Kent and Medway NHS
NHS and Social Care Partnership Trust

Quality Account 2011-12

www.kmpt.nhs.uk

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

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.

Our Values

respect
open
accountable
working together
innovative
excellence

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Chief Executive's Statement

I am delighted to present our third Quality Account, which outlines our progress against the priorities we set last year and looks ahead to those we have set for the coming year. Through the hard work and commitment of our staff, I am sure we can continue to make improvements and raise the quality of our services.

Our Quality Strategy continues to be led by our Executive Medical Director and the Quality Improvement team and our immediate priority over the coming year is to strengthen our core services; improve productivity and create a dynamic system of care which means that people who need help get the right treatment, at the right time, in the right place and, critically, the right outcome.

We now have a Clinical Strategy, which is fully supported by the Trust Board, and by deliverng this, we will see quality driven up and better outcomes achieved.

Despite the progress you can read about in this Account, we know we still have work to do and success can only be achieved by working together with our partners and taking on board the views of our services users and carers.

I hope you agree that quality is a central part of what we should be aiming to achieve – it is indeed one of our values. Through reading this report I hope you are able to recognise the commitment we have to providing high quality services both now and in the future.

The information contained within this document is, to the best of my knowledge, accurate. The directors' statement on page eight 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

Introduction

This Quality Account is an annual report, for the public, which focuses on the quality of the services the Trust delivers. This Quality Account demonstrates the Trust Board is assessing the quality of the services we provide and the Trust's staff are committed to continuous, evidence-based, quality improvement.

By publishing this report we are making clear our approach to quality and inviting and encouraging scrutiny, debate and reflection. Quality Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

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.

We are an organisation committed to continually improving the quality of the services we provide to our patients.

2012/13 Trust Objectives

improve patient experience:
Work with patients, carers, staff and our partners evidenced through national and local patient surveys.

become a better employer:
ensuring all staff are valued, motivated, listened to and have pride in everything they do reflected in continuous improvement in human resources Key Performance Indicators and an improvement in the staff experience survey.

be value for money:
increase our productivity reducing expenditure by £13m, effective deployment of resources measures of productivity.

improve our clinical models, including the quality and safety of services:
working with our partners, to further develop innovative and integrated health and social care services, underpinned by a focus on the recovery model all cluster pathways mapped by 31st March 2012 and 95% of eligible patients to be receiving care against mapped pathways by end of 31st March 2013).

become business focused, as well as being patient focused:
maintaining and growing our business by being the provider of choice as a result of the quality of our services and our commercial activities, including: implementing Payment by Results; mapping of income and expenditure; identifying and growing core business whilst recognising other opportunities for increasing income; defining our marketing approach; further cost apportionment to service lines; and finish implementation and ensure sustainability of business intelligence functions.

maintain and improve standards:
by continuing to support patients, and improve quality and safety, including: embracing change and continuing to deliver high standards of care, improving well-being and making improvements to services, continue to ensure robust governance during a time of significant organisational and external transformation as measured by delivery of Key Performance Indicators (KPIs) and monitoring of Serious Incidents and Complaints to ensure no deterioration in standards.

become a sustainable organisation:
through this become a Foundation Trust by 1st April 2013.

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

Children and young people (and their families) who have mental health needs

- Community teams covering West Kent and Medway

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
- Wheelchair Service
- Personality Disorder Service

The Trust has reviewed all the data available to it on the quality of care in all 27 of these NHS services.

The income generated by the NHS services reviewed in 2011-12 represents 100% per cent of the total income generated from the provision of NHS services by the Trust for 2011-12.

Directors' Statement

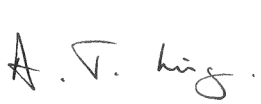
The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content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

By order of the Board



Andrew Ling
Chairman
28 June 2012

Angela McNab
Chief Executive
28 June 2012

Our 2012-13 Priorities

For 2012-13 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

- A further 5% reduction in the number of falls in older adult inpatient wards, which result in harm to the patient.
- Reduction in the number of patients who take their own life during an inpatient admission and a reduction in the number of patients who seriously harm themselves during an admission.
- To ensure all adults and children are effectively safeguarded.

Patient Experience

- Better communication between our staff and service users and their carers.
- To demonstrate improvements in patient experience using the 'Net Promoter Score'
- We will increase the number of service users in all parts of our service who have had a physical health check in accordance with our Physical Health and Examination Policy.

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 measure the number of patients working with our Recovery teams who recover sufficiently from their mental health difficulties to be discharged from our service

Over pages 10-19 we outline, for each priority, the reason for the choice, where the Trust is currently positioned (at the start of 2012-13), the way that the priority will be measured and the means of monitoring progress.

2012-13 Patient Safety Priority 1

A 5% reduction in the number of falls in older adult inpatient wards, which result in harm to the patient.

Rationale

In 2011-12 we set ourselves a priority to increase the number of assessments of patients at high risk of falls in order to reduce the numbers of slips, trips and falls on our older adult inpatient wards by 5% last year and a further 5% this year.

Current status

Reported service user slips, trips and falls increased slightly in 2011-12. Last year, our staff reported 360 slips, trips and falls which resulted in harm to patients on our older adult inpatient wards.

Plans

- Improve Access to Slip Trips & Falls training for our nursing staff
- Implementation of falls pathway for all at risk service users
- Improvement in falls assessments and screening for all inpatient older adults
  - Initial screening
  - Full screening
  - Care planning to put in place actions to reduce the risk of falls resulting in harm, such as the use of hip protectors
- Involvement in the National Falls Audit

How measured

Number of slips, trips and falls reported each quarter.
By the end of the year we aim to reduce the number of slips, trips and falls resulting in harm, by 5% and to reduce by a further 5% in the following year.

How monitored and reported

Monitored through the Trust's Modern Matrons Forum and the Trust-wide Falls Prevention Group.

2012-13 Patient Safety Priority 2

Reduction in the number of patients who take their own life or seriously harm themselves during an inpatient admission

Rationale

The Trust wishes to continue to work to ensure that its wards are as safe as possible and that during an inpatient admission, the risk assessment process is used effectively to plan safe care. Even though the numbers of patients who take their own life during inpatient admission is small, we recognise that this event is a tragedy for each family affected. This is why we continue to focus on this improvement priority. We also recognise the distress that serious self-harm causes and will focus on reducing the incidents of serious self-harm during admission.

In 2011, the Trust participated in a peer review organised by the Strategic Health Authority involving mental health Trusts in Kent, Surrey and Sussex. This demonstrated a suicide rate in people in contact with the Trust in line with the rate for England and Wales as a whole. It identified challenges faced by the three Trusts, which the Prevention of Suicide and Homicide Group has used to develop a Suicide Prevention Action Plan for 2012, within a Suicide Prevention Strategy for 2012 – 2015.

Current status

In order to raise standards in preventing suicide, we must focus our attention on effective risk assessment and management in both inpatients and outpatients. In 2011-12 one patient took their own life while on leave from a ward, no patients took their own life on a ward and 10 seriously harmed themselves on a ward or while on leave. We also recognise that patients have absconded from our in-patient wards and wish to reduce the incidence of unauthorised absence through improved risk assessment and management.

Plans

The effectiveness of the Suicide Prevention Toolkit pilot within inpatient wards will be evaluated. If it is demonstrated to be successful, it will be rolled out across Trust services. In November 2011, a version of the Suicide Prevention Toolkit was published for community clinical teams. The Community Recovery Service Line is preparing an audit proposal for the Toolkit to be implemented initially as a pilot in one locality.

The Galatean Risk Screening Tool (GRiST) will be piloted at the Thanet Recovery Service, based at the Beacon Community Mental Health Service, over a period of 12 weeks between June and August 2012. If it is evaluated to be successful, it will be rolled out across Trust services.

The Suicide Prevention Strategy will be presented at a number of forums and the Suicide Prevention Action Plan presented at the four service line senior clinical governance meetings during the course of May and June 2012, for each service line to develop their own response, according to issues raised by serious incidents in their services, together with national and local priorities.

How measured

The evaluation of the inpatient ward Suicide Prevention Toolkit pilot will be presented to the Prevention of Suicide and Homicide Group, as will the results of the proposed audit for the community Suicide Prevention Toolkit.

The Prevention of Suicide and Homicide Group will be directly involved in the evaluation of the GRiST, with a view to presenting recommendations regarding its roll-out to the Trust-wide Patient Safety Group.

Each of the four service lines will report progress on the Suicide Prevention Action Plan to the Prevention of Suicide and Homicide Group. This will include the measures taken to reduce absconding from our inpatient wards.

How monitored and reported

The Prevention of Suicide and Homicide Group will report progress on the pilot studies, GRiST and the Suicide and Homicide Prevention Action Plan to the Trust-wide Patient Safety Group. The Executive Medical Director will continue to report all serious incidents, including actual or suspected suicide or serious self-harm, to the Trust Board each month, as happens already.

2012-13 Patient Safety Priority 3

To ensure all adults and children are effectively safeguarded

Rationale

Safeguarding remains a priority for the organisation and we aim to ensure all children and adults and appropriately safeguarded. We aim to support children and their families through the use of appropriate systems and processes. We aim to support vulnerable adults through timely and skilled contacts and assessments.

Current status

We have prioritised Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DOLS) training throughout the organisation and now look to see full compliance with the MCA Act 2005. For children we are aiming to address the accuracy of data held on families to ensure that any concerns around safeguarding are dealt with in a timely manner. We are also aiming to equip staff with the skills and knowledge needed to address concerns that are not obviously child protection but require intervention on a multi-agency basis.

Plans

To meet our target of 20 Common Assessment Framework (CAF) completed for children and families by KMPT staff where there is a need for additional support for families who do not meet the Child Protection criteria.

To gather comprehensive data on the children of patients who have parental responsibility to ensure we have an overview of the issues they face and therefore are in a better position to respond to needs, risks and concerns.

To assess compliance with the Mental Capacity through the practice of staff, in wards and community teams.

