Kent and Medway NHS
NHS and Social Care Partnership Trust

Quality Account 2013/14

www.kmpt.nhs.uk

respect - open - accountable - working together - innovative - excellence

Contents

Kent and Medway NHS
NHS and Social Care Partnership Trust

Our Values

respect
– we value people as individuals, we treat others as we would like to be treated

open
– we work in a collaborative, transparent way

accountable
– we are professional and responsible for our actions

working together
– we work together to make a difference for our service users

innovative
– we find creative ways to run efficient, high quality services

excellence
– we listen and learn to continually improve our knowledge and ways of working

Our Vision

The Trust aims to deliver quality through partnership.
Creating a dynamic system of care, so people receive the right help,
at the right time, in the right setting with the right outcome.

www.kmpt.nhs.uk

Excellent care personal to you
Delivering quality through partnership

Kent and Medway NHS
NHS and Social Care Partnership Trust

Customer Care Charter

This Charter lists the commitments we make to our customers and what we expect from them.

KMPT's commitments to you. We will...

1. **Listen to your concerns and respect your views** – we will treat you as an individual and in the context of your whole life. We will listen to what you have to say and record it accurately.
2. **Involve you in planning your care** – you will be given the opportunity to determine the plan for your care, which will focus on your recovery. We will give you a copy of your care plan in a format acceptable to you.
3. **Be informative and engaged** – we will provide you with information about conditions and services and, if you agree, also communicate with those who care for you. We will answer your questions politely and carefully. If we do not know the answer we will tell you and get the information for you as soon as possible.
4. **Deliver best practice care** – we will learn from best practice and provide care that meets NICE guidelines. Our staff will be up to date and trained to deliver best practice in all that they do.
5. **Constantly improve** – we will ensure that service users and carers are able to influence service development. We will learn from your feedback and be accountable to you by making changes based on your concerns.

KMPT expects you to...

1. **Keep your appointments** – we ask that you attend, or advise us if you cannot meet an appointment given to you. If we have to change your appointment we will give you as much notice as possible and offer another date.
2. **Treat our staff with respect and without aggression** – while we appreciate that mental health problems can lead to frustration and anger, we ask that staff are treated with courtesy. We will be courteous and polite at all times.
3. **Be open about your views** – let us know your expectations and any concerns so that we can together plan the most appropriate care for you.

If you do not feel that we are meeting these commitments, we ask you to raise this with your key worker, the service manager, or write to:
PALS, KMPT HQ, Freepost SEA 5463, West Malling ME19 4BR, or email pals@kmpt.nhs.uk

Signed

Introduction

All providers of NHS services, no matter how large or small, or what services they provide, should be striving to achieve high quality care for all and, therefore, all are required to produce a Quality Account.

The Quality Account is an annual report for the public that focuses on the quality of the services the Trust delivers, the ways in which the Trust demonstrates that it frequently checks on the quality of those services, and that the Trust's staff are committed continually to improve the quality of those services.

Quality Accounts should assure commissioners, service users and the public that healthcare providers are regularly scrutinising their services and, therefore, are able to concentrate on those areas that need the most attention.

The Quality Account comprises three sections, as required in the guidance set by the Department of Health in the Quality Account Toolkit. Part one is the statement from the Chief Executive on page 8. Part two reviews our progress on our quality improvement priorities in 2013-14 and contains statements about various aspects of the quality of our services in the format set for us and comments on the Quality Account from our partners. Part three contains our priorities for improvement in the year ahead and tells you who was involved in determining our priorities. For ease, the latter statement is on page 64.

This report clearly demonstrates the importance to the Trust of the quality of the services we provide to our service users, and that we invite and encourage scrutiny, debate and reflection on those services at all times.

We hope you find this report both interesting and reassuring and, if you wish to make any comments about our services, please do get in touch. You'll find our contact details on the back page.

respect
open
accountable
working together
innovative
excellence

Key achievements in 2013-1014

It has proved to be yet another challenging year for the health sector in general, and especially for mental health with ever increasing demand for care. Despite these challenges, the Trust has not only continued to improve the quality of its existing services but also introduce new services, and it has done so within stringent financial targets. In the prevailing economic climate that is no mean feat and a clear reflection of the expertise, commitment and hard work of all its staff.

The past year has seen some exciting developments, not least of which has been the highly successful street triage service piloted in partnership with Kent Police. This has significantly reduced the number of people being detained by the police at a time when what they really needed was mental health care. This success has led to the programme's extension through to March 2015.

The Trust has also worked with Kent Police, clinicians and service users to produce a training video enabling police officers to deal appropriately with people experiencing mental health conditions.

Twelve new peer support workers have been appointed. Sometimes referred to as 'experts by experience', they play a vital role in helping people on their often challenging journey back to recovery,

providing hope, encouragement and support based on their own experiences.

In May 2013 the Trust organised a Customer Care Week during which front line teams took the opportunity to review the ways in which they relate to and communicate with service users and carers. The event comprised a wide range of activities and enabled the Trust to obtain invaluable feedback; it also led to the launch of the Trust's Customer Care Charter which sets out a clear set of commitments that underpin the way in which we look after the people in our care.

A key component of any personal care plan is the contribution of the patient. The Trust held an appreciative enquiry, the primary aim of which was examine how best to achieve collaborative working between service users and staff in effective care planning. The enquiry involved interviews with a wide range of stakeholders and has led to improved communications with service users at a critical point in their care.

In effectively treating people with Bipolar Affective Disorder it is essential to encourage and support them to self-manage their condition and promote recovery. To this end the Trust has joined forces with the Primary Care Mental Health Nurses in Medway to launch a bipolar focus group. The group is open to all service users with a diagnosis of Bipolar Affective Disorder, either under the care of their GP or the Trust, within the Medway area. The objective of the group is to share knowledge, empower service users and to provide them with the support they need.

The Trevor Gibbens Unit, which provides medium secure care for men and women, came 5th out of 65 secure units in the annual Forensic Quality Network Accreditation scheme. Peers from other trusts scored the Unit 100 per cent in six of the eleven test categories, including clinical, cost effectiveness and accessible and responsive care, while patient focus was well above average with 92 per cent.

The Trust is renowned for its focus on equality and diversity and, together in partnership with Medway Council and Rethink, held an Ensuring Quality, Valuing Difference Conference at Bishop of Rochester Academy in Chatham in October 2013. The conference enabled the Trust to tap into the invaluable experience of the delegates, comprising service users, carers, NHS Staff and representatives from statutory and voluntary organisations, in order to explore a range of themes in support of our service development.

The Chief Executive of the Trust signed a Time to Change pledge underlining the Trust's commitment to taking action on reducing mental health discrimination.

In partnership with Kent Health (University of Kent) and the Comprehensive Local Research Network, the Trust held a Quality and Innovation Conference on the Medway University Campus in November 2013. Through this event delegates were able to learn about national and local developments in Clinical Audit, Quality Improvement and Research and Development, as well as the annual Clinical Audit and Service Evaluation Awards and Research and Development Awards.

The Trust is also piloting a new crisis care service for people with personality disorders in Medway - one of the most comprehensive services of its kind in the country.

The year ahead will bring further change through-out the Trust and even more improvements to the way in which we provide care for the people of Kent and Medway. Through the development of our clinically led transformation programme and recovery-based approach, more people will be able to receive excellent community care services closer to home, so reducing the need for inpatient care.

The progress we have made over the past year will stand us in good stead for the future and we are confident that, with the support of our committed staff and by working in close partnership with our many stakeholders, we will successfully meet the challenges that lie ahead and further improve the quality of services we provide.

Review of Quality Performance:

Achieving Our 2013 – 2014 Priorities

Patient Safety

Title	RAG
A 25% reduction in the number of severe or moderate falls in older adult inpatient wards	Green
Reduction in suicide and serious self-harm during an in-patient admission or while in treatment with a working age adult community team	Green
To ensure all adults and children are effectively safeguarded	Green

Patient Experience

Title	RAG
Better communication between our staff and service users and their carers.	Green
Using the views of service users to monitor and improve services	Green
Physical Health and Examination	Green

Clinical Effectiveness

Title	RAG
Improving discharge planning from inpatient care and improving post discharge care	Green
To improve implementation of National Institute for Health and Clinical Excellence (NICE) guidance for people with a mental illness	Green
To further improve the implementation of the Recovery Approach for service users working with our recovery teams	Green

Red, Amber, Green (RAG) Key

Title	RAG
Improvement noted	Green
Remains the same	Amber
Worse	Red

Chief Executive's Statement

2013-14 has been a challenging year for the whole of the NHS, with the publication of three major reports (Francis, Keogh and Berwick) that emphasised the need for compassion and service quality to be placed at the heart of everything the NHS does for its service users.

The purpose of this our fifth Quality Account is to indicate progress made with the nine quality priorities we set last year, together with describing the nine priorities for the coming year to ensure that we continue to drive up the quality of the services we provide.

The Trust has continued with transforming its services, through the delivery of the clinical strategy, which has been designed to ensure that people who need help get the right treatment, at the right time, in the right place, thus leading to improved outcomes for service users.

From talking to service users and carers during the past year we know that we still have a lot of work to do. However the information presented in this document shows that a significant amount of good progress has been achieved. These improvements are the result of the hard work and commitment provided by all our staff and partners, in contributing to quality focused and compassionate services for service users and their carers.

The information contained within this document is, to the best of my knowledge, accurate. The directors' statement on page 11 further makes clear we have met the requirements for preparing this Account. Furthermore, our auditors have reviewed the account and their report can be found in Appendix D

Angela McNab
Chief Executive

Trust Objectives 2013-14

1. To enhance the quality and safety of services by maintaining or exceeding required standards of care.
2. To enhance service user engagement and patient experience (5 year objective)
3. To maintain and further establish our position as the provider of choice for mental health services in Kent and Medway (5 year objective)
4. To ensure sound financial management without compromising quality of service (5 year objective)
5. To become an exemplary employer, enabling staff to reach their full potential (5 year objective)
6. To develop dynamic and innovative clinical models, enhancing the quality, safety and effectiveness of services (5 year objective)
7. To incorporate sustainability and environmental management as an essential element of healthcare delivery (5 year target)

Our Clinical Strategy

To achieve the four key aims of our clinical strategy, set out below, we must build a culture of excellence within every part of our organisation, ensuring staff are supported, developed and valued and that clinical leadership drives improvements.

1. To provide excellent community services close to home, reducing the number of people who need inpatient care. Where such care is necessary our community services will support the length of stay being as short as possible.
2. To focus on the recovery model ensuring positive outcomes.
3. To improve the quality and dignity in services including a better physical environment and improved use of technology.
4. To expand some of our strongest specialist services, where appropriate, to potentially provide across a wider geography.

Our Services

We are focused on providing a range of mental health services. However, we also provide a range of other specialist services, they include:

Adults of working age who have mental health needs:

- Inpatient and community teams
- Rehabilitation inpatient units
- Psychological services
- Liaison Psychiatry services

Older adults who have mental health needs:

- Inpatient and community teams

Adults who have mental health problems and learning disabilities:

- Community teams
- Assessment and Intervention services
- Forensic mental health inpatient services

People with drug and alcohol problems:

- Detoxification inpatient unit
- Alcohol addiction service

Forensic mental health services:

- Medium-secure unit including specialist women's unit
- Low-secure unit
- Prison in-reach team
- Custody Liaison service

Specialist services:

- Eating Disorder services
- Early Intervention for Psychosis
- Mother and Infant Mental Health services
- West Kent Neuro-Rehab service
- Limb service
- Environmental Control service
- West Kent Clinical

Neuro-psychology service

- West Kent Mediation service
- Kent and Medway Chronic Fatigue/ ME service
- Community Brain Injury Team
- Personality Disorder service
- IAPT services

The Trust has reviewed all the data available to it on the quality of care in all 26 of these NHS services.

The income generated by the NHS services reviewed in 2013-14 represents 100% per cent of the total income generated from the provision of NHS services by the Trust for 2013-14.

Directors' Statement

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

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

- the Quality Accounts presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance
- The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account

Angela McNab
Chief Executive

Andrew Ling
Chairman

Review of Quality Performance: Achieving Our 2013-14 Priorities

The nine priorities were:

Patient Safety

- A 25% reduction in the number of severe or moderate falls in older adult inpatient wards
- Reduction in suicide and serious self-harm during an in-patient admission or while in treatment with a working age adult community team
- To ensure all adults and children are effectively safeguarded

Patient Experience

- Better communication between our staff and service users and their carers
- Using the views of service users to monitor and improve services
- Physical Health and Examination

Clinical Effectiveness

- Improving discharge planning from inpatient care and improving post discharge care
- To improve implementation of National Institute for Health and Clinical Excellence (NICE) guidance for people with a mental illness.
- To further improve the implementation of the Recovery Approach for service users working with our recovery teams

2013-14 Patient Safety Priority 1

A 25% reduction in the number of severe or moderate falls in older adult inpatient wards

Approach

To prevent harm and injury to service users by ensuring that falls assessments are completed for all older adults resulting in a decrease in the number of slips, trips & falls.

The Trust is part of the South of England's Mental Health Collaborative. The collaborative aims to "develop and build a culture of patient safety and quality improvement". There are various work streams, and one of them is "improving the physical care of service users which includes falls.

Through this collaborative our aim has been to reduce moderate and severe falls by 20% and we have used the NPSA definitions of harms for falls for reporting purposes.

Action

100% of service users admitted to older adult wards have received a falls assessment as well as anyone admitted to an adult acute bed who is over the age of 65.

All older adult wards have falls champions in place and continue to use the productive ward's safety crosses to measure the incidents of falls. Falls assessments are part of the nursing metrics and monitored on a monthly basis through the modern matrons meeting and reported to the Trust wide Patient Safety Group.

Two falls prevention workshops have been held in November and December 2013.

Results

For 2013/14 we have had a total of 12 moderate and 11 severe reported falls. This has given us a decrease of 32%.

Factors that may account for the decrease during this period are:

- A review of the Slip, Trip, Fall Policy by having a stronger clinical focus
- Local monitoring of falls as part of Productive Ward initiative
- Increasing staff awareness to report and investigate STF incidents as Serious Incidents (SI's)
- Embedding the definitions of moderate and severe falls as defined by the NPSA

KMPT signs up to better care for people with mental health issues

A Mental Health Crisis Care agreement has been published by the Government today, outlining how public services should best work together to deliver a high quality response when people with mental health problems urgently need help.

The agreement - developed by the Department of Health – has received the backing of Ann Barnes, Kent Police and Crime Commissioner, Kent Police, and the Kent and Medway NHS and Social Care Partnership Trust – that delivers mental health care services across the county.

The report aims to encourage early intervention, equal access to crisis care, providing a prompt, organised and respectful assessment process and appropriate care at all times.

It also stipulates that where Police Officers are the first point of contact for people in mental health crisis, the Police must be supported by health services and Police custody should not be considered an appropriate alternative just because there is a lack of local mental health provision.

Ann Barnes, Kent Police and Crime Commissioner said: "I'm delighted that all Police and Crime Commissioners in the country have become signatories of the Mental Health Crisis Care agreement. It has long been a deep concern of mine that vulnerable people suffering a mental health crisis are often forced to spend time in Police custody because no alternative is available – a Police cell is not the best place for someone with a mental health issue to get better – and it's not fair on our Police officers either.

"For me, this is about getting people with mental health issues the best possible care and making sure vulnerable people in our society are appropriately looked after and protected.

'I look forward to working with partner agencies to set the local action plan here in Kent in line with the new Mental Health Crisis Care agreement, to ensure all agencies are working together effectively and in a way which meets the needs of people with mental health problems."

Kent Police Chief Constable Alan Pughsley said: "The agreement represents, for the first time, a clear definition of the mutual responsibilities of the Police and mental health services. While in Kent we have excellent relationships with Kent and Medway NHS and Social Care Partnership Trust and the Sussex Partnership Trust, the agreement's clarity helps us work together and more effectively in our response to people in mental health crisis."

2013-14 Patient Safety Priority 2

Reduction in suicide and serious self-harm during an in-patient admission or while in treatment with a working age adult community team

Approach:
The Trust has continued in its work to maintain safe and effective care within inpatient wards so as to reduce the risk of suicide and serious self harm. Environmental improvements to minimise ligature is essential to reducing the risk of harm on inpatient wards however this does not negate the importance of effective risk assessment and risk management plans for all service users.

It is recognised that as environments have become safe the risks associated with service users harming themselves on the ward have reduced but there is a need to minimise service users going absent without leave from the ward as such event can result in patient safety incidents.

With acute care being provided within a service user's home as an alternative to admission the risk of suicide and serious self harm has moved from the ward to the Crisis Resolution Home Treatment Teams and there is a need to ensure risk assessment and effective care planning and intervention is in place to minimise this risk.

