Quality Account
2012/13

Our Values

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

open
– we work in a collaborative, transparent way

accountable
– we are professional and responsible for our actions

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

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

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

Our Vision

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

www.kmpt.nhs.uk

Excellent care personal to you
Delivering quality through partnership

Contents

Kent and Medway **NHS**
NHS and Social Care Partnership Trust

Customer Care Charter

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

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

1 **Listen to your concerns and respect your views** – we will treat you as an individual and in the context of your whole life. We will listen to what you have to say and record it accurately.

2 **Involve you in planning your care** – you will be given the opportunity to determine the plan for your care, which will focus on your recovery. We will give you a copy of your care plan in a format acceptable to you.

3 **Be informative and engaged** – we will provide you with information about conditions and services and, if you agree, also communicate with those who care for you. We will answer your questions politely and carefully. If we do not know the answer we will tell you and get the information for you as soon as possible.

4 **Deliver best practice care** – we will learn from best practice and provide care that meets NICE guidelines. Our staff will be up to date and trained to deliver best practice in all that they do.

5 **Constantly improve** – we will ensure that service users and carers are able to influence service development. We will learn from your feedback and be accountable to you by making changes based on your concerns.

KMPT expects you to...

1 **Keep your appointments** – we ask that you attend, or advise us if you cannot meet an appointment given to you. If we have to change your appointment we will give you as much notice as possible and offer another date.

2 **Treat our staff with respect and without aggression** – while we appreciate that mental health problems can lead to frustration and anger, we ask that staff are treated with courtesy. We will be courteous and polite at all times.

3 **Be open about your views** – let us know your expectations and any concerns so that we can together plan the most appropriate care for you.

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

Signed

Introduction

respect
open
accountable
working together
innovative
excellence

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

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

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

The Quality Account comprises three sections, as required in the guidance set by the Department of Health in the Quality Account Toolkit. Part one is

the statement from the Chief Executive on the next page. Part two contains our priorities for improvement in the year ahead and statements about various aspects of the quality of our services in the format set for us. Part three reviews our progress on our quality improvement priorities in 2012-13, contains comments on the Quality Account from our partners and tells you who was involved in determining our priorities. For ease, the latter statement is on page 11.

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

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

Chief Executive's Statement

Our third Quality Account outlines the tremendous progress we have made against the priorities we set last year. It also outlines the priorities we have set for the coming year to ensure we continue to drive up the quality of the services we provide.

Our Quality Strategy continues to be led by our Executive Medical Director and the Quality Improvement team but in reality it is the hard work and commitment of all of our staff that ultimately leads to improvements in the quality of our services.

In the past year we have set about establishing a programme of changes that is seeing us strengthen our core services whie improving productivity and creating a dynamic system of care. This means that people who need help get the right treatment, at the right time, in the right place and, critically, the right outcome.

This programme of change will see us deliver our Clinical Strategy, which will lead to better outcomes for service users.

Despite the progress you can read about in this Account, we know from increasingly talking to service users and carers over the past year that we still have work to do.

I know you will agree that quality must be a central part of what do and through reading this report I hope you are able to recognise the continued 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 9 further makes clear we have met the requirements for preparing this Account. Furthermore, our auditors have reviewed the account and their report can be found in Appendix D.

Angela McNab
Chief Executive

Trust Objectives 2012-13

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.

Our Clinical Strategy

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

1. To provide excellent community services close to home, reducing the number of people who need inpatient care. Where such care is necessary our community services will support the length of stay being as short as possible.

2. To focus on the recovery model ensuring positive outcomes.

3. To improve the quality and dignity in services including a better physical environment and improved use of technology.

4. To expand some of our strongest specialist services, where appropriate, to potentially provide across a wider geography.

Our Services

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

Adults of working age who have mental health needs:
- Inpatient and community teams
- Rehabilitation inpatient units
- Psychological services
- Liaison Psychiatry services

Older adults who have mental health needs:
- Inpatient and community teams

Adults who have mental health problems and learning disabilities:
- Community teams
- Assessment and Intervention services
- Forensic mental health inpatient services

People with drug and alcohol problems:
- Detoxification inpatient unit
- Alcohol addiction service

Forensic mental health services:
- Medium-secure unit including specialist women's unit
- Low-secure unit
- Prison in-reach team
- Custody Liaison service

Specialist services:
- Eating Disorder services
- Early Intervention for Psychosis
- Mother and Infant Mental Health services
- West Kent Neuro-Rehab service
- Limb service
- Environmental Control service
- West Kent Clinical Neuro-psychology service
- West Kent Mediation service
- Kent and Medway Chronic Fatigue/ ME service
- Community Brain Injury Team
- Personality Disorder service
- IAPT services

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

The income generated by the NHS services reviewed in 2012-13 represents 100% per cent of the total income generated from the provision of NHS services by the Trust for 2012-13.