To ensure a timely and robust response to DOLs assessments.

How measured

Monthly audits of records to monitor safeguarding children issues and quarterly audits and data collection on MCA/DOLs compliance and response to requests for assessments. Records will be checked via RiO.

How monitored

This will be monitored by the Safeguarding Team, the Trust-wide Safeguarding Group which includes the ADs and the Trust Executive Lead for Safeguarding.

2012-13 Patient Experience Priority 1

Better communication between our staff and service users and their carers

Ongoing analysis of complaints relating to staff communication/attitude after the introduction of the Customer Care Charter (relating to Priority 1 2011/12)

Rationale

During 2011/12 the Trust worked with service users, carers and other partners to produce a 'Customer Care Charter' which was launched in April 2012. This was in response to results from the National Patient Survey where staff were being perceived as being rude and not showing respect whilst patients did not feel listened to. The Trust feels that it is important to continue this piece of work and monitor the implementation of the Customer Care Charter across the organisation.

Current status

The Trust launched the 'Customer Care Charter' in April 2012.

Plans

The Customer Care Charter will be rolled out across the organisation and will be clearly displayed at the entrance to all of our buildings alongside the signatures of everyone that works there; during this time we will continue to monitor complaints particularly those relating to staff communication.

How measured

We will continue to monitor and analyse complaints relating to staff communication; we will ensure that the results of patient surveys, local and national are also considered including the results of Priority 2 – the Net Promoter scores.

How monitored

The Trust-wide Patient Experience Group will monitor these results and report to the Quality Committee.

2012-13 Patient Experience Priority 2

To demonstrate improvements in patient experience using the 'Net Promoter Score'

Rationale

The PM recently announced the need for a 'friends and family list'. This enables simple benchmarking and improvement to be identified. Analysis and response to the CQC National Patient Survey is by nature of the process a long-term measurement of Patient Experience; KMPT has committed to using the 'Net Promoter Score' as a method of measuring patient experience on an ongoing basis. This will enable the organisation to identify the 'headline' patient views of each team/ward in the organisation to compare results across Kent & Medway and take action to address patient experience issues promptly.

Current status

The Trust is in the process of trialing a postcard system of gathering patient views at discharge that will demonstrate clear commitment from board to ward to improve patient experience.

Plans

Trust staff will ask each service user at discharge the question "Please rate on a scale of 1 to 10 how likely is it that you would recommend this service to friends and family?" The results will be entered on a web-based survey system by volunteers and will allow comparison from team to team.

How measured

Net Promoter score, ensures perceptions of the local population about the health care they have received. The score is the difference between the number of people surveyed who said they would recommend the local service and the proportion who said they would not.
%number of Promoters minus the % number of Detractors from a minimum survey size of patients discharged in a calendar month.

How monitored

The Trust-wide Patient Experience Group will report to the Quality Committee.

2012-13 Patient Experience Priority 3

Physical Health and Examination

Rationale

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.

Current status

In 2011-12 physical health assessments were monitored for inpatients and reached 100% regardless of age. Data at present for community service users is low and needs to be enhanced.

Plans

- 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.

How measured

The percentage of inpatient service users who have had a physical health assessment

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.

How monitored

Physical health assessments will be monitored for inpatient wards through the nursing metrics and for community patients through the Business Intelligence data.

2012-13 Clinical Effectiveness Priority 1

Improving discharge planning from inpatient care and improving post discharge Care

Rationale

When people need help from our services we aim to provide that outside hospital as much as possible. When people are admitted to hospital we aim to make that admission as short as possible and discharge them to other types of care as soon as we can. Sometimes the planning of their discharge and the support given after discharge may not prevent them having to come back to hospital within the first month after leaving. We want to reduce the number of people needing to return to hospital within 28 days of being discharged from a ward.

Current status

In 2011 – 2012 4% of people under the age of 65 were re-admitted within 28 days of discharge.

96.9% of people were seen within 7 days of discharge from hospital.

Plans

- We will continue to review how we staff our Crisis Resolution and Home Treatment Teams, particularly at weekends so that Home Treatment packages can be maintained at weekends. This will include increasing the number of STR Workers on the Teams
- We will improve the interface between the Acute Service and Community Recovery Line by improved liaison and joint working at all levels of the Service.
- The Senior Management Team will regularly review the discharge plans for people whose discharge has been delayed or whose length of stay exceeds 60 and 90 days

How measured

The percentage of people re-admitted within 28 days of discharge from a ward.
The percentage of people followed up within 7 days of being discharged from one of our wards.

How monitored

The measures will be monitored by the Executive Team at monthly performance monitoring meetings and reported to the Trust Board.

2012-13 Clinical Effectiveness Priority 2

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

Rationale

NICE guidance provides recommendations on the treatment of patients that are based on current best evidence of clinical and cost effectiveness. Because of this implementing NICE guidance has many benefits for both patients and providers of care in terms of delivering a high quality service. It also helps to ensure that KMPT provides a more consistent service across the region.

Current status

During the year 2011/12 KMPT was able to report very good progress in identifying and completing gap analyses against new relevant NICE guidance.

Plans

During the coming year the NICE Reference Group will focus on improving training provision in relation to NICE guidance, in addition to continuing to ensure that gap analyses continue to be completed. This will be achieved initially be holding a Trust-wide multi-disciplinary event to discuss and promote implementation of NICE guidance. At this event an expert panel will discuss training provision for NICE recommendations.

How measured

Through completion of organisational gap analyses against new relevant guidance and formulation of a training plan based on discussions at the KMPT multidisciplinary event and wider consultation.

How monitored

By production of regular reports to the Clinical Effectiveness and Outcomes group on completion of gap analyses and agreement of a training plan for NICE.

2012-13 Clinical Effectiveness Priority 3

To measure the number of patients working with our Recovery teams who recover sufficiently from their mental health difficulties to be discharged from our service

Rationale

The concept of recovery is changing the way mental health services work. We want to support service users to define what they would like our services to help them with, which is a big change from the way services used to be. When our Recovery teams work with people with complex mental health problems, we aim to assist them in achieving goals they have set and help them access services and activities in their communities that everyone uses. When these goals are achieved, they can be helped by other services such as primary care services and will not need the level of support we provide. This is what an effective mental health service should do.

Current status

In 2011-12, 1482 service users were discharged from our services as a result of adopting the Recovery approach.

Plans

Our new electronic patient record system, known as RiO, will continue to make it easier for our staff to record information about patients accurately. By the end of 2012-13, we will report how many people who have recovered are discharged each quarter by our Recovery teams and will seek to increase this number.

How measured

How many people who have recovered are discharged each quarter by our Recovery teams.

How monitored

This will be monitored by the executive team at monthly performance monitoring meetings.

Developing staff capability and capacity to deliver these quality improvements

How are we supporting staff capability and capacity to deliver these quality improvements?

Supporting our staff is key to achieving success and the Trust's offers a variety of ways for staff to become more skilled through personal and team training, through developing our clinical leaders and through participation in Lean methodology such as the Productive ward.

We have reviewed the way we provide training to deliver it efficiently in ways that staff will find easier to access: for example, making greater use of e-learning to reduce travel times and hence reduce the amount of time staff have to spend away from their patients. However, due to the nature of mental health work, we appreciate that staff value the opportunity to discuss topics at face to face training with time to explore practical examples and apply the learning to their own area of expertise.

We are ambitious that all our staff understand their opportunities to identify clinical risks and have the confidence and skills to assess and manage them appropriately,. We therefore offer a robust package of training on Clinical Risk Assessment and Management and Suicide Prevention training and, in collaboration with the Learning Through Experience Group, action plans are implemented to ensure organisational learning takes place as a result of the outcomes from complaints, serious incidents and near misses.

We aim to harness the talent and commitment, and realise the potential, of all our employees. We know that well-trained and engaged staff are essential for excellent care quality and patient experience so our aim is that every single member of staff will be able to recognise the value of their contribution.

'Quality Through Leadership' is the brand for the KMPT management and leadership development programmeme. The overarching objective of the programmeme is to build capacity and capability within KMPT to deliver fundamental changes to the way that services are delivered as part of the Organisational Development plan. This will support the delivery of our Clinical Strategy as set out on page 6.

The programmeme is designed to target leaders at every level of the organisation and has delivery elements underpinned by Lean methodologies which include:

1) New managers induction and development toolkit
2) Ward managers development programmeme
3) Organising for quality and value
4) Productive leader
5) Board Development
6) Developing Medical Leadership
7) Innovation for front line managers

Through all of this work we want to ensure that our staff have pride in their jobs and are proud to work at KMPT.

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.

Participation in Clinical Audit and Quality Improvement activities

During 2011-2012 Kent and Medway NHS and Social Care Partnership Trust was actively involved in 11 National Clinical Audits/Quality Improvement activities and one National Confidential Enquiry that were relevant to the services provided by the Trust.

During the above period the Trust participated in all (100%) of the national clinical audits and national confidential enquires that it was eligible to participate in (see table below for a list of these projects):

- POMH: prescribing topics in mental health services
- National Organisations Audit of Falls
- National Inpatient Falls Audit
- National Audit of Psychological therapies for Anxiety & Depression
- National Audit of Schizophrenia
- National Confidential Enquiry Into Suicide and Homicide by People with mental illness

The Kent and Medway NHS and Social Care Partnership Trust also participated in the following national clinical audits and Quality Improvement activities during 2011-2012:

- Accreditation for Inpatient Mental Health Services
- Quality Network for Forensic Mental Health Services
- Quality Improvement Network for Multi-agency CAMHS (QIMAC)
- National Outcome database for CFS/ME
- Community of Communities: Therapeutic communities quality improvement network
- Psychiatric Liaison Accreditation Service (PLAN)

The national clinical audits, national confidential enquires and quality improvement activities that Kent and Medway NHS and Social Care Partnership Trust participated in, and for which data collection was completed during 2011-2012 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%
POMH: prescribing topics in mental health services	100%
Quality Network for Forensic Mental Health Services	100%
Quality Improvement Network for Multi-agency CAMHS (QIMAC)	100%
National Audit of Psychological Therapies for Anxiety & Depression	100%
National Audit of Schizophrenia	100%
National Inpatient Falls Audit	100%
National Outcome database for CFS/ME	100%
Community of Communities: Therapeutic communities quality improvement network	100%
Psychiatric Liaison Accreditation Service (PLAN)	100%
National Confidential Enquiry Into Suicide and Homicide by people with mental illness	98.77%

Please note that the National Organisations Audit of Falls was an organisational audit and did not require a patient sample. The reports of 14 national clinical audits and quality improvement activities were reviewed by the Trust during 2011-2012.