Over the past year the Trust has been part of the South of England Improving Safety in Mental Health Collaborative. One of the work streams is the safe and reliable delivery on mental health care and the aim is for:

- a reduction in deaths as a result of self harm in service users on inpatient wards
- zero or greater than 300 days between deaths as a result of self harm in service users in receipt of care from community teams including CRHT
- zero or greater than 150 days between severe harm in service users on inpatient wards
- zero or greater than 300 days between severe harm in service users in receipt of care from community teams.
- zero or greater than 300 days between AWOLs and missing service users. Reduce by 50%

Actions:
We have worked on improving younger adult inpatient environments by refurbishing old wards to a safe standard, and closing wards where refurbishment is not practical.

In addition work has been undertaken to improve the Therapeutic Observation Policy and provide clear guidance to staff to ensure service users who are assessed to be a high risk are kept safe on inpatient wards.

It has been recognised that those with a Personality Disorder often present at increased risk after admission to acute inpatient wards and there is a negative impact on their recovery and increased incidents of self harm. A clear pathway for the care and management of those with a personality disorder has been developed in line with NICE guidelines.

We identified a theme in serious incidents resulting in severe harm or death of those on acute inpatient wards and open to CRHTs relating to service user centred care planning. Work has been on-going to improve patient centred care planning in CRHTs to involve the service user and their carer, regular monitoring is completed monthly to all teams.

Results:
In 2013 – 14

- There have been 0 deaths on inpatient wards as a result of self harm. This is an improvement on the previous year when there was 1 death as a result of self harm
- There has been 1 death as a result of self harm of a patient open to a CRHT Team. 1 further death is currently unexplained. This is an improvement to the previous year when there were 8 confirmed suicides within CRHT teams
- There have been 10 incidents of severe self harm on younger adult inpatient wards. This is a reduction on the previous year when there were 12 such incidents. On 5 out of 11 wards the last incident of self harm is greater than 300 days.
- There have been 15 incidents of severe self harm in service users open to our CRHT teams. This is a reduction in the previous year when there were 25. In 2 out of 5 teams the last incident of severe self harm is greater than 300 days ago.
- In comparing the first 6 months of the year to the second 6 months we have achieved a 70% reduction in service users going absent without leave on our inpatient wards. Between April 2013 and September 2013 there were 78 such incidents. In the following 5 months there have been 23 such incidents.
- There have been 26 new suicides and 26 incidents of serious self harm across all community mental health teams
- All rehabilitation teams achieved zero death and 1 level 4 serious incident for over 300 days
- The analysis of Level 4 and 5 serious incidents did not present with any meaningful information. We are continuing our analysis of suicide in the general population and how this can be integrated in local team learning.

My Buddy App

The Buddy App is a simple idea a clinician signs a service user up and this then enables the clinician to send a text to the service user asking then how they feel since they last met.

The message can be adapted as a monitoring tool and the Buddy App can be used to set goals, remind and encourage service users to work towards goals. A number of users have described Buddy as "a user friendly, interactive life planning tool which empowers us in our recovery journey".

Over the last year, KMPT staff has been encouraged to sign up to the Buddy App software and a range of teams have since undergone training in the use the tool.

Feedback from clinicians who have used the app has been encouraging with many saying they have seen real benefits to service users. Currently 690 staff at KMPT are signed up to Buddy.

2013-14 Patient Safety Priority 3

To ensure all adults and children are effectively safeguarded

Approach

The organisation has continued to impress upon staff the importance of the data held on children when a patient in our service is also a parent. This is important to note the impact the illness may have on their ability to parent and in those circumstances staff need to be making timely referrals to partner agencies and working alongside them to get the best outcomes for families. We have monitored the data held on the children and the attendance at case conferences where life changing decisions are being made for these families. We have also monitored the compliance with the Mental Capacity Act to ensure the principles are being embedded in daily practice. We have also reviewed the actions taken to fulfil our delegated responsibility for the safeguarding process within working age adult teams.

Action

Case files of adults who are parents have been audited through a deep dive exercise involving over a thousand cases. The Named Nurses have made themselves available through workshops, drop in sessions and supervision to assist staff in record keeping around children's data.

Attendance at case conferences have been monitored quarterly as have the quality of the reports sent to conferences. We have asked the Children and Family teams to copy every request for attendance at a conference to our Named Nurses therefore allowing us to support the staff member to engage with the process. It must be noted that some of the clients known to us may have been recently discharged but we are still obliged to attend a conference and produce a report.

With regards to the Mental Capacity Act an audit was completed using three community teams for older people's mental health services.

To ensure we fulfilled our delegated responsibility in the safeguarding adult process an external audit was also completed.

Results

Case file audit on service users who are parents

Number of which were parents	Number of files reviewed	% of service users files where child data recorded.
1135	343	33%

Case conference attendance

Number of invites received	Client actually known to us	Conferences attended.
225	92	53 (56.25% compliance)

100% of all reports sent deemed adequate or above.

Adult safeguarding external audit 16 cases reviewed.

Number of cases	Results Conferences attended.
8 Cases	Excellent or good
4 Cases	Adequate
4 Cases	Inadequate

Mental Capacity Act Compliance

Number of case files reviewed	Results
27 cases	37% fully compliant (10)
	33% Partially compliant (9)
	30% Not compliant (8)

Staff at Rosewood Lodge, Dartford, holding an open day on Thursday, August 8 2013 to showcase activity programmes benefiting service users in north Kent.

2013-14 Patient Experience Priority 1

Better communication between our staff and service users and their carers

Approach

In April 2012 the Customer Care Charter was launched and was distributed throughout the Trust following some production difficulties. During the summer the physical copies of the charter were distributed across the organisation. Ongoing work is needed with teams and this is being addressed through the Customer Care Week.

In addition the Trust continued to monitor the percentage of complaints received relating to staff attitude and service line action plans are in place to improve patient experience. However the percentage of complaints relating to staff attitude remained the same this year as last.

Action

In order to address this, the Trust organised a Customer Care Week to take place in May 2013. During the week we re-launched the Customer Care Charter and also the new customer care training package, which has been co-produced with carers, service users and KMPT.

Results

The results for this indicator have been measured by monitoring the percentage of up held complaints relating to staff attitude. During the period being reported the percentage of upheld complaints relating to staff attitude has reduced from 17% to 14%. Kent and Medway NHS and Social Care Partnership Trust has increased the number of staff across Kent & Medway who have taken part in face-to-face Customer Care training and over 1000 staff have now taken part and we will continue to embed Customer Care Week throughout the organisation.

Ensuring Quality, Valuing Difference Conference Report

KMPT is committed to building and delivering services that are more equal, where every individual has the opportunity to achieve their potential and where people treat each other with dignity and respect. It's for that reason that, in collaboration with its partners (Medway Council and Rethink) KMPT held a very successful conference at the Bishop of Rochester Academy in Chatham in October to explore a range of issues that matter most to our service users across all communities.

As part of our ongoing conversations towards continuous improvements, the Trust invited service users, carers, NHS staff, representatives from statutory and voluntary organisations and other interested parties to participate in the 2013 conference, which was well attended by around 90 delegates.

The aim of the event was to tap into the valuable experience of the delegates taking part, helping to strengthen working relationships and explore a range of themes around equality and diversity – particularly, on the subject of quality, dignity, respect, transparency, accountability and fairness across the range of services we provide.

2013-14 Patient Experience Priority 2

Using the views of service users to monitor and improve services

Approach
It is clear that the patient experience is a crucial part of quality healthcare provision. The NHS Constitution, the Outcomes Framework 2011-12 and the NICE Quality Standards for Experience and Mental Health Experience all reinforce the need for patient centered care. Service users tell us that they care about their experience of care as much as clinical effectiveness and safety. They want to feel informed, supported and listened to so that they can make meaningful decisions and choices about their care.

Action
The Trust's Expert by Experience Research Group have trialed the Snap Mobile Anywhere web-based survey system, which has enabled the Trust to demonstrate that they are using service user views to improve services.

The Expert by Experience research group have carried out a planned cycle of visits to various Trust locations ensuring that services in each of the eight Clinical Commissioning Groups (CCG) areas are surveyed, using ipads linked to the Snap Mobile Anywhere software in order to collect real time service user views. These have been fed into the Trust governance system and used to support improvement in services.

Results
Surveys were carried out across the 8 Clinical Commissioning Group areas in Kent and Medway; 2 groups of service users were surveyed, those in 'long term planned care' and those in 'shared care' the results of the surveys were fed back to the service lines and the Commissioning Quality Assurance Group.

Service lines have introduced a system of 'You said, We did' boards across KMPT and these outcomes are shared on the website. In addition the Expert by Experience Research Group supported by the Patient Experience Team and the High Impact Innovation Team are carrying out a planned cycle of visits to the Community Mental Health Teams across Kent & Medway using iPads to collect service user views relating to a set of issues highlighted in the 2013 National Patient Surveys. The data collected was analysed by the High Impact Innovation Team add fed back to the service line for action/comment, these results also inform the 'You said, We did' style of management at the Local Leadership Groups.

2013-14 Patient Experience Priority 3

Physical Health and Examination

Approach
People with mental health problems are at significantly increased risk of a range of physical illnesses and conditions compared with the general population. Those with concurrent physical and mental health problems are also at an increased risk of these conditions negatively impacting on each other.

Action
100% of service users admitted to the inpatient wards regardless of age, will have a physical health assessment.

All service users within the community setting will have a physical health assessment either by their community team or by their GP.

The Physical Health in Mental Health bi monthly, two day training course continues to be well attended by staff from all service lines. There have been four training courses so far in 2013 in the new two day format and 102 staff have now attended.

There has been smoking awareness days for staff and several staff have also been trained to Level 2 smoking cessation advisors. A stop smoking message is being placed on the electronic boards within the Forensic Services in collaboration with the Kent Stop Smoking Service.

Within the Health Care Assistant's Conferences held in December 2013 there were presentations on physical health and the importance of monitoring.

Stop Smoking Service update
The Mental Health Project Lead from the Kent Stop Smoking Service has been working with teams within the Trust to promote the Stop Smoking Service to our service users and to train staff to undertake level 1 and 2 Stop Smoking Advisor training. Level1 training is given to all staff attending the KMPT Physical Health in Mental Health training.

Results
Physical health assessments are monitored for inpatients and are currently at 99.25% regardless of age. If a service user initially refuses this assessment staff try to engage with them to develop a therapeutic relationship with them and will continue to try to perform the physical health assessment.

Community teams continue to work hard to provide physical health checks for their service users, providing innovative ways of doing this; for example providing health checks at depot clinics or memory clinics. The overall percentage of all clients who have a physical health check in all community teams across the Trust, including all service lines is 24.16% and will be improved upon in 2014.



Grace Wright: Andy Inett; Anne Sheeran

ID Start paper published

Andy Inett (Forensic Psychologist, East Kent Community Forensic Psychology Service), Grace Wright (Forensic Psychologist in Training, Tarentfort Centre), and Anne Sheeran (Consultant Clinical & Forensic Psychologist in the forensic LD and low secure services at Dartford) have all collaborated together to conduct the
first research on the validity of the START (Short-Term Assessment of Risk and Treatability) in a population of low secure forensic in-patients with Intellectual Disability (ID). This was also carried out with the help of Louise Roberts who used to work as an Assistant Psychologist at the TGU.

The article has been published in Volume 16 of the Journal of Forensic Practice, and you can access this through the embedded document above or in the 'Peak of the Week' Folder on the S:Drive (S:\operations\Forensics\Peak of the Week).

The purpose of the paper was to evaluate the predictive ability of the START within this population, as they have been largely neglected in the majority of past forensic literature on the assessment of dynamic risk factors. The findings showed that the START Risk Scores had a significant high predictive accuracy for incidents of physical aggression to others and property damage/ theft over 30 days. This was found to still have a medium effect after 90 days. Medium effects of predictive validity were also found for incidents of verbal aggression, suicide, self-harm, stalking and intimidation. Lastly, START strength scores were found to be predictive of overt aggression.

The paper offers preliminary support for the use of the START with ID offenders in low-secure settings. Given the lack of validation of any previous dynamic risk assessment tools, multidisciplinary teams in such settings now have the option to use a tool which has potentially good validity with an ID population.

2013-14 Clinical Effectiveness Priority 1

Improving discharge planning from inpatient care and improving post discharge care

Approach:
We aim to ensure that best practice in facilitating safe and effective discharge is always followed which contributes to reducing pressures on inpatient wards by enabling more therapeutic and effective treatment and facilitating the wellbeing and recovery of service users. It is recognised that lengthy admissions and frequent readmissions to hospital can result in social inclusion and be detrimental to an individual's recovery.

In addition there is a wealth of evidence indicating that the immediate period post discharge can be very difficult for service users and carers and therefore effective discharge planning and follow up is essential to managing risk and maximising recovery.

We also aim to ensure that care planning is central to the delivery of care. Patient centred care planning is key to effective discharge planning and through involvement of the patient and their carers we aim to support a timely discharge to avoid future admissions and work in collaboration to support recovery.

Actions:
We have continued to measure the number of people of all ages who were re-admitted as an emergency within 28 days of discharge.

We have continued to regularly review the discharge plans for people whose discharge has been delayed or whose length of stay exceeds 60 and 100 days.

We have continued to measure the number of people who were seen within 7 days of discharge from hospital.

We have undertaken an on-going audit of care plans to ensure they are patient centred. The care plans and audit tool are based on the principles of person centred care planning as described within national standards CQC outcomes, law and legislation such as the Mental Health Act and best practice guidance such as those outlined within RCN and NICE Guidance.

Results:
In 2013 – 14

- 14.48% readmitted within 28 days
- 3.3% delayed transfers of care
- 78.19% Service users in hospital for 60 days or less – progress in year
- Achievement against 7 day follow up target = 96.48%
- Person Centred Care Planning audit: median of Yes scores = 77.50% (range 75% to 83%)

2013-14 Clinical Effectiveness Priority 2

To improve implementation of National Institute for Health and Clinical Excellence (NICE) guidance for people with a mental illness

Approach

The Trust aimed to continue to improve implementation of relevant NICE guidance through three main activities -

1. Continuing with a programme of NICE implementation monitoring, co-ordinated by the NICE Reference Group throughout 2013/14
2. Initiating a programme of measurement against NICE Quality Standards
3. Commissioning a nationally recognised medicines adherence course during 2013 for prescribers.

Action

1. NICE implementation

During 2013/14 the Trustwide NICE Reference Group continued to meet monthly. The group comprises professional representatives from all regions of the Trust and all service lines. All new guidance published by NICE during the year has been reviewed by members of the group to decide on it's relevance to KMPT services. Where guidance has been identified as relevant to KMPT services, the guidance has been disseminated to staff and the process of undertaking a gap analysis of current service provision against the recommendations in clinical guidelines has been initiated.

2. NICE quality standards

NICE quality standards differ from NICE clinical guidelines in that they are a set of explicit statements that are designed to be measurable. These statements are derived from high quality guidance either published by NICE or from sources accredited by NICE. NICE quality standards are intended to support measurable improvements in quality for particular areas of healthcare.

As part of KMPT commitment to continuously improving implementation of NICE guidance, the NICE Reference Group has been investigating how best to measure performance against relevant quality standard statements.

The first stage in this plan has been to identify which quality statements are relevant to KMPT services. The NICE Reference Group has been considering the relevance of quality standards alongside other NICE guidance and this has worked well. Relevant quality standards have also been disseminated to staff in the same way as other relevant NICE guidance.

Once relevant quality standards have been identified the next step has been to prioritise which quality standards and which statements within them are the most useful to concentrate on.

3. Medicines adherence training

Many service users do not take their medication according to the instructions they are given when the medication is prescribed. Failure to take medication correctly can have wide ranging consequences

- for the patient the likelihood of good health outcomes is reduced
- for the Trust and wider NHS money and time are wasted

KMPT made a commitment to give at least 35 members of staff access to nationally recognised medicines adherence therapy training. The training course chosen has received excellent feedback, including some Trusts that have reported a statistically significant reduction in relapse rates for early psychosis and improved psychopathology (positive and negative symptoms) in service users recovering from an acute episode of schizophrenia.

Results

1. NICE implementation

The total number of NICE clinical guidelines, technology appraisals and quality standards published to date this year is given in the table below. This table also shows whether the guidance was considered relevant or not relevant to KMPT services.

NICE guidance published since 1/4/2013	Not relevant	Relevant	Grand Total
Clinical Guidelines	14	5	19
Quality Standards	15	4	19
Technology Appraisal	24	0	24
Grand Total	**53**	**9**	**62**

Projects based around standards taken from NICE guidance continue to feature highly on the Trust clinical audit and effectiveness project programme, with 29% projects using NICE guidance in their methodology.

2. Quality Standards

Before any data could be compiled for the indicators within the depression quality standard, those people being treated for depression needed to be identified through a business intelligence report from the Trust patient information system. A small team worked to identify the diagnosis codes needed to create the report and the report was created.

