is already considered as part of a number of formal review processes’ (e.g. Care Programme Approach (CPA) review and wellbeing care plans). Staff felt that whilst information contained within the specific medication monitoring care plan is useful, adding an additional care plan can be confusing for both staff and patients (e.g. which care plan to follow). Therefore, it is proposed to formally integrate the medication and medication side effect aspects into the existing care plan structures and develop as supporting patient information.

Communication exchange with GPs

We have implemented a trial process for the exchange of information between Pennine Care and GPs to capture the patients who have a serious mental illness who have, or have not, accessed an annual physical health check undertaken in primary care.

The GP Quality Outcome Framework (QOF) indicators highlight the requirement for GPs to undertake an annual physical health check for patients who feature on their Serious Mental Illness (SMI) register. Our aim is to support patients to attend for this annual check in addition to the other support offered to meet physical health needs under the CPA framework.

For those clients who are identified as not attending their GP for a physical health check, the community teams have a responsibility to encourage attendance

and in exceptional cases undertake the physical health check using the agreed tool that has been developed and forward the results to the GP for further interpretation and action.

Pennine Care identified the patients in the cohort (patients with a diagnosis of schizophrenia or bi-polar affective disorder) under the care of community mental health teams (CMHT) and early intervention teams, through performance and information extracting data from the National Care Records System. This data was then cleansed by the community teams and electronically transferred to GP surgeries requesting them to identify those clients who had received an annual physical health check or were scheduled to receive one in the coming months.

This information was then distributed back to community mental health teams for care coordinators to actively work with patients who hadn't attended the GP to support attendance at the GP practice or undertake the physical health check with the multi-disciplinary team (if appropriate).

193 GP surgeries across the Trust footprint were contacted referencing 2651 patients within the identified cohort, 358 patients were included in the responses from GPs identifying that 211 patients had or were scheduled to receive an annual physical health check from their GP.

What next

As per the CQUIN requirements of the remaining patients within the cohort we have directly communicated with CMHT team managers who tasked the care coordinators with supporting and encouraging patients to attend their GP for an annual physical health check. We will continue to progress this workstream throughout 2014/15 with refreshed data and where non-attendance is identified care coordinators will offer for the physical health check to be undertaken by the multi disciplinary mental health team.

Due to relatively modest numbers returned by our method of exchange of information, we will explore with Commissioners more effective systems to improve this.

Our priorities for Quality Improvement for 2014/15

The Trust has undertaken wide ranging consultation to determine its quality priorities for the year, which have been discussed and put forward by the Trust's Quality Group with Board agreement.

Consultation on our priorities has included discussions with the Board, clinicians, operational managers, Council of Governors, service users and carers, and our wider staff from both the Mental Health and Community Services. In addition to the above, the views of the wider public have been considered through a number of consultation and engagement events where an overview of the Quality Account has been presented including; the Trust's AGM; Patient Advice Liaison Service (PALS) service user and carer consultation event and in liaison with Commissioners via CQUIN and our joint quality groups. The three priorities as set out below cover both Mental Health and Community Services and have been set out to align with agreed CQUIN indicators and Trust Quality Priorities. As per previous years, the quality priorities have been chosen to reflect areas addressing patient safety, clinical effectiveness and patient experience.

Priority 1: Quality Thermometer – Patient Safety

Priority 2: Self Management – Patient Experience

Priority 3: Skills Mix – Clinical Effectiveness

This year we have focused on three quality priorities for the coming year, in addition to those priorities, the Trust has set an ambitious programme of quality improvement which is set out in the Trust's Quality Strategy and will be monitored through the Trust's Quality group.

Priority 1: Quality Thermometer

Current performance and rationale for prioritising

The Trust has extensive service line reports across both mental health and community services, each of which contain multiple performance indicators under a range of headings (such as Human Resources (HR) and Finance) the reports whilst extremely comprehensive and detailed were not specifically designed to allow frontline clinicians to directly consider quality of care.

The Trust's Quality Group commissioned a piece of work to develop a tool which would promote consideration, interpretation and appropriate action planning in relation to quality: patient safety, patient experience, clinical effectiveness.

The central component of the Quality Thermometer is to provide services with an at-a-glance view of quality for their service at a team level. The model is based on service leads having identified and agreed three indicators for each quality domain (Safe Care, Effective Care and Experience of Care), which are then used to generate an overall score for quality.

We have already drafted and implemented a Quality Thermometer across Adult Acute Mental Health inpatient wards. Following the successful reception of this, the aim is to extend this to cover all clinical services across the organisation during 2014/15.

How will we track improvement?

The Quality Thermometer will be included as part of Service Line Reporting processes enabling services to review Quality, Performance, Financial and HR information together. This will provide a balanced view of the overall quality and performance within the service.

The Quality Thermometer will give an overall score for quality of service for the team or ward. The score will be calculated based on performance against each indicator in each of the three quality domains and allow individual teams to track quality indicators.

Areas for improvement

Following the initial development of the thermometers, there will be a process of review, which will enable each service to provide feedback and outline any improvements to be made.

There is also a general project improvement plan, which identifies key developments to improve the overall tool and increase assurance. This list will be developed and updated continually alongside the project, but includes:

- Automation of the report via Performance and Information
- Weighting of indicators
- Review of targets
- Development of an overall service line thermometer

Actions planned to improve performance

The quality reporting framework will allow identification of areas of best practice, identify opportunities for service improvement and highlight any areas that may require urgent attention.

How will we report this priority?

This priority will report into, and progress will be monitored by both internal and external groups. Internally this priority will be reported into the Trust's Quality group; externally the priority will provide updates in to the Trust Community and Mental Health Joint Commissioner Provider Quality Groups.

Priority 2: Self Management

Current performance and rationale for prioritising

As a Trust our vision is 'to deliver the best possible care to patients, people and families in our local communities by working effectively with local partners, to help people to live well'. This quality priority outlines our approach in supporting this vision through developing self-management options. There are a number of important considerations in the planning and delivery of care with our patients that reinforce the importance of developing a self-management ethos, these include:

- Around 15 million people in England have one or more long-term conditions. The number of people with multiple long-term conditions is predicted to rise by a third over the next ten years

- People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days
- Treatment and care of those with long-term conditions accounts for 70 per cent of the primary and acute care budget in England
- Around 70-80 per cent of people with long-term conditions can be supported to manage their own condition

Source – Department of Health Statistics

Self-management has been identified as a key organisational priority and enabler which contributes to achievement of the ambitions set out in the Trust Service Development Strategy.

A report will be submitted to the Service Transformation Group in April 2014, namely "Self-Management using an Organisational Development (OD) Approach" which will:

- Define what is meant by self-management
- Summarise the outcomes from mapping of self-management activity and highlighting themes
- Review of progress on the pilot underway within the Oldham cluster
- Provide feedback from the recent Service User and Carer conference where self-management was the main focus
- Propose a framework for the coordination and development of a programme to support the Divisional Business Units with the delivery of this agenda

How will we track improvement?

Acceptance of the recommendations contained within the paper by the Service Transformation Group in April will result in a number of activities which will be tracked through the Group.

Areas for improvement

A wealth of work has been undertaken to support the development of a self-management culture, although at present these comprise a number of separate activities rather than an agreed strategic approach. Greater benefits will come from viewing self-management as a major cultural change and adopting a planned approach from this basis. The approach being proposed is detailed within the "Self-Management using an OD Approach" report, which will be proposed to the Service Transformation Group to agree and oversee.

Actions planned to improve performance

- Self-management vision workshop be facilitated for Executive Directors and Service Directors
- A project approach for self-management to be agreed with Service Directors to ensure the enabling work with teams and services is in place prior to the Living Well Academy roll out
- The Service Transformation Group to maintain an overview of this agenda
- Service Directors agree with their local Clinical Commissioning Groups (CCG) the plans for joint working on self-management, and commission support from OD as required
- A patient experience strategy and delivery plan will be developed with a named organisational executive sponsor and operational lead to ensure this important agenda can deliver to its optimum potential

How will we report this priority?

Reporting mechanisms for this work stream will be identified and agreed by the Service Transformation Group and will be delivered and reported throughout the year.

Priority 3: Ward skill mix review

Current performance and rationale for prioritising

National concerns regarding staffing levels and the skills of staff were highlighted through the series of enquiries concerning the failings of care at Mid-Staffordshire Hospital. In October 2013 the Government published its response, which included a number of requirements for the future monitoring and measurement of staffing levels in all care settings.

Simply determining the number of nurses, midwives or care staff required is only one part of the equation. The skill mix of the workforce should reflect patient care needs and local requirements, considering the experience and capabilities of the workforce employed.

There has been much debate as to whether there should be defined staffing ratios in the NHS, but the current view is that there is no single ratio or formula that can calculate the answers to such complex questions. The right answer will differ across and within organisations, and reaching it will require the use of evidence and evidence based tools.

There are a number of key requirements for all Trusts regarding the reporting and monitoring of staffing levels which will be included in the 2014/15 National Standard Contract.

The evidence base in relation to workforce planning and safe and effective staffing within mental health, learning disability and community settings is less established than that for acute care settings. The composition of the multi-professional team in mental health settings, for example the presence of occupational therapists and psychologists, will have a direct impact upon nurse staffing requirements. This forms the basis for current and future work nationally.

All Pennine Care wards are engaged in a Trust-wide ward skill mix review project, the initial phase is to gather baseline information required to inform the development of local action plans and a proposal to Trust Board regarding continuous improvement.

How will we track improvement?

The project has been commissioned and will be overseen by the Director of Nursing and Allied Health Professionals and improvements will be tracked by delivering actions identified in the agreed Trust-wide action plan. Each area will then be accountable to their Divisional Business Unit with regards to agreeing and tracking improvements against their local action plan in their service areas.

The Trust board will be kept abreast of delivery of the project through regular updates and ad hoc board development sessions.

Areas for improvement

The project is focusing on improving the skill mix on the Pennine Care inpatient wards. This improvement will be grounded on intelligence and evidence of the required skill mix based on average patient dependency profiles and experienced multi-disciplinary professional judgement.

The average dependency of patients will be mapped over a period of time and calculated using evidence based tools.

Each service area will undertake an exercise to develop the staffing mix for their ward based on experienced multi-disciplinary professional judgement supported by sound rationale.

Each service area will also review the staffing mix required to support the delivery of all clinical and non clinical tasks identified through a patient journey.

