

A&PH Board Meeting

Mental Health Review

11 November

Question Responses

1. What outcomes are you achieving for people with mental health problems?

Many disorder specific outcome measurements are available in mental health services and they are widely used by clinicians on an individual patient basis to support care planning and care evaluation processes. However it is difficult to collate all of these individual outcomes to give an overall Trust or even pathway view.

To enable this, HoNOS (Health of the Nation Outcomes Scales) was developed during the early 90s by the Royal College of Psychiatrists, as a measure of the health and social functioning of people with severe mental illness.

The initial aim was to provide a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people' and it is intended that publishing HoNOS scores as well as Patient rated Outcome and Experience Scores will support the public in making choices about the services they wish to access.

The HoNOS scales also form part of the English Minimum Data Set for Mental Health and as such aspects of these are being incorporated into the contracting round for 2014 – 2015.

Versions of HoNOS are available for use with:

- Working age Adults (HoNOS)
- Older Peoples Services (HoNOS65+)
- Children and Young Adults (HoNOS-CA)
- Forensic Settings (HoNOS-Secure)
- For adults with Learning Disabilities (HoNOS-LD)
- Acquired Brain Injury (HoNOS-ABI)

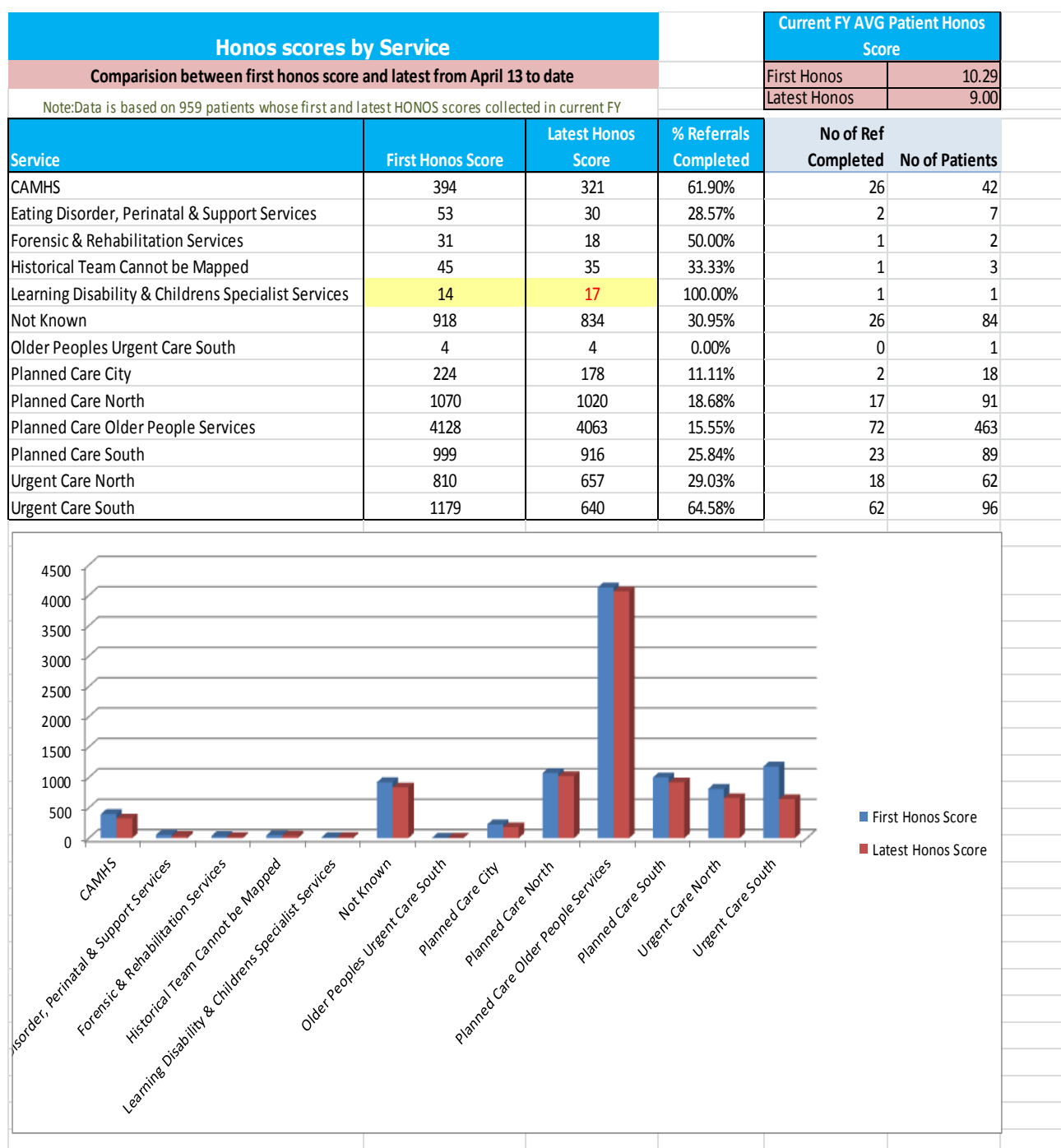
HoNOS is a set of 12 scales with a 5-point rating scale which are completed in a few minutes by mental health professionals after routine clinical assessment, CPA reviews and discharges.