- **A new treatment option for those struggling with issues of Personality Disorder in east Kent was launched in 2012 – the East Kent Personality Disorders Service (EKPDS) is based at Ash Eton in Folkestone.**
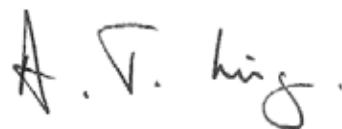
Directors' Statement

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 Quality Account has been prepared in accordance with the 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
13 June 2013

Angela McNab
Chief Executive
13 June 2013

Our 2013-14 Priorities

For 2013-14 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 25% reduction in the number of severe or moderate falls in older adult inpatient wards
- Reduction in suicide and serious self-harm during an inpatient admission or while in treatment with a working age adult community team
- To ensure all adults, children and young people are effectively safeguarded

Patient Experience

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

Clinical Effectiveness

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

Over pages 12-24 we outline, for each priority, the reason for the choice, where the Trust is currently positioned (at the start of 2013-14), the way that the priority will be measured and the means of monitoring progress.

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Who has been involved in setting our 2013-14 Priorities?

During 2012-13 KMPT has continued to involve a range of staff, people who use services and our partners in the non-statutory sector to help set our priorities for the coming year. Through the sustained monitoring of our Community Engagement Strategy; Kent and Medway LINks (Local Involvement Network) have provided valuable assistance in producing an in-depth report regarding elements of mental health provision and in commenting on the format of this Quality Account as well as undertaking their formal review of the document.

Our Patient Consultative Committees and the Community Engagement Strategy Monitoring & Implementation Group (CESMIG) have identified issues through their involvement with the organisation which they wished the Board to include in the Account, particularly those included in the Patient Experience section supported by an understanding of the NICE guidelines relating to patient experience in mental health services.

The Trust Board has continued to receive presentations from service users and carers through¬out 2012-13. As a result, the experience of service users and carers has helped the Board to establish its quality priorities by providing a real insight into the experience of people using the services.

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

2013-14 Patient Safety Priority 1

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

Rationale

We have been working to reduce falls on our Older Adult wards for the last two years (see pages 49-50) Our impact has been limited. As part of our work with the South of England Mental Health Patient Safety Collaborative, we intend to try a new approach to this work. The aim is to reduce falls which result in moderate or severe harm by 25% by March 2014.

Current Status

In 2012-13 we reported 438 slips, trips and falls in older adult inpatients, which resulted in harm to the patient. Within this number, 34 resulted in severe or moderate harm.

Plans

Starting with one pilot ward in April 2013, we will train staff to use Plan, Do, Study, Act methodology to try new solutions to problems that lead to patients falling.

This method and learning from the pilot ward will be rolled out across all of our wards by October 2013.

How Measured

Each ward will record falls which result in moderate or severe harm every day on a chart in the ward. We will monitor the number of days between incidents.

How Monitored

The Patient Safety Group will monitor every month and report to the Quality Committee every two months.

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2013-14 Patient Safety Priority 2

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

Rationale

We will continue our focus on keeping patients safe while using our services, as in our previous Quality Accounts. This year we will expand this objective to include reduction in suicide and serious self-harm for patients of our working age adult community teams, as well as our inpatient wards.

The South of England Patient Safety Collaborative work includes this priority and our objective is to increase the number of days between incidents of suicide and serious self-harm to at least 300 days on each ward; and to at least 150 days in each community team. Both of these to be achieved by March 2014. These are the objectives set by the collaborative. We already achieve more than 300 days between suicides on our inpatient wards. The targets are very challenging and many take more than one year to achieve.

Unplanned absences from wards to be reduced by 50% by March 2014.

Current Status

In 2012-13, one patient took their own life on our wards. This happened more than 365 days after the last time anyone took their life on a ward.

There were 13 incidents of serious self-harm during an admission.

Across all community teams, 50 took their life and 106 incidents of serious self-harm were reported.

Plans

We will improve our process to identify learning from suicide incidents by ensuring that investigation of these cases is undertaken by an investigator who is independent of our service lines.

Community teams will all work on the suicide prevention toolkit.

We will complete our programme of tailored risk assessment training to community teams for adults of working age.

How measured

The incidence of suicide and serious self-harm will be recorded by each team and reported on a team by team or ward basis, the objective being to increase the interval between incidents in each team or ward.

How monitored

Reviewed by the Patient Safety Group each month and by the Quality Committee each month.