The current staffing establishment and budget on each ward will be reviewed taking into consideration a number of factors:

- The type of inpatient ward e.g. Acute/ Rehabilitation, single rooms
- Dependency of patients
- National changes to human resource law (e.g. maternity and paternity leave)
- Trust expected sickness levels
- Mandatory and additional (Care Quality Commission (CQC) required) training

Actions planned to improve performance

The project group will continue to gather the baseline information and local intelligence. All baseline information will be collated and analysed by the project team using the evidence based tools to produce a proposal for consideration by the Trust Board with regards to local level actions to improve the skill mix in each ward area (services will be grouped e.g. all adult acute inpatient wards).

The Board proposal will focus on areas such as:

- Developing the skill mix through robust training and education
- Identification of areas where there is a definite need to change the existing staffing model to facilitate the improved skill mix
- Ability of wards to develop the required skill mix within existing staffing establishment and budgets

Opportunities will be provided for staff to attend relevant courses and seminars related to the project to improve their skills and knowledge.

As of the 1st April 2014 all ward areas will clearly display the expected and actual ward staffing numbers for each shift on a display board outside of the ward area. Where there is a discrepancy between the actual and expected staffing numbers there will be a section to provide further information regarding actions being taken to address the shortfall.

How will we report this priority?

The priority will be reported on a quarterly basis to Trust board and also to Commissioners on a quarterly basis to support the achievement of the additional quality incentive for 2014/15.

Each service area will be required to report progress locally via their Divisional Business Unit in the spirit of devolved autonomy.

Statements of assurance from the Board

During 2013/14 the Pennine Care NHS Foundation Trust provided and/or sub-contracted one relevant health services.

The Pennine Care NHS Foundation Trust has reviewed all the data available to them on the quality of care in one of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100% of the total income generated from the provision of relevant health services by the Pennine Care NHS Foundation Trust for 2013/14.

The data is reviewed through Board's monthly review of the Integrated Governance Report. The data reviewed covers the three dimensions of quality: patient safety, clinical effectiveness and patient experience.

Information on participation in clinical audits and national confidential enquiries

During 2013/14 six national clinical audits and one national confidential enquiries covered relevant health services that Pennine Care NHS Foundation Trust provides.

During 2013/14, Pennine Care NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Pennine Care NHS Foundation Trust was eligible to participate in during 2013/14 are as follows:

Area	Time of audit	Applicable to Pennine Care?	Participation from Pennine Care?
Psychological conditions	Prescribing in mental health services (POMH)	Yes	Yes, (in 4 out of 4 topics)
	National Audit of Schizophrenia	Yes	Yes
	National Audit of Memory Clinics	Yes	Yes
Mental Health	National Confidential Enquiry into Suicide and Homicide by people with mental illness	Yes	Yes

The national clinical audits and national confidential enquiries that Pennine Care NHS Foundation Trust participated in during 2013/14 are as follows: (all as detailed in the table above).

The national clinical audits and national confidential enquiries that Pennine Care NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, 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:

Title of audit	Percentage of cases submitted	Notes
POMH Topic 7d, Lithium Monitoring	N/A	222 cases were submitted across 37 teams
National Audit of Schizophrenia	N/A	External report not yet completed
National Audit of Memory Clinics	100%	All of the Trust's 5 Memory Clinics participated
POMH Topic 4b: Prescribing anti-dementia drugs	N/A	External report not yet completed
POMH Topic 14a: Prescribing for substance misuse: alcohol detoxification	N/A	External report not yet completed
POMH Topic 10c: Use of antipsychotic medication in CAMHS	N/A	External report not yet completed
National Confidential Enquiry into Homicide and Suicide	N/A	Ongoing participation

The reports of one national clinical audits were reviewed by the provider in 2013/14 and Pennine Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit name: POMH Topic 7d, Lithium Monitoring

Action	Coordinator	Timescale
Consultant Psychiatrists and their teams to be reminded in writing by the Medical Director that it is a Trust requirement for recording baseline lithium and related monitoring to be included in Trust medical notes of patients prescribed lithium	Medical Director/Chief Pharmacist	June 2014
Community Mental Health Teams to be reminded in writing by the Director of Nursing/Medical Director that it is a Trust requirement for recording of ongoing lithium and related monitoring to be included in Trust medical notes of patients prescribed lithium	Medical Director/Director of Nursing/Chief Pharmacist	June 2014
Report (including conclusion, recommendations and action plan) to be placed on the agenda of the Quality Group for discussion	Medical Director/Chief Pharmacist	June 2014

The Trust undertakes a programme of local audit on clinical performance which is reported to the Board of Directors.

The reports of 48 local clinical audits were reviewed by the provider in 2013/14 and Pennine Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (these represent a selection of key actions from 3 of the audits):

Audit name: Community Services Quality Monitoring Records Audit

Action	Coordinator	Timescale
Where alterations have been made to a health record, the date and time of alteration, and name and designation of the person making the alteration should be recorded	Clinical Lead/Team Manager	September 2014
Past medical history should be recorded in all cases, or a statement made if no past medical history	Clinical Lead/Team Manager	September 2014

Audit name: Audit of Safeguarding Children processes in Health Visiting and School Nursing (Community Services)

Action	Coordinator	Timescale
Ensure staff maintain documentary evidence of child safeguarding supervision plans with the health record	Named Nurses	November 2014
Explore reasons why Looked After Children (LAC) Review documentation is not evident in the health records and identify ways to improve	Named Nurses	November 2014
Explore reasons why child protection conference and review documentation is not evident in the health records and identify ways to improve	Named Nurses	November 2014

Audit name: Physical Health Audit

Action	Coordinator	Timescale
Increased monitoring of documentation being used by inpatient teams. Increase awareness amongst staff of how to access Trust Approved Documentation (TAD) to ensure up to date documentation is in use	Modern Matrons/Ward Managers	March 2014
Increased monitoring of the completion of height, weight and BMI recordings on Trust Approved Documentation	Modern Matrons/Ward Managers	March 2014
Following the launch of the TPR/MEWS chart, additional support in embedding the use of this to be identified through monitoring of completion	Modern Matrons/Ward Managers	March 2014

Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Pennine Care NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 182.

Participation in clinical research demonstrates Pennine Care's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Pennine Care was involved in conducting 48 clinical research studies during 2013/14.

There was approximately 200 clinical staff participating in research approved by a research ethics committee at Pennine Care during 2013/14. These staff participated in research covering five medical specialties.

In addition, in the last three years, three publications have resulted from our involvement in National Institute of Health and Research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Our engagement with clinical research also demonstrates Pennine Care's commitment to testing and offering the latest medical treatments and techniques.

Information on the use of the CQUIN Framework

Commissioner quality schedule

A proportion of Pennine Care NHS Foundation Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between Pennine Care 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 2013/14 and for the following 12 month period are available online at: **www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275** or on request from the Trust at Pennine Care NHS Foundation Trust, 225 Old Street, Ashton-under-Lyne, OL6 7SR.

In 2013/14 £4,941,486 was contingent on performance against a range of National, Greater Manchester and Local indicators. The Trust has received the full value as a result of its performance. Further information on the financial performance of the Trust is available within the Annual Accounts. The monetary total for the associated payment in 2012/13 was £4,179,417.

These standards have been based on quality indicators outlined in the model contract and some locally driven indicators. Some of the areas of focus are outlined below:

- National Safety Thermometer
- Transfer of Care
- Physical Health Checks
- RAID
- Identification of problematic alcohol

In addition the Trust has worked to achieve a variety of quality indicators that are not income contingent, but nonetheless form part of an agreed quality schedule between the Trust and its Commissioners. The Quality Schedule has considered a range of indicators including the following:

- All Serious Incident investigations to be completed and issued to Commissioners within 45 working days from date of incident (60 days for homicides) – National Indicator
- % malnourished patients >60 years who have a treatment plan agreed with dietetics – Greater Manchester Indicator
- Provision of evidence of involvement and actions of AMH, CRT or EIT in the care planning of all 16 and 17 year olds admitted to the Hope/Horizon Unit – Local indicator

Information on registration with the Care Quality Commission

Pennine Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Registered". Pennine Care NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Pennine Care NHS Foundation Trust during 2013/14.

Pennine Care NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Response to regulators

Pennine Care NHS Foundation Trust is fully registered with the Care Quality Commission, without conditions.

Use of the Care Quality Commission's registration and quality and risk profile

The Health and Social Care Act 2008 identifies a number of regulations which the CQC has interpreted into 28 outcomes. Pennine Care NHS Foundation Trust has been given registration to provide services for the regulated activities:

Mental health services

- Treatment of Disease Disorder and Injury
- Assessment or Medical Treatment of People Detained Under the Mental Health Act 1983
- Diagnostic and Screening Procedures

We have provided these activities within services registered at the following locations:

- Fairfield General Hospital, Rochdale Old Road, Bury
- Royal Oldham Hospital, Rochdale Road, Oldham
- Birch Hill Hospital, Union Road, Rochdale
- Tameside General Hospital, Fountain Street, Ashton under Lyne
- Stepping Hill Hospital, Poplar Grove, Stockport
- Heathfield House, Cale Green, Stockport
- Meadows, Offerton, Stockport
- Stansfield Place, Rochdale
- Rhodes Place, Oldham

Community healthcare services

- Diagnostic and Screening Procedures
- Sexual Health
- Surgical Procedures
- Treatment of Disease, Disorder or Injury
- Accommodation for Persons Who Require Nursing or Personal Care
- Nursing Care
- Personal Care

We have provided these activities within services registered at the following locations:

- Trust Headquarters, 225 Old Street, Ashton under Lyne
- Bealey Community Hospital, Dumers Lane, Radcliffe
- Cambeck Close, Whitefield, Greater Manchester
- Moorgate Primary Care Centre, Derby Way, Bury
- Prestwich Walk in Centre, Fairfax Road, Prestwich
- Butler Green House, Wallis Street, Chadderton
- Grange View, Grange Road South, Hyde
- Whitehall Street Clinic, Rochdale
- Nye Bevan House, Rochdale
- Integrated Care Centre, Oldham
- Radcliffe Primary Care Centre, Radcliffe
- Milnrow Health Centre, Rochdale
- Phoenix Centre, Rochdale

We have had to register all of our services against the following regulations and assess our own compliance with the outcomes underpinning each of these.