The resultant report showed a much smaller number of service users with a diagnosis of depression than expected. Discussion with colleagues and further investigation led to the discovery that diagnosis was not routinely being recorded in the correct place within the patient information system. This issue was not limited to people with a diagnosis of depression but applied to other service users too.

However, current mandatory requirements are for mental health Trusts to record diagnosis when a service user is discharged from acute inpatient care. Therefore data for these service users was available.

Data against the first statement in the depression quality standard is given in the box below. This data is for service users discharged from in-patient services between 2/4/13 – 2/3/14 inclusive and is measured by whether the person has had a HoNOS assessment.

Quality Statement	Compliance
People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode.	95%

However, the vast majority of service users do not have a period of inpatient care and use community mental health services. Most of these service users do have a diagnosis but it is not recorded in a way that can be reported using the electronic patient information system. The NICE Reference Group is committed to improving formal recording of diagnosis for community service users as this will have many other benefits in addition to facilitating reporting against the NICE quality standards. Discussions with doctors about how and where diagnosis is recorded are taking place. A member of the business intelligence team is working with doctors to develop guidance on how diagnosis should be recorded in the patient electronic notes. Regular reports will then be used to monitor improvements in the percentage of service users with a formal diagnosis recorded.

3. Medicines adherence therapy training

The medicines adherence therapy training course ran 7 times and a total of 84 members of staff completed the training. The table below shows the course dates and the number of staff who attended. This far exceeded the plan to train 35 members of staff. Feedback from the staff that completed the course was very positive.

Date	Total
April 2013	10
May 2013	23
October 2013	6
October 2013	11
November 2013	9
November 2013	15
December 2013	10
Grand total	**84**

2013-14 Clinical Effectiveness Priority 3

To further improve the implementation of the Recovery Approach for service users working with our recovery teams

Approach

It is important that the Trust works to continually improve its services to become more recovery focused. This local and national challenge is supported by the Centre for Mental Health and the ImROC program (Implementing Recovery for Organisational Change).

Action

The Trust has paid to be part of the ImROC project for over five years, sharing ideas and learning about new recovery initiatives with other UK Trusts.

1. This work has led to the development and recent employment of a new peer support workforce.
2. The Trust has been working to deliver more recovery focused groups, which have continued to run all year. These introduce recovery action planning, which is considered a vital part of mental health recovery and wellbeing.
3. In addition to the recovery groups, a major wellbeing centre pilot has been initiated, with further recovery focused educational modules. This is being researched and evaluated at the present time, with robust outcome measures.
4. The Trust continue to work in collaboration with partners to further build the Kent based Live it library, which supports patient recovery. This runs four times a year, with a team filming people talking about their personal stories.
5. The Trust continues to support teams to complete advanced care plans and recovery stars to improve quality in our care delivery and interventions.

Results

1. The Trust now employs 10 peer support workers on permanent contract. There are four new positions currently being recruited into.
2. Over 213 service users have created their own recovery action plan in the last year.
3. The wellbeing centre has been very well attended and positively received. It is currently being researched and evaluated with service users, as to its benefits for supporting Recovery.
4. The Live it Library has recorded approximately 50 personal recovery stories, which are promoted across the Trust via the Internet and in recovery groups, to share hope for service users who are on their own recovery journey.

These stories are also used to educate staff and challenge stigma.

5. There are currently 2620 advanced care plans uploaded - a rise of 42% since last year.

There are currently 665 recovery stars uploaded - a rise of 42% since last year.

Comments on 2013-14 Performance from Local Healthwatch and Local Authorities

The Quality Account guidance and toolkit require us to ask external stakeholders and partners for their comments on our Quality Account.

We are required to ask Healthwatch Kent, Healthwatch Medway, Kent Health & Wellbeing Board, Medway Health & Wellbeing Board and the Clinical Commissioning Group (CCG) who have referred the most service users to us during 2013 – 2014. From the table below, you will see this is West Kent CCG.

Access and CMHTOP Referrals in 2013-14

Practice Consortium/Practice Name	All Referrals
Ashford Locality Commissioning Group	1503
Canterbury and Coastal CCG	3493
Dartford, Gravesham and Swanley Locality	2726
Medway Consortium	3755
Outside Kent	390
South Kent Coast CCG	2896
Swale Locality Group	1496
Thanet GP Consortium	2205
Unknown	228
West Kent CCG	5001
GRAND TOTAL	**23693**

Please see responses on next page

Kent County Council
kent.gov.uk

Lou Bean
KMPT
Queen Victoria Memorial Hospital
King Edward Avenue
Herne Bay
Kent
CT6 6EB

Members' Suite
Sessions House
County Hall
MAIDSTONE
Kent
ME14 1XQ
Direct dial/Ext: 01622 696276
Fax: 01622 694212
Email: roger.gough@kent.gov.uk

Date: 9 May 2014

Dear Mr Bean

Thank you for your recent letter inviting me to comment on the Quality Account for KMPT on behalf of the Health and Wellbeing Board. It has been useful to have the opportunity to view the draft version.

The idea of producing an annual report reporting on quality and improvements in local services that can be accessed by both the public and stakeholders is a laudable one. However, the Board will not be providing any formal comment on Quality Accounts this year.

The issue of quality surveillance and using information to generate improvements is one which all members of the Health and Wellbeing Board take seriously. This is an area of work currently being developed and we are exploring different ways in which the Board can most effectively gain an overview of the quality of health and care services across Kent, within the wider context of the Board's role.

It may be that in future years the Board will wish to comment on Quality Accounts where we have been invited to do so, and our not doing so this year should not be taken as any reflection on the quality of services offered by your Trust.

If possible, I would be interested in receiving a copy of your final Quality Account.

Yours sincerely

Roger Gough
Chair of the Kent Health and Wellbeing Board
Cabinet Member for Education & Health Reform

kent.gov.uk

Healthwatch Medway CIC
Kingsley House, Second Floor
37-39 Balmoral Road
Gillingham
Kent
ME7 4PF
Tel: 01634 566777
Fax: 01634 383767
info@medwayhealthwatch.co.uk

12th May 2014

Lou Bean
Clinical Audit & Effectiveness Manager
Queen Victoria Memorial Hospital
King Edward Avenue
Herne Bay
Kent
CT6 6EN

Email: clinicalaudit@kmpt.nhs.uk

Dear Sir/Madam

Re: Kent & Medway NHS and Social Care Partnership Trust
Quality Account 2013-2014

Please find attached Quality Accounts Statement submitted by The Very Reverend Dr Mark Beach on behalf of Healthwatch Medway CIC.

Yours faithfully

Bridget Bygrave
Operations Manager
Healthwatch Medway CIC

Response received from the Chair of the Kent Health and Wellbeing Board

Response received from Healthwatch Medway

DRAFT Statement from Healthwatch Medway
Within the timescale of these Kent and Medway NHS and Social Care Partnership Trust (KMPT) quality accounts a range of high-profile independent Government reviews (Francis Report (2013), Berwick (2013), Keogh (2013) and Clwyd Hart (2013)) took place all highlighting the critical need to 'put patients first' and for services to have mechanisms in place to continually learn from patient experience.

Healthwatch Medway is the' independent consumer champion' of Medway residents who use care and health services in Medway. As a result of the role is to champion rights in health and care and the comment for these Quality Accounts focuses on the systems and processes which Kent and Medway NHS and Social Care Partnership Trust has in place to hear, learn and improve from patient experiences.

Kent and Medway NHS and Social Care Partnership Trust Performance during 2013/2014

Healthwatch Medway welcomes Kent and Medway NHS and Social Care Partnership Trust:

- Engaging with Healthwatch Medway as a stakeholder.
- Re-launching the Kent and Medway NHS and Social Care Partnership Trust Care Charter in May 2013 – which has been co-produced with people who use their services.
- Holding, in partnership with Medway Council and Rethink, an 'Ensuring Quality, Valuing Difference' Conference in Chatham in October 2013 in order to understand about the different needs of the communities of Medway.
- Introducing 'You said, We Did' boards across the Trust – so that it is transparent to people who use the service that their feedback is being listened to and action is being taken as a result.
- Involving their 'Experts by Experience Research Group' team to visit Community Mental Health Teams across Kent and Medway to collect service user views relating to issues highlighted in the 2013 National Patients Surveys.
- Discussing issues connected with patient dissatisfaction at the Trust's Trust Patient Consultative Committee.
- Launching, with Primary Mental health Nurses, a bipolar focus group in Medway.
- Producing, with Kent Police, a DVD containing input from services users on how Police officers might deal with certain mental health issues.
- Included both a list of abbreviations and a glossary of key terms within the Quality Accounts.
- Provided information within the Quality Accounts that stated that alternative versions were available of this document.

Healthwatch Medway notes:

- During this period the West Kent Clinical Commissioning Group and the Chief Executive of Kent and Medway NHS and Social Care Partnership Trust reconfigured inpatient beds in Medway. This affected the Kent and Medway NHS and Social Care Partnership Trust service provision in Medway as it resulted in moving away services from the Medway area, resulting in an increase in distance for people to use services and as a direct result of this change negatively affecting patient experience.
- There is a lack of clarity within the Quality Accounts about the role and performance of the Kent and Medway NHS and Social Care Partnership Trust's Patient Advice and Liaison service.
- The Medway NHS and Social Care Partnership Trust's website and Quality Accounts do not provide Medway specific information – instead providing information for Kent as a whole.
- There is a lack of reference by Kent and Medway NHS and Social Care Partnership Trust regarding meaningful data which is captured about the patient experience of those individuals and communities with perceived 'protected characteristics' (according to the Equality Act 2010).
- The 2013 National Patient Survey identified a poor patient experience in connection with Care Planning at Kent and Medway NHS and Social Care Partnership Trust. The survey asked patients ' How effective was the care plan in helping you

achieve your goals?' and the Trust was scored 6 out of 10, which means that it is preforming 'worse than expected against other mental health trusts in England'.

- Kent and Medway NHS and Social Care Partnership Trust have not produced an Easy-Read version of their 2013/2014 Quality Accounts – limiting the accessibility of the Quality Accounts to Medway citizens.

Kent and Medway NHS and Social Care Partnership Trust Priorities for 2014/2015

Healthwatch Medway welcomes Kent and Medway NHS and Social Care Partnership Trust:

- Having Patient Experience Priorities in 2014-2015.
- Discussing their Patient Experience priories for 2014-2015 with their Trustwide Patient Experience Group.
- Have identified Patient Experience priorities that will increase the control and choice of people who use their services.

Healthwatch Medway notes:

- There is a lack of reference by Kent and Medway NHS and Social Care Partnership Trust regarding whether meaningful data will be captured in 2014/2015 about the patient experience of those individuals and communities with perceived 'protected characteristics' (according to the Equality Act 2010).
- The Trust reports that it intends to work in a 'closer partnership' with the people who use their service. A lack of clarity exists about how working arrangements will differ in order to provide those people who use the service with greater empowerment when working in partnership with the Trust.
- To achieve a year-end target of no more than 10% of upheld/partially upheld complaints due to staff attitude – this would be a 29% reduction across the board. This is an ambitious target; for it to be achieved successfully it is important that people who may use the service and staff both have a shared understanding of 'what is a good and fair complaints process' and what 'good staff attitude' is.
- The Quality Accounts do not provide Medway specific information – instead providing information for Kent as a whole.
- There is a lack of clarity whether Kent and Medway NHS and Social Care Partnership Trust will publish an Easy read version of its 2014/2015 Quality Accounts – in order to reach more Medway citizens.

Conclusion/comment

- Healthwatch Medway believes that it is important to understand what matters to consumers, especially those least included or who have protected characteristics, by always starting with their needs and rights. Healthwatch Medway is disappointed that Kent and Medway NHS and Social Care Partnership Trust Accounts lacks clarity about this important issue
- Healthwatch Medway welcomes the opportunity to engage with Kent and Medway NHS and Social Care Partnership Trust in 2014/2015. In addition, Healthwatch Medway looks forward to learning about the action that has been taken by the Kent and Medway NHS and Social Care Partnership Trust following the Healthwatch Medway comments on it's 2013/2014 Quality Accounts

KPMT will be responding to these comments from Healthwatch Medway.

Response received from Healthwatch Kent

Healthwatch Kent response to the Quality Account for Kent & Medway NHS & Social Care Partnership Trust

As the independent champion for the views of patients and social care users in Kent we have read the Quality Accounts with great interest.

Our role is to help patients and the public to get the best out of their local health and social care services and the Quality Account report is a key tool for enabling the public to understand how their services are being improved. With this in mind, we enlisted members of the public and Healthwatch staff and volunteers to read, digest and comment on your Quality Account to ensure we have a full and balanced commentary which represents the view of the public.

On reading the Accounts, our initial feedback is that the accounts are very lengthy and not written in plain English making this hard for the general public to read, understand and digest. This is not a unique problem as we have seen similar issues with all the Quality Accounts from Kent providers. For future reports we would like to work with you, and other providers, to ensure the reports are accessible and understandable for a wider audience. For this year, a list of acronyms would help.

The report references engagement with the public and patients but there is no detail, nor is there evidence of how the Trust plans to reach seldom heard communities. We would like to hear more detail about how you are working with patients and the public and would be happy to help you to develop ideas for the year ahead as this is such a vital part of your work.

We note in the report the positive news that the Trust plans to improve engagement with staff. However this seems to be triggered by the level of complaints received about staff attitude rather than a desire to improve communications amongst employees. We have received feedback from patients and their families that they can be anxious about complaining and the impact that this could have on their care or the care of a loved one. With this in mind we would encourage the Trust to consider additional measures to gauge improvements in this area for the coming year.

We found no mention of the difficulties faced by families, patients and carers following the closure of A block ward in Medway and the subsequent transfer of patients to either Dartford, Maidstone and Canterbury. Again, we have received feedback from a number of patients and their families following the closure and we have been working on a project to assess the impact that this has had on the people involved.

Healthwatch Kent has proposed a partnership with KMPT. Part of this agreement pledges our support to help the Trust develop a meaningful conversation with the public. We hope to secure agreement on our proposal soon so we can help the Trust to better engage and understand the needs and views of their patients and the public.

In summary, we would like to see more detail about how you involve patients and the public from all walks of life in decisions about the provision, development and quality of the services you provide. We hope to develop our relationship with the Trust to ensure we can help you with this.

Healthwatch Kent May 2014

KPMT will be responding to these comments from Healthwatch Kent

No responses have been received from Medway Health & Wellbeing Board and the West Kent Clinical Commissioning Group

Bipolar Focus Group launched in Medway

A new Bipolar Focus Group jointly facilitated by Medway Community Mental Health team and Medway Primary Care Mental Health nurses has launched.

Based on the shared care theme a new Bipolar Focus Group is jointly facilitated by Medway Community Mental Health team and Medway Primary Care Mental Health nurses. Sitting on the interface, the group is open to both Primary and Secondary care service users with a diagnosis of Bipolar Affective Disorder and their carers.

The key objectives are to share knowledge, empower and support the service users to self-manage illness and promote their own recovery while bolstering the links with primary care mental heath services.

This group will also be a key platform to:

- Help reduce stigma of mental illness
- Improve access to all aspects of primary care as well as fast tracking to secondary care: "people seeing the right professional at the right time in right place"
- Provide a holistic and consistent approach focusing on recovery beyond realms of secondary care mental health into primary care.

For further information please contact
Dr Pamadeth Shobha, Consultant Psychiatrist,
Medway Community Mental HealthTeam,
Canada House, Gillingham, Kent.

Overview Statements Relating to Quality of Services

The following sections of the Quality Account are mandatory. All Trusts must include them so that readers can compare one Trust with another.

Mandatory Quality Indicators

KMPT has achieved the target levels of these indicators consistently throughout 2013-14 and have performance levels above national average in most cases. Robust procedures are embedded within the Trust to ensure continued compliance against these indicators; additionally there is constant review of any instances of non-compliance to ensure lessons are learnt to further improve our performance in the future.

7 day follow up

KMPT considers that this data is as described for the following reasons: Robust processes are embedded within the Trust to aid effective discharge, planning and follow up. The data has been extracted from central DoH repository and correlates with the data submitted by KMPT, therefore no concerns exist over its data quality.

KMPT has taken the following actions to improve this percentage and so the quality of its services, by: The Community Recovery Service Line committing to the 7 day follow up of all service users discharges

Indicator	Performance	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4
7 Day Follow Up	KMPT	97.4%	96.4%	96.2%	95.9%
	National Average	97.4%	97.5%	96.7%	97.4%
	Highest Nationally	100%	100%	100%	100%
	Lowest Nationally	94.1%	90.7%	77.2%	93.3%

http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/

CRHT Gatekeeping

KMPT considers that this data is as described for the following reasons: Clear admission protocols exist within the Trust. The data has been extracted from central DoH repository and correlates with the data submitted by KMPT, therefore no concerns exist over its data quality.