2013-14 Patient Safety Priority 3

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

Rationale

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

Current status

Engagement in the Adult Protection process with partner agencies in a timely and robust manner has been a priority for the organization and having reached an evaluation of 'good' we now seek to maintain this and aspire to reaching a level where an evaluation of excellent is possible. Both RiO (patient information system) and the adult protection monitoring tool are now equipped to aid compliance with Mental Capacity, therefore this will be audited. We aim to maintain the audits of information held on patients who are parents but also to ensure it is used appropriately. This means monitoring attendance at Child Protection conferences and the quality of reports presented.

Plans

To audit case files of those with children to ensure data collation remains focused and have a comparison with the standards achieved during the previous year's audit. Compliance expected: 85% (current status 80%).

To monitor the attendance of staff at Child Protection conferences and quality of reports. Compliance with attendance: 80%. Quality of reports: No more than 10% returned to staff because they are below expectations (current status 40%).

To achieve adequate and above in external audits of Adult Protection Cases: 100% compliance (current status 91.6%).

To provide information on mental capacity compliance and recording of such in case files: 90% compliance.

How measured

Case file audits on patients who are parents will continue monthly with at least two deep dive exercises in Medway and the east of the organization in the coming year for the purpose of safeguarding children and young people. It is important to gauge compliance and standards in the east as they have had much disruption with changes of Named Nurses for safeguarding children over the past year. Information on case conferences and reports for same will be collated quarterly. The compliance and recording of mental capacity issues will be audited monthly and overall compliance with adult protection processes will be audited six-monthly.

How monitored

This will be monitored by the Safeguarding Team, the Trustwide Safeguarding Group and the Executive Lead for Safeguarding.

• **KMPT was awarded 'MHFA Champion' status at the second annual Mental Health First Aid awards at the House of Lords. Service Development Lead Vicky Stevens collected the award from Lord Kamlesh Patel.**

2013-14 Patient Experience Priority 1

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

Continuing analysis of complaints relating to staff attitude after the introduction of Customer Care Week (relating to Priority 1 2012-13).

Rationale

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

In addition the Trust continued to monitor the percentage of complaints received relating to staff attitude and service line action plans are in place to improve patient experience. However the percentage of complaints relating to staff attitude remained the same this year as last.
In order to address this the Trust has organised a Customer Care Week to take place in May 2013. During the week we will re-launch the Customer Care Charter and also launch the new customer care training package, which has been co-produced with carers, service users and KMPT.

Current status

The Trust continues to monitor complaints and is organising a Customer Care Week in May 2013.

Plans

Customer Care Week will take place from May 13th 2013 with all teams/wards in the Trust taking part. The Customer Care Charter will be re-launched, the new in-house Customer Care training package will be launched and partner organisations will be involved. The aim of the week is to continue highlighting the importance of communication and partnership working to enhance the patient's experience of services. There will also be additional Customer Care training for staff.

How measured

We will continue to monitor and analyse complaints relating to staff attitude; we will ensure that the results of patient surveys local and national are also considered including the High Impact Innovation surveys using the web-based system 'Snap Mobile Anywhere'.

How monitored

The Trust will monitor the percentage of the complaints received relating to staff attitude and by the end of the financial year will have reduced the percentage from the current 27% to 20% of all reportable complaints. The Trustwide Patient Experience Group will monitor these results and report to the Quality Committee.

Share your story at

The Live It Library

Recovery

Share

Stigma

Hope

You
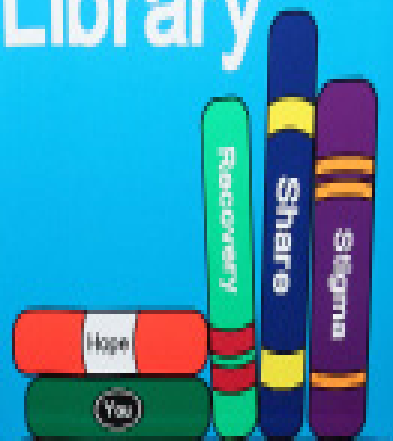
www.liveitwell.org.uk

"A real sense of acheivement"

"It was empowering to tell my story"

"I hadn't talked about it before"

"It was fun!"

"Go for it!"

KMPT staff help and encourage service users to take part in the Live it Library, helping reduce stigma often associated with mental health issues.

2013-14 Patient Experience Priority 2

Using the views of service users to monitor and improve services.

Rationale

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

Current status

The Trust's Expert by Experience Research Group are in the process of trialing the Snap Mobile Anywhere web-based survey system that will allow the Trust to demonstrate that they are using service user views to improve services.

Plans

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

How measured

The results of various surveys will be analysed using the Snap Mobile Anywhere system, the results will be fed back to the service lines where changes to services can be implemented. Changes made to services will be included in service line patient experience action plans and the work will be shared with other service lines through the Trustwide Patient Experience Group.