The scales:

- Are designed for use in any setting in secondary mental health care services
- Are based on a rating of the worst symptoms/problems within a specified time period
- Provide a numerical record of the clinical assessment
- Are ratings of mental health outcome, not health care outcomes

The total score is used to measure health outcome and in the future the score will be used to help allocate to a 'Care Cluster' which will be used as the basis for mental health commissioning tariff going forwards.

Derbyshire Healthcare Foundation Trust is at the forefront nationally of these developments and we are already able to produce some service line specific data that shows aggregated trends for patients' HoNOS scores within that service line. The table below starts to demonstrate the outcome trend for those patients first seen after April 2013 until October 2013. To show an overall improvement in outcomes we would be looking to see a reduction between the first score and the latest score. So for example for the 89 patients referred to planned care city, who have been through a second HoNOS assessment, there was around a 9% improvement in outcomes.



Over the coming months the Trust is determined to support people who may need to use our services to make informed choices and to that end similar data to this will be available on our website and on our Core Care Standards website.

2. Dual diagnosis – how do people with multiple mental health problems access services; how do you know they are given the right treatment?

Service users with a dual diagnosis usually access services through whichever route they find more practical, this usually depends upon which issue was identified first. The Core Care Standards approach means that mental health and substance misuse issues are often identified at assessment and support provided by the most relevant service to meet an

individual's needs. An example of this would be a number of dual diagnosis service users whose primary issue is their mental health but receive their specialist prescribing from a Substance Misuse Consultant and their mental health support via a Recovery Team CPN with clear information sharing between the two services.

Several service developments across both Derby and Derbyshire ensure that dual diagnosis is recognised, assessed and treated correctly, such as:

- Specialist Substance Misuse Consultant in-reach within the Radbourne Unit (Dr Sarkar) and Hartington Unit (Dr Sirur) to assist with diagnosis and treatment as required.
- The Liaison Team (RAID model) at Royal Derby and the HADLT and Mental Health Liaison Team at Chesterfield Royal can refer service users directly from an emergency care environment into mental health or substance misuse treatment.
- The Mental Health Liaison Group (chaired by Bob Gardner) held at Chesterfield Royal links with emergency care leads, substance misuse and mental health services to ensure smooth transfer of service users in particular those identified as High Impact Users.
- Both in the City and County the Trust has specialist parts of the drug and alcohol treatment system that are specifically targeted around dual diagnosis. These teams are the High Intensity team within the Derbyshire Substance Misuse Service within the county. Whilst in Derby City there is the Mental Health Drug Team (as part of the Derby Substance Misuse Service) and Specialist Alcohol Misuse Service.

Moving forward there will be a new dual diagnosis training programme for all practitioners within the Trust which aims to refresh the skills and knowledge from the training previously undertaken. The Dual Diagnosis Steering Group is leading on the development of the training at present.

Dr Pang consultant psychiatrist Killamarsh Recovery Team is also undertaking an audit of dual diagnosis patients to review the quality of intervention offered.