KMPT has taken the following actions to improve this percentage and so the quality of its services, by: ensuring each case is reviewed by the CRHT prior to admission to validate that this is the best course of treatment for the service user.

Indicator	Performance	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4
CRHT Gatekeeping	KMPT	100%	100%	100%	100%
	National Average	97.7%	98.7%	98.6%	98.3%
	Highest Nationally	100%	100%	100%	100%
	Lowest Nationally	74.5%	89.8%	85.5%	93.3%

http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/

28 day readmission Rates

KMPT considers that this data is as described for the following reasons: This is a locally produced percentage based on the agreed methodology of readmissions within 28 days as a percentage of all admission. No national benchmarking has been possible as there is no recent data published. It should be noted that the increase in this rate may be caused by KMPT in-patients that had been transferred to an acute hospital and then transferred back to a KMPT in-patient facility being included in the data.

KMPT has taken the following actions to improve this percentage and so the quality of its services, by: Improve discharge planning and community treatment following discharge to minimise the chance of a readmission being required.

	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4
28 day readmission rate OP Acute	13.5%	14.8%	15.9%	13.9%
28 day readmission rate OP Acute	12.8%	14.4%	10.1%	22.0%

Staff recommending the Trust as a place for family or friends to receive treatment

KMPT considers that this data is as described because it is taken from responses to the National NHS Staff Survey 2013. It is taken from responses to the question:

If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.

The figure has been arrived at by calculating the 'agree' and 'strongly agree' responses and adding them together.

We have calculated the average for Mental Health and Learning Disability Trusts by adding together the 'agree' and 'strongly agree' responses for each Trust, adding all these Trust scores together and then dividing them by the 57 mental health and learning disability Trusts who took part in the survey.

While the national staff survey results for 2013 showed improvements in staff satisfaction, effective team working and ability to contribute to improvements at work KMPT recognises that it has a way to go to improve its score for this indicator. The Staff Forum and Clinical Cabinet are working closely with the Director of Human Resources (HR) and Executive team to identify key areas for improvement. Additionally, each service line has robust plans focusing on key areas supported by Trustwide actions in the following areas:

1. Investigating the perceptions of bullying and harassment
2. Reducing violence, incidents and harassment of service users and carers towards staff
3. Improving health and wellbeing of staff and access to mental wellbeing support
4. On-going staff engagement activities and listening exercises to enable staff to identify issues that are affecting them and to ensure an ongoing dialogue is maintain

Indicator	Performance	2012	2013
	KMPT	40%	47%
If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust	National Average	58%	59%
	Highest Nationally	80%	85%
	Lowest Nationally	39%	38%

http://idicators.ic.nhs.uk/webview/.

Patient experience of community mental health services

KMPT considers that this data is as described for the following reasons: Robust processes are embedded within the Trust to aid effective improvement in the patient experience of services provided by KMPT. The data has been extracted from the Care Quality Commission (CQC) National Community Patient Survey and correlates with the data submitted by KMPT, therefore no concerns exist over its data quality.

KMPT has taken the following actions to improve this score, and thus the quality of its services, as follows: Applying effective processes with robust action plans and monitoring regularly at the Trustwide Patient Experience Group, with feedback and learning being provided across the Trust it should be noted that KMPT has a slightly improved performance for 2013/14 whereas the national average has decreased over the same period.

In order to monitor the action plans resulting from the results of the National Patient Survey (NPS) KMPT uses a variety of different methods including Community Services Feedback Form (CSFF), the Friends and Family Test (F&F) to gather the views of service users, issue relating to patient satisfaction are also raised and discussed at the Patient Consultative Committees that meet across Kent and Medway,

Indicator	Performance	2012	2013
Patient experience of community mental health services based on contact with a health and social care worker	KMPT	83.2	83.6
	National Average	86.6	85.8
	Highest Nationally	91.8	90.9
	Lowest Nationally	82.6	80.9

https://indicators.ic.nhs.uk

Rate of Patient Safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

KMPT considers that this data is as described for the following reasons; the data for National figures is taken, where available, from the National Reporting and Learning System (NRLS). We have calculated the national average by using the total figures for Mental Health Trusts (MHT) and also determined the Highest and Lowest MHT from the same set of data. Up to date KMPT Total figures for 2013-14 are taken locally from the incident reporting system (Datix) as this provides a more accurate position of the Trust against the National figures. The local figures have been reported to the Quality Committee, the Patient Safety Committee and Trust Board (public part) monthly and bi-monthly throughout the year. KMPT is taking the following actions to improve this rate and so the quality of its services, in having a patient safety manager undertaking some of the level 5 clinical learning reviews independent of the service lines. All service lines have meetings that review serious incidents and ensure learning is shared with practioners. The Trust is regularly reviewing how best to share learning across the Trust. This work is supported by the Trust's ongoing involvement in the South of England Improving Safety in Mental Health Collaborative.

Trustwide reporting of serious incidents has become more robust and incidents are now being more accurately reported. This has included incidents which are initially reported at a higher level and are then subsequently downgraded as they did not meet the Trusts criteria for that level of incident.

Full year data for 2013/14 for KMPT for severe harm & death/all reported patient safety incidents 52/3769(1.4%) as compared to 75 / 3858 (2.0%) 2012-13, which was compliant with the previous reporting requirement.

Indicator	Performance	2013-14 Total KMPT*	2013-14 Q1/Q2	2012-13 Q1/Q2	2012-13 Q3/Q4
		Internal data	Data from NRLS		
	KMPT	52	2% (32)	2.2% (46)	1.2% (21)
Severe harm/death	National Average %		1.3% (1548)	1.6% (1747)	1.3% (1485)
	Highest Nationally %		5.3% (48)	9.4% (334)	5% (44)
	Lowest Nationally %		0%	0%	0%

*Local data – KMPT incident reporting system, patient safety incidents
National data - **http://idicators.ic.nhs.uk/webview/.**

Participation in clinical audit and quality improvement activities

National clinical audit and quality improvement activities

During the period 1st April 2013 to 31st March 2014 Kent and Medway NHS and Social Care Partnership Trust was actively involved in 11 National Clinical Audits/Quality Improvement projects and one National Confidential Enquiry that were relevant to the services provided by the Trust.

National Confidential Enquiry Into Suicide and Homicide by People with mental illness
National Audit of Schizophrenia
POMH-UK: Prescribing Observatory Mental Health – UK: Prescribing topics in mental health services (3 topics) - Topic 7d: Monitoring of patients prescribed lithium (re-audit) - Topic 4b: Prescribing anti-dementia drugs - Topic 14a: Prescribing for substance misuse: alcohol detoxification

During the above period the Trust participated in 100% of the national clinical audits and national confidential enquires which it was eligible to participate in, see table below for a list of projects that the Trust was eligible to participate in.
The Kent and Medway NHS and Social Care Partnership Trust also participated in the following national clinical audits and quality improvement activities during 2012-2013:

Accreditation for Inpatient Mental Health Services (Two in-patient wards)
Home Treatment Accreditation Scheme (1 Crisis Resolution & Home Treatment Teams)
Quality Network for Forensic Mental Health Services
National Outcome database for CFS/ME
Community of Communities: Therapeutic communities quality improvement network
Memory Services National Accreditation Programme (1 Memory Clinic)

The national clinical audits, national confidential enquiries and quality improvement activities that Kent and Medway NHS and Social Care Partnership Trust participated in, and for which data collection was completed during 2013-2014 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, enquiry or activity.

Topic	Number of Cases %
Accreditation for Inpatient Mental Health Services	100%
Home Treatment Accreditation Scheme	100%
POMH: Prescribing Topics in Mental Health Services	100%
Quality Network for Forensic Mental Health Services	100%
National Audit of Schizophrenia, 2nd Round	100%
National Outcome database for CFS/ME	100%
Community of Communities: Therapeutic Communities Quality Improvement Network	100%
Memory Services National Accreditation Programme	100%
National Confidential Enquiry Into Suicide and Homicide by People with mental illness	98.17%

The reports of 9 national clinical audits and quality improvement activities were reviewed by the Trust between 1st April 2013 and 31st March 2014

Case study: National Clinical Audit and Quality Improvement Projects:

Prescribing Observatory for Mental Health (POMH) UK: Topic 7d (re-audit): Monitoring patients prescribed lithium

KMPT is a registered member of the Prescribing Observatory for Mental Health which aims to help mental health Trusts improve their prescribing practice. Topic 7d, monitoring patients prescribed lithium was last audited in 2011 and the data collection for the current audit was carried out during June and July 2013.

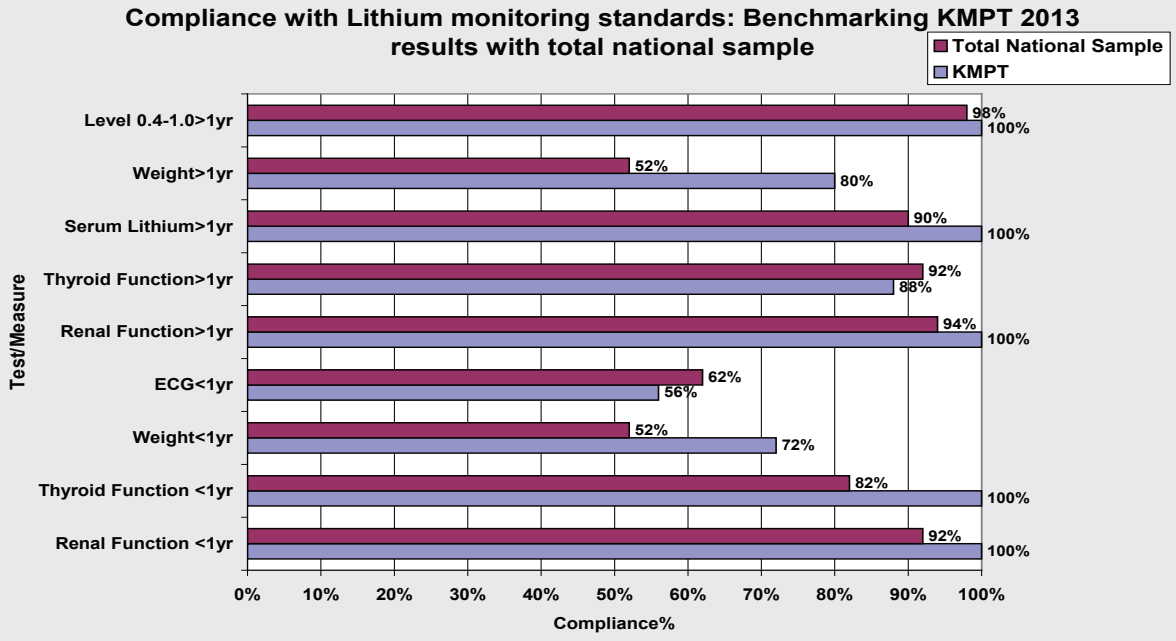
The standards used in the audit were developed from NICE Guidance, Drugs and Therapeutics Bulletin, and the British National Formulary and included the recording of Renal Function tests, Thyroid Function Tests, Weight or BMI or waist circumference for both patients within their first year of lithium therapy and patients who had been prescribed lithium for more than a year prior to the audit.. Serum lithium tests including lithium levels were also measured for patients prescribed lithium for longer than a year

When benchmarking Trust compliance with the total national sample, KMPT compliance was higher for seven of the nine audit standards than the total national sample, as shown in the graph below:

When comparing compliance with standards between 2011 and 2013, for patients prescribed lithium for under a year compliance in recording Thyroid Function Tests were found to have improved from 74% in 2011 to 100% in 2013. Patients prescribed lithium for more than a year improvements in compliance were noted for the following tests/measures:

- Serum lithium tests (94% in 2011 to 100% in 2013)
- Weight (30% in 2011 to 88% in 2013)
- Lithium level between 0.4 -1.0 mmol/L (90% in 2011 to 100% in 2013)

Sustained good practice was highlighted in the documentation of Renal Function tests for both patients on lithium for less than a year and more than a year, which was 100% in both 2011 and 2013. An action plan has been implemented to promote further improvements in the monitoring of patients prescribed lithium.



Examples of action being taken to improve services as a result of involvement in national clinical audits and quality improvement activities are given below (title of project shown in brackets):

- A `Use of Intra Muscular Injection Medication in Community Mental Health Centre Clinics' Policy ratified and implemented. (POMH-UK Topic 6c Assessment of side effects of depot medication)
- A focus is being made to improve follow up data collection by making follow-up measures available at the end of group and individual sessions (National Outcome Database for CFS/ME)
- All doctors prescribing antipsychotic medication to service users with dementia must clearly document the target symptoms, aggravating factors and medication risks/benefits, together with undertaking and recording regular medication reviews and outcomes. (POMH-UK Topic 11b Prescribing of antipsychotics for people with dementia)
- The Trevor Gibbens Unit has continued to support the development of the recovery approach throughout the service by specifically linking this with the CQUIN targets for the year, including the implementation of the My Shared Pathway. (Quality Network for Forensic Mental Health Services, Cycle 7)
- A training pack for nursing staff on screening neurological side effects has been designed, agreed and implemented. (POMH-UK Topic 6c Assessment of side effects of depot medication)

The learning points and action taken from all national clinical audit projects and quality improvement activities reported during 2013-14 can be found in the Kent and Medway NHS and Social Care Partnership Trust Annual Clinical Audit and Service Evaluation Report 2013-2014 available at www.kmpt.nhs.uk

Local Clinical Audit and Quality Improvement Activities

The reports of **53** local clinical audits and service evaluation projects were reviewed by the Trust between 1st April 2013 and 31st March 2014.

Case Study: Local Clinical Audit:

Inter-service line Clinical re-audit measuring compliance to the thrombo-embolism (VTE) prevention policy

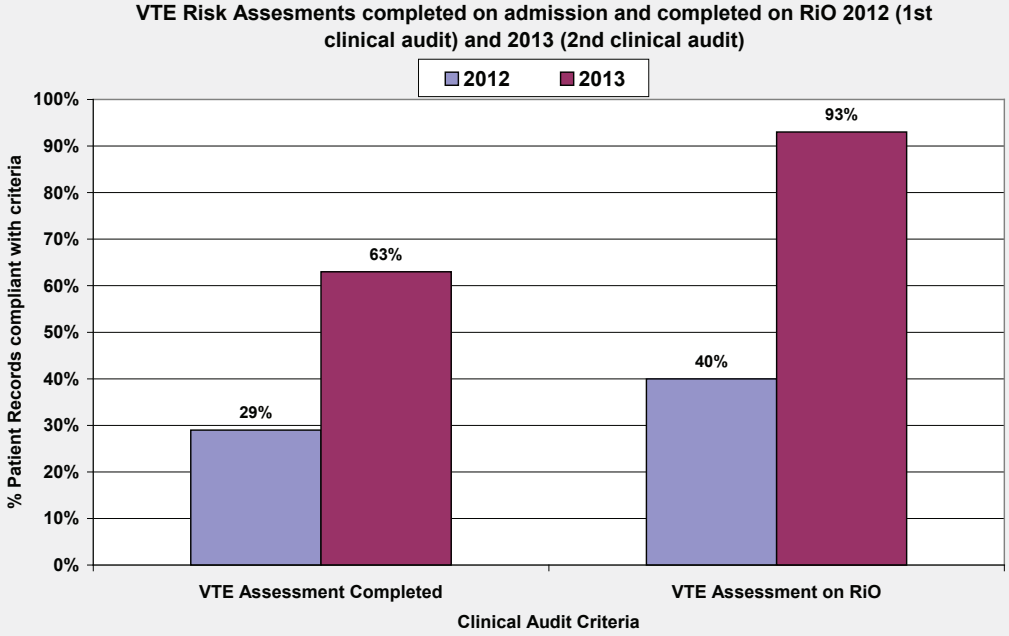
This project was designed to measure the impact and sustainability of changes made in VTE assessment recording practice, since the last clinical audit on the same topic carried out in 2012. The criteria & standards used in this clinical audit project have been developed from the Trust VTE policy, NICE Clinical Guideline 92 and CQUIN for VTE prevention.

The data for the audit was obtained from the last 5 admissions sets of notes for each in-patient ward/ unit between 1st September and 14th October 2013.