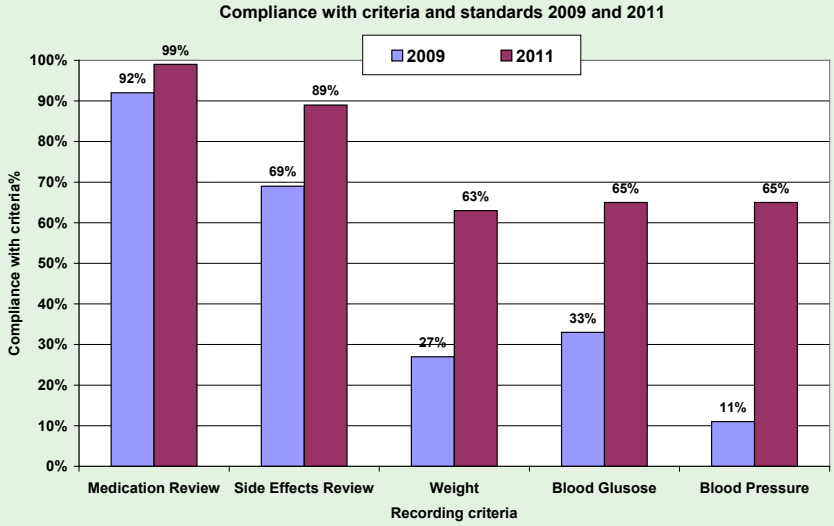
National Clinical Audit Case Study

POMH-UK: Topic 9b: Use of antipsychotic medicine in people with learning disabilities

This project was designed to measure if patients with a learning disability that had been prescribed antipsychotic medicine had an annual medication review, together with a range of physical health checks such as weight, blood tests and blood pressure and a review of medication side effects recorded within the last year.

This was the second time that the Trust had participated in the project, thus providing the opportunity to see the impact of improvements made as a result of the implementation of the action plan produced when the first audit of this topic was carried out in 2009.

The following graph shows compliance with criteria and standards as reported in the first audit (2009) compared with the findings of this re-audit (2011)



The actions taken to promote further improvements on this topic are as follows:

- Communication to all Learning Disabilities Consultants stating that medication reviews and the reason why an antipsychotic had been prescribed must be recorded.
- All Learning Disabilities Consultants have been informed to use the Glasgow antipsychotic side-effects scale to monitor side-effects for all patients prescribed antipsychotic medication.
- Physical Health monitoring (Weight, Blood tests and Blood Pressure) must be recorded on the Physical Health Check List on RiO (patient electronic information system).

National Clinical Audits

Examples of action being taken to improve services as a result of involvement in National Clinical Audits are given below:

- A Community Development Worker (seconded from Rethink) has been appointed to enhance access for minority groups (National Audit of Psychological Therapies, Primary Care Services)

- Extra staff have been recruited in order to ensue that Cognitive Behavioural Therapy (CBT) is provided for the number of sessions as recommended by NICE (National Audit of Psychological Therapies, Secondary Care Services)

- Indication and risks/benefits of antipsychotic medication, underlying causes of Behavioural Psychological Symptoms of Dementia (BPSD), Medication Reviews and Adverse events to be recorded on RiO (Patient Information System) (POMH-UK Topic 11: Prescribing Antipsychotic medication for people with dementia)

- Local Falls champions have been identified and trained (National Inpatient Falls Audit)

- Patients are encouraged to consider returning to the ward in a peer support role (Accreditation of Inpatient Mental Health Services)

The learning points and action taken from the other National Clinical Audit projects and quality improvement activities reported during 2011-12 can be found in the Kent and Medway NHS and Social Care Partnership Trust Annual Clinical Audit and Effectiveness Report 2011-2012 available at www.kmpt.nhs.uk

Local Clinical Audits

The reports of 66 local clinical audits and service evaluation projects were reviewed by the Trust in 2011-2012.

Examples of action being taken to improve services as a result of Local Clinical Audits are given below:

- ECT prescribing and outcome guidance sent to all consultants (ECT re-audit)
- Use of learning points from suicide audit used in clinical risk assessment training (Retrospective Suicide Audit)
- To review the Trust's Do Not Attempt Resuscitation (DNAR) Policy, DNAR recording form and to produce a patient information leaflet which is consistent with The NHS South East Coast, End of Life Care Clinical Advisory Group overarching principles for NHS and voluntary sector organisational policies on Do Not Attempt Cardio-Pulmonary Resuscitation (DNA CPR). (Clinical audit of do not attempt resuscitation practice in older adult wards)
- E-mail to Consultant/Ward Managers reminding them of the need to regularly update risk assessment with management plans. (Clinical audit of compliance with NICE cg25 on the management of disturbed / violent behaviour in West Kent psychiatric inpatient settings)
- To provide psychoeducation material, in particular with reference to NICE guidelines, to patients with regards to the clinical evidence on the pharmacotherapy and psychotherapy interventions in order to aid clinical management of service users. (A clinical audit on the current practice in the treatment and management of Borderline Personality Disorder against recommendations in the NICE guidelines)
- Risk assessments to include Risk from asphyxiation (Plastic Bag Audit)

Learning points and actions taken as a result of Kent and Medway NHS and Social Care Partnership Trust participation in national clinical audits, local clinical audits and service evaluation projects can be found in the Kent and Medway NHS and Social Care Partnership Trust Annual Clinical Audit and Effectiveness Report 2010-2011 available at www.kmpt.nhs.uk

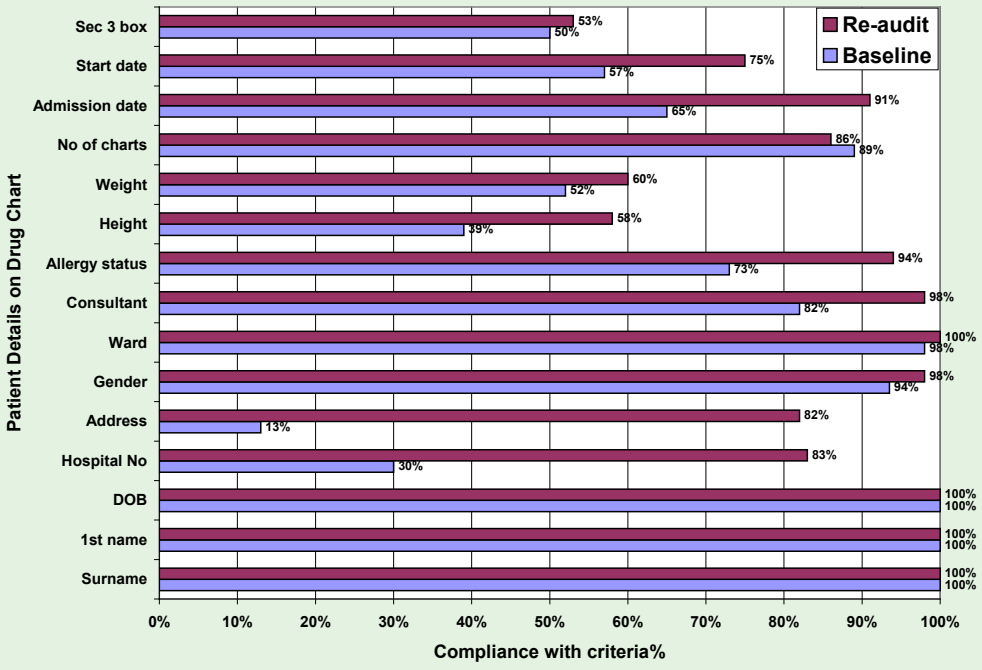
Local Clinical Audit Case Study

Is essential patient information missing on drug charts? Re-audit

The purpose of this project was to improve the quantity and quality of information recorded on patient drug charts within the wards of `A' Block at the Medway Maritime Hospital. The standard for the audit was that all sections of the drug chart should be completed in full. It is important that the information on the drug chart is completed in full in order to promote the safe prescribing of medication. The first audit was conducted during April/May 2011 and the second audit was carried out in November/December 2011. An action plan was drafted and implemented after the first clinical audit., which involved both medical and nursing staff.

The results from the re-audit show an improvement in drug chart section completion for 14 out of 15 sections.

The following graph shows the compliance percentage for each drug card section, on all the drug charts audited found to have been completed when first audited and when re-audited:



An action plan has been implemented after the re-audit, with actions focused on all ward clinical staff taking responsibility for ensuring that all patient details are entered on to the appropriate drug charts.

Research and Development

The number of patients receiving NHS services by the Trust in 2011-12 that were recruited during that period to participate in research approved by a research ethics committee was 165.

KMPT was involved in conducting 47 approved clinical research studies in the period April 2011 – December 2011. During this time period eight projects were completed, one abandoned, leaving 39 ongoing. Abstracts are available for all completed studies.

Of the 39 active studies, 25 are adopted by the Mental Health Research Network (MHRN) as 'Portfolio' studies. The remaining 14 are being conducted by employed staff from KMPT and trainees. With regard the Portfolio research, there have been 136 recruits to the research studies.