3. How do you assess the effectiveness of local arrangements for people with alcohol/drug problems?

There are clear routes of referral to both Derbyshire and Derby Substance Misuse Services. Both drug services offer a Mon-Fri drop-in assessment service to be responsive to the needs of the service users for rapid access and assessment. The smaller Derby City Specialist Alcohol Misuse Service has a priority referral system which sees service users within 48 hours from accessing the Single Point of Entry.

The benefit of having specialist services, such as the Specialist Alcohol Misuse Service (City), Mental Health Drug Team (City – as part of integrated drug treatment with Phoenix Futures)

and High Intensity team (County – as part of integrated High and Low Drug Treatment Service), is that service users with dual diagnosis get rapid access to experienced staff with lower caseloads, who are able to offer rapid and regular support and recovery focused interventions. Access to specialist consultants (2 in Derbyshire and 1 in Derby) by these teams also enables them to seek additional clinical support around complex cases where required.

The service known as 'Addaction' provide the specialist alcohol service for Derbyshire and are therefore not part of the above integrated services that exist for people with alcohol addiction in Derby city.

Training for inpatient areas on new and developing drug trends such as MCAT, "legal highs" is enhancing the skills of frontline care staff in how to manage service users with psychosis in a rapidly expanding area of drug misuse.

Service users entering into Substance Misuse treatments are seen by a prescriber within 21 days of referral. The National Drug Treatment Monitoring Service (NDTMS) showed Derbyshire and Derby as 99% compliant with this, on a target of 90%. During this period they receive a comprehensive assessment, general health assessment and recovery care plan, which all identify mental health issues, as well as their impact upon the individual's drug and alcohol use.

4. What preventative work is being done to stop people from developing mental disorders?

Preventative work can fall into many categories but for ease of reference it is perhaps worth considering this in three parts:

- a) *Early prevention activities.* These are activities often aimed at children and young people, the communities they live in and the places they go. Over the past year for example we have delivered mental health awareness sessions in:
 - i. Schools
 - ii. Family centres
 - iii. Universities (during freshers week)
 - iv. Local health centres
 - v. Community centres
 - vi. Dementia question and answer sessions for the public at a range of venues
 - vii. Football clubs
 - viii. Large Derby based employers
 - ix. Engaging on 'faith tours' within Derby to give Trust staff the opportunity to understand more about the specific needs of differing communities within Derby but also the opportunity for us to reduce mental health stigma and deliver some basic mental health awareness.
- b) *Developing support that promotes 'Recovery'.* It is clear from research evidence that supporting individuals to optimise their independence and re-integrate into local

communities in their broadest sense is vital to achieving the best long term outcomes for people who have been mentally unwell. To this end a few examples of our activities are:

- i. Creating links with local colleges and education establishments.
 - ii. Developing links through our occupational therapy services with return to work programmes.
 - iii. Creation of a volunteer programme within the Trust to give service users an early opportunity for meaningful activity.
 - iv. Liaising with local volunteer programmes in local communities
 - v. Creation of 'peer mentoring' opportunities to enable individuals with lived experience to support others.
 - vi. Early development of specific full employment opportunities for people with lived experience.
 - vii. Working towards the development of a 'recovery college' in Derby in association with other statutory and non-statutory providers mirroring some of the development work already undertaken in Chesterfield around the 'Hope Springs' Recovery College.
- c) Working with partner agencies – we believe that if we can influence how partner agencies respond (often they are the first point of contact that an individual with emerging mental health difficulties may have) we can improve the outcomes for those individuals. For example, we have this year:
- i. Implemented a very well-resourced psychiatric liaison service at Royal Derby Hospital to both educate their staff around mental health issues but also to ensure a rapid and comprehensive, specialist assessment is available to anybody at the hospital who needs one.
 - ii. Joint working with Derbyshire Police around both general mental health awareness, assessments in custody and reducing mental health act section 136 arrests (we have now been recognised as a national pilot site for this initiative).
 - iii. The siting of mental health practitioners in 111 call centres to support call handlers and general nurses in their triage of people with mental health difficulties.
 - iv. Education sessions with Derbyshire Fire and Rescue Service.