The results for all Acute Service Line and Older Peoples and Specialist Service Lines wards regarding compliance with the critiria on all service users having a VTE assessment complted on admission and VTE risk assessments must be completed on RiO (electronic patient information system) are as follows:

The following actions are being implemented to promote further improvements in VTE risk assessment practice:

- VTE risk assessment form to be included with the admission pack
- All wards to ensure that they have robust local working arrangements to ensure that VTE risk assessments are uploaded on to RiO in a timely manner.
- VTE risk assessment and prescribing prophylaxis to be included on Junior Doctor Induction programme
- VTE risk assessment e-learning package developed and now available on the Trust's e-learning web site
- To be re-audited in the Autumn 2014



Examples of action being taken to improve services as a result of local clinical audit and service evaluation projects are given below *(title of project shown in brackets):*

- A poster has been developed detailing the standards which service users can expect at CPA Reviews, these are to be placed in all community base receptions. *(CPA Reviews Service Evaluation, Re-Evaluation)*
- Pre-admission checks carried out over the phone found, from service user feedback, to alleviate some of the normal concerns for admissions. *(Bridge House Patient Satisfaction Survey)*
- Using the Memory Service leaflet at the end of a session with every client who comes through the memory service to orient them to the next step *(Ashford Memory Clinic- Service User Feedback)*
- `Music Box' sessions had a noticeable impact on the mood and well being on both wards, for the patients, staff and visiting relatives *(Evaluation of the impact of music boxes : patients', staff and relatives experience)*
- It has been agreed that cases presenting on section 136 will be followed up by the duty team. *(Thanet Section 136 of the Mental Health Act Service Evaluation)*
- Psychological therapists have now been embedded into Medway Integrated Team (MIT) to assist discussions about acceptance criteria for service users referred by primary care psychological services with MIT colleagues to ascertain suitability for both secondary care mental health input and secondary care psychological therapies. *(Who gets referred to secondary psychological services and why?)*
- Involving the Trusts' communication team earlier in the Seasonal Flu campaign has been identified as an essential strategy in publishing dates and venues of planned clinics. This will enable staff both working in hospital and community to plan ahead in their diaries. *(Seasonal Flu Campaign for Frontline Healthcare Staff Service Evaluation)*

The learning points, Improvements and action taken from all local clinical audit projects and quality improvement activities reported during 2013-14 can be found in the Kent and Medway NHS and Social Care Partnership Trust Annual Clinical Audit and Service Evaluation Report 2013-2014 available at www.kmpt.nhs.uk

Internal Audit Review of Clinical Audit within KMPT

During the reporting period the systems associated with the production and reporting of clinical audit and service evaluation projects within KMPT were subject to an internal audit. South Coast Audit, the organisation that carried out the audit, gave significant assurance that the systems for clinical audit within KMPT were effective.

Outstanding results for forensic unit

The Trevor Gibbens Unit has produced outstanding results in a national review of forensic mental health services endorsed by the Royal College of Psychiatrists.

It came 5th equal out of 65 secure units across England, Wales, Ireland and Scotland.

In its seventh year, the Annual Forensic Quality Network Assessment sees Trusts rate their services against a thorough checklist, which is then reviewed by peers from other Trusts who can downgrade or improve ratings.

Director of Forensic Services, Kevin Halpin, said: "The annual review of secure mental health services places the Trevor Gibbens Unit among the top facilities nationally. This result is a great credit to the dedication and hard work of all the staff involved. It also serves to recognise and validate the quality of patient care provided by the service."

Peers scored the TGU 100 percent in six of the eleven test categories including clinical and cost

effectiveness and accessible and responsive care, while patient focus was well above average with 92 percent.

One of the aims of testing is to raise standards across forensic services by identifying areas of good practice and achievement for other Trusts to follow. The review team was highly impressed with the provision of physical healthcare and health promotion available at the TGU.

The service has input from a dietician, podiatrist, and optician and there is a practice nurse who provides Wellman and Wellwoman health promotion advice. There are also dedicated sport and exercise staff, access to smoking cessation programmes and a volunteer provides massage and Tai Chi classes.

The review team was impressed with 'Peak of the Week' which disseminates examples of good practice within the service. The service was praised for the patient information available on all of the wards, for the atmosphere on wards and interaction between staff and service users. They also considered that the newly opened Lakeside café for service users was an excellent addition to the facilities available to service-users.

Peer review helps to promote a culture of openness and enquiry. Units use the feedback and results to develop action plans to achieve continual improvement. Results are shared with key stakeholders, including Commissioners and the CQC, those making referrals to their service and local user and carer groups.

Consultant, Dr Jon Pyott, (pictured above) led the TGU team who worked on the Quality Network Cycle 7 results.

"The Trevor Gibbens Unit has consistently performed well in terms of benchmarking with other services," Jon said. "In addition, we have managed to improve our standing with respect to other services year on year. The outstanding current results are particularly pleasing as they reflect the hard work and dedication of all staff in delivering a high-quality service at the TGU."

Research and Development

The number of service users receiving NHS services by the Trust in 2013-14 recruited to participate in research approved by the Research Ethics Committee and adopted by the Mental Health Research Network (MHRN) was 274; this exceeded our target of 175. KMPT was the highest performing Trust in Kent and Medway in exceeding the recruitment targets set by the Comprehensive Local Research Network (CLRN).

KMPT was involved in recruiting service users to 21 MHRN adopted clinical research studies during this period. This includes one industry study. A further 5 studies are in the "set up" phase. In addition a further 9 studies were undertaken by professional trainees and staff at the Trust. These were all approved by the Research Ethics Committee, but were small scale unfunded studies.

There were two multi-site portfolio studies undertaken that were led by KMPT. One of these was awarded 'Best User Service Involvement' by the MHRN. The other was awarded 2nd place for best research study at the CLRN / Kent University and KMPT 2013 Quality Conference.

KMPT is strengthening its research activity and is supported across the Trust. Each of the four service lines has a lead for R & D, with local research meetings occurring regularly. Academic links are strengthened with regular research meetings between Kent University and Canterbury Christ Church University and KMPT. KMPT was awarded Research Capability Funding from the Department of Health. This has funded two Research Associate posts at the Trust whose role is to help develop grant proposals and research activity.

KMPT has an active partnership with the University of Kent. The Forensic Service Line and Kent are jointly funding a PhD student to develop and evaluate a structured risk assessment tool for fire setting. Professor Gannon, Forensic Psychologist from Kent continues to consult one day a week in the Forensic Service too and has been integral in the service's increased research activity.

The Older Adults' Service is active in dementia research and strengthening links with the Dementia and Neurodegenerative Diseases Research Network (DENDRON). The Trust is currently involved in three Older Adult Portfolio Studies.

The Expert by Experience group is represented at the Trust Research Group and active support is being provided to develop meaningful input into research activity.

Quality and Innovation conference

Above:
The Quality and Innovation conference organising team

A Quality and Innovation conference for Clinical Audit and Research and Development (R&D) was held at the Pilkington Suite, Medway Universities Campus at Chatham Dockyards in November – a partnership venture between KMPT, University of Kent and the comprehensive Local Research Network, supported by Canterbury Christ Church University.

The conference was well attended by KMPT colleagues from across the county and by staff from the Trust's academic partners – a very successful day that will promote further innovation and partnerships.
The Trust's Chief Executive Angela McNab opened the conference, followed by key note speakers – Liz Smith from Healthcare Quality Improvement Partnership (HQIP) and Dr David Smithard, Clinical Director from the Comprehensive Local Research Network. KMPT's Medical Director, Dr Karen White, chaired the event.
The conference provided a great opportunity to showcase some of the high quality clinical research and audit work currently being undertaken across the Trust, and what impact this has on care for our service users.

The Chair of the Trust's Experts by Experience (EbE) group, Nigel Beswick, gave a presentation about the work of the group and the benefits of a collaborative approach, essential to ensuring service users and carers are at the centre of all of KMPT's initiatives.

Awards were then presented by Professor Margaret Andrews for the best clinical audit and for the best research. Results were as follows:

Research and Development awards:

1st place: Living Well with Dementia: extending the NICE evidence base for cognitive stimulation therapy – Alison Culverwell and team (older adults and specialist services service line).

2nd place: The evaluation of the fire setting intervention programme for mentally disordered offenders – Nicola Tyler and team (Forensic service line).

3rd place: Cognitive behavioral therapy for psychosis and anxiety: nurse-led research – Alison Welfare-Wilson (Community Recovery).

Clinical Audit awards:

1st place: The TGU patient satisfaction survey: development and results – Lona Lockerbie and team (Forensic service line).

2nd place: Evaluating the East Kent life story volunteers' projects, East Kent roll outs – Ian Asquith (older adults and specialist survey service line).

3rd place: Healthy mind in health and body: results of the inpatient metabolic monitoring clinic – Shantala Satisha, Little Brook Hospital (Acute service line).

Above: Lona Lockerbie and the TGU team took first place in the Clinical Audit award.

Above right: Alison Culverwell receives the first place award for R&D from Professor Margaret Andrews

Goals agreed with commissioners - use of the CQUIN payment framework

A proportion of the Trust's income in 2013-14 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.
The CQUIN payment framework aims to support the cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of discussions between West Kent Clinical Commissioning Group as the Co-ordinating Commissioner, the other seven Clinical Commissioning Groups (CCGs) across Kent and Medway, the Kent and Medway Commissioning Support Unit (KMCS) and KMPT.

Local quality improvement priorities and progress in achieving them in 2013-14 were discussed and agreed at Board level and monitored at monthly internal CQUIN Programme Board and Service Line Performance Review Meetings and at external Quarterly Assurance Meetings between the Trust and KMCS throughout the year.

The CQUIN framework made part of KMPT's income dependent on locally agreed quality and innovation goals (2.5% of annual contract value in 2012-13 and 2013-14). The use of the CQUIN framework indicates that KMPT has been actively engaged in quality improvements with commissioners.

For 2013-14 CQUIN indicators agreed with commissioners aim to support tangible improvements in Quality and are linked to both the Quality, Innovation, Productivity and Prevention (QIPP) and Outcomes Framework. The main CQUIN areas for 2013-14 are concerned and support whole system delivery and integration across planned and urgent care pathways, transition and patient experience, concerned with improving outcomes for service users.

Please see Appendix A for details of the full CQUIN Payment Framework for 2013-14. Appendix B shows the other Quality Performance Indicators reported to our Commissioners in 2013-14.

Registration

The Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008 and is registered without conditions for its 19 registered locations. The CQC carried out a number of unannounced visits at these locations between the 1st of April 2013 and the 31st of March 2014, under Section 46 of the Health and Social Care Act 2008; in line with other Trusts, in order to assess and monitor compliance with the essential standards of quality and safety.

The locations visited included; St Martin's Hospital – three acute wards and one older adult ward, the Red House eating disorder inpatient unit, the Jasmine Centre – older adult ward, Littlestone lodge – older adult ward, the Trevor Gibbens Unit – forensic secure wards and Littlebrook Hospital – the Psychiatric Intensive Care Unit (PICU) and the

Crisis Resolution Home Treatment Team (CRHT). All of these locations were found to be fully compliant with the outcomes reviewed.

A follow-up inspection was also conducted unannounced at the West Kent Neuro-rehab unit. Following a visit in December 2012, where the unit was found to be non-compliant with two outcomes; 14 – Supporting workers and 21 – Records, an action plan had been put in place to rectify those areas identified as being non-compliant. The unit was then re-inspected by the CQC in September 2013 and found to be fully compliant with the outcomes reviewed.

All reports and any subsequent actions are discussed at the CQC Compliance Monitoring Group.

During 2013-14, internal compliance reviews have continued to be provided by the Compliance and Assurance Manager. At these reviews, evidence is reviewed and areas of both good practice and those for improvement are identified. Feedback is given at the time of the review and following this a report is produced highlighting recommendations to be taken forward. The team/ward themselves are then responsible for producing an action plan for implementation. The implementation of these action plans are then monitored within each service line's governance framework.

In November 2013, the CQC published the document 'A Fresh Start for the Regulation and Inspection of Mental Health Services' which outlined how the new inspection model for mental health Trusts would be changing from 2014 onwards. In response to this, the Compliance and Assurance Manager has been promoting the new approach to all staff via presentations and is continuing to conduct compliance reviews which focus on the five questions (which will be used at inspection) of our services; caring, responsive, effective, well-led and safe. A CQC Compliance Steering Group has also been established to focus on the preparation required across the organisation as a whole.

Key staff continue to meet regularly with the Trust's Lead CQC Compliance Inspector ensuring that the Trust continues to develop a positive working relationship with the CQC.

Data Quality

The Trust will be taking the following actions to improve data quality.

The Trust's data quality improvement plan is contained within the KMPT Information and Data Quality Strategy. It is based on addressing the three key areas that the Audit Commission report 'Figures you can Trust: A briefing on data quality in the NHS'.

The focus is on:

- profile, prominence and understanding of data quality at board level
- integration and embedding data quality into organisational practice
- assurance and review programmes

This Information and Data Quality Strategy has been developed to set out the steps that are necessary for KMPT to take in order to introduce a structured methodology for information and data quality improvement. It will concentrate on addressing the three areas above by:

- Focusing on key data items in the MHMDS [Mental Health Minimum Data Set] and to support the accurate clustering in preparation for the move to Payment by Results.
- Developing, implementing and embedding a Trustwide Data Quality Culture sponsored and monitored at senior management level
- Integrating data quality with the new Performance Management Framework as a key element of the Trust's reporting activities

NHS Number and General Medical Practice Code Validity

Kent and Medway Partnership Trust have submitted records within prescribed deadlines for 2013-14 to the Mental Health Minimum Data Set (MHMDS). Results are published at: http://www.hscic.gov.uk/mhmdsmonthly

The percentage of records in the published data which included the patient's valid NHS number was:

15,663 of 15,666 = 99.98% for valid NHS Number
15,462 of 15,666 = 98.70% for valid General Medical Practice Code

(data as at October 2013 final position- MHMDS publications run some months in arrears)

Information Governance Toolkit Attainment Levels

The Information Governance Toolkit (IGT) is a performance tool produced by the Department of Health and is now hosted by the Health and Social Care (HSCIC). Where partial or non-compliance is revealed, the Trust must take appropriate measures (e.g. assign responsibility, put in place policies, procedures, processes and guidance for staff) with the aim of making cultural changes and raising Information Governance Standards through year on year improvements.

The 2013/2014 version of the IGT is the eleventh iteration of the audit and includes 45 initiatives to be scored (from 0 to 3, see key below) and evidenced in a baseline audit in July 2013, an update in October 2013, in a compliance audit in January 2014 and in the final submission (of completeness) in March 2014.

Compliance with the IGT audit is part of the programme of assurance with which the Trust must comply, both now and after Foundation Trust Status has been granted. All Trusts must work to achieve a level 2 in all initiatives.

The table below details the Trust's submitted scores for the Information Governance Toolkit's 2013-2014.

The Trust was audited by TIAA in March 2014 and received "significant assurance" for its Information Governance processes.

Key to Scores

Score	The Trust has…
0	Nothing in place to manage the requirement
1	A named person has been identified to take responsibly and they have produced an action plan to achieve compliance
2	Suitable polices and procedures in place or has conducted the necessary training or audit required
3	Robust processes in place to manage the requirement and these processes are regularly reviewed

The total score is calculated by adding together all the scores and dividing by the maximum possible score the whole toolkit

Initiative Details	IGT Lead	Final Submission possible March 2014
Information Governance Management		
101 There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	KS	3
105 There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	KS	3
110 Formal contractual arrangements that include compliance with Information Governance requirements, are in place with all contractors and support organisations	CR	3

Initiative Details	IGT Lead	Final Submission possible March 2014
Information Governance Management		
111 Employment contracts with include compliance with Information Governance standards are in place for all individuals carrying out work on behalf of the organisation	CR	3
112 Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	KS	2
Confidentiality and Data Protection Assurance		
200 The Information Governance agenda is supported by adequate confidentially and data protection skills, knowledge and experience which meet the organisation's assessed needs	CR	3
201 Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users	CR	3
202 Personal information is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	CR	3
203 Individuals are informed about the proposed uses of their personal information	CR	3
205 There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	CR	3
206 There are appropriate confidentiality audit procedures to monitor access to confidential personal information	CR	2
207 Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	CR	3
209 All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	CR	3
210 All new procedures, services, information systems and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	CR	3
300 The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	KS	3
301 A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	CR	3
302 There are documented information security incident / event reporting and management procedures that are accessible to all staff	CR	3
303 There are established business processes and procedures that satisfy the organisation's obligations as a Regulation Authority	CR	3
304 Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	CR	3

Initiative Details	IGT Lead	Final Submission possible March 2014
Information Security Assurance continued		
305 Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	KS	3
307 An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	CR	3
308 All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure – specific measures are in place	CR	3
309 Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service – specific measures are in place	KS	3
310 Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	KS	2
311 Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	KS	3
313 Policy and procedures are in place to ensure that Information Communications Technology (ICT) networks operate securely	KS	3
314 Policy and procedures ensure that mobile computing and teleworking are secure	KS	3
323 All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	CR	2
324 The confidentiality of service user information is protected through use of pseudonymisation techniques where appropriate	CR	3
Clinical Information Assurance		
400 The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	JB/NL	3
401 There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	NL	3
402 Procedures are in place to ensure the accuracy of service user information on all systems and / or records that support the provision of care	JB	3
404 A multi-professional audit of clinical records across all specialities has been undertaken	JB	2
406 Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	JB	3

Initiative Details	IGT Lead	Final Submission possible March 2014
Secondary Use Assurance		
501 National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	NL	3
502 External data quality reports are used for monitoring and improving data quality	NL	3
504 Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	NL	3
506 A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	NL	2
507 The Completeness and Validity check for data has been completed and passed	NL	2
508 Clinical /care staff are involved in validating information derived from the recording of clinical / care activity	NL	3
514 An audit of clinical coding, based on national standards, has been undertaken by a member of staff from the NHS Connecting from Health list of registered clinical coding auditors within the last 12 months	JB	2
516 Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	JB	3
Corporate Information Assurance		
601 Documented and implemented procedures are in place for the effective management of corporate records	JB	2
603 Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	CR	3
604 As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	JB	2
Maximum Compliance Score Possible		90%

Please note: that in 2012-13 the trust scored 90% which ranked the trust as being the 4th best of all mental health trusts in the country and the highest performing trust in the south east (of all the acute, mental health and ambulance trusts and Clinical Commissioning Groups)

Clinical Coding Audit

The Trust was not subject to the payment by results clinical coding audit during 2013-14 by the Audit Commission. However, the Trust did undertake its own audit of patient records and the discharge summaries, when present, were an excellent source of information, thus aiding the coding process.