There are currently three multi-site Portfolio studies being approved that are being led by KMPT. This is an increase from the one that has run over the past year. The Comprehensive Local Research Network (CLRN) have continued to carry out Research Governance Scrutiny of all studies. All studies were approved within the '20 working days' target. The CLRN will continue to carry out the governance process for CLRN and MHRN studies, but Canterbury Christchurch University will take over trainee and other local studies.

Our research and development strategy

KMPT continues to support the development of R&D across the Trust. Each of the four Service Lines have Research Leads, who both monitor and promote research within the Service Line and sit on the R&D Committee. A well attended conference was held in October 2011, in collaboration with the CLRN and Canterbury Christchurch University. Each Service Line presented research currently underway within their area.

The MHRN's clinical support workers are now embedded within KMPT.

The Trust is strengthening its partnership with Canterbury Christchurch and Kent University, with representation at the Knowledge Exchange Transfer groups. This has led to the development of two collaborative multi-site, grant supported, research studies (both in the approval process).

Finally, KMPT has a positive commitment to Service User involvement in R&D. There is close collaboration with the Expert by Experience group, with representation at the Trust R&D group.

The COMQUAL research study has just been awarded the best Service User Involvement in a Portfolio study by the National User Involvement team – part of the MHRN.

Goals agreed with commissioners - Use of the CQUIN payment framework

A proportion of the Trust's income in 2011-12 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.

Details of the agreed goals for 2011-12 and for the following 12 month period from April 2012 are available on our website www.kmpt.nhs.uk where further information can be obtained.

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 NHS Medway, our lead commissioning Primary Care Trust and the Clinical Commissioning groups (CCGs) in Kent and Medway and KMPT.

Local quality improvement priorities and progress in achieving them in 2012/13 were discussed and agreed at board level and discussed at quarterly quality performance review meetings and quarterly assurance meetings between the Trust, Primary Care Trust, CCGs and Strategic Health Authority throughout the year.

The CQUIN framework made part of KMPT's income dependent on locally agreed quality and innovation goals (1.5% on top of actual outturn value in 2011-12, increasing to 2.5% on top of actual outturn value in 2012-13). The use of the CQUIN framework indicates that KMPT has been actively engaged in quality improvements with commissioners.

For 2012/13 CQUIN indicators agreed with commissioners aim to support tangible improvements in Quality and are linked to both the QIPP and Outcomes Framework as well as the move to Payment by Results for mental health services from April 2013. The main CQUIN areas for 2012/13 are concerned with the transformation of services through care pathway redesign and patient experience, both concerned with improving outcomes for service users.

Please see Appendix A for deatils of the full CQUIN Payment Framework.

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 22 registered locations. The Care Quality Commission (CQC) carried out a number of unannounced visits at these locations between the 1st of April 2011 and the 31st of March 2012, under Section 46 of the Health and Social Care Act 2008; in line with other Trusts.

During this period the Trust also implemented action plans associated with the privacy and dignity concerns raised by the CQC in the prior year, which has been acknowledged by the CQC, resulting in a favourable Quality Risk Profile position by the end of March 2012.

The Trust was deemed compliant with all CQC reviews undertaken in that period (with improvement actions in some instances), with the exception of the Birling Centre review undertaken in December 2011, by the CQC under Section 48 of the Health and Social Care Act 2008, where compliance actions were identified for one outcome on two wards.

The Birling Centre was reviewed as part of a national Learning Difficulties review. On 16 March 2012 the Trust received the draft report from the CQC, which incorporated an assessment of the Birling Ward's compliance with two essential standards, (Care and Welfare of people who use services), and outcome 7, (safeguarding vulnerable people from abuse). The CQC deemed the Trust compliant with the Safeguarding standard, and non-compliant with the Care and Welfare standard. This largely related to a lack of evidence of information that had been used to plan care or manage people's behaviours in a way that focused on their individual needs.

However, the CQC report also acknowledges the action plan, and the steps that were being taken to address these deficiencies, at the time of their visit. The Service Line Director has provided subsequent assurance that all patients do have an up-to-date care plan. In addition all wards are now providing assurance to the Director of Nursing and Governance, through monthly audits of care plans, to ensure a truly person-centered approach is considered.

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; and
- assurance and review programmemes.

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:

- Focussing 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 Business Intelligence reports to support operational services to improve data completeness and data quality on Rio
- Developing, implementing and embedding a Trust-wide 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

The data quality action plan is being updated for the coming year to achieve these objectives. In addition, each Service line will implement data quality improvement plans in 2012/13.

NHS Number and General Medical Practice Code Validity

Kent and Medway Partnership Trust has submitted records during within prescribed deadlines for 2010-11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 99% for admitted patient care, and
- 99.97% for outpatient care

The percentage of records in the published data which included the patient's valid General Medical Practice was:

- 97% for admitted patient care, and
- 99.7% for out patient care

Information Governance Toolkit attainment levels

Information Governance attainment for the Trust in 2011-12 assessed using the Information Governance toolkit was 85% up from 80% in 2010/11. This toolkit submission covers all processes to administer: information governance management; confidentiality and Data Protection; information security; data quality; manual health records and corporate records management.

This year the Trust submission was rated 'Satisfactory' overall as the Trust achieved at least a level 2 (out of 3) in all of the 45 elements, registering green according to the IGT Grading Scheme.

The Trust's score of 85% was the highest compliance score for any Trust in the Strategic Health Authority.

The Trust's evidence and Information Governance processes were audited by South Coast Audit [SCA] at the beginning of 2012 and they gave the Trust 'Significant Assurance'.

SCA also audited staff understanding of information matters and the results show an increased awareness of all area of information governance processes from the SCA staff survey in 2010/11.

Clinical coding error rate

The Trust was not subject to the payment by results clinical coding audit during 2011-2012 by the Audit Commission. However, the Trust did undertake its own audit of case notes. The comprehensive case notes were found to be in very good order; everything was neatly filed in chronological order. 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

	Total from episodes audited	Total correct	% correct
Primary diagnosis	50	46	92%
Secondary diagnosis	206	160	77.7%

correct coding.
Of the 50 episodes audited, there were a total of 50 primary diagnoses present: 92% of these were correct compared to 83% last year; and secondary diagnoses: 78% correct this year compared to 74% correct last year. Historic system constraints identified on previous audits prevent the recording of procedures codes, with the exception of recording ECT treatments.

The Trust has followed the Secondary Use Assurance – Mental Health Trusts Guidance IGT 8-514 and attained level 2 in diagnostic coding.

Who has been involved in setting our 2012-13 priorities?

We have involved a range of staff and people who use services to help set our priorities for the coming year. Through the implementation of our Community Engagement Strategy, Kent and Medway LINks have provided valuable assisatnce in undertaking reviews and audits within services and in commenting on the format of this Quality Account as well as undertaking their formal review of the document.

Our Patient Consultative Committees have identified and reported issues which they wished the Board to include in the Account, particularly those included in the Patient Experience section.

The Trust Board has received presentations from service users and carers throughout 2011-12. As a result, the experience of service users and carers has helped the Board to establish its quality priorities.

Staff have also played 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.

Review of Quality Performance: Achieving Our 2011-12 Priorities

In 2011-12 the Trust had eight priorities for improvement divided into the three areas that constitute quality: the patient experience, patient safety and clinical effectiveness. We focused on three issues for improvement in each area.

The eight priorities were:

Patient safety

- Reduction in the number of falls in older adult inpatient wards, which result in harm to the patient
- Reduction in the number of patients who take their own life during an inpatient admission
- To ensure all adults and children are effectively safeguarded

Patient experience

- Better communication between our staff and service users and their carers
- Improving staff engagement

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 measure the number of patients working with our Recovery teams who recover sufficiently from their mental health difficulties to be discharged from our service

2011-12 Patient Safety Priority 1

Reduction in the number of falls in older adult inpatient wards, which result in harm to the patient

Increase the number of assessments of patients at high risk of falls.

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 Slip Trips & Falls (STF).

Action

100% of service users admitted to older adult wards have received a falls assessment. All moving and handling link professionals are now the falls champions within their areas. 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.

Results

Reported service user Slips, Trips & Falls resulting in harm increased slightly in 2011-12.

	2010- 11	2011-12	% change
Older adult inpatient falls resulting in harm	354	360	+1.7%

The numbers reported here for 2010-11 are different from those in our previous Quality Account. This is because in 2011-12 we closed two wards. The data presented here shows the figures for wards open in 2010-11 and the same wards in 2011-12.

Despite a small increase there has been a drive in staff awareness, training and reporting. Factors that need greater focus to decrease these the number of falls resulting in harm include:

- Establishment of the Trustwide Falls Prevention Group
- Embedding of the Slip, Trip, Fall Policy
- Implementation of actions arising from Falls audit
- Local monitoring of falls as part of Productive Ward initiative
- Reporting on falls assessments for the Nursing Metrics
- Increasing staff awareness to report and investigate STF incidents as Serious Incidents (SI's) where these require medical attention

All moving & Handling link professionals now undertake the role of Falls Prevention link professionals. Training is available through the moving and handling training and an E-learning package is currently being procured.

2011-12 Patient Safety Priority 2

Reduction in the number of patients who take their own life during an inpatient admission

Approach

There have been two major initiatives undertaken to achieve this aim:

1. The introduction of the National Patient Safety Agency's Suicide Prevention Toolkit for inpatient wards.

2. The scoping and introduction of a risk assessment tool to be used in a pilot study, with a view to its extension – if successful – to use throughout Trust services.

Action

1. At present, the Suicide Prevention Toolkit is implemented by the Acute Service Line as a pilot at the Arundel Unit, which is using the Managers' Audit Tool within the acute wards.

2. The scoping exercise for a risk assessment tool was undertaken in 2011. The Prevention of Suicide and Homicide Group accepted the GRiST (Galatean Risk Screening Tool), which is endorsed in 'Best Practice in Managing Risk' (Department of Health, 2007).

Results

During 2011-12, no inpatients took their life on one of our wards. One inpatient took their life when on agreed or unauthorised leave from a ward.