5. What measures have you got that demonstrate you are delivering effective and efficient services?

Derbyshire Healthcare (NHS) Foundation Trust operates a range of indicators, dashboards and processes that together provide us with assurance that we are delivering effective and efficient services. These indicators cover a number of areas such as:

- Quality
- Financial performance
- Regulatory performance
- Contractual performance

- Service viability

Quality

The Trust has developed a quality framework that is applied to all teams and services and that is reported through our Quality Committee to the Board of Directors on a quarterly basis. The framework is made up of a number of indicators that are derived from a combination of national and locally agreed metrics that together give a good overview of the quality health of the area being reviewed. The framework of metrics can be seen in appendix 1.

The Board recognises that times of change for services can lead to increased risks of reducing quality. To this end a 37-point quality impact assessment is in place that is completed monthly by any project team leading a process of change (appendix2). This quality impact assessment draws heavily on the quality framework and gives the Trust the ability to halt or pause changes very early if an adverse impact on quality is noted.

The Trust Board is keen that assurance is sought not just via reports but also through an 'in person' team visiting approach known within the Trust as 'quality visits'. For the past 4 years all teams within the Trust, including corporate services, have received a quality visit with the visit team made up of an Executive Director, a Non-Executive Director and a supporting senior manager. In addition external people such as Commissioners and Governors are also invited to attend these visits. This year the outcome of the quality visits was:

Platinum Award Teams (3 years at Gold or more)	30
Gold – our award for highest quality	62
Silver – our award for 'good quality'	24
Bronze – our award for 'acceptable quality'	4
Non podium – designates the team needs more support	2

Finance Performance

Financial performance is reviewed monthly within all levels in the Organisation culminating in an overview paper being presented to each Trust Board meeting highlighting current performance, forecast and risk, along with mitigating actions.

Financial performance is never viewed in isolation from clinical and quality factors and this information is reviewed monthly by operational and clinical managers jointly with a more detailed Board level review occurring monthly at the Finance and Performance Committee (Board Committee).

Regulatory & Contractual Performance

The Trust has to be able to assure both its regulators and commissioners that performance is meeting or ahead of expectations thus contributing to a view of the effectiveness of the Organisational management. We have adopted an approach of ensuring that all performance indicators are embedded in day to day line management across all of our teams. To support this we have developed a 'live' performance dashboard that enables us to review compliance in the here and now for either individual practitioners, a team, a group of teams making up a pathway (such as urgent care) or the whole Trust. An example of this can be seen in appendix 3.

Service Viability

It is vital to understand if a service or group of services is able to continually meet expected quality standards, financial standards, and performance standards looking forward over the next 3-5 years, and this amalgamated approach to over-viewing healthcare effectiveness and efficiency is a key method in providing the Board of Directors with assurance. There are three main ways that this is completed:

- a) Monthly 'Deep Dive' reports presented to the Board of Directors – relevant operational and clinical staff attend the Board of Directors to deliver a detailed report on their area, drawing links between clinical quality issues (for example complaints, compliments, serious incidents), financial performance, contractual performance, workforce issues (such as training compliance, vacancies, and the amount of bank and agency being used). The combination of direct questioning by the Board along with an opportunity to understand multi-faceted cause and effect is why this is such a strong form of assurance.
- b) A specific report is discussed each month at the Finance and Performance Committee that endeavours to understand and report the varying factors for differing service areas that could indicate efficiency. This report is more factually based using hard metrics and allows Non-Executive Directors the opportunity to see the detail below a routine service line report.
- c) Commercial Assessment Framework – The Trust has in place a formal review process, looking at all-round service viability that managers and clinicians complete at least on an annual basis and certainly prior to any decision being taken to bid for new business in the form of tender opportunities. This process does then support our recently launched 5 year service transformation programme.

6. What is your relationship with the voluntary and community sector organisations dealing with mental health issues?

In order to maximise choice, an outcomes for people with a mental health difficulty partnerships are vital, both formal and informal.

As a Trust we are committed to the development of formal partnership arrangements and the following are organisations where we have more formal arrangements in place:

- a) Phoenix Futures – delivery of drug services in Derby City
- b) First Steps – delivery of eating disorder services
- c) Derwent Rural Counselling Services – delivery of 'improving access to psychological therapy services'.