Section 1:
Involvement and information

- Respecting and involving people who use services
- Consent to care and treatment

Section 2:
Personalised care, treatment and support

- Care and welfare of people who use services
- Meeting nutritional needs
- Cooperating with other providers

Section 3:
Safeguarding and safety

- Safeguarding people who use services from abuse
- Cleanliness and Infection Control
- Management of medicines
- Safety and suitability of premises
- Safety, availability and suitability of equipment

Section 4:
Suitability of staffing

- Requirements relating to workers
- Staffing
- Supporting staff

Section 5:
Quality and management

- Statement of purpose
- Assessing and monitoring the quality of service provision
- Complaints
- Records

Section 6:
Suitability of management

- No declarations were made under this heading

The CQC publish a Quality and Risk Profile (QRP) for the Trust that is refreshed almost every month. This indicates to the CQC and the Trust potential areas of concern. It shows where we are achieving better, average or worse than other similar organisations against a range of indicators, including the patient survey and the staff survey.

Pennine Care NHS Foundation Trust uses the QRP as part of its quality monitoring processes. This allows the organisation to ensure compliance with the regulations and where this is not the case take appropriate action.

Pennine Care NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

99.9% for admitted patient care;

99.9% for outpatient care; and

N/A for accident and emergency care.

Which included the patient's valid General Practitioner Registration Code was:

100% for admitted patient care;

100% for outpatient care; and

N/A for accident and emergency care.

Pennine Care NHS Foundation Trust's Information Governance Assessment Report overall score for 2013/14 was 72% and was graded green.

Pennine Care NHS Foundation Trust was not subject to the Payment by results clinical coding audit during the reporting period by the Audit Commission.

Information on the quality of data

Pennine Care NHS Foundation Trust will be taking the following actions to improve data quality:

We will continue to work with our Data Quality Governance Group that reports into the Trust's management structure. The group has developed a Data Improvement Action plan to focus on outstanding areas for improvement.

The Data Quality Governance Group led by the Performance and Information Department have a duty to support operational services to ensure that all activity data is recorded timely, accurately and robustly on Pennine's electronic clinical/ patient systems. The Performance and Information Department work closely with operational services to ensure they take responsibility for the quality of data recorded on the clinical system. They engage and encourage our teams to improve both the level and quality of activity information recorded and ensure the teams understand the importance of this.

We feel the clinical record is an important tool for our practitioners to understand the care being provided to our service users. Having an accurate record ensures our staff have the most accurate information in which to work from.

DH Mandatory quality indicator set to be included in the 2013/14 Quality Accounts

In addition to the indicators detailed later in this report, the following additional indicators and statements are required to be reported in 2013/14.

	2012/13	2013/14	National range	Threshold/ national average
CRHT Gatekeeping	99.3%	99%	90.7 – 100%	95% – 98.3%

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reason; to show the percentage of admission to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by continuing to monitor adherence to the above target and to take any remedial action if required. (Figures reported as per compliance framework).

	2012/13	2013/14	National Range	Threshold/ National Average
CPA 7 day follow up	98.4%	95.1%	92.5 – 100%	95% – 97.4%

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reason; to show the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by continuing to monitor adherence to the above target and to take any remedial action if required. (Figures reported as per compliance framework).

Mental health 28 day emergency readmission rates	Age range	2012/13	2013/14	National range	Threshold *
Adult Wards	18 – 65	11.3%	11.5%	N/A	10%
Older Adult Wards	Over 65	5.8%	8.5%	N/A	5%
CAMHS Wards	0 – 14	0.0%	0.0%	N/A	NK
	Over 15	5.8%	8.5%	N/A	NK

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons; to show the percentage of patients aged 0-14; and 15 or over, readmitted to a hospital which forms part of the Trust, within 28 days of discharge, from a hospital which forms part of the Trust, during the reporting period.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by continuing to monitor readmission rates to feed these back into operational services to look at systems and processes to make improvements (e.g. RAID).

*Averages taken from NHS Benchmarking MH Inpatient Report. Internally generated reported readmission percentages.

	2012/13	2013/14	National range	National average
Patient Experience – Community Mental Health	8.8	8.3	8.0 lowest 9.0 highest	N/A

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reason; to show the Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by continuing to actively engage with our service users to capture patient experience through the use of satisfaction kiosks and other means to provide direct service feedback to inform any required actions.

Note: Scores are out of a possible ten, information obtained from CQC NHS National Patient Survey 2013

DH Mandatory quality indicator set to be included in the 2013/14 Quality Accounts continued

Patient Safety Incidents		2012/13 Q1 + Q2	2012/13 Q3 + Q4	*National range		National total
				Lowest	Highest	
Total number of incidents ***		2,350	2,103	405	6737	91,983
Rate per 1000 bed days		28.2	25.3	8.2	99.8	N/A
Number of incidents resulting in	Severe harm	0	0 (0%)	0 (0%)	122 (1.8%)	507 (0.6%)
	Death	14 (0.6%)	15 (0.7%)	0 (0%)	59 (1.9%)	746 (0.8%)
Total number of incident resulting in severe harm or death		14 (0.6%)	15 (0.7%)	**N/A	**N/A	1.4%

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons; to show the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number of percentage of such patient safety incidents that resulted in severe harm or death.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by reviewing SUI's the Trust's Patient Safety Improvement Group will identify learning to improve systems and the quality and safety of patient care.

Note: * Data filtered by Trusts reporting six months of activity.** Different NHS Trusts, unable to combine to provide total *** This is not intended to indicate performance but instead to show the National range, the number of incidents will vary influenced by the size of the NHS organisation and differences in population.

2012/13 Data reflects six monthly reporting period Quarter 1 + Quarter 2 April – September 2012 and Quarter 3 + Quarter 4 October 2012 – March 2013 (updated figures not yet available).

	2012	2013	National range	National average
Staff who would recommend the Trust as a place to work or receive treatment	3.64	3.54	3.01 lowest 4.04 highest	3.55

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons; to indicate the extent to which staff employed by the Trust during the reporting period would recommend the Trust as a provider of care to their family or friends.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by implementing a Trust Quality Group which considers, oversees and develops actions concerned with and to ensure the quality of our services and the care we provide.

Note: Scale = 1 (unlikely to recommend) to 5 (likely to recommend), information obtained from CQC NHS National Staff Survey (2012) and Picker Institute Europe (2013), page 20, KSF finding 24 available online at: http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2013_RT2_full.pdf

Other than the other data sources stated, the above information was obtained from the Health and Social Care Information Centre, via the Indicator Portal March 2014.

Part 3: Review of quality performance, involvement, and external statements

Working closely with commissioners to drive quality

Throughout 2013/14 we have continued to work closely with our Mental Health and Community Services Commissioners to ensure that providing quality care remains the central and most important aspect of how we develop and deliver services.

Our Joint Commissioner and Provider Quality groups provide challenge and scrutiny as to how we provide services and in doing so promote an ongoing culture of openness, transparency and collaborative working.

As providers and Commissioners we have a joint commitment and responsibility to ensure that our local communities receive high quality health services and we will continue to build and strengthen our focus on quality throughout 2014/15 and into the coming years.

Current view of the Trust's position and status for quality

During 2013/14 the Trust has continued to drive service improvement schemes with a focus on quality. Part three of this Quality Account details nine of the quality improvement priorities chosen by the Board following ongoing consultation with our service users and carers, Commissioners, Trust membership, and our local communities and partner organisations.

In response to requests from our Commissioners we are pleased to introduce a review of our quality initiatives in 2013/14 by giving an overview of how we are taking an organisational approach towards:

- Our response to the Francis report
- Capturing Patient Experience
- Safeguarding Adults and Children

Our response to the Francis Report

The Francis report outlines serious failings in patient care which occurred at Mid Staffordshire NHS Trust. Detailed within the report are 290 recommendations for all NHS Trusts, Commissioners and external regulators to ensure similar failings in care and safety are not repeated.

Led by the Director of Nursing and Allied Health Professionals, as a Trust, from frontline staff to our Trust Board, we have actively consulted on, and considered the recommendations contained within this and other reports (such as Keogh and Berwick), and developed a Trust-wide action plan to ensure that we keep quality care central to all we do. Our action plan outlines our commitment to providing safe and effective care, with a focus on positive patient experience across the following areas:

Putting the patient first

We will ensure that patients receive effective services from caring, compassionate and committed staff, working to a common culture. Patients must also be protected from avoidable harm and any deprivation of their basic rights.

Common culture

We have a commitment to a common set of values and accessible basic care and treatment standards, which we will embed through our Principles of Care.

Values and standards of service

Fundamental basic standards of care will be applied by all those who work and serve in healthcare.

Openness, transparency, candour and effective complaints system

We will work to ensure a culture of:

- Openness: enabling concerns to be raised and disclosed freely without fear
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public
- Candour: ensuring that where patients are harmed they are informed of that fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question raised about it

Leadership

We will provide common professional training on leadership and management to promote healthcare leadership and management as a profession and promote research best practice.

Nursing

The 6 Cs of nursing, as outlined in the national strategy: care, compassion, competence, communication, courage and commitment, will continue to underpin and direct our fundamental approach to how we deliver nursing care.

Performance management and information

We will work to ensure that detailed and essential information is available to frontline services, and progress with introducing an electronic integrated health records system through the implementation of the PARIS clinical information system.

We will continue to review our effectiveness in relation to our action plan throughout the coming year and where necessary will take any appropriate actions to ensure we continue to deliver high quality care across all our Mental Health and Community services.

Capturing patient experience to enhance quality

The Trust has continued to focus on the variety of mediums available to capture the experiences of service users and carers accessing services, whilst ensuring these methods are routinely available and promoted.

Listening to the voice of the patient whilst capturing their experiences enables us to identify areas for change, as well as driving service enhancements and improvements.

We aim to provide all service users and carers with the opportunity to comment on their experience whilst accessing Pennine Care services, using real-time initiatives which the Trust has employed, in the forms of the Elephant Kiosks and SMS texting. Where these methods have yet to be adopted, we have alternative methods available to capture feedback.

Introducing friends and family test

The Friends and Family test involves directly asking both service users and our staff:

''How likely are you to recommend Pennine Care NHS Foundation Trust to friends and family should they require similar care or treatment?"

In 2014/15 reporting the friends and family test will be fully rolled out across all our community and mental health services. However, during 2013/14 we began collecting this feedback resulting in 91%* of patients stating that they would be 'extremely likely' or 'likely' to recommend Pennine Care NHS Foundation Trust to friends and family should they require similar care or treatment.

The friends and family test is included on all Elephant Kiosks, SMS texting and is included in all bespoke paper based questionnaires which are developed.

*Based on 3253 responses out of a total of 3693

Our approach to safeguarding

As a leading healthcare provider Pennine Care NHS Foundation Trust recognises its requirements to demonstrate that we have safeguarding leadership and commitment at all levels of our organisation and that we are fully engaged and in support of local accountability and assurance structures, in particular via the Local Safeguarding Child and Adult Boards (LSCB, LSAB) and our Commissioners. Most importantly, we strive to ensure that a culture exists where safeguarding is 'everybody's business' and poor practice is identified and tackled.