The audit examined 50 finished consultant inpatient episodes only and none were unsafe to audit.
The table below shows a summary of the overall percentage of correct coding.

	Total from episodes audited	Total correct	% correct
Primary diagnosis	50	44	88%
Secondary diagnosis	174	141	81%

Of the 50 episodes audited, 88% of these were correct compared to 96% last year; and secondary diagnosis: 81% this year compared to 86%% last year. Historic system constraints identified on previous audits prevent the recording of procedures codes.

The Trust has followed the Secondary Use Assurance – Mental Health Trusts Guidance IGT 10 -514 and attained level 2 in diagnostic coding.

Our 2014-15 Priorities

For 2014-15 the Trust has set nine priorities for improvement; divided into the three areas that constitute quality, the **patient experience, patient safety** and **clinical effectiveness**.

The nine priorities are:

Patient Safety

- Reduce the number of moderate and severe falls in all in-patient Services by 20%
- Reduce all serious incidents including absence without leave (AWOL), absconding, suicide and serious self-harm during an inpatient admission or while in treatment with a working age adult community team
- To ensure all adults, children and young people are effectively safeguarded

Patient Experience

- Better communication between our staff and service users and their carers
- Monitoring the Patient Experience of service user views relating to the effectiveness of their CPA
- Ensuring Service Users are informed of changes in Care Co-ordinators

Clinical Effectiveness

- We will work in closer partnership with our service users to ensure that care is always service user centred
- We will work in closer partnership with our service users to ensure access to physical health care monitoring
- To further develop and implement the recovery and wellbeing approach for all of our service users

Over pages 58 to 78 we outline, for each priority, the reason for the choice, where the Trust is currently positioned (at the start of 2014-15), the way that the priority will be measured and the means of monitoring progress.

Who has been involved in setting our 2014-15 Priorities?

During 2013-14 KMPT has continued to involve a range of staff, people who use services and our partners in the non-statutory sector to help set our priorities for the coming year. The sustained monitoring of our Community Engagement Strategy has provided valuable assistance in producing an in-depth report regarding elements of mental health provision and in commenting on the format of this Quality Account as well as undertaking their formal review of the document.

Our Patient Consultative Committees, Community Engagement Strategy Monitoring & Implementation Group (CESMIG) and Experts from Experience Research Group have identified issues through

their involvement with the organisation which they wished the Board to include in the Account, particularly those included in the Patient Experience section supported by an understanding of the NICE guidelines relating to patient experience in mental health services.

The Trust Board has continued to receive presentations from service users and carers throughout 2013-14. As a result, the experience of service users and carers has helped the Board to establish its quality priorities by providing a real insight into the experience of people using the services.

Staff from across all areas of the organization, both clinical and non-clinical, always play a key role in priority setting. Our Quality Committee and its sub-groups, including the Patient Safety Group, Patient Experience Group and Clinical Effectiveness and Outcomes Group, have discussed and approved the priorities and, most importantly for all staff, have played a key role by continuing to report and record day-to-day incidents, taking part in audits and supporting investigations that helps the organisation to learn.

2014-15 Patient Safety Priority 1

Reduce the number of Moderate and Severe Falls in all in-patient Services by 20%

Rationale:
To prevent harm and injury to service users by ensuring that falls assessments are completed for all service users regardless of age, resulting in a decrease in the number of slips trips & falls by 20%.

Current status:
The current number in 2013/14 is 23; a 20% reduction will be 5 less.

100% of service users admitted to older adult wards have received a falls assessment and this will now be implemented for all service users regardless of age.

Plans:

- Improve access to Slips, Trips & Falls awareness workshops
- Implementation of the "Falling star" initiative across all areas
- Improvement in falls assessments and screening for all service users which will include
  - Initial screening
  - Full screening
- Audit of the falls assessment tool
- Continued involvement in the MH patient safety collaborative
- To ensure no more than 18 moderate/severe falls during 2014/15.
- All service users, regardless of age, admitted to all in-patient wards will receive a falls assessment.

Measures:
Measured monthly through the nursing metrics for the number of assessments and Datix for the number of moderate and severe falls.

Monitoring:
Monitored through the modern matrons forum, Trust wide Falls Prevention Group, Quality Committee and Board.

Street Triage Service
The Street Triage Pilot was a joint initiative between Kent Police and KMPT that set out to enhance working relationships between KMPT and the Police and provide a responsive service to people in a mental health crisis.

It aimed to achieve improved outcomes for individuals ensuring services are provided in the right place, by the right person at the right time. The service is based in the East Kent Crisis Resolution Home Treatment (CRHT) team in St Martins Hospital, Canterbury, and comprises a Police Officer and a Mental Health clinician.

It has been estimated that Police officers around the country spend 15% to 25% of their time dealing with people with mental health problems.

Chief Inspector Martin Wilson, of Kent Police, said officers and mental health nurses had access to computer systems.

"And that way the two professionals can collaborate on the decision and probably do the right thing for the patient each time round," he added.

Nigel Ashurst, a Consultant with the Kent and Medway NHS and Social Care Partnership Trust, said: "We don't necessarily want or need our officers to be experts in mental health, that's what the NHS is there for.

"I think the way I view it is that the Police officers are maybe the first port of call and the first point of contact.

"But one of our jobs is to introduce people to the NHS at the earliest opportunity so they can get the care they want from professionals.
Street Triage Service was piloted for three nights a week for 12 weeks at the end of 2013, and continued until the end of March 2014.
And now, funding has been agreed from both Kent Police and KMPT for it to become a 7-nights-a-week service from this summer.

2014-15 Patient Safety Priority 2

Reduce all serious incidents including absence without leave (AWOL), absconding, suicide and serious self-harm during an inpatient admission or while in treatment with a working age adult community team.

Rationale
Keeping service users safe from harm is central to the care we provide therefore we will continue to work to reduce all serious incidents including absence without leave (AWOL), absconding, serious self harm and suicide for all service users in hospital or open to our working age adult community teams. We will continue to build on the positive results achieved from the South of England Patient Safety Collaborative work to reduce incidents of suicide and self harm to zero or greater than 300 days between. We will continue to improve our inpatient environment to further reduce ligatures identified as risk areas following learning from serious incidents.

We will continue to focus on reducing the number of service users who abscond from inpatient wards or fail to return from agreed leave so as to reduce the risk of harm following such incidents.

Current status

In 2013 – 14

Suicide and Serious Self Harm

- There have been 0 deaths on inpatient wards as a result of self harm / suspected suicide.
- There has been 1 death as a result of self harm of a patient open to a CRHT Team.
- There have been 39 incidents of suicide within community mental health teams.
- 2012/13 figures recorded 55 incidents of suspected suicide.
- 2013/14 has seen a reduction of 16 suspected suicides

Serious Self harm

- There have been 10 incidents of severe/moderate self harm on younger adult inpatient wards. On 5 out of 11 wards the last incident of self harm is greater than 300 days
- There have been 14 incidents of severe/moderate self harm in service users open to our CRHT Teams. In 2 out of 5 teams the last incident of severe self harm is greater than 300 days ago
- In Community recovery service line there were 29 incidents for serious self harm, resulting in Sever/moderate harm and 15 incidents within the Specialist service and older adult service line.
- There was one incident of serious self harm in the Forensic service line.

AWOL and Absconding

- There have been 70 serious incidents of service users absconding from inpatient wards or failing to return from agreed leave.
- In the community teams during the year we have committed to the closure of 78% of all open serious incident investigations.
- We have identified fewer level 5 incidents over the last 6 months

Plans

We will improve our process across services to ensure there is cross service line learning following any patient safety incident. There is a drive for integration of service lines on locality leadership level to ensure this learning is shared and implemented across all service lines.

Crisis Resolution Home Treatment Teams and Community teams will continue to improve the care planning process to ensure that service users and carers are fully involved and have a copy of their care plan and what to do in the event of a crisis.

Crisis cards, Buddy app and Patient portal are new innovations to encourage service users in their involvement with their own care planning – including the crisis plans.

Responsibility of investigation of serious incidence and self harm episodes are given to the locality leadership groups in an attempt to encourage local responsibility, learning and ownership.

We will undertake improvements to all inpatient wards to reduce ligatures in identified areas of risk. The community service line is committed to maintaining the low ligature risk currently in place on all inpatient rehabilitation wards.

Acute inpatient wards will ensure there is a multi-disciplinary approach to the management of risk in relation to the decision making process and care planning to minimise the risk of service users absconding or failing to return from agreed leave.

Measures

The incidents of suicide, serious self harm and service users absconding or failing to return from agreed leave (AWOL) will be recorded by each team, measuring the interval between each incident in each team.

Monitoring

The community and acute service lines have robust monitoring processes through the locality leadership groups, the serious incident panel and the service line clinical governance process, which are monitored by Patient Safety Group, Quality Committee and Board.

KMPT Pledge – Live It Library event

The Tonbridge Shaw Trust Centre recently played host to the 5th Live It Library roadshow - the innovative partnership project between KMPT, KCC and Re think mental illness.

Live it Library encourages service users across Kent to share their journeys as a way of helping others experiencing similar issues and challenging stigma around mental health.

Those willing to have their story filmed, recorded or written down for an online Live it Library become part of a Kent-wide resource.

In the 18 months since the project's inception, 40 people have recorded their recovery stories. Last week's event saw up to 30 people converge on the former charity shop to support service users and hear a Time to Change spokesperson talk about their latest campaign to get more people talking about mental health.

The Time to Change pledge is a public statement of aspiration that an organisation wants to tackle mental health stigma and discrimination. It is a commitment to take action that is hoped to lead to a reduction in discrimination either within the organisation or the wider community. It is about breaking the silence around mental health. KMPT's Chief Executive signed a Time to Change pledge as a sign that the Trust was committed to taking action to reduce mental health discrimination.

2014-15 Patient Safety Priority 3

To ensure all adults, children and young people are effectively safeguarded

Rationale

Safeguarding is a priority for the organisation and we aim to ensure all children, young people and adults are appropriately safeguarded. We will provide support to all through the use of appropriate systems and processes. We will provide support through skilled and timely contacts and assessments.

Current status

The application of the principles of the Mental Capacity Act requires further scrutiny to ensure we have consistency in standards of practice across the organisation (Current compliance rate 37%). Auditing will therefore continue. Staff need to demonstrate in a robust manner that they are fully compliant with the Act in their daily practice.

We are striving for consistency in the recording of data with regards to service users who are parents. This information is vital in safeguarding the children but also in obtaining services appropriately for the family (Current status 33%). We aim to maintain the audits in this area of practice. Not only do we need to maintain the right level of information but it must be shared appropriately and to that end we will continue to monitor closely our attendance at case conferences and the provision of quality reports for such meetings (current status 78% attendance and 0 reports inadequate).

Plans

The following are 2 year targets:

- To audit case files of those with children to ensure data collation remains focused and improve on the standards achieved the previous year. Compliance target 80% of files audited against checklist by the end of 2014 -15 and 100% by the end of 2015 -2016
- To monitor the attendance of staff at Child Protection conferences and quality of reports provided. Compliance with attendance: 80% by the end of 2014 -15 and 100% by the end of 2015 -2016 and for quality of reports no more than 10% returned because they are below expectations
- To provide information on Mental Capacity Act compliance and consistency in recording in case files. Compliance 80% by the end of 2014 -15 and 100% by the end of 2015 -2016

In order to improve practice the following actions will be taken:

- Provision of bespoke training and workshops on safeguarding and MCA with individual teams as well as with staff members.
- Increased supervision around safeguarding.
- Named nurses basing themselves with the teams on a regular basis therefore staff treat it as a `drop-in' surgery
- Reporting directly to line managers when the concerns are around individual practitioners
- Liaising directly with local authorities to ensure that the safeguarding team are notified of correspondence sent to frontline staff so that they can receive appropriate support

How measured

Case file audits on service users who are parents will continue quarterly with 3 deep dive exercises in Medway, Shepway and Dartford & Gravesham but

also returning to monthly random audits. Actions taken during the previous year should allow for an improved picture across the localities. Information on case conferences and reports for the same will be collated quarterly. The compliance and recording of mental capacity issues will be audited quarterly using case files.

How monitored

This will be monitored internally by the Safeguarding Team, the Trustwide Safeguarding Group and the Executive Lead for Safeguarding, Patient Safety Group, Quality Committee and the Board. Trust safeguarding practice is monitored by the Medway Safeguarding Children Board, Kent Safeguarding Children Board, NHS Kent and Medway Clinical Commissioning Groups and Adult Safeguarding Board.

2014-15 Patient Experience Priority 1

Better communication between our staff and service users and their carers.

Rationale
The percentage number of complaints relating to staff attitude has remained static during 2013-14 despite a great deal of work being carried out in relation to staff training and the increased involvement by staff in Customer Care Week. In discussion at the TWPEG it was suggested that we continue to monitor this issue as a priority.

Current status
The current percentage of reportable complaints relating to staff attitude is 31% however by looking at the number of complaints relating to staff attitude that are upheld/partially upheld the percentage is 14%.

Plans
To continue with the roll out of the face-to-face Customer Care Training; to implement the new Customer Care e-learning package and to ensure that Customer Care Week take place; the rationale for this is to ensure that as part of the work relating to the KMPT visions and values customer care is embedded throughout the organisation. This will also be monitored through the Local Leadership Groups and the Trustwide Patient Experience group (TWPEG)

How Measured

To continue to monitor the percentage of complaints relating to staff attitude and in addition to monitor the number of upheld and partially upheld complaints relating to that category. To achieve a year end target of no more than 10% of upheld/partially upheld service user complaints being due to staff attitude. (This would be a 29% reduction across the board)

How Monitored
This will be monitored via the Trust wide Patient Experience Group and the Quality Committee and the Board

Peer Support Workers Get Onboard
Twelve new peer support workers are now in post and have been really enjoying their new positions, leading the way for this recently created workforce offering hope and support for our service users.
A Peer Support Worker is someone with significant knowledge of mental health issues, who works alongside others with similar difficulties in order to guide them on their journey to recovery through promoting hope and providing support based on common experiences.

The peers have recently completed a successful training course at the Practice Development Centre in Maidstone covering important subjects such as the Mental Health Act, safeguarding children and vulnerable adults, conflict management, equality and diversity, health and safety, and the Care Programme Approach.

2014-15 Patient Experience Priority 2

Monitoring the Patient Experience of service user views relating to the effectiveness of their CPA

Rationale
Looking at the effectiveness of CPA; in the 2013 National Patient Survey one of the questions asked was: 'How effective was the care plan in helping you to achieve your goals?' KMPT scored 6 out of 10 which means that it is performing 'worse than expected' against other mental health trusts in England. The Trustwide Patient Experience Group felt that this would be a good priority to work on in 2014.

Current status
Currently KMPT is not performing well in the National Patient Survey in relation to the question about the effectiveness of CPA. KMPT has an aspiration to be in the top 20% performing mental health trust in England and needs to improve the patient experience of CPA.

Plans
To work through the service line action plans monitored by the Trustwide Patient Experience Group; ensuring that all service users are encouraged to co-produced a person centered care plan aimed at supporting their recovery.

How Measured
This would be measured by surveys using the 'Snap mobile Anywhere' system as changes in the National Patient Survey 2014 mean it will not be possible to compare results with the 2013 survey. In order to address this we will carry out a baseline survey by the end of quarter 1 and a repeat survey in quarter 4.

How Monitored
The service line action plans and the 'Snap mobile Anywhere' survey results will be monitored through the Trustwide Patient Experience Group, the Quality Committee and the Board

CPA report much appreciated
A report on KMPT's Care Plan Assessment Engagement Project was launched last week at an event comprising project participants, service users, staff and senior management, including our Chief Executive Angela McNab and Chairman Andrew Ling.