As well as formal arrangements, we work collaboratively with many local Organisations. Our pathfinder teams (assessment teams) have specific named link workers with a range of local community groups such as LGBT, Gypsy Liaison, Bosnian and Roma communities, deaf community, Sikh temple and Afro Caribbean society.

The Trust has actively supported people who have used our services to set up independent support groups such as Recovery in Derbyshire (RID), supporting people who have a drug problem, now on its way to becoming a social enterprise.

Many of our memory assessment services for people with a suspected dementia are run in conjunction with the Alzheimer's Society and Making Space (a carer support organisation) workers are co-located in many of our community recovery teams.

Our CAMHS services regularly liaise with the YMCA and share joint training opportunities whilst the joint working with 'Family Nurse Partnership', 'Children in Care Council' and 'Derbyshire Voice' provide vital consultative services to our Specialist and Universal Children's service.

Questions linked to Hospital visit

1. How many mental health beds are there in the city for people? Are they sufficient to meet the needs of Derby residents?

Derbyshire Healthcare NHS Foundation Trust provides inpatient beds covering a wide range of service needs. These include Adult Acute, Enhanced Care Beds, Older Adult Acute, Dementia beds, Rehabilitation beds, Low Secure Forensic beds and specialist female locked door rehabilitation beds. None of our inpatient bed provision is solely focused on the City catchment area and are based across Derbyshire. We do all we can to ensure if service receivers require an inpatient bed this is provided as near to their home and community as we can. However, at times of increased pressure on inpatient beds, we will utilise the bed capacity across the county. We have done some work recently on bed capacity and are collaboratively working with our commissioners to increase our Adult Acute inpatient capacity. It is our view that once this increase in beds is in place there is sufficient bed capacity for Derby residents.

The number of beds related to each service area are as follows;

- 131 Adult Acute Beds
- 10 Enhanced Care Beds
- 44 Older Adult Acute
- 50 Dementia Beds
- 35 Rehabilitation beds
- 10 Specialist female locked door rehabilitation beds
- 20 Low secure forensic beds

2. Do you think the mental health problems in the city are on the increase and if so why?

It is clear on a national basis that there has been an increase in acuity and people presenting with mental health problems. Evidence would suggest that City localities will always have higher levels of mental health presentations. This can be linked to deprivation and economic drivers and also the complexity of issues such as migrant communities and BME groups.

3. How many people are in police custody under section 136 of the Mental Health Act 1983 during any given time? What support do you have for this?

Police data for 2012 indicates there were 38 detentions under Section 136 within the Police Custody Suite. This data however does not differentiate between the city and county, this year there has been 12 so far. Data spanning from 2010 does indicate the use of police cells as a place of safety has been decreasing year on year. It is widely recognised that, in most cases, a police cell is not an appropriate place of safety. However there are times, when the level of risk to others particularly, leads to a police custody suite being utilised. Our Crisis resolution Home Treatment Service would attend the police station, as the clinical team required to assess the service receiver, as defined within the Section 136 process.

Derbyshire Healthcare operates two Section 136 suites, one based within the Radbourne Unit which is based on the Royal Derby Hospital campus, the other is based at the Hartington Unit which is based within the Chesterfield Royal Hospital campus. This is where most service receivers detained under Section 136 are brought to for assessment.

4. Timely assessment of patients with mental health - What resource do you have at Derby Royal hospital to conduct initial assessment?

Derbyshire Healthcare NHS Foundation Trust provides a 24 hour, 7 day per week, Psychiatric Liaison Service within the Royal Derby Hospital. This is a comprehensive service and includes a senior multi-disciplinary team. The service became fully operational at the start of October and provides a service to all of the Royal Derby Hospital.

5. Crisis point – increasing numbers of patients presenting themselves at the hospital with self-harm, overdose but they have nowhere to go. Hospital are saying they have placed patients as far away as Harrogate and Sussex. What do you estimate to be the costs of making placements outside the city?

Derbyshire is experiencing a huge amount of pressure in relation to the provision of adult acute inpatient bed capacity. This is not just a Derbyshire issue and is mirrored across the country. This has at times led to the use of bed provision outside of Derbyshire. We fully acknowledge this is not good for service user experience and we have been working very closely with our commissioners to manage this and to develop a sustainable strategy for managing this longer term. We have embarked on a transformational programme that will produce a five year plan for Urgent Care and a key aspect of this will be to deliver Urgent Care services for service receivers in Derbyshire and not outside of Derbyshire.