The Director of Nursing and Allied Health Professionals in collaboration with Divisional Directors has embarked upon a work stream to review the form and function of safeguarding within the organisation. The aim of the work stream is to define a model of safeguarding for the Trust in its changing form that will give a high level of 'fit for purpose' assurance both internally and externally.

Children's safeguarding

Safeguarding children is underpinned by legislation, statute and best practice guidance and incorporates a clear framework outlining the roles and responsibilities for clinical safeguarding practitioners in terms of competency and training requirements.

Roles and responsibilities outside and within the Trust reflect current practice in the realm of safeguarding children taking into account the statutory guidance in 'Working Together'. The guidance makes explicit the governing principles required for provider services and Foundation Trusts and states that NHS Trusts and NHS Foundation Trusts must demonstrate strong local leadership, work as committed partners and invest in effective co-ordination and quality assurance of safeguarding.

Key work streams – child safeguarding

- Trust staff working in borough based Multi-Agency Safeguarding Hubs (MASH)
- Trust representation at LSCB's identified by the Chief Executive to be at Divisional Director Level. The strategic position that Directors hold will ensure that Pennine Care is represented at the highest level by the most appropriate people who hold accountability for service provision and can commit resources
- Embedding child sexual exploitation guidance in to pathways and processes
- Preparation and contribution to the new CQC inspection processes in respect of safeguarding and Looked After Children
- Working with OL&D Directorate to ensure accurate reporting on compliance with training requirements

Key achievements – safeguarding and looked after children

- 100% attendance of Health Visitors and School Nurses at case conferences
- Increase in the uptake of Level 2 safeguarding children training

- Local lessons from Serious Case Reviews have been disseminated into Level 3 safeguarding training
- Harmonisation of Domestic Abuse policy and procedures across Pennine Care community services
- Compliance with Section 11 requirements

Adult safeguarding

Given the understanding that Safeguarding Adult Boards (SABs) will become statutory via the implementation of the Care and Support Bill in 2014 and the continuing engagement of NHS organisation will be strengthened, it is timely that the current form and function for Safeguarding Adults within Pennine Care is under review.

Government reform ensures that health providers will be held to account by patients, the public, their Commissioners and regulators. The Care and Support Bill sets out comparable requirements with respect to safeguarding adults, including membership of Safeguarding Adults Boards.

The Trust Board understands its statutory duties to safeguard adults and recognises we play an essential role in safeguarding patients in the most vulnerable situations. Safeguarding adults is integral to: patient care, regulations, legislation and cost effectiveness.

Key work streams – safeguarding adults

- Working with OL&D Directorate to ensure accurate reporting on compliance with training requirements
- Working with Commissioners to review Adult Safeguarding leadership and prepare business cases to secure permanent funding and deliver new ways of working across health and social care

Key achievements – safeguarding adults

- Compliance with LSAB assurance audits
- Compliance with CCG Audits
- Delivered Prevent training (as part of the Government counter-terrorism strategy)

Review of Quality Performance in 2013/14 against the three quality domains

Below is a review of various performance quality indicators in the year 2013/14. These indicators cover three examples each contained within the three quality domains of patient safety, clinical effectiveness and patient experience. Three of these indicators fully detail the Quality Priorities for 2013/14, identified in last year's Quality Account and detailed in Part two of this report.

The following indicators have been chosen to represent the broad overview of service quality across the organisation; comparative data has been included to indicate continuity and progression where available.

Patient Safety Indicator 1 RAID (year 2) – Alcohol, is an extension of the RAID project described in last year's Quality Account, however, this year's indicator gives a different aspect of RAID and no comparative data is available. Clinical Effectiveness Indicator 1, Physical Health, Mental Health expands upon themes from previous Quality Accounts, aimed to address inequalities in physical health outcomes for those with a mental illness however no comparative is data available. Patient Experience Indicator 1, Telehealth builds on work commenced as part of the Hospital in the Community initiative, detailed in last years Quality Account, but no comparative data is available. The remaining indicators are new for 2013/14.

The rationale for changing the reporting in priorities in 2013/14 against those presented in 2012/13 is as follows: the remaining priorities are new initiatives commenced in 2013/14 and are presented with the intention to show that the Trust continues to introduce new and innovative service improvement projects to improve the quality of care for service users and carers across the organisation.

These initiatives have also been introduced in response to changes in the needs of local populations and in response to changes in commissioning priorities and national programmes; these reflect themes from previous Quality Accounts in relation to safety, effectiveness and experience.

Where available, comparative and benchmark data has been included and unless otherwise stated the indicators are not governed by standard national definitions and the source of the data is the Trust's local systems.

Review of Quality Performance in 2013/14 against the three quality domains

Review of Patient Safety Indicators:

Patient Safety Indicator 1: RAID (Year 2) Alcohol

Description of issue and rationale for prioritising

The RAID practitioners continue to work with a small cohort of people who are high users of unscheduled hospital care, primarily as a result of alcohol dependency, in order to reduce high rates of alcohol-related hospital attendances and admissions.

The RAID alcohol approach aims to support the following:

- A focus on A&E 'frequent flyers'
- To increase the successful engagement of alcohol dependent clients who place most demand on urgent care resources into community-based treatment and recovery
- To deliver intensive community support
- To improve engagement of this very complex group of clients
- To support a multi-agency approach – engaging with a wide range of partners including police, housing, citizen's advice etc
- To support the fast-track of clients into mainstream alcohol services
- To work with clients to improve their chances of successful treatment and recovery in the community

Aim/goal

Identifying the most appropriate people for the RAID practitioners to work with is often challenging due to a number of factors. In some boroughs the teams receive referrals from Alcohol Liaison colleagues working within the A&E departments, who have a responsibility to screen and undertake brief interventions with people presenting with alcohol issues or where alcohol is a factor.

Those identified as 'frequent flyers' can then be referred to the RAID team for assertive community outreach work in an attempt to address their alcohol issues and change their behaviour in terms of utilisation of urgent care services.

Not all acute Trusts have this specific liaison function available; where this is not in place the RAID practitioners are often reliant on local intelligence concerning the frequent attenders.

Clinical coding, in terms of alcohol also presents difficulties. Often, the primary reason for attendance is not coded as alcohol; even though alcohol misuse is frequently the contributing factor. Therefore, electronic searches of A&E presentations often do not identify the most appropriate people to work with. This also presents difficulties when evaluating the service if the evaluation utilises data from A&E systems, in terms of looking for a reduction in the number of people presenting where alcohol is a key factor.

Current status

Access to all data required has presented challenges in terms of the evaluation and in demonstrating to Commissioners the value of the service. Throughout the pilot project, the practitioners have collated numerous case studies which highlight the quality outcomes achieved with patients, however from a cost-saving evaluation perspective it has been difficult to quantify.

Identified areas for improvement

As a result, and as RAID moves into Year 3 of being in operation, the data collection and evaluation tool for the RAID Alcohol service is being reviewed. Starting from April 2014, each RAID practitioner will report monthly on the number of people they are actively working with. Each patient will be referenced (anonymously) on the reporting framework, together with the number of contacts made by the practitioner (in an attempt to demonstrate the level of community engagement). The RAID practitioners will also utilise A&E systems to record on the reporting framework, the patient's history in terms of A&E attendances or admissions prior to working with the RAID team and this will be subsequently documented each quarter post-engagement. This process will rely on a manual recording process by the practitioners themselves, as in order to demonstrate the value of this service, it is essential that the Trust accesses data from the Acute Trust A&E systems.

Ultimately, through this approach, it is envisaged that cost-savings can be calculated against individual patients.

Current initiatives

This approach will be piloted through the month of March with a view to be implemented from April 2014 onwards.

New initiatives

CQUIN funding to support the RAID approach has been confirmed for 2014/15 in order for the project to be formally evaluated and further performance evidence to be collated. It is hoped this evaluation will inform and influence commissioning intentions regarding the provision of long-term funding for the RAID project.

Patient Safety Indicator 2: Caring for complex children at home: The work of the Childrens' Long Term Ventilation Team

Description of issue and rationale for prioritising

The Childrens' Long Term Ventilation Team (LTVT) provide bespoke packages of care to children with complex life limiting conditions, some of whom are technology dependant in their own homes, the team supports the children in many different settings, in complete partnership with the child's parents.

Each package of care is carefully tailored to the individual needs of the child and family through a partnership approach. The LTVT ask families what their expectations are and ensure these are met in a meaningful, safe way to promote the independence of the child.

The team regularly obtain feedback from families regarding the care received and act upon any suggestions to improve service delivery.

Due to our staff working within the child's home a partnership approach is vital as is the feedback from families throughout their child's health journey.

Aim/goal

The aim of the LTVT is to ensure children cared for by this service remain as healthy as possible utilising the skills of a multi-agency team enabling rapid assessment, diagnosis and prescribing of medication (if needed). This approach enables the team to safely deflect children from secondary and tertiary care.

Current status

The Childrens' LTVT was set up in 1997 after it was noted that children requiring technology to maintain life were occupying beds on Paediatric Intensive Care Units in the tertiary centres. The service started with one child and a team of five care staff and a team leader. The team has increased year on year and the team now supports up to 11 children in their own homes with packages of support tailored to the child and family's individual needs.

Each client has an individual assessment and all care plans are undertaken in partnership with clients and the family; parents sign the nursing assessment and nursing care plans, to indicate their participation. Care plans are evaluated on an ongoing basis in partnership with parents and families. All care plans are signed by parents. All care plans are annually reviewed and updated.

The service has an on call system from 06:30 to 22:30, where a paediatric nurse is available 365 days a year to answer any issues.

The CQC assessment completed in October 2013 highlighted many areas of good practice within the service.

Identified areas for improvement

The results of a recent CQC assessment were excellent with no areas noted for immediate improvement; however the team continually strives for the gold standards that it sets themselves.

The team has recently improved the training package that it uses to train new staff members. This package now gives the carers much more theory regarding why a procedure is carried out and what systems of the body are affected at any given time.

Staff skill core competencies have been improved, and are completed by staff for each child they work with at patient specific level.

The team also continually works with parents to achieve the best outcomes supporting families in a variety of inventive ways including supporting family holidays, taking children to school and on shopping trips, attending to all the child's health needs during the trips.

Current initiatives

Current Initiatives include continuing to ensure all staff have competency checks each year regarding medical tasks and administration of medication. Ensure all mandatory training is up to date, and to ensure all staff receive managerial supervision on a 6-8 weekly basis.