2011-12 Patient Safety Priority 3

To ensure all adults and children are effectively safeguarded

Approach

In order to support services and ensure children and adults were adequately safeguarded the organisation emphasised the importance of collating data on families where our patients had parental responsibilities and having systems in place to record alerts raised on our most vulnerable adults. The right information would assist in the most appropriate intervention for each individual.

Action

The importance of robust data collation was emphasised to staff during training sessions and reinforced with a checklist for use during assessments. The checklist covered areas that staff needed to ask questions on, in order to have a comprehensive set of data on families, children and safeguarding concerns.

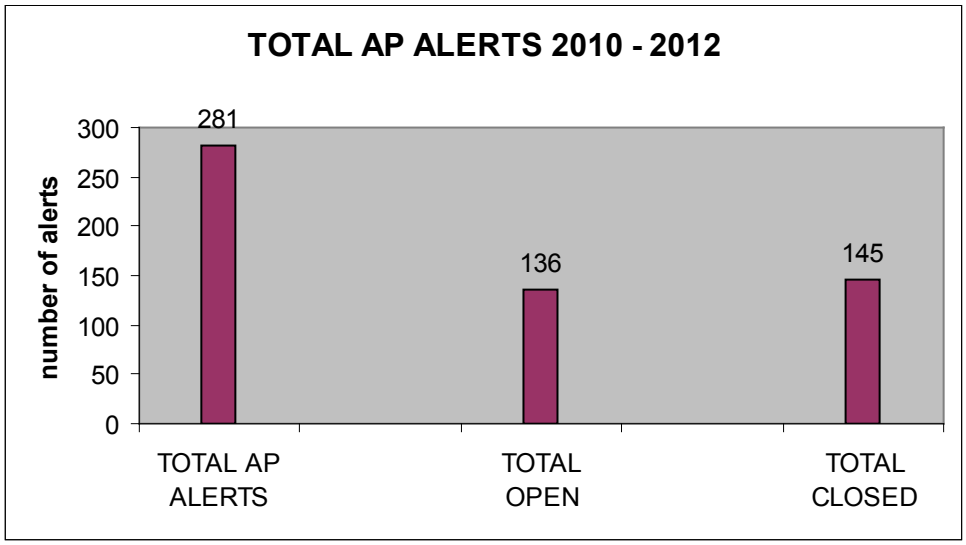
A system for recording and monitoring adult safeguarding processes was also put in place using a data base that collated information on all alerts raised in the organisation. Data was collected on a monthly basis.

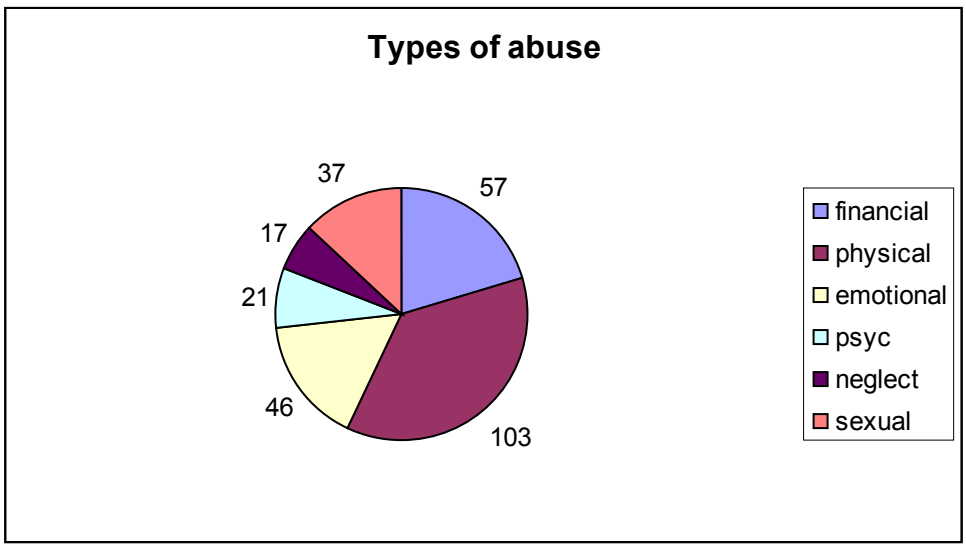
Results

For year end 2011-12 the numbers of our clients with children including those with identified safeguarding concerns are as follows (approx):

Year	No. clients	Number that are parents of children under 18 yrs	Number with safeguarding concerns	% of patients who are parents
2011-2012	18 057	949	95	5.25

For adult protection (AP) data on concerns raised the result are as follows;





We will continue to monitor data collation through the safeguarding team and the Trust-wide Safeguarding Group

2011-12 Patient Experience Priority 1

Better communication between our staff and service users and their carers

Approach

The Trust committed to producing a 'Customer Care Charter' to be clearly displayed at the entrance to all of our buildings alongside the signatures of everyone who works there, in order to demonstrate that all of our staff are committed to the highest standards of communication and care.

Action

Trust staff worked with service users, carers and other partners to establish a steering group to look at the issues that should be highlighted in a 'Customer Care Charter'. Once the group had gathered views from stakeholders across Kent & Medway a draft charter was drawn up. The draft charter was circulated to the Patient Consultative Committees, Locality Planning & Monitoring groups and local service user and carer forums for comment. Members of the Patient, Public & Community Involvement attended these events to ensure that all views were considered.

This piece of work was also linked to a Trustwide 'Vision & Values' initiative organised by Human Resources, there was a great deal of synergy between the two pieces of work and resulted in the KMPT Customer Charter being launched by the Trust Board on 26 April 2012.

Results:

By the end of the year KMPT had produced a 'Customer Care Charter' in partnership with service users, carers and partner organisation that linked with the organisations Vision & Values.

Case Study: Customer Care Charter Launched

Trust Chief Executive Angela McNab and Chairman Andrew Ling launch the Customer Care Charter, which was signed by all members of the Board.

The Trust launched its first Customer Care Charter, at its April 2012 Board Meeting in Canterbury. The Charter outlines what those who use the services provided by the Trust can expect from staff. It also outlines what staff should reasonably expect from the people who use services.

The Charter has been developed by service users and carers, together with Trust staff.

Over the coming weeks the staff working in all services will sign a copy and display it in their service reception areas.

Speaking about the launch of the Charter Executive Medical Director Dr Karen White said, "The introduction of our Customer Care Charter gives a clear message to service users and carers that they can expect all staff to always offer a high standard of customer care. Our service user surveys show that, as well as good clinical care, service users and carers also see courtesy, respect, dignity and communication as vital parts of our service. By also giving some clarity to service users about what we expect from them we hope we can also improve working lives for staff and become more effective and efficient."

The Trust will also use the Charter internally to ensure that all internal departments operate with the same commitments to their colleagues and customers.

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

2011-12 Patient Experience Priority 2

Improving staff engagement

Approach

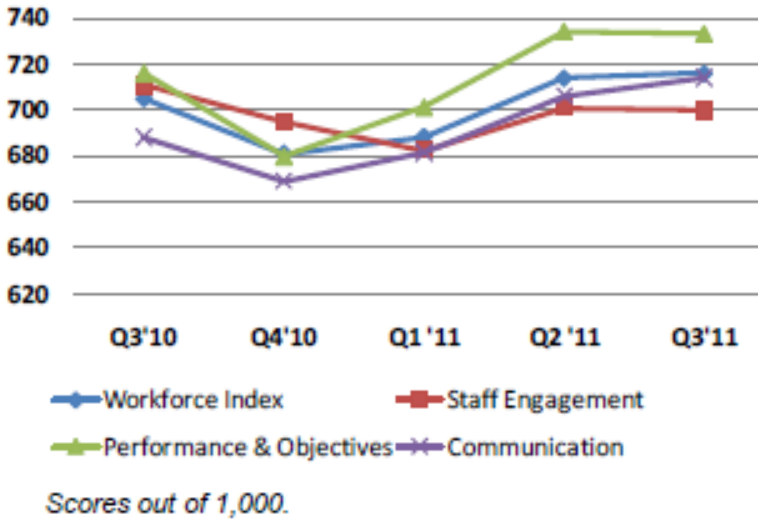
In order to improve Staff Engagement KMPT has taken a number of steps as part of an on-going Organisational Development (OD) Strategy and accompanying plan. The Trust recognises that there is no one driver of engagement and that actions need to be focussed in a number of areas including communication, visibility of senior leadership, quality line management and commitment to wellbeing.

Action

The Executive management team have held regular' viewpoint' events to listen to staff. The HR director has changed the structure of the Human Resources department to put strategic HR capability with a focus on engagement into service lines. The board and senior management team have taken part in back-to-front days and regularly attended team meetings. Internal communications channels have been reviewed and improved in response to staff feedback. In the last quarter of 2011 the Board has invested in a two-year programmeme with the NHS Institute for Innovation and Improvement to develop our leadership capacity, improve quality and support the creation of a culture of innovation, across all levels and localities: from front line practitioners to senior managers.

Results

Staff engagement, like cultural change, takes time and the impact of the actions taken are yet to be fully realised. We have continued to measure our staff's perceptions of their working lives through use of quarterly surveys. Improvements have been seen across three quarters in 2011 in the staff engagement and communication indices of these surveys. Disappointingly these improvements are not reflected across the 2011 national staff survey results. There have been improvements in staff reporting that they have received a quality appraisal and we will continue to build on this as a key tool for engagement. We will continue to work on this improvement programmeme as part of our Organisational Development Strategy for 2012-2015.



Scores out of 1,000.

2011-12 Clinical Effectiveness Priority 1

Improving discharge planning from inpatient care and improving post-discharge care to reduce readmissions to hospital within 28 days of discharge from a ward

Approach

In March 2010 the Trust relaunched its Care Programmeme Approach (CPA) Policy in accordance with Department of Health Policies 'Refocusing CPA' and 'High Quality Care for all'. A review date was set for 2011. However, due to the evolving way in which the Trust will be delivering services in accordance with Payment by Results and a clustering model, the Review will be undertaken in 2012 to fully reflect the Care Programmeme Approach within the Clustering pathways.