How monitored

The Trust will add a section to the public facing website that will be updated at least quarterly highlighting service changes that have taken place as a direct result of service user and/or carer views. The Trustwide Patient Experience Group will report to the Quality Committee.

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2013-14 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 2012-13 physical health assessments were monitored for inpatients and continued to reach 100% regardless of age. For community service users 58% was reached 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 six 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. This will be reported through the Governance groups to the Quality Committee.

2013-14 Clinical Effectiveness Priority 1

Improving discharge planning from inpatient care and improving post discharge care.

Rationale

We will continue with our focus on improving discharge planning from inpatient care and improving post discharge care. This priority aims to promote a successful return to living at home following discharge and also aims to reduce the number of people needing to return to hospital as an emergency, particularly within the first 28 days following discharge.

This year we will further support this objective by starting to develop a whole system approach to care planning, in which all patients, both community and inpatient based have a patient-led care plan which travels with them through their recovery pathway, which ensures ongoing attendance to and development of their recovery objectives if the setting of their care changes.

Current status

In 2012-13, 2.4% of people under the age of 65 were re-admitted within 28 days of discharge as an emergency and 97.2% of people were seen within seven days of discharge from hospital.

Plans

- We will measure the number of people of all ages who were re-admitted as an emergency within 28 days of discharge.

- We will continue to measure the number of people who were seen within seven days of discharge from hospital.

- The Senior Management Team will continue to regularly review the discharge plans for people whose discharge has been delayed or whose length of stay exceeds 60 and 90 days

- The Trust will commission the Whole Systems Operational Board to initiate a pilot project during 2013, to develop and trial a whole system approach to care planning and care delivery. Central to this initiative will be the development of a patient-led care plan, which travels with the patient through their recovery pathway. This pilot will focus on an identified group of patients who have experienced more than two re-admissions to hospital over an 18-month period.

How measured

- Measurement of the percentage of people re-admitted within 28 days of discharge from a ward, as an emergency.

- Measurement of the percentage of people followed up within seven days of being discharged from one of our wards.

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How monitored

The measures will be monitored by the Executive Team at monthly performance meetings and reported to the Trust Board. The Trust Clinical Effectiveness and Outcomes Group will also monitor these measures and the development of the whole system approach to care planning pilot.

- The Trust Clinical Effectiveness and Outcomes Group will receive progress reports on the care planning pilot from the Whole Systems Operational Board on a quarterly basis.

2013-14 Clinical Effectiveness Priority 2

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

Rationale

The continual implementation of NICE recommendations on the treatment of patients is crucial to ensuring the provision of accountable, high quality, clinically evidenced and cost effective services.

Current status

During the year 2012-13 the Trust has continued to implement a robust programme of NICE implementation gap analyses and has progressed to the implementation of comprehensive action plans in each service to address these gaps in service provision.

This work has been supported by a Trust Wide NICE Conference and the introduction of e-learning packages to enable staff to achieve greater understanding and competency in the implementation of NICE recommendations.

Plans

A programme of NICE implementation monitoring will continue to be co-ordinated by the NICE Reference Group throughout 2013-14.

A programme of measurement against NICE Quality Standards across services will be finalised and implemented during 2013-14

35 Trust staff members will attend a nationally recognised medicines adherence course during 2013. This new training course has received excellent feedback, including some trusts, who have reported statistically significant reduction in relapse rates for early psychosis and improved psychopathology (positive and negative symptoms) in patients recovering from an acute episode of schizophrenia.

How measured

Progress and outcome reports for all these initiatives will be received and considered by the NICE Reference Sub-Group. The implementation of NICE guidelines will be measured against NICE Quality Standards.

How monitored

By production of regular summary reports by the NICE Reference Sub-Group, to be reviewed by the Clinical Effectiveness and Outcomes Group.

2013-14 Clinical Effectiveness Priority 3

To further improve the implementation of the Recovery Approach for patients working with our Recovery teams.

Rationale

The principle, of care being based on patient defined recovery objectives, is central to the work of our mental health teams. Since 2011 the Trust has engaged in a comprehensive programme of recovery focused care initiatives to expand the Recovery Approach to care. These initiatives have included the introduction of the Recovery Star tool to inform treatment plans and enable people to influence and maintain control of their own recovery journey, a Recovery Group Programme and the provision of comprehensive Patient Recovery Packs.

To date the Trust has monitored the impact of its Recovery Approach by measuring the number of patients each quarter, working with our Recovery teams, who recover sufficiently from their mental health difficulties to be discharged. This measurement allows us to understand the broad impact of the Recovery Approach. However, we now need to focus on understanding how to further develop and improve our approach, to enable us to support greater numbers of patients to recover but also to support optimal levels of recovery for each individual patient. To do this, further service evaluation at team level is required.