New initiatives

The team is currently looking at working with OL&D and Salford University to develop the apprenticeship scheme being promoted by Pennine Care utilising the current teaching package. This will enable all Support Workers to have a recognised qualification.

The team is also looking at introducing medication reviews on a 6 monthly basis or sooner if required, following a recommendation from the CQC assessment.

Patient Safety indicator 3: The development of Condition Orientated Groups (COGs) to enhance quality and patient safety

Description of issue and rationale for prioritising

The Community Rehabilitation Teams operating within Trafford division consist of four teams of Occupational Therapists (OT), Physiotherapists and Support Workers providing home based interventions to adults with physical disabilities. We also have one outpatient service.

Each team, with the exception of the outpatient team, covers a different geographical area within Trafford and are therefore based separately. The majority of the caseloads consist of older adults.

We identified several issues across the teams which initiated the idea to draw together the recommended best practice for the conditions that our clients most commonly present with. There was a difference in skills across the four teams; one OT had a particular interest in treating people with Parkinson's disease and another for people diagnosed with cancer, one OT had specialist knowledge of pain management and another within stroke rehabilitation. Whilst it is useful and expected that clinicians have their areas of expertise, this clearly led to inequalities of knowledge and skills across the localities.

Aim/goal

The aim of COG is to be able to clearly demonstrate equitable access to the quality, evidence based rehabilitation service that we provide and the skill level of the staff providing this across all teams.

Current status

We have developed multi-disciplinary team working groups for Falls, Oncology, Dementia and Parkinson's disease (known as COG). We gathered together existing recommendations for best practise from a variety of sources including the College of Occupational Therapists, the Chartered Society of Physiotherapists, NICE, NSF, and compiled a checklist of interventions for each profession and each condition. This list was not prescriptive but provided options of best practice and allowed for clinical reasoning.

We were then also able to identify which grades of staff would be expected to carry out which interventions, for example not all grades would be expected to be confident in splinting. The checklists are used as part of each client's documentation.

Benefits

- Increased confidence that we are meeting best practice guidelines in areas which may not be our speciality. The checklist provides a quick way of doing this and ensuring that areas are not being overlooked
- Checklists of clinical competencies allowing each grade of staff to be able to sign off the areas they feel confident in and to identify their own training needs. A training programme has been completed and there has been a consequent increase in skills and knowledge
- The clients are receiving a more equitable service across the borough
- It has enabled some staff to develop an area of expertise by being involved in researching the best practice and delivering and organising training

Identified areas for improvement

Reviews are underway to ensure that the most appropriate guidelines are placed in the patient's records, specifically when a patient has more than one condition.

Current initiatives

The COGs are under review at present to enable the inclusion of the patient support workers in the signing of competencies. A Cardiovascular Accident COG is under development.

The format of the COGs is under review to enable each document to be printed in a user friendly way.

New initiatives

We plan to run two events to promote awareness and share best practice:

- The first to take place within the Trust to raise awareness of the COGs and share their development and the transferable opportunities across other professions and services
- The second event will be available for clinicians outside of Pennine Care to attend and share the development of the COGs, their uses and potentially generate income

Review of Clinical Effectiveness Indicators

Clinical Effectiveness indicator 1: Physical Health, Community Mental Health

Description of issue and rationale for prioritising

People with serious mental illness are at increased risk of developing cardiovascular and respiratory disease as a result of lifestyle factors and side effects of anti-psychotic medication. Evidence suggests that people with severe mental illness (SMI) die 15-20 years younger than people without a SMI. Research presented in the British Journal of Psychiatry suggests that people with schizophrenia have a mortality risk that is two to three times that of the general population. Most of the extra deaths are from natural causes, particularly cardiovascular disease, and in addition, people with schizophrenia appear to be missing out on the improved cardiovascular mortality of the general population.

Results from the CQC survey show that less than 60% of patients are asked about physical health needs, receive support for physical health needs or are told about the side effects of medication.

Surveys undertaken by Rethink suggest that people with schizophrenia and bipolar disorder are less likely to attend routine check-ups, and a survey found that only one in three people with mental illness had been offered a physical health check.

NICE Guidance states that GPs and other primary care professionals should monitor the physical health of people with schizophrenia at least once a year.

Evidence suggests that having a protocol in place and monitoring form is not enough to ensure physical health checks are completed but the use of education, visits, and media campaigns can help.

The recent English Mental Health Strategy No Health without Mental Health has made a commitment to 'parity of esteem between mental and physical health services', and has a clear objective to improve the physical health of those with a mental disorder.

The more recent report, Whole-Person Care: From Rhetoric to Reality, highlights the significant inequalities that exist between physical and mental health care, including preventable premature deaths, lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems.

Aim/goal

The aim of this priority is to raise awareness of the importance of physical health checks with both mental health service users, staff and carers and also to improve collaborative working between primary and secondary mental health care services to support patients with severe and enduring mental illnesses to routinely access annual physical health checks and improve their health outcomes.

Current status

The Tier 4 community group has overseen the delivery of the Physical Health CQUIN objectives of the initiative.

To date the CQUIN has proved beneficial in terms of delivering the aims and objectives.

The following work has been undertaken to deliver this objective:

Pennine Care in collaboration with a local user and carer group has developed a standardised letter for service users explaining the importance of good physical health, the link between physical and mental health and also encouraging attendance at their GP practice for an annual physical health check. Care co-ordinators have the responsibility to distribute this letter to all service users at an appointment/review to facilitate further discussion, address issues or anxieties and offer support to the service user to attend the physical health check appointment.

A patient information physical health leaflet has also been developed providing detailed information on what to expect at the annual physical health check and why it is beneficial to attend. This leaflet will be made available to all secondary care community based mental health services, including Early Intervention and Review and Recovery.

We have developed and implemented a medication specific monitoring care plan to be implemented for all service users who are newly prescribed or changed anti-psychotic medication. The medication monitoring care plan will be accompanied with medication specific information sheets available from the Choice and Medication website.

Pennine Care have implemented a process for the exchange of information between Pennine Care and GPs to capture the services users who have not accessed a health check.

The tables below demonstrate the outcome of the information exchange between Pennine Care and GPs across the five boroughs where mental health services are delivered by the Trust.

CCG	Number of GPs contacted	% of GPs responded	Total number of patients in the cohort	Number (%) of patients included in the response
Oldham	44	22%	518	59 (11%)
HMR	35	22%	744	98 (13%)
Stockport	42	21%	500	69 (13.8%)
Tameside and Glossop	44	18%	428	72 (16%)
Bury	28	14%	461	60 (13%)

CCG	Of those GPs responding the number of Patients who have received a physical health check at the GP (%)	Of those GPs responding the number of Patients who had not received a physical health check at the GP but had a check scheduled (%)	Of those GPs responding the number of Patients who had not received a physical health check at the GP (%)
Oldham	32 (54%)	2 (4%)	25 (42%)
HMR	63 (64%)	9 (11%)	26 (26%)
Stockport	20 (28%)	5 (9%)	44 (63%)
Tameside and Glossop	44 (61%)	4 (6%)	24 (33%)
Bury	32 (53%)	0 (0%)	28

The method of exchange of information between us and local GPs was very labour intensive, both in identifying the patient cohort and in the information exchange methods. We could not do this via shared electronic retrieval systems. This may have contributed to the relatively modest returns received; we are committed to working with Commissioners to improve this as detailed below.

Identified areas for improvement

Areas of improvement moving forward include:

- In partnership with CCGs further develop strategies for timely communication with GPs with regards to patients who do not attend for their annual physical health check
- Working with community teams to relook at the medication care plan to ensure this is fit for purpose
- Continue to work with community mental health team staff to develop an approach to supporting patients to attend their GP for a physical health check or alternatively Pennine Care staff providing the physical health

Current initiative

Community teams are now actively working with the patients who have not attended the GP for a Physical Health check nor have a scheduled appointment booked to attend, to encourage them to attend and in exceptional circumstances arrange for the physical health check to be undertaken by a member of the multi-disciplinary team.

The physical health check undertaken by the community mental health team will be documented using an agreed template which reflects the GP QOF requirements. These results will be forwarded to the GP for expert interpretation or further follow up if required with the support of the mental health services acknowledging that these patients are often difficult to engage.

A review of community mental health service records is underway to review the implementation of the physical health letter and medication care plan; this will be formally reported to Commissioners in Quarter 1 2014/15 as part of the CQUIN return.

New initiatives

Throughout 2014/15 the Trust will continue to work with Commissioners to implement initiatives to improve physical health of people with severe and enduring mental illness.

Next year significant focus will be paid to:

- Reviewing and improving compliance with the Maudsley/Pennine Care guidelines with regards to pre and follow up monitoring of clients newly prescribed or changed anti-psychotic medication
- Clarification and reconfirmation of responsibility of monitoring post initiation/change of antipsychotic medication between primary and secondary care. This initiative will involve identifying medical champions across the Trust, whose role will be to drive improvements, undertaking a baseline and year end audit to review performance against the prescribing guidelines with regards to physical health monitoring and testing, following target interventions throughout the year
- Demonstrating through the National Audit of Schizophrenia full implementation of appropriate processes for assessing, documenting and acting on cardio-metabolic risk factors in patients with schizophrenia
- Completion of a programme of local audit of communication with patients' GPs, focusing on patients on the CPA, demonstrating by year end that, for 90% of patients audited, an up to date care plan has been shared with the GP, including ICD codes for all primary and secondary mental and physical health diagnosis, medications prescribed and monitoring requirements, physical health conditions and ongoing monitoring and treatment needs

The Trust will also consider the implications and plan appropriate actions in response to the 25 Good Practice Examples as outlined in "Improving physical health for people with mental illness: What can be done?" Published by the Royal College of Psychiatrists December 2013.

Clinical Effectiveness indicator 2: Learning Disability Directorate review of clinical care pathways

Description of issue and rationale for prioritising

Providing continuing quality assurance across all Community Learning Disability Services is a priority for Pennine Care Learning Disability (LD) Directorate Services. In April 2011 the establishment of Learning Disability Directorate brought together Community Learning Disability services from five boroughs across the Trust. The rationale for prioritising pathway development was to provide an evidence based framework for key areas of service delivery across all boroughs. The process of selecting areas of provision for pathway development was informed by the reporting of local priorities from Learning Disability Partnership Boards, referencing of guidance provided to emerging Clinical Commissioning Groups by the Improving Health and Lives (Public Health England Learning Disability Observatory) alongside a review of referral trends and activity from each Community Learning Disability service.