Action

Along with the relaunch of CPA Policy the Trust reviewed both content and delivery of Training in the role of Care Co-ordinator, which is core training derived from the CPA Policy context. The Training is integrated within the partnership arrangements with the Local Authority to ensure it reaches a multi-disciplinary workforce within the Trust. Along with the relaunch the Care Coordinator Training was remodelled into modular components which enabled staff to work through and complete all models – the purpose of this was to reduce staff having to be out of the office for three days in succession, which was putting stress on service delivery. This also enabled staff to prioritise and update on their specific learning needs, rather than risk unnecessary repetition.

In addition to this the CPA lead delivered a half-day overview of the Policy and its content.

Over the last year the Crisis Team Working Group has been reviewing how Crisis Teams are operating across KMPT to ensure standardised practice across the County. This includes looking at staffing levels during working hours, at weekends and at night time.

Staffing levels at weekends are now the same as during weekdays with the exception of medical staff. During the week teams have input from dedicated Acute Service Medical Staff. Out of hours, including weekends, medical support is provided by KMPT Medical Staff who are On Call.

The review of staffing has not been completed and is an ongoing piece of work for 2012/2013.

Results

7 day follow up - The Trust has achieved in excess of the 95% target in 2011/12 with 96.85 of all discharges followed up within the seven days. The Trust has been above target consistently for the last 9 months.

Period	%
Q1	93.2
Q2	97.9
Q3	98.1
Q4	98.2
2011/12	96.8

28 day emergency readmission - The percentage of people readmitted within 28 days of discharge for non-elective reasons has been below target in both younger adult and older adult services for 2011/12.

In younger adult reviews, 4% of people were re-admitted within 28 days and in older adults, 3%. This is a deteriation in performance so we have retained this priority for the coming year.

2011-12 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 following is a summary of the progress made during 2011/12 to improve the implementation of NICE guidance for people with mental illness as set out in the KMPT Quality Account, published 2010/11. The focus during this year has been to build on the good work already achieved by updating the NICE implementation policy in line with the requirements set out by the NHS Litigation Authority. Then ensure the policy was implemented rigorously across all services provided by KMPT.

Action

The NICE implementation policy was reviewed and amendments made to improve the implementation process. The process is designed to ensure that any guidance published by NICE that is relevant to KMPT services is firstly identified. The group responsible for identifying relevant guidance is the NICE Reference group and is comprised of multi-professional members representing all service lines in KMPT. Once identified, the services within the Trust whose practice is covered by the recommendations need to be made aware of the new guidance. They must then undertake a gap analysis against the recommendations, using the documentation supplies by NICE.

The gap analysis involves a group of clinicians representing services covered by the recommendations reviewing and discussing each recommendation. They then decide to what extent the service follows the recommendations. This enables the service to identify where their practice is already consistent with the recommendations in the NICE guidance and where changes in practice are required. Where changes in practice are agreed, these are documented in an action plan and reported up through the service line clinical governance structure.
Progress has been monitored through service line reports to NICE Reference Group and NICE Reference Group reports to Clinical Governance Group.

Results

There were 18 new NICE clinical guidelines published between April 2011 and March 2012 (see forward planner produced by NICE). The NICE Reference Group reviewed the new guidance and found seven to be relevant to KMPT service (see table below for progress). There is no specific time limit on how quickly a gap analysis should be completed following publication of a new relevant guideline. However, three months may be considered reasonable depending on the complexity and length of the guidance.

NICE Guidance Title	Relevance	Gap Analysis Progress
Common mental health disorders	Mmanagement of common mental health disorders in primary care, ie GPs. Therefore this guidance only has limited relevance to KMPT services.	Gap analysis undertaken by specialist, acute, community and primary care counselling
Autism spectrum disorders in children and young people	This guidance is relevant to child and adolescent mental health services	Gap analysis completed
Self-harm (longer term management)	This guidance has some relevance to all service lines in KMPT.	The gap analysis has been completed by acute and specialist services, started in community services and is still to be undertaken in forensics
Service user experience – adult mental health	This guidance is relevant to all adult mental health services provided by KMPT.	There are a large number of recommendations in the guidance therefore undertaking full gap analysis represents a considerable amount of work. Gap analysis undertaken by PALS and acute services. Community and forensic services have still to undertake the gap analysis.
Epilepsy (CG137)	Some specialist epilepsy nurses in the learning disability service.	The guidance and gap analysis documents have been sent to the relevant clinicians for completion.
Infection control	Limited relevance to KMPT services as it focuses on invasive procedures in community settings.	The guidance has been sent to the lead nurse for infection control for review.

The above table demonstrates that KMPT has made very good progress in identifying and completing gap analyses against new relevant NICE guidance. During the coming year the NICE Reference Group will focus on improving training provision in relation to NICE guidance, in addition to continuing to ensure that gap analyses continue to be completed. This will be achieved initially by holding a Trust-wide multi-disciplinary event to discuss and promote implementation of NICE guidance. At this event an expert panel will discuss training provision for NICE recommendations.

NICE Guidance in Practice Case Study

Violence: The short term management of disturbed/ violent behaviour in psychiatric inpatient settings and emergency departments (CG25)

It is well known that inpatient psychiatric settings and emergency departments for a variety of reasons, which can be non-patient related or sometimes patient related, have the potential to be settings where violent behaviour is exhibited.

It is important that patients and staff within these settings are competent to manage violent behaviour – being able to predict and prevent it where possible or intervene safely when the need arises in order to ensure the safety of patients, others within the setting and the safety of property.

Audits have been carried out in West Kent and Medway to ascertain Kent and Medway NHS and Social Care Partnership Trust's compliance with CG25. The more recent audit carried out in West Kent reviewed casenotes of 99 patients admitted to the four inpatient wards during September 2009. The standards for the audit were adopted from the key priorities for implementation of the guideline based on Prediction Training; working with Service Users, Rapid Tranquillisation, Physical Intervention and Seclusion.

The findings indicate that there is a good awareness of the need to document risk of violence in the Trust risk assessment form. Non-pharmacologic approaches were being used to de-escalate violence in instances where possible to avoid use of pharmacological strategies.

The Action Plans that follow on from the audit include ensuring that all acute staff are trained in CPR and resuscitation procedures. This is to be monitored via 6 monthly reports from the Training Department on ward uptake of training.

The use of Advance Directives as recommended by the guideline was not being implemented and the Ward Managers as part of the action plan following the audit are being tasked with ensuring this is incorporated into care plans.

Overall, there is good compliance with documentation of risk but there needs to be clear evidence of attendance of all inpatient staff at CPR training. The training is currently yearly and mandatory. There also needs to be a raised awareness of the use of Advance Directives through incorporation into care plans.

2011-12 Clinical Effectiveness Priority 3

To measure the number of patients, working with our Recovery teams, who recover sufficiently from their mental health difficulties to be discharged

The Trust is committed to delivering high quality care and to promoting Recovery within all mental health services.

Approach

The Trust has introduced the use of the Recovery Star assessment to enable good quality person centred care planning and treatment. This assessment tool helps to inform treatment plans and enables people to influence and maintain control of their own recovery journey. Use of this planning tool enables people to reflect on their priority areas, and encourages choice and personalised care. In addition this tool is intended to promote better signposting to community services.

The Trust has worked in collaboration with service users to develop a standardised Recovery group programme. This will be available and delivered in all localities, alongside a comprehensive trust recovery pack during 2012.

Action

A training programme has been developed to raise staff awareness of the Recovery Star tool, and to improve person centred care planning.

An electronic recording tool has been developed by the Trust that will enable recording of how many assessments have been offered, and progress in individuals' Recovery.

The Trust has worked collaboratively with Live it Well developers to create a Recovery Star web based resource that enables better signposting to community services. There are plans to continue this work by adding pod casts and Recovery stories to this site.

Trust staff are being trained in the importance of Recovery action planning and in the delivery of the Trust Recovery packs. Clinical guidelines are being written regarding the recording of this information into electronic notes.

The Trust monitors the number of service users who have been receiving services for up to one year, two years and three years and the PCT monitors the number of service users discharged from Recovery services, on a monthly basis.

Results

Across the Trust, 1482 service users were safely discharged as a result of our adoption of the Recovery approach.

Comments on 2011-12 Performance from LINks, PCT Cluster and Local Authorities

Medway council's Health and Social Care Overview and Scrutiny Committee

The Committee has responded to say it will not be commenting on KMPT's Quality Account this year.

Kent County Council's Health Overview and Scrutiny Committee

The Committee has responded to say it will not be submitting a statement for any Quality Accounts this year, but Kent County Council's officers have responded as follows:

Kent County Council supports the Trust's ambition of improving communication between staff, service users and carers and welcomes the participation of service users and Kent and Medway LiNK in producing this Quality Account. We look forward to further progress in giving service users more choice and control through the implementation of Personalisation. Kent County Council will work with KMPT in the coming year to continue to improve safeguarding practice and the quality of services for patients and carers.

Kent LINk

The Kent LINk would like to thank Kent and Medway NHS and Social Care Partnership Trust for the opportunity to comment on their Quality Account prior to publication. The Kent LINk has used various methods throughout the year to collect patient experience data from users of Kent and Medway NHS and Social Care Partnership Trust services in order to provide this statement for the Account:

- Kent LINk Governors' Group and Priorities Panel members' comments, in line with Department of Health document 'Quality Accounts: a guide for Local Involvement Networks'.
- Kent LINk participants and Kent and Medway NHS and Social Care Partnership Trust service users, commenting on their experience of using the services, as well as the Trust's performance against last year's priorities and how appropriate they felt this year's priorities are, via an online and paper survey.
- Face to face interviews with patients and visitors within hospitals throughout Kent, who were also asked to comment on the above areas.
- The LINk has also used intelligence gathered throughout the year through its projects and community engagement events.
- LINk participants with an interest in mental health were also asked to comment on the presentation and layout of the Account.