6. There are disproportionately high numbers of people with mental health issues in the criminal justice system from the black and ethnic minority communities, particularly African and Muslim communities. What preventative work is being carried out to address this situation and what are you doing to ensure provision is appropriate services?

Derbyshire Healthcare NHS Foundation Trust provide a Criminal Justice Diversion and Liaison service which attends the offender health improvement group. The group was set up, following the release of the Bradley Report 2009, which identified that people with a mental illness or learning disability where appropriate should be diverted away from the criminal justice system. This includes responding to the needs of BME groups.













7. How many transfers are there from the prison to mental health institutions?












In quarters one and two of this year, Derbyshire Healthcare NHS Foundation Trust received the following transfers from Foston and Sudbury prisons:

Quarter	Number of Transfers
Q1 12-13	1
Q2 12-13	3
Q3 12-13	3
Q4 12-13	1
Q1 13-14	2

Q2 13-14	2
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SUMMARY QUALITY DASHBOARD

PATIENT SAFETY Overall score for indicators 1-12 (JUNE 2013) The shaded left hand column indicates it has been updated since the last dashboard in January 2013.					
Quality Framework indicator number	Indicator	Baseline	Trajectory Point for March 2013	Position as of March 2013 (if update is available)	Progress towards target
1	To decrease the level of harm of incidents reported	8.1% moderate or above	7.07%	Update available Sept 2013	
2	Patient saying that they “always” feel safe on our inpatient wards	49%	52.67%	49.34%	
3	Overall score for Harm Free Care across all elements as measured by the ‘Safety Thermometer’(falls, urinary tract infections, venous thromboembolisms, and pressure ulcers)	95.45% harm free	96.63%	96.77%	
4	2012 Inpatient Survey Q24: Purposes of medications explained“Completely”	34%	45.67%	49.38%	
5	CPA 7 day follow up	95%	96%	98.88%	
6	2012 Inpatient Survey Q34:“Definitely”felt enough care taken of physical health	47%	64.67%	Update available Sept 2013	
7	When we assess a patient we will consider the wider family, in particular, any children within the home ‘Think Family’ standards, DOH guidance	-	100%	Target established	
8	The Trust will fulfill an active role in partnership in the protection of a vulnerable child or adult	-	100%	Target established	
9	Crisis Gatekeeping- to ensure the effective assessment prior to admission to an inpatient unit	95%	96.67%	96.83%	
10	2012 Inpatient Survey: Hospital ward or room “very clean”	59%	69.33%	62.96%	
11	2012 Inpatient Survey Q11: Toilets and bathrooms very clean	44%	59.33%	51.22%	
12	Patient Environment Action Team scores (PEAT) for Environment	4.77 out of 5	5	Changing to PLACE.	

PATIENT EXPERIENCE Scores for indicators 13-23					
Quality Framework indicator number	Indicator	Baseline	Trajectory Point for March 2013	Position as of March 2013 (if update is available)	Progress towards target
13	Friends and Family Test (Golden Question)	+35.71%	+50%	+46.55	
14	Overall Patient experience of community mental health services as set in the survey 2011	6.8 out of 10	7.0 out of 10	Update annually on CQC website	
15	Quality of care plans taken from a number of questions in national community survey	7.2 out of 10	7.53 out of 10	Update annually on CQC website	
16	Quality of care co-ordinators taken from a number of questions in national community survey	8.4 out of 10	8.6 out of 10	Update annually on CQC website	
17	Quality of care reviews taken from a number of questions in national community survey	7.5 out of 10	7.83 out of 10	Baseline and target established	
18	Community Survey 2012 Q46: Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?	6.6 out of 10	7.23 out of 10	Update available Jul 2013	
19	National Community Survey 2012 Q29: Were you told that you could bring a friend, relative or advocate to your care review meetings?	7.8 out of 10	8.2 out of 10	Update available Jul 2013	
20	Overall patients experience of health and social care workers that provided the care between July and September 2011 (community survey)	8.4 out of 10	8.6 out of 10	Update annually on CQC website	
21	EDS Annual assessment grading – benchmark locally with health organisations	"Developing"	"Developing"	Baseline and target established	
22	Inpatient survey 2012 QA3: When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine of the ward, such as times of meals and visitors times?	37% said "yes"	44.67% saying "yes"	39.02%	
23	Community inpatient survey 2012 QB9: Were you able to get the specific diet that you needed from the hospital?	25% said "yes"	36.67% saying "yes"	33.33%	