The areas for pathway development across the Learning Disability Directorate were identified as:

- Positive Behavioural Support (PBS)
- End of Life
- Psychological Wellbeing
- Physical Health
- Dysphagia

The development of evidence based pathways also contributes to the delivery of quality assurances for:

- Care Quality Commission – 5 Key Questions
- Compassion in Practice 6 Cs – Care, Compassion, Competence Communication, Courage, Commitment
- NHS Constitution – Commitment to Quality of Care
- Pennine Care – Principles of Care
- Winterborne View – Transforming care

Aim/goal

Our aim is to develop pathways across key areas of service provision, supporting the delivery of services that are underpinned by the Learning Disability Directorate principles

- Values driven
- Safe and effective
- Evidence Based
- Person/Child Centred
- Outcome Focused

Current status

Pathways have been developed for End of Life, Positive Behaviour Support while working groups have been established and produced draft pathways across all other areas of provision.

Identified areas for improvement

Upon the establishment of the Trust's LD Directorate in April 2012, each borough-level community service developed unique service models in response to national drivers and local priorities. Working with local partners the Trust have identified opportunities for borough-level services to build upon existing expertise and mitigate potential gaps in knowledge and experience through the delivery of specialist training which supports the implementation of pathways.

Current initiatives

The LD Directorate have supported the implementation of the PBS Pathway by delivering PBS training to over 60 staff across the footprint. This pathway included the review and harmonisation of approaches to psychical intervention resulting in a new policy document.

The ongoing development of expertise in the area of PBS is supported through the delivery of a Learning Disability Supervision Framework offering practitioners a range of options for clinical supervision designed to support competent and motivated teams offering person centred support.

New initiatives

2014/15 will see Pennine Care's LD Directorate pilot the Health Equalities Framework (HEF); an outcomes framework based on the determinants of health inequalities.

HEF provides a way for all specialist learning disability services to consistently agree and measure outcomes with people with learning disabilities; it can be used by all services with regard to demonstrating effectiveness in tackling a range of

health and social determinants of health inequalities. The HEF will provide the Trust with the opportunity to demonstrate outcomes across services and pathways from individual caseloads aggregated up to whole service areas.

Clinical effectiveness indicator 3: Piloting a comprehensive stroke rehabilitation service in Bury

Description of issue and rationale for prioritising

The Early Supported Discharge Team (ESDT) in Bury provides a co-ordinated high quality, stroke specialist, multi-disciplinary, rehabilitation service to enable people to be discharged from hospital earlier than if the service was not provided.

The nationally recognised and supported criteria for Early Supported Discharge are robust, and as such a large cohort of stroke survivors do not meet the remit for admission to this team.

Providing a service for patients who do not meet these criteria but who still have rehabilitation needs became a priority as these patients were being seen by uni-disciplinary teams who were not able to co-ordinate input due to varying waiting times and service pressures. This fell short of the Royal College of Psychiatry guidelines, Stroke strategy (2007) and best practice guidelines, and meant that some patients were waiting up to 12 weeks for rehabilitation post hospital discharge.

Stroke patients who had received ESD rehabilitation, which is provided with the level of intensity of inpatient rehab, were referred onto waiting lists, often losing the functional gains they had made while with ESD. In addition, stroke patients who had identified new problems post discharge or some time following hospital discharge, were not able to re-access a co-ordinated service which was highlighted in the CQC audit of 2010 as a shortcoming of the Bury service.

Aim/goal

The aim of the pilot project was to extend the stroke service to include all people with stroke related rehabilitation needs. This would ensure an equitable service for all Bury patients and ensure the service met best practice and Royal College of Psychiatry guidelines.

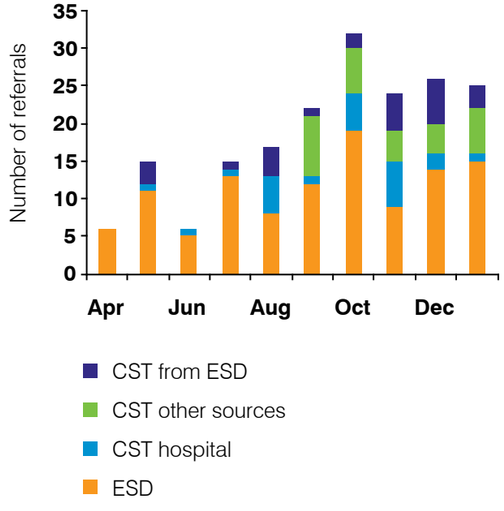
In addition it is hoped that this service will impact on length of stay, ensuring a timely discharge for more patients and allow work on longer term functional goals to assist towards integration into community life.

Current status

The extended service has been in place since September 2013 with a slight increase in resource.

We have been able to see an additional 62 patients with this small increase in resource, which is a 122% increase for the five month period compared to the five months previously; because we are able to target our resource more efficiently. Knowing that patients will receive a timely follow on service after ESD means we step them down from ESD when they are ready, and continue to see them less intensively as their condition improves. This also stops the 'cliff edge' scenario whereby patients reported (following our intensive input), that they felt 'abandoned', whilst waiting for the services to pick them up.

Referrals for stroke team (pilot commenced September 2013)



Identified areas for improvement

We have increased our capacity by over 100%; however we are still working on systems to ensure that administration keeps pace with the workload. For example, a new national database for all stroke patients has been commenced since the extended service began. This has increased the administration workload, and with higher volumes of patients, the administrative burden is felt more keenly. We are currently reviewing the data collection methods to enable us to collect the relevant data in a way which enables us to efficiently input into the national database.

Current initiatives

We recognised that we needed to reduce dependency on the service and the goal of rehabilitation is to promote independence. We therefore successfully bid for one off funding from the Greater Manchester Cardiac and Stroke Network to implement the Bridges Stroke Self-Management Programme.

Our method of implementing this has won us recognition nationally, resulting in an invitation to speak at the UK Stroke Forum. More importantly patients are identifying their own goals, allowing us to work on things which are relevant to them and therefore ensuring we target resources appropriately.

New initiatives

Should we be successful in securing continued funding for this service, we have several new initiatives we would like to take forward:

- Multi-disciplinary clinics to enable rapid assessment of patients, particularly those who have been referred some time post stroke, to ensure resources are targeted appropriately and patients are seen at their convenience as quickly and with as little disruption as possible
- Group work. Many of our patients would benefit from group work as they share similar rehabilitation needs and goals, and stroke often contributes to social isolation. Group work would enable more patients to be seen, but would also help to increase confidence and decrease the social isolation frequently felt
- We plan to work with Speakeasy, a local aphasia charity, to scope a befriending service to provide peer support for people after stroke
- Our assistant practitioners are currently taking part in the 'Help yourself to health' training, with a view to implementing stroke specific self-care and health promotion training. This will complement our Bridges ethos and further promote independence, self management and shared decision making

Review of Patient Experience Indicators

Patient Experience Indicator 1: Telehealth

Description of issue and rationale for prioritising

The vital role of innovation in the modern NHS is emphasised by both the Department of Health paper 'Innovation, Health and Wealth' and the 2012/13 NHS Operating Framework, which highlight the importance of implementing innovative technologies to improve outcomes for patients and deliver value for money.

The importance of assistive technologies are underpinned by national findings from the Whole System Demonstrator Programme and the 'Three Million Lives' campaign, whereby delivering care closer to home is reported to be essential in order to improve quality of life for patients with long-term conditions and respond to the financial challenges currently faced by the NHS.

Furthermore, the emphasis and importance placed on development and implementation of assistive technologies, to support an increase in quality, and realise efficiencies has been reiterated by the adoption of 'Three Million Lives' as a pre-qualification requirement for Commissioning for Quality and Innovation payments.

Aim/goal

Through the Hospital in the Community project, existing expertise in the utilisation of Telehealth technology was spread across Bury and HMR boroughs, by the introduction of new models of care delivery incorporating remote monitoring of vital signs, with a fully monitored back-up system for patients who show signs of deterioration and need support from the health teams involved in their care. A robust evaluation framework was devised to capture the benefits across the range of quality domains: experience, effectiveness and safety. The evaluation phase has now been concluded and positive findings have been reported, with the potential to further develop the scope of the existing technology, as well as introduce new Telehealth technologies to further enhance the patient experience and outcomes.

Current status

All three boroughs are continuing to use the existing model of Telehealth, with 'next steps' plans emerging in each borough, to support the further development of other models of implementation, using existing and new assistive technologies.

Identified areas for improvement

It has been recognised by the clinical teams that implementation of Telehealth requires a culture change in how care pathways are delivered, and that there is a significant learning curve when moving to the new ways of working. For example, in Bury, patients were signed up to receive Telehealth for a one-year period, however now clinicians are recognising that patients can use Telehealth to support their knowledge, skills, and self-management abilities over approximately three months, and are now considering amending the model of implementation to use the Telehealth as a learning tool, rather than creating a new long-term dependency for their patients.

As another example, in Oldham, initially patients who were at highest risk of hospitalisation as identified by risk stratification were selected for Telehealth. Clinicians now recognise that although there are benefits for these patients, the impact of Telehealth can be strengthened by selecting patients who are earlier in their disease process, and using Telehealth as a tool to support the patient to recognise deterioration of their symptoms at a much earlier point in time, thereby maintaining optimal health and preventing avoidable hospital attendances or admissions.

Current initiatives

To further develop Telehealth, and as a part of the pre-qualification CQUIN scheme around 3 Million Lives, Pennine Care has hosted two workshops spanning its footprint (Stockport, Tameside and Glossop, Trafford, Bury, Oldham, and HMR), to stimulate the development of local joint strategies and delivery plans around assistive technologies. The events have been well received across all agencies, with clear aims and action plans being identified by attendees from CCGs, local authorities, third sector, and provider organisations. Within the workshops it has been identified that a joint approach across health and social care can enhance patient benefits, and local boroughs are working together across organisational boundaries to develop this agenda further.

New initiatives

As part of the horizon scanning function of the Implementation Group, Flo Simple Telehealth (a text-based Telehealth solution) was identified as another Telehealth solution that warranted further exploration. Pennine Care has now implemented three pilot projects to test out Flo within health (diabetes management), mental health (stress and anxiety management) and public health (smoking cessation) pathways. It is expected that these pilots will provide recommendations for further roll-out if it demonstrates effectiveness.

Furthermore, the Drug and Alcohol service within Rochdale borough will soon be implementing a text-based Telehealth solution, which will identify people at risk of relapse and ensure timely interventions are delivered to support those individuals appropriately.