Current status

In 2012-13, 14,249 patients were discharged from our services as a result of facilitating personal recovery. Improved Business Intelligence Systems now enable us to provide this information on an individual team level. This information is then used by the executive team in monthly performance and service improvement meetings.

Plans

- To continue to measure and monitor the number of patients each quarter, working with our Recovery teams, who recover sufficiently from their mental health difficulties to be discharged.

- To measure the number of patients discharged from Recovery Teams with a Recovery Star.

- To fully implement, by the end of 2013-14, the use of a Patient Reported Outcome Measure (PROM) throughout all Recovery Teams.

- To raise awareness among staff regarding the recovery approach and provide additional training where necessary.

How measured

Reports on the numbers of patients recovered sufficiently to be discharged and the numbers for who a Recovery Star will be produced from the Business Intelligence System.

The Trust Clinical Effectiveness and Outcomes Group will commission snap shot audits throughout Quarter 3 & 4. These audits will measure the extent of the use of a PROM throughout Recovery Teams.

How monitored

All data from these measurements and snap shots will be monitored by the executive team at monthly performance meetings and by the Trust Clinical Effectiveness and Outcomes Group on a monthly basis.

Developing staff capability and capacity to deliver these quality improvements

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

'Quality Through Leadership' is the brand for the KMPT management and leadership development programmes. The overarching objective of the programme 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 7.

Since the last quality account was published over 200 managers and leaders have been on programmes and learning events to equip them with the skills to manage and lead more effectively. Interventions including psychometric testing, 360 feedback and action learning have been developed as an in house capability to support management and leadership development.

The current Quality Through Leadership programme 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) Clinical managers development programme

3) Area Administration manager development programme

4) Productive leader

5) Board Development

We are working closely with the local leadership collaborative to maximise access to national leadership programmes which are due to launch in September 2013 and link this with our internal talent identification processes.

Case Study: Group coaching approach to develop and improve staff capabilities

The Acute service line had created a lean senior structure as part of the transition to service lines. There was the opportunity to use some organisational development facilitation to further develop the effectiveness of the senior team to strengthen and embed the service line.

The individuals decided that a group coaching approach would be the most effective use of the resource available to them with the aim being to develop individuals and the team towards the changing needs of the service.

With the end result being a closely knit, multi-professional, management team with a substantial degree of mutual trust and a common interest in strengthening the effectiveness of the team as a whole. The project was carried out initially over a period of three calendar months and included:

•   identification of the major team and organisational issues that the team needed to address and the strategies to tackle them

•   coaching on live management issues and planning for the future

•   focus on how the team was going to maximise its effectiveness in addressing the tasks

Over the three-month period there were three group coaching sessions which lasted between an hour and half and a whole day each. The consultant combined a coaching approach with action learning tools and methodologies to support, educate and challenge, be it the individual or the team, in the endeavour to grow and develop.

Individual benefits

•   each participant became more aware of themselves, their colleagues and the dynamics of the management team

•   each participant reported feeling they had more clarity and focus on key tasks and objectives

•   time out for thinking through the issues produced more strategically minded decisions

•   behaviour has changed in a number of respects to cover the broach spectrum of management style and healthier (ie more support and more challenge) interaction with line reports, peers and other staff

Team benefits

•   the team process has improved; individual members are feeling more confident now that the management team is working as a team, aware of the group process and committed to the whole process

•   the management team has clarity of vision and a clear direction for itself and the Trust

•   the management team has increased efficiency and its effectiveness in all aspects of its purpose

•   effective use of time and resources available

Overview Statements Relating to Quality of Services

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

Mandatory Quality Indicators

KMPT has achieved the target levels of these indicators consistently throughout 2012-13 and have performance levels above national average in most cases. Robust procedures are embedded within the Trust to ensure continued compliance against these indicators; additionally there is constant review of any instances of non-compliance to ensure lessons are learnt to further improve our performance in future.

7-Day Follow-up.

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

KMPT has taken the following actions to improve this percentage and, so, the quality of its services by: Applying effective processes and monitoring regularly with feedback and learning being provided across the Trust. The average for the whole of 2012-13 was 97.2%, which was an improvement on the 2011-12 average of 96.9%.

Indicator	Performance	2012-13 Q1	2012-13 Q2	2012-13 Q3	2012-13 Q4
7-Day Follow-up	KMPT National Average Highest Nationally Lowest Nationally	97.4% 97.5% 100.0% 94.9%	97.6% 97.2% 100.0% 89.8%	97.3% 97.6% 100.0% 92.5%	96.1% 97.3% 100.0% 93.6%

http://transparency.dh.gov.uk/2012/06/21/mental-health-community-teams-activity-data-downloads/

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

CRHT Gatekeeping.