In spite of adverse weather conditions (and a hole in the M2!) the launch was attended by a respectable number of over 30 who had battled against the elements to make it to St Martin's Hospital in Canterbury.

The attendees discussed the aims and approach of the project, using Appreciative Enquiry methodology, as well as how the project was delivered and our key findings and recommendations.

The project was a collaboration between service users and KMPT staff, looking at how we can improve collaborative working between service users and staff in care planning. The presentations were also delivered by staff and service users working together.

Chairman Andrew Ling was very complimentary about the work that's been carried out and said he hoped to look at ways of using Appreciative Enquiry methods in his work within the Trust.

2014-15 Patient Experience Priority 3

Ensuring Service Users are informed of changes in Care Co-ordinators

Rationale
To ensure that all service users are keep informed of changes in care coordination due to long-term sickness and annual leave; ensuring that no patient is left without a care coordinator to contact. This issue has been raised through the patient Experience team both as Patient, Advice & Liaison Service (PALS) queries and complaints.

Current status
KMPT has been aware that issues relating to service users not being kept informed of changes in care coordination due to long-term sickness and annual leave have been raised through the Patient Experience Team and raised as a trend at the Trustwide Patient Experience Group

Plans
To ensure that each Community Mental Health Team has in place a protocol to ensure that service users are not left without a named coordinator if staff are on long-term sick leave or annual leave. Service users receiving services from the Community Recovery Service Line (CSRL) will be surveyed and KMPT would expect to have a minimum of 80% of positive responses in the last quarter.

How Measured
This would be measured by surveys using the 'Snap mobile Anywhere'; we will carry out a baseline survey by the end of quarter 1 and a repeat survey in quarter 4.

How Monitored
Issues raised and results will be monitored through the Trustwide Patient Experience Group, the Quality Committee and the Board.

Mark Dinwiddy, Director of Community Recovery Services and Carer Dawn with the Trust's Customer Care Charter

Staff get involved in Customer Care Week

Customer Care Week at KMPT took place in May 2013 and was a week to focus on how we relate to, and communicate with, those people who access the service we provide; or care for someone who does. KMPT asked teams, units and services to take action within Customer Care Week to engage service users, carers and staff around customer care. Some of the activities that teams got involved in were:

- Highlighting new developments within their service
- Formal launch of the Customer Care Charter
- Collecting feedback from service users and carers on services using iPads
- Held a social event for service users and carers
- Reduced waiting times by clearing backlog of referrals
- Customer Care Training

2014-15 Clinical Effectiveness Priority 1

We will work in closer partnership with our service users to ensure that care is always service user centred.

Rationale
Delivering patient centred care, in partnership with our service users is the central focus of our clinical strategy.

Current status
This last year has seen an increased focus on the development of fully collaborative, patient centred care through the appreciative enquiry project – 'Improving Engagement in Care Planning'.

This project has brought together service users and clinicians, in a series of partnership based workshops and interviews, to understand how to further improve our care planning process, thus ensuring that all aspects of care are patient centred.

Plans
The Trust will develop and implement service level plans to address the recommendations of the 2014 'Improving Engagement in Care Planning' project. The Trust believes that implementing these recommendations will further ensure that care is always service user centred and service user led.

How measured
Measurement for this priority will be achieved through the community and inpatient 'Patient Centred Care Plan' (PCCP) audit programmes.

The PCCP audit programmes were developed to ensure that service users are involved in all aspects of their care, particularly the care planning process.

The PCCP audit tool is completed on a monthly basis across the community, acute and specialist service lines. The monthly audits consider a minimum of 8 inpatient care plans from each inpatient area and findings are submitted to the Clinical Audit and Effectiveness team for inclusion into a monthly report. For community teams 5 service users' care plans are audited within each team on a monthly basis. There are some minor variances in the questions across service lines to reflect the care of the different patient groups.

In addition specialist care plan monitoring, based on the My Shared Pathway project, is in place in our forensic secure services.

We recognise that some service users face specific challenges in engaging in their care planning process and we will continue to strive to support all service users to engage in planning their own care and we will set a target of 75 per cent met, for audit Item 4 'Is there evidence of service user involvement throughout all aspects of the care plan?'.

How monitored
Care planning audit results are routinely monitored by the executive within service line performance meetings.

In addition the following will be routinely and formally reported to the Clinical Effectiveness and Outcomes Group (CEOG), with highlight reports being sent to the Quality Committee and the Board as appropriate.

- Service Line progress on the implementation of projects relating to care planning.
- Service Line results from all care plan audit programmes.

2014-15 Clinical Effectiveness Priority 2

We will work in closer partnership with our service users to ensure access to physical health care monitoring

Rationale
People with a mental health difficulty have a significantly increased risk of developing a range of physical health problems. People with concurrent physical and mental health challenges have a further increased risk of these conditions compounding and greatly impacting on their overall wellbeing.

Current status
The provision of physical health assessment in our inpatient services is monitored, with current provision standing at 99.25 per cent across adult and older peoples' services. If a service user initially declines this assessment, staff will work to further discuss the importance of physical health assessments to support the person to access this important health care facility.

Community teams continue to work hard to provide physical health checks for their service users, providing innovative ways of doing this; for example providing health checks at depot clinics or memory clinics. The overall percentage of all clients who have a physical health check in all community teams across the Trust, including all service lines is 24.16 per cent.

Plans
All service users admitted to our inpatient services, regardless of age, will be supported to utilise our physical health assessment service and we will set a target of 100 per cent of people to have received an assessment.

All service users within the community setting will be supported to access a physical health assessment with an appropriate community mental health care professional or with their GP. We will work to initially increase the numbers of people actually receiving an assessment in the community to 50 per cent in 2014/15 and raise targets thereafter.

Our two day 'physical health in mental health' bi monthly training course continues to be well attended by staff from all service lines, with 102 staff trained to date. This training will continue to be offered and will include:

- Awareness and understanding of the Trust's Physical Health & Examination Policy
- The documenting of physical health checks
- Normal ranges for blood pressure, pulse, temperature, oxygen saturation and respiration
- The modified early warning scoring system (MEWS)
- Recognising the physically deteriorating service user
- Healthy diet, physical activity, venous thrombus embolism (VTE), coronary heart disease and chronic obstructive pulmonary disease (COPD), pressure injury prevention, diabetes, diet and exercise, medication side effects management
- Smoking cessation Level 1 advisors training

How measured
We will continue to measure and monitor the percentage of people admitted to our inpatient services who have had a physical health assessment.

We measure and monitor the percentage of people receiving care in our community settings for 6 weeks or more, who have received a physical health assessment by either the community team or via their GP.

How monitored
Physical health assessments will be measured and monitored for inpatient services through the nursing metrics, with data collated via the Business Intelligence system and the same process will be used for our community service users and will by monitored by the Clinical Effectiveness and Outcomes Group, Quality Committee and the Board.

2014-15 Clinical Effectiveness Priority 3

To further develop and implement the Recovery and Wellbeing Approach for all of our service users

Rationale
Fully implementing the national Mental Health Recovery and Wellbeing agenda is critical to the development of our services.

Current Status
The Trust has become a member of the ImROC Learning Set programme and has established a multi-professional Recovery & Wellbeing Development Group internally.

We have seen an increase in 2013/14 of the numbers of clients achieving clinical improvement levels which allow full discharge from our services, with numbers reaching over 85 per cent.

We have introduced peer support workers and recovery groups into some localities and developed a full Recovery and Wellbeing Centre pilot.

Plans
Our Recovery & Wellbeing Development Group will become a subgroup of the Trust Clinical Effectiveness and Outcomes Group (CEOG). The subgroup will be directly supported by CEOG to develop a Trust Recovery and Wellbeing manifesto to inform and underpin all clinical service developments and improvement initiatives.

We will strengthen the appropriate use of the Recovery Star with our clients. This system will enable us to collect a service user reported outcome measure (PROM) and will ensure that care is client centred and recovery based.

How measured

We will measure the number of clients who are offered the use of the Recovery Star as part of their usual care and set a target of 80 per cent.

We know that the use of the Recovery Star is a choice, ultimately for the client which will require further introduction to our client group, so we will set a second initial target of 35 per cent of service users in clusters, 6, 10, 13,16 and 17 having a minimum of two scores on recovery star by end of Q4 from which we can measure recovery progress.

How monitored
The following will be routinely and formally reported to the Clinical Effectiveness and Outcomes Group (CEOG), with highlight reports being sent to the Quality Committee and the Board as appropriate:

- Progress and outcome reports from service lines regarding the further introduction of the Recovery Star, including recovery outcome data.
- Progress and outcome reports from the Recovery & Wellbeing Development Group.

Appendices

A: CQUIN framework 2013-14

B: Quality Performance Indicators

C: Glossary and Abbreviations

D: Auditor's Report

Appendix A: CQUIN framework 2013-14 with RAG rating of attainment at year end:

Ref No	Description of indicator	Outcome	Value £	RAG Status
1.1-1.3	**Urgent Care Assessment** - Improvements to the Urgent Care Pathway	Q1 and Q3 milestones were not achieved. Q4 milestones to improve the urgent care pathway were met	£303,000 achieved from total value of £540,000	
1.4-1.6	**Urgent Care Crisis Planning** - – across Health Economies Increase number of known patients with an agreed crisis plan to 85% in planned care clusters	East Kent CCGs - 87.9% North Kent CCGs - 95.8% West Kent CCG - 95.2%	£225,000	
1.7	**Liaison** - Ongoing support of whole system collaboration between KMPT / DVH/ MTW	Improvement in indicators at Acute Hospitals	£117,000	
2.1	**Quality Metrics** Develop and show measurement of at least one quality indicator for each cluster (4-21), measured by CCG	National quality metrics adopted and reported by cluster	£150,000	
2.2	**Clinician Reported Outcome Measure (CROM)** Develop and show measurement of Clinically recorded outcome measure (CROM)	4 Factor HoNOS score developed and reported to measure change in HoNOS scores	£120,000	
2.3	**Patient Reported Outcome Measure (PROM)** Develop and apply the methodology to use patient recorded outcome measure	Report developed and provided to measure change in Recovery Star scores WEMWEB pilot undertaken in Maidstone Access team	£120,000	
2.4	**Patient experience** Implement measurement of patient experience at CCG level. Report on patient experience survey results for urgent and planned care clusters.	Surveys undertaken across the 3 CCG areas and Service line action plans provided	£150,000	

Ref No	Description of indicator	Outcome	Value £	RAG Status
2.5	**Quality of care planning** Assessments of quality of care planning and delivery through completion of a series of audits and implementation of action plans	Care plan audits completed and action plans developed to improve care planning in each Service line	£180,000	
3.1	Improving the care planning and discharge arrangements by all partner agencies for MHLD inpatients	Reports provided to evidence implementation of multi agency care and discharge planning	£99,000	
4.1	**Discharge communications** Implement more effective discharge communications to all GPs	Electronic discharge summaries developed and provided to GPs	£165,000	
4.2	**Physical Health** - Nutritional assessment and support for high risk continuing care older mental health patients	Nutritional assessment undertaken and referral for dysphasia assessment	£96,000	
4.2	**NHS Safety Thermometer** (national CQUIN) Achieve a reduction of 20% in number of severe and moderate fall events resulting in harm	34% reduction achieved from 2012/13 baseline by end of 2014/15	£96,000	
4.2	**Recovery-oriented practice 1** Continue development of recovery-oriented practice - continued implementation of peer support strategy	Recruitment of 11 peer Support Workers in support of the strategy	£96,000	
4.2	**Recovery-oriented practice 2** Continue development of recovery-oriented practice - continue increase in number of patients that have accessed recovery group education	287 individuals completed KMPTs Recovery group against a target of 150.	£96,000	
5.1	Identify more accurate demand for dementia care in secondary care through more complete clustering of patients in Older adult teams	97% clustering achieved at year end with maintenance of performance from Q3	£120,000	
5.2	**Aligned MH practitioners (dementia) to primary care** At least 90% of practices in K&M to have named aligned MH practitioner (dementia)	All GP practices had a named Mental Health Practitioner by year end	£105,000	

Ref No	Description of indicator	Outcome	Value £	RAG Status
5.3	Target low prevalence practices Named MH practitioners (dementia) to target lowest quartile dementia prevalence practices	Work has begun using data from the CANTAB mobile clinical trial to enable KMPT to target practices into 2014/15	£105,000	
6.1	**Ongoing development of High Impact Innovations** Delivering continued growth in use and user benefit measurement with assistive technology.	Wandaplus personal electronic 'vault' for family carers (for people with dementia) - target has been achieved with 120 carers set up	£105,000	
6.2		BUDDY SMS and web based self management tool – 1082 users against a target of 900	£105,000	
6.3		KMPT Patient Portal – over 558 registered users against a target of 1,000	£73,500 achieved from a total value of £105,000	
6.4		Mobile Anywhere - CQUIN target of 600 real time surveys exceeded with 710 collected. SNAP Mobile Anywhere is now the main surveying tool being used in the Trust.	£105,000	
7	Forensic CQUIN			
7.1	Forensic CQUINs	Improving the CPA process	£82,389.79	
7.2		Improving physical healthcare	£82,389.79	
7.3	Forensic CQUINs	Innovative access to secure services	£82,389.79	
7.4		Optimise pathways	£82,389.79	
7.5		Vocational support	£82,389.79	

Appendix B: Quality Performance Indicators

Appendix A-Quality Performance Indicators				
Quality Performance Indicator	**Target**	**Freq of Report**	**12/13 actual**	**13/14 YTD**
Never Events - inpatient suicide using non-collapsible rails.	Nil	Monthly	0	0
Death or severe harm as a result of a patient falling from an unrestricted window.	Actual	Monthly	na	0
Number of suicides while in KMPT care - inpatient or community	Actual	Monthly	51	38
Number of patient safety incident related deaths reported to NPSA	Actual	Monthly	27	44
Number and % of service users in PbR clusters 4 , 8 and 10 who is a designated care co-ordinator	Actual	Quarterly	82.9%	**79%**
Number and % of service users in PbR clusters 4, 8 and 10 receiving a comprehensive assessment . Definition agreed was those who had a Care plan, HoNOS (under 12 months old) and Risk assessment (under 12 months old)	Nil	Quarterly	62.7%	**69%**
Never Events - inpatient suicide using non-collapsible rails.	Nil	Monthly	0	0
Death or severe harm as a result of a patient falling from an unrestricted window.	Actual	Monthly	na	0
Number of suicides while in KMPT care - inpatient or community	Actual	Monthly	51	38
Number of patient safety incident related deaths reported to NPSA	Actual	Monthly	27	44
Number and % of service users in PbR clusters 4 , 8 and 10 who is a designated care co-ordinator	Actual	Quarterly	82.9%	79%
Number and % of service users in PbR clusters 4, 8 and 10 receiving a comprehensive assessment . Definition agreed was those who had a Care plan, HoNOS (under 12 months old) and Risk assessment (under 12 months old)	Nil	Quarterly	62.7%	69%
Risk assessment and Management Plan within 24 hours of admission to acute inpatients	100%	Monthly	100%	100 %
CPA clients in all clusters who have advance care plans in place	Actual	Quarterly	514	659
The number of patients using recovery star	>700	Monthly	n/a	n/a
Complaints - number - report trends & actual (not including MP enquiries)	Actual	Quarterly	294	380
Complaints - ratio to contacts - report actual	Actual	Quarterly	na	0.09%
Complaints - number - report trends & actual - Communication and attitude of staff	Actual	Quarterly	72	117
Complaints - % of all formal complaints relating to communication and attitude of staff	Actual	Quarterly	30%	31%
Incidents of serious self harm by inpatients (all level 4/5 SI) includes mod and severe	Actual	Monthly	16	11
Incidents of serious self harm by inpatients (all level 4/5 SI) severe only	Actual		1	2