Patient Experience Indicator 2: Patient Advice Liaison Service

Description of issue and rationale for prioritising

In the wake of the failings at Mid-Staffordshire NHS Foundation Trust, a key focus for care quality policy and practice is responding to recommendations made by the Francis Enquiry reports. As a result of this, the scrutiny around the quality of user and carer experience and engagement has intensified markedly in the last 18 months.

It is crucial for Trusts to have confidence in the internal systems and processes they have in place around measuring, understanding, monitoring and improving patient experience and engagement.

Aim/goal

Pennine Care is currently investigating governance and reporting structures that would permit greater focus and a more rounded view of patient experience. This includes, specifically, closer linkages between the main patient-focussed teams within Corporate Services – Patient Advice and Liaison Service, Patient Experience, Complaints (and Compliments) – and better triangulation and integration of the currently discrete information flows that exist in these areas. The aim of this is to promote better organisational learning and for the Trust to have more meaningful tools to drive service improvements.

Current status

PALS has recently recruited an Involvement Coordinator for Community Services to mirror the role in mental health services, with the aim of involving service users and carers in the work of the Trust including:

- Reviewing and planning how services are provided
- Considering how new and existing services are developed
- Ensuring our services meet the needs of service users and carers

Involvement opportunities:

- Trust meetings
- Working groups
- Recruitment panels
- Staff training and development
- Public relations and promotional activities
- Service activities

There are PALS officers covering all divisions providing confidential advice and support to service users and carers, helping to resolve worries and concerns they may have about the carer and treatment they receive.

Areas for improvement

The Trust faces technical challenges in inputting all patient experience data into the enhanced Safeguard system alongside information from PALS, Complaints etc. The patient experience information constitutes a large volume of data which would be inappropriate for manual input into Safeguard.

Trust-wide engagement activities are organised primarily by the PALS team. However there are a variety of informal engagement activities taking place at all levels of the Trust and across all service lines. These are outside the control, and in some instances, the knowledge of the PALS team. Because of this fact, there is a risk that important feedback is gathered from service users on an informal basis that is not formally recorded or reported internally.

Current initiatives and activity

PALS host a monthly Service User and Carer Mental Health Involvement Forum, which is attended by the Trust Chair, alongside 20 service user and carer members. This group is used to monitor involvement activities, with an emphasis on the view of the service users and carers.

Forum members have been regularly consulted and engaged in developing Patient Information literature for the CQUIN target relating to the physical health needs of those with serious mental illness. Members are already reporting personal experience of this service development as recipients of Trust services relating to their serious mental illness.

The Trust has built up a database of over 250 individuals consisting of current service users, former service users and carers, who have declared their interest in the Trust's involvement initiatives. This database is used for a variety of purposes including acting as a conduit between the Trust and its service users, volunteering in the Trust's involvement activities, and being involved in working groups and panels covering a wide range of Trust operations.

Individuals from the database described above are involved in a number of involvement initiatives, including:

- Co-training: service users and carers from the involvement database have assisted the delivery of 'customer care' training to over 2,000 members of Trust staff in recent years. The next step is that bespoke training for specific services will also be delivered in various areas, with participation of service user or carer volunteers
- Mens' Mental Health Awareness training: service users and carers have worked with PALS to develop and deliver training to the male workforce of local businesses and are currently working with Greater Manchester Fire and Rescue Service to deliver the training to all 1500 of its frontline fire-fighter staff
- Interview panels: service users and carers have historically participated in interviews for staff positions at the Trust. This did not, however, take place across the board and momentum for service user involvement in interview/recruitment panels has diminished in recent months
- Research projects: service users have been involved in the Personal Social Services Research Unit, which is run by the University of Manchester with support from Pennine Care

PALS hosts an annual service user and carer conference which this year focused on how the Trust provides services for those with Long Term Conditions (LTC), this was co-facilitated by the Organisational Learning and Development department and the Trust LTC Strategic Lead. The event was held at The Queen Elizabeth Hall in Oldham, and was attended by approximately 100 people, filling the room to capacity. A significant number of staff were involved in setting up, facilitating and also evaluating the huge volume of outputs from the day. This was a whole day event, comprising two key elements:

- Presentations providing background and context in relation to both self-management and the Principles of Care
- Interactive facilitated workshops to explore each of the Principles of Care and identify behaviours that would support the achievement of the principles of care in relation to behaviours from service users, carers and staff

A working group of service users, carers and staff has been established to identify key priorities and actions generated at the event.

New initiatives

The initiative has a number of priorities:

- Engagement and involvement of carers in the Living Well Academy initiative, which aims to provide resources and educational packages for carers of those with Long Term Conditions
- To establish steering and reference groups as well as engagement events with the wider LTC service user and carer population
- Exploring Experience Based design and its components to ensure systematic engagement and involvement of service users and carers in service design
- To implement the Safeguard system to capture and record involvement activity

Patient Experience Indicator 3: National Early Warning Scores (NEWS)

Description of issue and rationale for prioritising

Early warning scores are frequently used in the assessment of patients presenting as unwell. Patients within both hospital and community settings can experience unexpected physiological deterioration that, if not identified and managed, can lead to hospital admission, critical illness requiring intensive management, cardiac arrest and even death. Deterioration can be detected in physiological signs i.e. pulse, blood pressure, pulse oximetry, or symptoms such as deterioration in mental state.

Various United Kingdom government agencies have recommended implementing early warning score systems: (National Patient Agency (2007) NICE (2007) National Confidential Enquiry into Patient Outcome and Death (2005).

Studies within secondary care e.g. by the National Patient Safety Agency (2007), reported that a number of patients had died as their deterioration was not identified or acted upon. It is essential to have standard operating procedures and competency frameworks in place to underpin the use of any early warning score to ensure that the scores are thoroughly completed and actions on results are timely and clinically effective.

Community services can utilise the National Early Warning Score effectively if underpinned by strong governance and the clinical frameworks are in place; patients placed within community beds can be monitored frequently and staff can be trained to recognise the clinical signs, changes in patient presentation and objective measurement changes which herald deterioration.

Aim/goal

The aim and goal of using the National Early Warning Score (NEWS) is to enable community teams who manage patients with acute needs, or who are in crisis, to make effective and accurate clinical decisions for ongoing management from the calculations delivered by the NEWS. Non-registered staff who collate results will be able to feedback findings to registered staff who will make clinically reasoned decisions regarding patient management; registered staff will also collate, and act directly on results.

It is important to highlight that the NEWS is a supportive tool and does not replace the clinical reasoning of clinicians.

The tool will enable the improved quality of baseline patient observations and monitoring and allow for timely intervention or hospital admission if required. The tool will enable support of clinical judgment and aid in securing timely response by the right professional.

The ultimate goal would allow the whole system to engage with the use of the early warning score i.e. primary care, community services and secondary care, consequently allowing a seamless communication in relation to patient status.

Current status

One borough within the Trust (Heywood, Middleton and Rochdale), is ready to use the NEWS score within hospital avoidance schemes i.e. where patients present with acute on chronic or acute illness which then requires management within a community bed or within their own home.

Registered and non-registered staff in HMR have received training in relation to the use of the score, a Standard Operating Procedure is in draft and ready for ratification prior to the official launch of the NEWS.

Competency frameworks will be in place to underpin good practice in relation to measuring vital signs and scoring the NEWS. Standards of documentation within the Trust support the recording of the score and the related clinical reasoning and reporting mechanisms.

The development of this scheme has recognised the impact of long-term conditions on scoring by the NEWS; the clinicians reasoning and judgement is still the most important aspect of any assessment but is underpinned by the NEWS.

Identified areas for improvement

- The Trust plans to engage with the CCGs to enable the tool to be implemented more broadly, for example within primary and secondary care and also North West Ambulance Service, ensuring the “whole system” communicates patient status in the same format
- Implementing the use of the tool across other boroughs within the organisation
- The use of audit to monitor, evaluate and modify the use of the tool across services as required i.e. to ensure use of the tool dovetails with hospital avoidance schemes and ensures quality and effectiveness of care

Current initiatives

The use of the NEWS will be monitored as part of the Greater Manchester CQUIN, relating to clinical effectiveness, across community services, specifically focusing on those services who are required to avoid admission for acute on chronic/ acute crisis episodes.

New initiatives

The Trust will ensure the standardisation of the use of the tool via a clinical guideline and its related guidance on the accurate reading and clinical reasoning of vital signs.

Detecting the deterioration of a person’s status is more robust if the patient’s norm is known; it is recognised that the knowledge of families and carers cannot be overlooked in identifying a patients decline from their norm. There is value in pursuing new mechanisms of reporting timely carer feedback to health care professionals as part of this scheme.

Performance against key national priorities and national core standards

We have chosen to measure our performance against the following metrics, in line with last year. Please note, some indicators have been added and some have been removed from what we are required to report as part of the compliance framework.

Monitor Compliance Framework Key Indicators			2012/13	2013/14	Threshold
Mental Health	Admissions to inpatient services had access to CRHT (Gatekeeping)		99.3%	99.0%	**95%**
	Care Programme Approach (CPA) Adults	receiving follow up contact within 7 days	95.1%	95.0%	**95%**
		having a formal review within 12 months	95.3%	0.0%	**95%**
	Minimising mental health delayed transfers of care		2.9%	1.3%	**<=7.5%**
	Meeting commitment to serve new cases of psychosis by Early Intervention Teams (Based on VSMR Target Line 5378)		103.4%	205 99.0%	**95% (quarterly target)**
	Mental Health data completeness: identifiers (MH MDS)		99.0%	99.3%	**97%**
	Mental Health data completeness: outcomes for patients on CPA	Employment status	98.9%	98.9%	**50%**
		Accommodation status	98.6%	98.6%	**50%**
		Having HoNOS assessment in last 12 months	89.1%	89.1%	**50%**
		Overall – combined results of above	96.0%	96.0%	**50%**
	Certification against compliance with requirements regarding to health care for people with learning disability		Achieved	Achieved	**N/A**
Community	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge		100%	99.9%	**95%**
	Data Completeness: Community Services	Community care – referral to treatment information	57.8%	65.4%	**50%**
		Community care – referral information	82.8%	51.7%	**50%**
		Community care – treatment activity information	78.9%	79.2%	**50%**
Trust-wide		MRSA bacteraemias	0	0	**0%**
Trust-wide		Clostridium Difficile toxin positives	0	1* *Classified Unavoidable	**N/A**

Other additional content relevant to the quality of NHS Services

As Pennine care NHS Foundation Trust has expanded to comprise services across mental health and community settings, the delivery of quality care remains at the forefront of the organisation. The Board has reviewed the quality of care and the results have led to numerous service improvement initiatives detailed in this year's Quality Account.