1. Is the Quality Account clearly presented for patients and public?

The draft presented to the Kent LINk was well structured and clearly laid out. There is a good use of colour throughout the document and a good font size used.

This helps to make the document accessible to the general public. The document is of a good length (50+ pages when presented to the LINk).

The LINk would commend the Trust for clearly identifying the priorities for the coming year at the start of the document, and for ensuring that details were included about how progress against priorities would be measured, monitored and reported. For the lay reader acronyms can be daunting, and the LINk is pleased to note that the use of acronyms was kept to a minimum within the document and a glossary has been included. Graphs and tables within the document were clearly labeled, making them easier to interpret.

2. Priorities for 2011 / 2012

Respondents to Kent LINk surveys and those who took part in face to face engagement indicated that the Trust appear to have made mixed progress with their priorities laid out in last year's Quality Account. The LINk is therefore pleased to find that the document clearly identifies where there are still improvements to be made.

The Kent LINk has worked with Kent and Medway NHS and Social Care Partnership Trust closely over the past year. A Memorandum of Understanding between the two organisations is in progress, and the LINk hopes that this will further develop partnership working. The LINk's Mental Health Network has been working with the Trust on four areas identified in the LINk's Mental Health Action Plan. These are as below:

- Payment by results including care pathways
- Treatment in mental health crisis at home and in hospital
- Number of inpatient beds
- Patient Transport focusing on the three centres of excellence as identified by the Trust.

LINk participants raised issues to the LINk over the closure of the inpatient ward at Ashford, and the Trust worked with the LINk Priorities Panel during this time.

3. Priorities for 2012 / 2013

Respondents were in agreement with the priorities set out within the Quality Account, and the LINk would like to commend the Trust for placing the priorities together at the beginning of the document. Respondents were also positive about the inclusion of detail regarding the monitoring of progress with priorities over the coming year.

4. Safety, Communications and Staff

The Kent LINk receives comments about the services provided by Kent and Medway NHS and Social Care Trust throughout the year from patients and the public. Feedback from the LINk's patient experience questionnaire has been fed back to the Trust on a regular basis. This feedback has been mixed, and the LINk is committed to working with the Trust over the coming months to ensure that improvements are made in patient experience.

The LINk was pleased to note that the Trust is aiming to strengthen the relationship between staff and patients with the introduction of a Customer Care Charter. The LINk also noted that a review of staffing would be ongoing throughout 2012 / 2013, and would recommend that quantitative data covering staff numbers, absenteeism and staff turnover be included as this would provide added information on staff continuity and assist with the measurement of these initiatives.

5. Who has been involved in the preparation of the Quality Account?

The Trust has clearly demonstrated in the document that it has engaged with staff and service users in the preparation of the Quality Account, and the setting of Trust priorities for the coming year. The Kent LINk would like to thank the Trust for the opportunity to comment on the Quality Account in advance of publication and for the increased levels of partnership working over the past year. Under the Health and Social Care Act 2012, LINk's are to be abolished in March 2013 and a Local Healthwatch will commence operation in Kent in April 2013. The Kent LINk would like to recommend that a Local Healthwatch utilises the LINk Quality Accounts toolkit when making a
statement on next year's Kent and Medway NHS and Social Care Trust, and would hope that Local Healthwatch and Kent and Medway NHS and Social Care Trust can continue the good working relationship that exists between Kent LINk and the Trust.

Kent and Medway PCT Cluster

NHS Kent and Medway welcome KMPT's commitment to create a dynamic system of care to deliver high-quality treatment in the most appropriate setting at the right time.

The Trust has put a great deal of effort into improving engagement with service users during 2011/12 and embedded their feedback into practice. KMPT are listening and acting upon what their service users say to improve the service. Notable achievements in 2011/12 include more timely access to services; improvements in Care Plan Approach 7 day follow up, more people in settled accommodation and employment; and the delivery of more home treatment episodes.

We would particularly like to acknowledge the significant progress made by the Community Recovery Service Line in their achievement to move towards recovery-focused care pathways. The development and implementation of these pathways through 2012/13 will go a long way towards delivering the Trust's commitment to improve quality of service and care.

NHS Kent and Medway has also worked with KMPT to agree areas that CQUIN payments (Commissioning for Quality and Innovation) could deliver the most improvement in quality and outcomes for service users and their carers during 2012/13. These include the continued redesign of care pathways to improve care and recovery, better information for service users and their families, improved patient experience, better physical health care and more choice and control for service users through personal social care budgets.

Appendices

A CQUIN Payment Framework

B Quality Performance Indicators

C Glossary

D Auditors' Review

Appendix A - CQUIN Payment Framework 2011-12

Ref No	Indicator name	Description of indicator	Value £
1	**Community Mental Health Service Redesign (30% - £690k)**		
1a	To redesign community MH services to deliver: i. improved access and outcomes for those referred from primary care ii. improved access to advice for GPs iii. more referrals managed in primary care with primary care supported to manage (fewer referrals exceed six months held by service, and continued reduction in long-term held (>3yrs)) iv. increased direct referrals from SECAMB v. practice variation significantly reduced across teams vi. patients enabled to be more self-directing, with choice and control demonstrated vii. patient experience at discharge measured, including agreed patient-reported outcome measures viii. identified savings	A service model for the redesigned Community MH Services is agreed between KMPT and commissioners (inc. GPCC) and KMPT, together with a transition plan to delivery and with key milestones	£194,221
1b		90% of referrals needing a routine appointment for assessment are seen for first assessment within 4 weeks, and the worst-performing team exceeds 75%, by end Dec 2011 and maintained for Q4	£64,740
1c		Arrangements are in place to enable GPs to access advice about client management from MH professional within 24hrs.	£64,740
1d		Patient experience at discharge for community MH services - survey / sampling undertaken, including patient-reported outcome measures.	£86,321
1e		Transition plan with milestones - all agreed milestones, including structural changes, are implemented by end March 2012	£237,382
2	**Acute beds (utilisation / productivity) (20% - £460k)**		
2a	Servce quality and outcomes for adult and older inpatients / potential inpatients is improved, and productivity demonstrably increased, by: a. developing the psychological-mindedness of the acute workforce b. strengthened CRHT functioning / gate-keeping c. continued improvement of bed utilisation metrics d. practice variation reduced for CRHTs and bed utilisation e. Acute bed number reductions agreed f. improved quality of discharge planning	"A plan, agreed with commissioners, to strengthen functioning of the CRHTs and the acute workforce across K&M - covering at least: clarifying a clear therapeutic model underpinned by range of explicit modailities and psycho-social interventions, developing 'psychological mindedness' of clinical staff, review of skill mix, access to psychiatric expertise, improving communications with referrers (especially OOH services), improving links between CRHT and in-patient services, improving 24/7 coverage, and how variation will be addressed - with key milestones and timetable"	£64,740
2b		Acute admission rates (A & OP) for 2011-12 (last 2 quarters) are less than for 2010-11 (last two quarters) by >5%	£107,901
2c		ALOS for Adult beds is no longer than 23 days by q4 in all of three localities	£43,160
2d		ALOS for OPMH beds is no longer than 55 days (for functional patients) by q4 and no longer tan 60 days (for organic patients) by q4 in all of three localities	£43,160
2e		Delayed transfers for Adults are <7.5% (average over last six months of year) (Monitor definition)	£32,370
2f		Delayed transfers for OPMH are <7.5% (average over last six months of year) (Monitor definition)	£32,370
2g		Delayed transfers for TGU and Tarenfort are <7.5% (average over last six months of year)	£32,370
2h		Acute Adult beds - agreed reconfiguration plans agreed in all three localities, with any closure plan agreed by end Sept 2011 (or by end Dec 2011 if public consultation required).	£75,531

Ref No	Indicator name	Description of indicator	Value £
3	**Rehabilitation beds (reconfiguration of use) (7.5% - £172.5k)**		
3a	Rehabilitation service redesigned to ensure that rehabilitation beds are optimally used across all KMPT. Reconfigured bed usage shows a reduction in OATs number and costs, and appropriate placements in the community.	Service specifications for all units are developed and agreed with commissioners, with any accompanying KPIs, that reflect the focused needs of higher intensity rehabiliation for that catchment.	£32,370
3b		A transition plan to deliver appropriate bed utilisation, according to specifications and covering all affected units, is produced and agreed with commissioners.	£32,370
3c		Progress reports on transition, including KPI information, are provided quarterly, with each report demonstrating progress over the previous.	£32,370
3d		A reduction of at least 50% of inappropriately-placed residents (in rehab beds) is achieved over the year. Baseline in April 2011, and improved position shown at end of Feb 2012.	£64,740
4	**Supporting GP commissioning and GP commissioning pathfinder(s) (7.5% - £172.5k)**		
4a	All emerging GP commissioning groups are supplied with the information agreed that they need, and at frequency required. GP pathfinders are supported with additional one-off pieces information as requested to enable them to review and reconsider commissioning intentions for 2012-13.	A standard data set is agreed to supply to all GP commissioning groups as they develop, and frequency is agreed. Comprehensive data is supplied to those frequencies.	£86,321
4b		GP commissioning pathfinders are supported with additional one-off pieces of information during the year, as requested and agreed with the commissioner	£75,531
5	**Continued development of Payment By Results (7.5% - £172.5k)**		
5a	Development of PBR continued to enable full implementation from 2012-13	"Provide monthly data to an agreed set of KPIs and data requirements - tranche 1 agreed from end July 2011, tranche 2 agreed from end Nov 2011, tranche 3 agreed from end March 2012. Please refer to PBR KPI Dashboard 2011-12 v8.xls for detail of tranche content"	£53,950
5b		"95% of new patients to have HONOS PBR score by end September 2011 95% of all patients to have HONOS PBR score by end December 2011"	£21,580
5c		Provide report on proposed care interventions per cluster, for each cluster, and follow-up report reviewing implementation and success by end Dec 2011	£21,580
5d		"Preparation for local prices 2012-13 - Produce indicative prices for all PBR clusters using local prices and within contract envelope costs. Report monthly from October onwards on readiness to achieve a locally priced contract using national care clusters and local tariffs for 2012-13, degree of accuracy, coverage, risks, and indicate actions being taken to mitigate. Report in March 2012 on ongoing work required into 2012-13."	£64,740