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

KMPT has taken the following actions to improve this percentage and, so, the quality of its services by: Ensure each case is reviewed by the Crisis Resolution Home Treatment Team (CRHT) prior to admission to validate that this is best course of treatment for the patient. The average for the whole of 2012-13 was 99.1%, which was an improvement on the 2011-12 average of 96.7%.

Indicator	Performance	2012-13 Q1	2012-13 Q2	2012-13 Q3	2012-13 Q4
CRHT Gatekeeping	KMPT National Average Highest Nationally Lowest Nationally	98.2% 97.8% 100.0% 83.0%	99.2% 98.0% 100.0% 84.4%	99.2% 98.4% 100.0% 90.7%	100.0% 98.6% 100.0% 84.9%

http://transparency.dh.gov.uk/2012/06/21/mental-health-community-teams-activity-data-downloads/

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

28-Day Readmission Rates.

KMPT considers that this data is as described for the following reasons: This is a locally produced percentage based on the agreed methodology of readmissions within 28 days as a percentage of all admission. No national benchmarking has been possible as there is no recent data published. All these re-admissions are in the category 'Aged 15 and over' as the Trust does not provide inpatient services for children under 18.

KMPT has taken the following actions to improve this percentage and, so, the quality of its services by: Improve discharge planning and community treatment following discharge to minimise the chance of a readmission being required. The average for the whole of 2012-13 was 13.4%, which was an improvement on the 2011-12 average of 14.2%.

	2012-13
28-Day Readmission Rate	13.4%

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

KMPT considers that this data is as described because it is taken from responses to the National NHS Staff Survey 2012. It is taken from responses to the question:

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

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

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

While the national staff survey results for 2012 showed improvements in staff satisfaction, effective teamworking and ability to contribute to improvements at work KMPT recognises that it has a way

to go to improve its score for this indicator. The staff forum and clinical cabinet are working closely with the Director of Human Resources (HR) and Executive team to identify key areas for improvement. Additionally, each service line has robust plans focussing on key areas supported by Trustwide actions in the following areas:

1. Investigating the perceptions of bullying and harassment
2. Reducing violence, incidents and harassment of service users and carers towards staff
3. Building workforce resilience
4. On-going staff engagement activities and listening exercises to enable staff to identify issues that are affecting them and to ensure an ongoing dialogue is maintained

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

Patient experience of community mental health services

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

KMPT has taken the following actions to improve this score, and thus the quality of its services, as follows: Applying effective processes with robust action plans and monitoring regularly at the Trustwide Patient Experience Group, with feedback and learning being provided across the Trust.

Indicator	Performance	2011	2012
Patient experience of community mental health services based on contact with a health and social care worker	KMPT	83.2	83.2
	National Average	86.8	86.6
	Highest Nationally	91.4	91.8
	Lowest Nationally	81.9	82.6

https://indicators.ic.nhs.uk

In order to monitor the action plans resulting from the results of the National Patient Survey (NPS) KMPT uses a Community Services Feedback Form (CSFF). These forms are printed on A4 sheets using the relevant questions from the NPS. Service users are asked to answer the questions using a tick box; the forms can then be folded in half and put in the post using a freepost address.

Once received by the Trust, the data is entered onto an electronic data collection system that can generate reports allowing comparison through time and across teams. The current results for the question 'Overall, were you satisfied with care you have received from NHS Mental Health Services' has a positive response of 95%.

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

KMPT considers that this data is as described for the following reasons; the data for National figures is taken, where available, from the National Reporting and Learning System (NRLS). We have calculated the national average by using the total figures for Mental Health Trusts (MHT) and also determined the Highest and Lowest MHT from the same set of data. Up to date KMPT figures for 2012-13 are taken locally from the incident reporting system (Datix) as this provides a more accurate position of the Trust against the National figures. The local figures have been reported to the Quality Committee and Trust Board (public part) during the year.

KMPT is taking the following actions to improve this rate and so the quality of its services, by improving our process to identify learning from suicide incidents by ensuring that investigation of these cases is undertaken by an investigator who is independent of our service lines. Community teams will all work on the suicide prevention toolkit. We will complete our programme of tailored risk assessment training to community teams for adults of working age.

The requirements for reporting deaths to the NRLS have changed in the period 2012-13. All deaths are now reported; excluding natural causes and expected deaths, this will contribute to the increase in reported patient safety related deaths for the period 2012-13. In the course of preparation of this Quality Account, we identified eight cases that should have been reported to the NRLS but which we had not reported at the time of the incident in 2012-13. These cases had been included in the data the Trust Board received in public each month, have now been reported to the NRLS, and are included in these figures.