The Trust continues its commitment to improving the services we provide and positive patient experience and provision of quality care remains central.

We have continued to ensure that as services develop, quality is maintained and against any Cost Improvement Programmes, the Trust has a clear governance and accountability framework in place to manage these. All relevant service redesign schemes are subject to a quality impact assessment and are measured in terms of patient experience, patient safety and clinical effectiveness. Schemes are assigned a risk rating and are monitored closely through identified corporate structures.

Complaints

As an organisation we place high emphasis on positive patient experience, however, we have seen a 36% increase in the number of complaints received in mental health services during 2013/14 (from 142 in 2012/13 to 194 in 2013/14).

Although there are small pockets of trends within the complaints received, there is no overall theme emerging; clinical care remains the top reason for a complaint being reported but this is consistent across all organisations.

We report all complaints and respond to our Commissioners on a monthly basis. Moving in to 2014/15 we will report progress against monitoring and responding to complaints received in to the Trusts' Quality Group and continue to work with our service users, carers, families and Commissioners. We will also be reviewing the complaints process to ensure that it delivers resolution for complainants and learning for the Trust in a robust and efficient manner alongside the consideration of other sources of patient feedback as referenced in other areas of the Quality Account.

Following releasing the draft Quality Account for external consultation, the following was added to Part 2 Indicator 1 RAID (Alcohol, year 2):

Overall, the RAID team has had 3430 contacts in 2013/14. This resulted in over 2100 hours of engagement. 1199 referrals were made to the team with 29% (347) of these referrals being signposted or referred on to other teams etc.

This is broken down by quarter in the table below:

Measure	Q1	Q2	Q3	Q4	Total (2013/14)
Total number of referrals made to RAID team	347	333	281	238	1199
Number of referrals who were signposted or referred into other services	113	107	71	56	347

Annex

Statement from Commissioners, Local Healthwatch organisations and Overview and Scrutiny Committee

Statement from Clinical Commissioning Groups (CCGs) CCG commentary on Pennine Care NHS Foundation Trust Quality Account 2013/14 (mental health and community services)

NHS Heywood, Middleton and Rochdale CCG (HMR CCG) is the lead commissioner for Pennine Care NHS Foundation Trust mental health services. We are pleased to respond to Pennine Care Foundation Trust's Quality Account 2013/14 on behalf of the following CCGs:

- NHS Bury CCG
- NHS Oldham CCG
- NHS Stockport CCG
- NHS Tameside and Glossop CCG
- Nine other associate CCGs

Bury CCG leads in seeking assurance for the quality and safety of Pennine Care Foundation Trust community services on behalf of NHS Heywood, Middleton and Rochdale CCG and NHS Oldham CCG.

Quality and safety of services is of paramount importance to the CCGs. As such we welcome the continued commitment of Pennine Care to implement the recommendations of the Francis Report, Winterbourne View Report and to embed the six C's (Compassion, Courage, Commitment, Competency, Care and Communication) into practice. The CCGs will work with Pennine Care to ensure that this commitment is realised in 2014/15, so that patients and service users can be confident that they will be treated with dignity and respect.

The information presented in this Quality Account reflects the performance on quality reported to the CCGs through its contract monitoring processes; Pennine Care and the CCGs meet monthly to review its performance in relation to quality and safety, including monitoring progress against CQUIN schemes and quality indicators, for both mental health and community services. The CCGs are not responsible for verifying data contained within the Quality Account that is not part of these contractual or performance monitoring processes.

We acknowledge the improvements achieved by Pennine Care against its priorities for 2013/14, as described in the Quality Account.

We support the priorities identified across the mental health and community services for 2014/15 to promote service improvement, patient experience and to ensure the implementation of the Francis and Winterbourne View recommendations. These priorities are also supported by the CQUIN schemes for 2014/15. We will monitor the implementation and outcomes of such plans to further improve patient safety.

We are pleased with the progress to ensure appropriate and safe staffing in mental health in patient services, and would like to see the skill mix reviews extended into all services to focus on improving effectiveness and safety of care for service users.

We welcome the actions identified following audit programmes; of note is safeguarding in community services and the importance of improving these areas. We will be seeking further assurance in 2014/15 of good practice in safeguarding being demonstrated across community and mental health services. Last year we asked for the important role of safeguarding to be included in the Quality Account so are pleased to see this has been reflected this year.

The inclusion of the service user stories brings to life the reality of living with mental health or long-term conditions for people, and how improvement to health outcomes and experiences are being achieved through effective services.

We recognise the extensive good practice already underway to engage patients and service users, and welcome the improvement plans for learning from PALS and complaints; we will look for the outcomes of improved systems to capture patient experience effectively through quality monitoring processes.

Last year we also asked for further focus on lessons learned across services; whilst this work stream is not fully reflected in this Account we will continue to work with PCFT to realise this using a CQUIN scheme in 2014/15.

We recognise the challenge to present the breadth of the quality improvements across the mental health and community services, and as such consider this Account provides a snapshot of the extensive programme for quality improvement that has been undertaken. To further demonstrate this we would like to see more reflection of the outcomes we know have been achieved in localities across the mental health service footprint.

Overall, we support the significant quality improvements achieved and look forward to working with Pennine Care to further develop high quality services for our populations in 2014/15.

Yours sincerely

Dr Chris Duffy
Chair – NHS HMR CCG
Chair – North East Sector
Commissioning Board

Feedback from Tameside Health and Wellbeing Board

Comments from Dr Gideon Smith, Consultant in Public Health, Tameside MBC:

- Very clearly presented summary of a very useful set of projects
- Would be interested to understand whether the Health Improvement Teams are in scope for this work
- Pleased with commitment to 'Physical Health, Community Mental Health – Clinical Effectiveness' workstream. Disappointed that only 18% of T&G GPs have engaged with the project to date, but also pleased that this piece of work will be continuing going forward. The client group experience significant disadvantage in terms of life expectancy, and this project will help to address an important local health inequality
- There is scope to make use of the Joint Strategic Needs Assessment when considering priorities for future work
- Tameside Council contracts for community drug and alcohol services, and an Early Attachment Service with Pennine Care, and would welcome future workstreams focused on these.

Joint Health Overview and Scrutiny Committee for Pennine Care – Response to the Quality Account 2013/14

The Joint Health Overview and Scrutiny Committee discussed the Trust's Quality Account at two meetings of the Joint Committee, in September 2013 and April 2014.

The primary aim of the Quality Account is to support the NHS in improving the quality of healthcare services, while at the same time enhancing public accountability. Members of the Joint Committee have scrutinised the three priorities identified as well as additional data provided by the Trust.

The Joint Committee supports the declared levels of compliance in relation to Priority one and two. With regards to Priority three, "Physical Health, Community Mental Health – Clinical Effectiveness"; members of the Joint Committee wish to commend the Pennine Care NHS Foundation Trust on the work undertaken in this area, but would like to place on record their disappointment at the lack of engagement from some GPs in relation to this priority area.

The Pennine Care NHS Foundation Trust has continued to demonstrate on numerous occasions a commitment to openness and transparency. Trust Executives have attended every meeting of the Joint Committee during this municipal year and the desire to provide high quality service for mental health patients, as well as those it serves in the community, has been well evidenced.

Members of the Joint Committee are mindful of the ongoing financial challenges faced by the Trust, and want to ensure that the Trust's commitment to high quality service provision would continue to underpin all areas of service development.

All Members of the Joint Health Overview and Scrutiny Committee April 2014

Statement of Director's responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor 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 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 2013/14;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes for the period April 2013 to March 2014;
  - Papers relating to Quality reported to the Board over the period April 2013 to March 2014;
  - Feedback from Heywood, Middleton, and Rochdale Clinical Commissioning Group dated 23/04/2014;
  - The Trust's complaints and compliments quarterly reports for 2013/14 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
  - Feedback from other stakeholders involved in the sign-off of the Quality Report: Joint Health Overview and Scrutiny Committee for Pennine Care dated April 2014; and Tameside Health and Wellbeing Board dated April 2014;
  - The national patient survey 2013;
  - The national NHS staff survey 2013;
  - Care Quality Commission quality and risk profiles dated 31/05/13, 30/06/13, 31/07/13, 31/10/13, 30/11/13, 31/01/14, 28/02/14, and 31/03/14;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 23/05/2014;
- 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

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

John Schofield
Chairman
28 May 2014

Michael McCourt
Chief Executive
28 May 2014

Independent Auditors' Limited Assurance Report to the Council of Governors of Pennine Care NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Pennine Care NHS Foundation Trust to perform an independent assurance engagement in respect of Pennine Care NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor[1]:

Specified indicators	Specified indicators criteria (exact page number where criteria can be found)
100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital	Page 104
Admissions to inpatient services had access to crisis resolution home treatment teams	Page 104

[1] The full specified indicator criteria can be found in the Monitor guidance at the following link: www.monitor-nhsft.gov.uk/sites/default/files/publications/DetailedGuidanceExternalAssurance2014.pdf

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2013/14" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2013/14";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2013/14 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2013 to March 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to March 2014;
- Feedback from Heywood, Middleton, and Rochdale Clinical Commissioning Group dated 23/04/2014;
- The Trust's complaints and compliments quarterly reports for 2013/14 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- Feedback from other stakeholders involved in the sign-off of the Quality Report: Joint Health Overview and Scrutiny Committee for Pennine Care dated April 2014; and Tameside Health and Wellbeing Board dated April 2014;
- The national patient survey 2013;
- The national NHS staff survey 2013;
- Care Quality Commission quality and risk profiles dated 31/05/13, 30/06/13, 31/07/13, 31/10/13, 30/11/13, 31/01/14, 28/02/14, and 31/03/14;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 23/05/2014; and
- Care Quality Commission inspection reports dated 09/05/2013 and 05/03/2014.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Pennine Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting Pennine Care NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Pennine Care NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2013/14";
- Reviewing the Quality Report for consistency against the documents specified above;
- Obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- Based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- Making enquiries of relevant management, personnel and, where relevant, third parties;
- Considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- Performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- Reading documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Pennine Care NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2014,

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2013/14";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2013/14 Detailed guidance for external assurance on quality reports".

PricewaterhouseCoopers LLP.

PricewaterhouseCoopers LLP
Chartered Accountants
Manchester
29 May 2014

The maintenance and integrity of the Pennine Care NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

www.penninecare.nhs.uk