Ref No	Indicator name	Description of indicator	Value £
6	**Improving staff morale (7.5% - £172.5k)**		
6a	Deliver significant and measurable improvements to staff morale during the year and beyond	Devise a comprehensive action plan, agreed with commissioners, that will deliver significant and measurable improvements to staff morale over over a 1 year and 3 year timescale. Demonstrate engagement with other high-achieving MH Trust(s) through benchmarking links, and demonstrate a learning-forum driven improvement process in the plan.	£64,740
6b		As part of the above plan, implement a co-ordinated programme of activities/events/mentoring with staff in acute in-patient wards to improve morale among this staff group. Develop measures and report on improvements quarterly (from triangulating data such as sickness absence, staff turnover, and routine internal staff surveys).	£64,740
6c		"Undertake targeted work which will deliver a trust-wide improved score in at least two areas of 2011 national staff survey: a. increase number of staff with well-structured appraisals in the last 12 months b. increase number of staff reporting good quality of job design"	£32,370

Ref No	Indicator name	Description of indicator	Value £
7	Enhancing Quality - Dementia (20% - £460k)		
7a	Continue progress with EQ Dementia programme	2.1 Care initiated through your service to people with dementia will achieve a 20% reduction in anti-psychotic prescribing as part of the Dementia pathway	£431,603
		2.2 Provide support to Primary Care Services to develop processes to reduce antipsychotic prescribing in people with dementia	
		2.3 Provide support to Care Homes to develop processes to reduce antipsychotic prescribing in people with dementia	
		2.4 Care provided to people with dementia, achieve good performance scores in the 'assessment and diagnosis' pathway	
		"2.5 Design methodology and implementation plan for EQ measures: • Care Planning • Patient and Carer Information • End of Life According to the EQ timetable Design methodology and implementation plan for EQ measures: • Care Planning • Patient and Carer Information • End of Life According to the EQ timetable	
		2.6 Mental Health Providers will create a methodology to identify all people diagnosed with dementia who are in receipt of Trust services	
		2.7 Working closely with the external partner, participate in algorithm development of the reduction in antipsychotic prescribing and assessment and diagnosis measures	
		2.8 Identify process to gather patient population data from MHMDS system into external partners quality toolfor the reduction in antipsychotic prescribing and assessment and diagnosis measures	
		2.9 Successfully engage in shared learning opportunities demonstrated by maintaining EQ Lead structure and Trust contribution in EQ programme	
		2.10Engage and contribute in the development and implementation of an EQ quality indicator for Patient Experience Measures (PEMs).	
		2.11 Participate in the development of data quality assurance audits to validate data completeness	
	Total		**£2,158,015**

Appendix B - Quality Performance Indicators

QPI	Target	Freq of Report	10/11 Actual	"YTD Actuals/ END OF YEAR"
CORE - Psychological Therapies (% clients) - Primary Care	90%	Qtrly	98%	100%
CORE - Psychological Therapies (% clients) - Secondary Care	60%	Qtrly	91%	87%
Mental Health Minimum Data Set - submitted on time	Y	Qtrly	YES	YES
Mental Health Minimum Data Set - degree of completion	95%	Qtrly	97%	99%
Clostridium difficile - actuals	0	Monthly	0	2
MRSA Bacteraemia - actuals	0	Monthly	0	1
Audits of Hand Hygiene (All Inpatient sites listed)	100%	Annually	100%	100%
Hand Hygiene Training - All staff/non clinical		Monthly	100%	85%
Hand Hygiene Training - Clinical		Monthly	91%	84%
Nutrition - % of nutritional assessments completed	95%	Monthly	97%	99%
Falls - OPMH inpatients - Assessments of risk within one week of admission to service		Monthly	99%	100%
"Falls - OPMH inpatients - Actuals (excluding suspected)"	actuals	Monthly	742	711
Percentage of patients admitted who had a physical health check at admission	95%	Monthly	96%	100%
Percentage of community patients in Enhanced Recovery who had a physical health check on admission or have had a primary care physical health check		Monthly	1209	39%
% Spiritual needs recorded	90%	Monthly	new	100%
Risk Management Plan	100%	Monthly	new	100%
CPA clients in receipt of advanced care plans	actual	Qtrly	776	645
Number of SIs - reported on STEIS, trends, ethnicity & actual	actual	Monthly	65	55
Number of patient safety incident related deaths reported to NPSA	actual	Monthly	7	11
Number and % of Grade 1 SUIS that are over 45 days	actual	Monthly	new	9
Number and % of Grade 2 SUIS that are over 60 cays	actual	Monthly	new	1
Number of medication errors	actual	Qtrly	new	153

QPI	Target	Freq of Report	10/11 Actual	"YTD Actuals/ END OF YEAR"
Never Events - inpatient suicide using non-collapsible rails. Escape from within the secure perimeter of medium or high secure mental health services by patients who are transferred prisoners	0	Monthly	0	0
Percentage of acute inpatients (all age) experiencing one or more incidents of control and restraining (MH02) - Quarterly reported	actual	Qtrly	10%	11.4%
Percentage of acute inpatients (all age) experiencing one or more incidents of seclusion (MH03) - excludes forensics	actual	Qtrly	6%	5.80%
Percentage of acute inpatients (all age) experiencing one or more incidents of seclusion (MH03) - forensics	actual	Qtrly	new	0%
Number of all patients who had recorded incidents: physical assault on the patient (MH10)	actual	Qtrly	957	713
The proportion of detained acute inpatients who have absconded in last three months (MH14) (exc for)	actual	Qtrly	2%	6%
Number of incidences of patients experiencing mixed sex accommodation	0	Monthly	0	0
Number of incidences reported of patients using the wrong gender bathroom	0	Monthly	6	0
Antipsychotic prescribing reduction - target		TBA	yes	
Complaints - number - report trends & actual	actual	Qtrly	236	213
Complaints - ratio to contacts - report actual	%	Qtrly	0.26%	0.10%
% eligible/qualified staff receiving child safeguarding training at level 1 (basic awareness total overall)	95%	Monthly	100%	66%
% eligible/qualified staff received adult safeguarding training at level 2 (basic awareness total overall)	95%	Monthly	100%	60%
% eligible staff who have received an enhanced CRB check	100%	Monthly	100%	100%
Violence against MH Staff (inpatient) assaults (MH11) - actual	actual	Qtrly	1449	1463
Violence against MH Staff (community) assaults (MH11) - actual	actual	Qtrly	26	36
% of the eligible staff that are actively and regularly working with children subject to a child protection plan who have accessed supervision bi- monthly	100%	Qtrly	99%	97%

QPI	Target	Freq of Report	10/11 Actual	"YTD Actuals/ END OF YEAR"
% of the eligible staff that are actively and regularly working with adults subject to an adult protection alert who have accessed supervision bi- monthly	100%	Qtrly	98%	98%
Number of Medical Locums in place >1 yr	actual	Monthly		6
Number of suspected suicides while in KMPT care - inpatient	actual	Monthly		1
Number of suspected suicides while in KMPT care - community	actual	Monthly		32
Medications - CQC patient survey questions % increase - report actual & trends		Annually		
The proportion of all clients on CPA who have had a HoNOS assessment in last 12 months (MH07) 95% by December 2011	95%	Monthly		92.1%
The proportion of all clients not on CPA who have had a HoNOS assessment in last 12 months (MH07) by December 2011 95%	95%	Monthly	new	
% inpatients allocated to a structured therapeutic programme of activity - Forensic Service		Qtrly	new	100%
% of patients on discharge from inpatient care have a physical health check, nutrional assessment and advance decisions		Annually		88%
Incidents of serious self harm by inpatients	actual	Monthly		10

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
BME	Black Minority Ethnic
BPPC	Better Payment Practice Code
CAB	Citizen's Advice Bureau
CAMHS	Children and Adolescent Mental Health Services
CEO	Chief Executive Officer
CIPs	Cost Improvement Programmemes
CMHTs	Community Mental Health Teams
CNST	Clinical Negligence Scheme for Trusts
CoG	Council of Governors
CSIP	Care Services Improvement Partnership
CRES	Cash Releasing Efficiency Savings
CRS	Care Records Service
DGH	District General hospital
DOH	Department of Health
DRE	Delivering Race Equality
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
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
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
MH	Mental Health
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
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
PSA 2	Public Service Agreement
PSPP	Public Sector Payment Policy
RAG	Red, Amber, Green
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
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 patients 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 programmemes.

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. Patients 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 Programmeme Approach)

Care Programmeme Approach (CPA)
The Care Programmeme 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 patients' care from admission through to discharge and ongoing care. The aim is 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 patients 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 - Auditors' Review

Independent auditor's limited assurance report to the Directors of Kent and Medway NHS and Social Care Partnership Trust on the annual Quality account

I am required by the Audit Commission to perform an independent assurance engagement in respect of Kent and Medway NHS and Social Care Partnership Trust's Quality Account for the year ended 31 March 2012 ("the Quality Account") as part of my 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 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

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 National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

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.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.

I read the Quality Account and conclude whether it is consistent with the requirements of the Regulation and to consider the implications for my report if I become aware of any inconsistencies.

This report 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.

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:

- making enquiries of management;
- comparing the content of the Quality Account to the requirements of the Regulations.

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

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

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. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

A C Mack

Andy Mack
Appointed Auditor
Audit Commission, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ
Date 28 June 2012

Your Views

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

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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 01732 520441

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 bulunun.

Quality Account 2011/12