EFFECTIVENESS Score for indicators 24-27					
Quality Framework indicator number	Indicator	Baseline	Trajectory Point for March 2013	Position as of March 2013 (if update is available)	Progress towards target
24	Median length of stay	53 days	50 days	40 days	
25	Delayed transfers of care	<6.8%	<1%	0.73%	
26	Patient clustered not breaching today	81.43%	90.72%	87.98%	
27	18 week referral to treatment, non-admitted patients started treatment	>95%	100%	97.45%	
STAFF EXPERIENCE Scores for indicators 28-35					
Quality Framework indicator number	Indicator	Baseline	Trajectory Point for March 2013	Position as of March 2013 (if update is available)	Progress towards target
28	Compliance with essential training for all eligible staff	70%	80%	82.50%	
29	Staff recommendation of the Trust as a place to work (Q34 of annual staff survey 2011)	3.33 out of 5	3.49 out of 5	3.62 out of 5	
30	Staff recommendation of the trust as a place to receive treatment (Q34 of annual staff survey 2011)	3.33 out of 5	3.49 out of 5	3.62 out of 5	
31	% of staff having equality and diversity training in last 12 months	72%	77.33%	77%	
32	Overall engagement of staff taken from a number of questions from staff survey 2012	3.55 out of 5	3.63 out of 5	3.76	
33	% of staff feeling there are good opportunities to develop their potential at work (Q10 of staff survey)	36%	43%	Question not repeated in 2012 Survey	N/A
34	% of staff believing the Trust provides equal opportunities for career progression and promotion	87%	90%	89%	
35	% of staff having well-structured appraisals in last 12 months	34%	39.67%	43%	

Quality Impact Analysis tool for Change Management Programmes

Appendix 2

Project:				
Iterations:		{Latest Version}		
Quality Summary Totals 13-14		QIA 13-14 Please respond using the drop down lists		
Name	Value	Name	Value	Comment
Not Set	0	Date of QIA	07 Oct 2013	
Maintain Total	0	Evaluation Period	Eval' Month 6	
Worsen Total	0	Safety	No Impact	
Improve Total	0		No Impact	
No Impact Total	36	To decrease the level of harm of incidents reported.	No Impact	
		Patient always feeling safe on our inpatient wards.	No Impact	
		Overall score for Harm Free Care - falls, UTIs, venous thrombo and pressure ulcers	No Impact	
		Purposes of medications explained completely	No Impact	
		CPA 7 day follow up	No Impact	
		Patient felt enough care was taken of physical health.	No Impact	
		Consideration of wider family when assessing patient. (Think Family standards)	No Impact	
		Trust in active role in protection of vulnerable adult or child.	No Impact	
		Crisis gatekeeping effectiveness prior to admission to inpatient unit.	No Impact	
		Inpatient Survey - Hospital ward or room is 'very clean'.	No Impact	
		Inpatient Survey - Toilets and bathrooms 'very clean'.	No Impact	
		PEAT score for Environment	No Impact	
		Patient Experience		
		Friends and Family Test (Golden Question)	No Impact	
		Patient experience of CMH services as set in 2011 Survey	No Impact	
		Quality of care plans from questions in National Community Survey (NCS)	No Impact	
		Quality of care co-ordinators from questions in NCS.	No Impact	
		Quality of care reviews from questions in NCS	No Impact	
		NCS 2012 Q46 - Have MH services involved someone close as much as you would like?	No Impact	
		NCS 2012 Q29 - Were you told you could bring someone to your care review meetings?	No Impact	
		Overall experience of health and social care workers provided July - Sept 2011 (NCS)	No Impact	
		EDS Annual assessment grading.	No Impact	
		Community Inpatient Survey (CIS) QA3 - Were new admissions informed of ward routine asap.	No Impact	
		CIS 2012 QB9 - Were specific diets provided where necessary?	No Impact	
		Effectiveness		
		Median Stay length	No Impact	
		Delayed transfers of care	No Impact	
		Patient clustered not breaching today	No Impact	
		18 week referral, non-admitted patients started treatment.	No Impact	
		Staff Experience		
		Compliance with essential training	No Impact	
		Staff recommend the Trust as a place to work.	No Impact	
		Staff recommend the Trust as a place to receive treatment.	No Impact	
		% of staff having equality and diversity training in last 12 months.	No Impact	
		Overall engagement of staff taken from a number of questions from staff survey 2011.	No Impact	
		% of staff feeling there are opportunities to develop their potential at work.	No Impact	
		% of staff believing the Trust provides equal opportunities for career progression and promotion.	No Impact	
		% of staff having well structured appraisals in last 12 months.	No Impact	
		REGARDS		
		What effect will this have on vulnerable groups?	No Impact	
		Remember this also includes staff. Provide comment or attach document, (EIA if necessary).		