Full year data for 2012-13 for KMPT for severe harm&death/all reported patient safety incidents

Indicator	Performance	2012-13 Q1/Q2	2012-13 Total KMPT	2011-12 Q1/Q2	2011-12 Q3/Q4
severe harm/death	KMPT	2.2% (46)	2.0% (75)*	0.3% (6)	1.3% (25)
	National Avg	1.6% (1747)		0.9% (936)	1.2% (1310)
	Highest MHT	9.4% (334)		5.6% (85)	6.9% (57)
	Lowest MHT	0% (0)		0% (0)	0% (0)

75 / 3781 (2.0%) as compared to 31/4060 (0.8%) 2011-12, which was compliant with the previous reporting requirement.

*Local data – KMPT incident reporting system
National data - http://www.nrls.npsa.nhs.uk/resources/?entryid45=135147

Participation in Clinical Audit and Quality Improvement activities

National Clinical Audits

National clinical audit and quality improvement activities

During the period 1st April 2012 to 31st March 2013 Kent and Medway NHS and Social Care Partnership Trust was actively involved in 12 National Clinical Audits/Quality Improvement projects and one National Confidential Enquiry that were relevant to the services provided by the Trust.

During the above period the Trust participated in 89% of the national clinical audits and national confidential enquires which it was eligible to participate in. See below for a list of projects that the Trust was eligible to participate in.

- POMH-UK: Prescribing Observatory Mental Health – UK: Prescribing topics in mental health services (Five topics)
- National Audit of Psychological therapies for Anxiety and Depression
- National Audit of Schizophrenia
- National Confidential Enquiry into Suicide and Homicide by people with mental illness

The Trust participated in the first National Audit of Psychological therapies for Anxiety and Depression in 2010-11. However, due to a major re-organisation of psychological services within the Trust and the local NHS health economy during 2012 the Trust decided that it would not be very productive to register any psychological services for the 2012 re-audit.

The Kent and Medway NHS and Social Care Partnership Trust also participated in the following national clinical audits and Quality Improvement activities during 2012-13:

- Accreditation for Inpatient Mental Health Services (Two inpatient wards)
- Home Treatment Accreditation Scheme (One Crisis Resolution & Home Treatment Team)
- Quality Network for Forensic Mental Health Services
- National Outcome database for CFS/ME
- Community of Communities: Therapeutic communities quality improvement network
- Psychiatric Liaison Accreditation Service (PLAN)
- Shared Pathway Documentation Pilot (for use in Forensic services)

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 2012-13 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit, enquiry or activity.

Topic	Number of cases %
Accreditation for Inpatient Mental Health Services	100%
Home Treatment Accreditation Scheme	100%
POMH: prescribing topics in mental health services	100%
Quality Network for Forensic Mental Health Services	100%
National Audit of Schizophrenia*	102%
National Outcome database for CFS/ME	100%
Community of Communities: Therapeutic communities quality improvement network	100%
Psychiatric Liaison Accreditation Service (PLAN)	100%
Shared Pathway Documentation Pilot	100%
National Confidential Enquiry into Suicide and Homicide by people with mental illness	98.17%

The reports of **13** national clinical audits and quality improvement activities were reviewed by the Trust between 1st April 2012 and 31st March 2013.

*We were required to submit completed questionnaires for 100 patients; we submitted 102 completed questionnaires, thus making our submission rate 102 per cent, as the required submission rate was 100, which is 100 per cent.

Case Study: National Clinical Audit and Quality Improvement Projects

The Trevor Gibbens Unit and the Quality Network For Forensic Mental Health Services, Standards for Medium Secure Services (Royal College of Psychiatrists, College Centre For Quality Improvement), 6th Cycle.
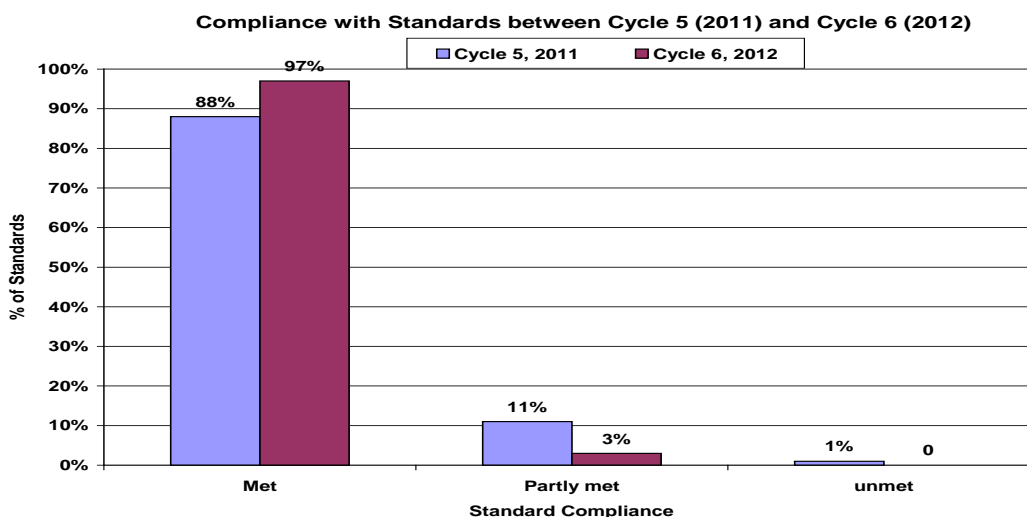
As a member of the Quality Network For Forensic Mental Health Services the staff working on the Trevor Gibbens Unit measure the services they provide against nationally agreed best practice standards of care for medium secure inpatient services every year. This involves a self-assessment against the standards by staff on the unit and a peer review visit from staff that work in similar units in other mental health service organisations across the UK.