Appendix A-Quality Performance Indicators continued				
Quality Performance Indicator	**Target**	**Freq of Report**	**12/13 actual**	**13/14 YTD**
Percentage of acute inpatients (all age) experiencing one or more incidents of control and restraining (MH02) - Quarterly reported	Actual	Quarterly	16.0%	15%
Percentage of acute inpatients (all age) experiencing one or more incidents of seclusion (MH03) - excludes forensics	Actual	Quarterly	9.00%	7%
Number of all patients who had recorded incidents: physical assault on the patient (MH10)	Actual	Quarterly	754	649
The proportion of detained acute inpatients who have absconded in last three months (inc AWOL on MHA) (MH14)	Actual	Quarterly	59	AWOL 42 ABSC 27
Number of Serious incidents - reported on STEIS, trends, ethnicity & actual	Actual	Monthly	91	120
Number and % of Grade 1 SIS that are over 45 working days				
breached this month (not currently possible due to Commissioner delays)	Actual	Monthly	13(54%)	
inc w/ends	13 (57%)			
2 breaches				
Number and % of Grade 2 SIS that are over 60 working days				
breached this month (not currently possible due to Commissioner delays)	Actual	Monthly	1(100%)	1(50%) 0
Quality Performance Indicator	Target	Freq of Report	12/13 actual	13/14
YTD				
Number of medication errors	Actual	Quarterly	169	180
Falls - OPMH inpatients over 65 - Assessments of risk within 24 hours of admission to acute inpatients (NPSA definition)	100%	Monthly	100%	100%
% of the eligible staff that are actively and regularly working with children subject to a child protection plan who have accessed supervision bi- monthly		Quarterly	98%	98%
% eligible staff receiving child safeguarding training at level 1	85%	Monthly	89%	97%
% eligible staff received adult safeguarding training at level 2 = KMPT level 1	85%	Monthly	93%	92%
% eligible staff who have received an enhanced CRB check	100%	Monthly	100	100%
% of the eligible staff that are actively and regularly working with adults subject to an adult protection alert who have accessed supervision bi- monthly		Quarterly	98%	100%
Number of Medical Locums in place >1 yr	Actual	Monthly	7	5
Violence against MH Staff (community) assaults (MH11) - actual	Actual	Quarterly	19	11
Violence against MH Staff (inpatient) assaults (MH11) - actual	Actual	Quarterly	1181	969

Appendix A-Quality Performance Indicators continued				
Quality Performance Indicator	**Target**	**Freq of Report**	**12/13 actual**	**13/14 YTD**
The number of falls in older adult inpatient wards which result in harm to the patient (incl suspected)	Actual		438	297
25% reduction in the number of falls in older adult inpatient wards which result in harm to the patient (incl suspected) (Also CQUIN data) moderate/severe harm	26	Monthly	34	21
1. Reduction in the number of patients who take their own life during an inpatient admission 2. Reduction in the number of patients who seriously self harm (SSH) themselves during an admission. (severe)	< 3 < 13	Monthly	3 13	0 2
The percentage of inpatient service users who have had a physical health checks	95%	Monthly	100%	98%
The percentage of community service users who have been in the team for 6 weeks or more, who have received a physical health assessment by either the community team or via their GP	Actual	Quarterly	33.08%	28%
Clostridium Difficile - actuals	0	Monthly	1	0
MRSA Bacteraemia - actuals	0	Monthly	0	0
Number of incidences of patients experiencing mixed sex accommodation	0	Monthly	0	0
Number of incidences reported of patients using wrong gender bathroom	0	Monthly	0	0

Appendix C: Glossary and Abbreviations

A & E	Accident and Emergency
AfC	Agenda for Change
AGM	Annual General Meeting
AIMS	Accreditation for Acute Inpatient Mental Health Services
ALE	Auditors Local Evaluation
ALOS	Average Length Of Stay
AWOL	Absent Without Leave
BME	Black Minority Ethnic
BPPC	Better Payment Practice Code
CAB	Citizen's Advice Bureau
CAF	Common Assessment Framework
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CIPs	Cost Improvement Programmes
CMHTs	Community Mental Health Teams
CNST	Clinical Negligence Scheme for Trusts
CoG	Council of Governors
COPD	Chronic Obstructive Pulmonary Disease
CQUIN	Commissioning for Quality and Innovation
CQC	Care Quality Commission
CRES	Cash Releasing Efficiency Savings
CRHT	Crisis Resolution Home Treatment Team
CSFF	Community Services Feedback Form
CSIP	Care Services Improvement Partnership
CRS	Care Records Service
DGH	District General hospital
DOH	Department of Health
DOLs	Deprivation of Liberty Safeguards
DRE	Delivering Race Equality
DToC	Delayed Transfer of Care
EBITDA	Earnings Before Tax Depreciation Amortization
EFL	External Financing Limit
EMT	Executive Management Team
EPEX	Effective Project Executive Programme
ESR	Electronic Staff Record
EWTD	European Working Time Directives
FT	Foundation Trust
FTE	Full Time Equivalent
GIS	Geographical Information System
GP	General Practitioner
GRiST	Galatean Risk Screening Tool
HCC	Health Care Commission
HIS	Health Informatics Service
HR	Human Resources
IAPT	Improving access to Psychological Therapies
IBP	Integrated Business Plan
ICT	Information and Communication Technology
I&E	Income & Expenditure

IFRS	International Financial Reporting Standard
IGT	Information Governance Toolkit
IM&T	Information Management & Technology
IT	Information Technology
JNF	Joint Negotiating Forum
KCC	Kent County Council
KDAAT	Kent Drug and Alcohol Action Team
KMPT	Kent and Medway NHS and Social Care Trust
KPIs	Key Performance Indicators
KSF	Knowledge & Skills Framework
LA	Local Authority
LD	Learning Disability
LDP	Local Delivery Plan
LNC	Local Negotiating Committee
LTFM	Long Term Financial Model
MAPPA	Multi-Agency Public Protection Arrangements
MDT	Multi-Disciplinary Team
MEWS	Modified Early Warning Scoring System
MH	Mental Health
MHRN	Mental Health Research Network
MHT	Mental Health Trusts
MP	Member of Parliament
NED	Non Executive Director
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NHSP	National Health Service Professionals
NICE	National Institute of Clinical Excellence
NPSA	National Safety Patient Agency
NSF	National Service Framework
NWW	New Ways of Working
OATS	Out of Area Treatments
OBDs	Occupied Bed Days
OLAP	OnLine Analytical Processing
OPMH	Older People's Mental Health
OPMHN	Older People with Mental Health Needs
PALS	Patient Advice and Liaison Service
PbC	Practice Based Commissioning
PbR	Payment by Results
PBL	Prudential Borrowing Limit
PCT	Primary Care Trust
PDC	Public Dividend Capital
PEST	Political, Economic, Social, Technological
PFI	Private Financial Initiative
PICU	Psychiatric Intensive Care Unit
PROM	Patient Reported Outcome Measure
PSA 2	Public Service Agreement
PSPP	Public Sector Payment Policy
RAG	Red, Amber, Green
RiO	Patient information system
SBS	Shared Business Services
SfBH	Standards for Better Health
SHA	Strategic Health Authority

SIC	Statement on Internal Control
SLA	Service Line Agreement
SLM	Service Line Management
SLR	Service Line Reporting
SMF	Senior Management Forum
SMT	Senior Management Team
SSAS	Specialist Supported Accommodation Services
STR	Support Time Recovery
SUIs	SeRiOus Untoward Incidents
SWOT	Strengths, Weaknesses, Opportunities, Threats
TFT	Thought Field Therapy
VTE	Venous Thrombus Embolism
VfM	Value For Money
WC	Working Capital
WF	Workforce

Acute
Acute, in medicine, refers to an intense illness or affliction of abrupt onset.

Admission
The point at which a person begins an episode of care (see definition), e.g. arriving at an inpatient ward.

Advance statements/directives
There are various types of advance statement/directive. They can include statements of an individual's wishes in certain circumstances, for example instructions to refuse some or all medical treatment or requests for certain types of treatment. They can also state someone to be consulted at the time a decision needs to be made. The individual should seek advice about the legal status of these statements/directives. They might be called Living Wills.

Advocate
An advocate is a person who can support a service user or carer through their contact with health services. Advocates will attend meetings with service users and help service users or carers to express concerns or wishes to health care professionals. Although many people can act as an advocate (friend, relative, member of staff), there are advocacy services available that can be accessed through the Trust. These advocates are trained and independent.

Aftercare
This is the support or care that a person can expect to receive once discharged from inpatient care. Typically a discharge plan will be developed by the multidisciplinary team with the service user which will make clear what care and support will be provided. (See Care Plan, CPA).

Appropriateness of care
When in a clinical situation, the expected benefits (e.g. improved symptoms) of care outweigh the expected negative effects (e.g. drug side effects) to such an extent that the treatment is worth carrying out.

Approved Social Worker (ASW)
Approved Social Workers (ASW) have specialist training and experience in identifying disorders of mental health and are familiar with the problems experienced by users of mental health services and their families. They are employed by Local Authority Social Services and work in hospitals and in the community as part of the community mental health teams. They will organise social care support for people in contact with mental health services, such as helping with housing and getting welfare benefits. They work closely with health professionals and, under the current Mental Health Act, they work with two doctors to assess a person who

may need admitting to hospital. Social workers can also act as care coordinators for people on care programmes.

Assertive Outreach
Assertive outreach services aim to support people in the community who find it difficult keeping in contact with mental health services.

Assessment
Assessment happens when a person first comes into contact with health services. Information is collected in order to identify the person's needs and plan treatment.

Caldicott Guardian
A senior healthcare professional in each NHS organisation is responsible for safeguarding the confidentiality of patient information. The name comes from the Caldicott Report, which identified 16 recommendations for the use and storage of patient identifiable information.

Care Co-ordinator
A care co-ordinator is the person responsible for making sure that a patient gets the care that they need. Service users and carers should be able to contact their care co-ordinator (or on-call service) at any reasonable time. Once a patient has been assessed as needing care under the Care Programmeme Approach they will be told who their care co-ordinator is. The care co-ordinator is likely to be community mental health nurse, social worker or occupational therapist.

Care plan
A care plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy (see Care Programme Approach).

Care Programme Approach (CPA)
The Care Programme Approach is a standardised way of planning a person's care. It is a multidisciplinary (see definition) approach that includes the service user, and, where appropriate, their carer, to develop an appropriate package of care that is acceptable to health professionals, social services and the service user. The care plan and care co-ordinator are important parts of this. (See Care Plan and Care Co-ordinator).

Carer
A carer is someone who looks after their relatives or friends on an unpaid, voluntary basis often in place of paid care workers.

Client (see also service user)
An alternative term for patient which emphasises the professional nature of the relationship between a clinician or therapist and the patient.

Cognitive Behaviour Therapy (CBT)
Cognitive Behaviour Therapy (CBT) is a talking treatment designed to alter unwanted patterns of thought and behaviour; it addresses personal beliefs which may result in negative emotional responses, concentrating on understanding behaviour rather than the actual cause of a problem.

Community Mental Health Team (CMHT)
A multidisciplinary team offering specialist assessment, treatment and care to people in their own homes and the community.

Consent to treatment
If you are an informal patient, you have the right to refuse any treatment you do not wish. You have a right to receive full information about the treatment, its purpose and possible side effects. If consent is not obtained the treatment cannot normally be given.

Discharge
The point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan (see Care plan).

Episode of care
The period when a service user enters the care of the Trust to when they are discharged from all services provided by the Trust. This care could be, for example a combination of care provided by inpatient stays, outpatient attendances, a CPN, or use of services from an OT and a day hospital.

Home treatment team
A team usually consisting of a psychiatrist, nurse and social worker. The team provides a mobile service offering availability 24 hours, seven days a week and an immediate response. The team provides a gate keeping function to hospital admission and enables earlier discharge from hospital.

Integrated Care Pathway
Integrated Care Pathways are a multi-disciplinary and multi-agency approach to mapping service users' care from admission through to discharge and ongoing care. The aim is to pull together all the information into one file that will make it easier for the clinicians involved to give the best care for the patient.

Mental Health Act (1983) (MHA)
The Mental Health Act (1983) is a law that allows the compulsory detention of people in hospital for assessment and/or treatment for mental disorder. People who are detained under the mental health act must show signs of mental disorder and need assessment and/or treatment because they are a risk to themselves or a risk to others. People who are detained have rights to appeal against their detention.

National Institute for Clinical Excellence (NICE)
It provides clinical staff and the public in England and Wales with guidance on current treatments. It coordinates the National Collaborating Centres from whom it commissions the development of clinical practice guidelines.

National Service Framework for Mental Health
The Department of Health's National Service Framework for Mental Health sets national standards for promoting mental health and treating mental illness.

Patient Advice and Liaison Service (PALS)
All NHS Trusts are required to have a Patient Advice and Liaison Service. The service offers service users information, advice, quick solution of problems or access to the complaints procedure.

Primary Care
Primary care is the care that you will receive when you first come into contact with health services about a problem. These include family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

Secondary care
Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional. Mental Health Services are included in secondary care (see also tertiary care).

Section
This is used to refer to one of the sections of any Act of Parliament. A person who is detained in hospital under the Mental Health Act (1983) is commonly referred to as 'sectioned'.

Service user
This is someone who uses health services. Other common terms are patient, service survivor and client. Different people prefer different terms.

Single Assessment Process (SAP)
The Single Assessment Process (SAP) for older people was introduced in the National Service Framework for Older People. The purpose of the single assessment process is to ensure that older people receive appropriate, effective and timely responses to their health and social care needs, and that professional resources are used effectively.

Talking treatments
These are psychological treatments in which improvement in a person's symptoms or wellbeing is achieved by talking with a therapist or counsellor rather than, or as well as, taking medication.

Therapeutic relationship
The therapeutic relationship (also called the helping alliance, the therapeutic alliance, and the working alliance) refers to the relationship between a mental health professional and a service user. It is the means by which the professional hopes to engage with, and effect change in, a service user.

User involvement
User involvement refers to a variety of ways in which people who use health services can be involved in the development, maintenance and improvement of services. This includes patient satisfaction questionnaires, focus groups, representation on committees, involvement in training and user-led presentations and projects.

Appendix D: Independent Auditor's Limited Assurance Report to the Directors of Kent and Medway NHS and Social Care Partnership Trust on the Annual Quality Account

INDEPENDENT AUDITOR'S LIMITED ASSURANCE REPORT TO THE DIRECTORS OF KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Kent and Medway NHS and Social Care Partnership Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- Percentage of patients on Care Programme Approach (CPA) followed up within seven days of discharge (page 37);
- Percentage of patient safety incidents resulting in severe harm or death (page 41).

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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 Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 24 February 2014 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback received in May from the Commissioners on the period April 2013 to March 2014;
- feedback received in May from Local Healthwatch on the period April 2013 to March 2014;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 30/07/2013;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the 2013 national patient survey dated 26/09/2013;
- the 2013 national staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2014;
- the annual governance statement dated 28/04/2014;
- Care Quality Commission quality and risk profiles for 2013/14.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively "the documents"). Our responsibilities do not extend to any other information.
This report, including the conclusion, is made solely to the Board of Directors of Kent and Medway NHS and Social Care Partnership Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Kent and Medway NHS and Social Care Partnership 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 under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower 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 Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Kent and Medway NHS and Social Care Partnership 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 Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
London NW1 2EP

6 June 2014

Your Views

We want to know what you think. Therefore, if you have any comments to make about this Annual Report, or you would like further copies, please contact:

Communications
Trust Headquarters
Farm Villa
Hermitage Lane
Maidstone
Kent
ME16 9PH

Tel: 01622 724100
e-mail: **communications@kmpt.nhs.uk**

This report can be downloaded as a PDF from www.kmpt.nhs.uk

If you or someone you know cannot read this document, please advise us of your/ their specific needs and we will do our best to provide you with the information in a suitable format or language. Contact 01622 724100

If you require any information about the Trust, its services or your care, please ask our staff to arrange for some information to be provided in your preferred language.

Bengali

ট্রাষ্ট, এর সার্ভিসসমূহ, বা আপনার কেয়ারের (যত্নের) ব্যাপারে আপনি কোন তথ্য চাইলে, অনুগ্রহ করে আপনার পছন্দসই ভাষায় কিছু তথ্য সরবরাহের আয়োজন করার জন্য আমাদের কর্মীদের বলুন।

Chinese

如果你需要什麼訊息有關這個基金信託會、它為你提供的服務或你得到的照料，請向我們的工作職員要求將一些相關訊息翻譯成你能閱讀的語言。

Polish

Jeśli potrzebujesz informacji na temat Trustu, zakresu naszych usług lub otrzymywanej opieki, poproś kogoś z personelu o udostępnienie informacji w Twoim języku.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਟ੍ਰਸੱਟ ਬਾਰੇ, ਇਸ ਦੀਆਂ ਸੇਵਾਵਾਂ ਬਾਰੇ ਜਾਂ ਤੁਹਾਡੀ ਕੀਤੀ ਜਾਂਦੀ ਦੇਖ-ਭਾਲ ਬਾਰੇ ਕਿਸੇ ਵੀ ਪ੍ਰਕਾਰ ਦੀ ਜਾਣਕਾਰੀ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਤੁਹਾਡੀ ਪਸੰਦ ਦੀ ਬੋਲੀ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਦਾ ਪ੍ਰਬੰਧ ਕਰਨ ਲਈ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਕਰਮਚਾਰੀਆਂ ਨੂੰ ਪੁੱਛੋ।

Turkish

Trust (Vakıf), sunduğu hizmetler veya size verilen bakım hakkında bilgi edinmek istiyorsanız, lütfen personelimizden size tercih ettiğiniz dilde bilgi sağlanması için istekte

KM20 30062014