Appendix 3

13-14 Trust Key Performance Indicators

	Oct 2013		
	No.	%	Target
Monitor Targets			
CPA 7 Day Follow Up	91	96.70%	95.0%
CPA Review in last 12 Months (on CPA > 12 Months)	3797	97.92%	95.0%
Delayed Transfers of Care	432	0.28%	7.5%
Data Completeness: Identifiers	18583	99.18%	97.0%
Data Completeness: Outcomes	8051	97.47%	90.0%
Crisis Gatekeeping	38	96.87%	95.0%
Early Interventions New Caseloads	N/A	N/A	95.0%
NHS Outcomes Framework			
CPA MoNOS Assessment in last 12 Months	8051	92.19%	90.0%
CPA In Paid Employment	1893	11.81 %	5.0%
CPA Employment Status	8051	99.90%	90.0%
CPA Settled Accommodation	8051	99.90%	90.0%
Under 18 Admissions To Adult Inpatient Facilities	0	N/A	0
Data Completeness: Identifiers	18583	99.18%	99.0%
Mixed Sex Accommodation Breaches	0	N/A	0
Data Completeness: Outcomes	8051	97.47%	90.0%
Patients On CPA	22338	20.14%	N/A
Locally Agreed			
Consultant Outpatient Appointments Trust Cancellat...	4362	2.45%	4.0%
Consultant Outpatient Appointments DNAs	2957	14.47%	15.0%
7 Day Follow Up - All Inpatients	91	96.70%	95.0%
Discharge Letters Sent in 5 Working Days	148	33.78%	90.0%
Discharge Letters Sent in 10 Working Days	148	77.03%	100.0%
Outpatient Letters Sent in 10 Working Days	2919	55.57%	90.0%
Outpatient Letters Sent in 15 Working Days	2919	75.09%	100.0%
Schedule 4 Contract			
CPA Review in last 12 Months	5885	89.85%	90.0%
Patients Clustered not Breaching Today	18074	89.44%	99.0%
Patients Clustered Regardless of Review Dates	18074	95.78%	100.0%
Discharge Fax Sent in 5 Working Days	78	100.00%	90.0%
Discharge Fax Sent in 10 Working Days	78	100.00%	100.0%
Complex Needs: Assertive Outreach Clinician Caselo...	11.09	N/A	12.00
Delayed Transfers of Care	1212	0.00%	6.2%
Delayed Transfers of Care - Rehab	135	0.0%	6.2%
Deputy Care Co-ordinator Assignment	4834	99.5%	90.0%
15 Week RTT Less Than 18 Weeks - Incomplete	505	97.82%	92.0%
15 Week RTT Less Than 18 Weeks - Non-Admitted	193	97.93%	95.0%
Assertive Outreach % DNA Rate	892	19.82%	N/A
Schedule 8 Contract			
CPA In Settled Accommodation	2893	92.42 %	N/A
Average Community Team Waiting Times (Weeks)	744	4.41	N/A
Inpatient 28 Day Readmissions	99	3.03%	10.0%
Crisis Home Treatments	111	N/A	0
LD Patients in Contact with Teams	22338	28.19%	N/A
Assertive Outreach Caseload	259	N/A	0