Each time a self-assessment and peer review is undertaken this is referred to as a cycle and in 2012 the network had reached its 6th cycle, which means this is the 6th time that the unit has been through the process. Being involved in the Quality Network provides the unit with an opportunity to benchmark their practice against the same type of services provided by other organisations as staff from the Trevor Gibbons Unit participate in the peer review team visits to other members of the Network across the UK.

The standards measured are presented in seven groups, which are titled:

- Safety and security
- Clinical and cost-effectiveness
- Governance
- Patient focus
- Accessible and responsive care
- Environment and amenities
- Public health

When compared against the 5th Cycle self-assessment and peer review team visit in 2011, a substantial improvement in compliance with the project's standards was reported by the peer review team in 2012 (see graph below). The unit was rated 4th out of the 68 units that participated in the 6th Cycle.

Compliance with Standards between Cycle 5 (2011) and Cycle 6 (2012)

Standard Compliance	Cycle 5, 2011	Cycle 6, 2012
Met	88%	97%
Partly met	11%	3%
unmet	1%	0

● **KMPT Forensic services and local partners were awarded 'Best user involvement design in a portfolia study' by the Mental Health Research Network. The study was based at six medium secure locations in London and Kent, including the Trevor Gibbens Unit in Maidstone. Dr Kinane (left) receives the award from Professor Swaran Singht.**

The peer-review team were pleased to note that some improvements have been made over the past year, since the Cycle 5 review. During the Cycle 5 review the child visiting facilities were highlighted as a challenge, as the peer-review team deemed them not to provide a homely and welcoming environment for hosting a child visit. During this review it was acknowledged that work was planned to improve this. The peer-review team during this most recent review were pleased to note that this work has been completed and noted the range of facilities available for hosting a child visit.

Morale amongst the frontline staff was highlighted as an issue during Cycle 5. It was noted that this was largely due to the high sickness levels and policy changes at Trust level. However, as outlined above, the peer-review team noted the morale amongst the staff team during the Cycle 6 review to be good and commended the cohesive team and evident ethos of Multi-Disciplinary Team (MDT) working, as well as the improved numbers available on the wards. The review team considered this praiseworthy.

The 6th Cycle results have been published in the Trust newsletter `Partnership Matters'. The Trevor Gibbons Unit will continue to make further improvements to services and is currently participating in the 7th cycle of the network.

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

- A Glasgow Antipsychotic Side Effects Scale must be completed and scanned into the clinical documentation section in RiO (Patient information system – under assessments – Glasgow Scale) (POMH-UK Topic 6c Assessment of side effects for depot antipsychotic medication)

- The availability of self-catering opportunities was also praised by the peer-review-team, who noted the choice and autonomy this promotes to be excellent (National Quality Network For Forensic Mental Health Services, Standards for Medium Secure Units)

- Care Programme Approach (CPA) Care Plan will be developed in consultation with the service user and carer (if appropriate) at least a week prior to each CPA Meeting (National Audit of Schizophrenia)

- All patients with a primary diagnosis of personality disorder must have a written crisis plan agreed with the patient, and this should include all prescribed medication (POMH – UK Topic 12a Prescribing for people with a personality disorder)

- All patients prescribed Lithium must have a six monthly CPA review and the following tests and measurements must be carried out and recorded at every CPA review: U&ES including creatinine (or e-GFR or creatinine clearance), Thought Field Therapy (TFT), Weight or BMI or waist circumference (POMH – UK Topic 7c Monitoring of patients prescribed Lithium)

- If the service user failed to respond to anti-psychotic medications, the possibility of Clozapine therapy will be discussed with the service user. Note about the discussion will be recorded on the RiO (Patient information system) progress notes. (National Audit of Schizophrenia)

- The learning points and action taken from all national clinical audit projects and quality improvement activities reported during 2012-13 can be found in the Kent and Medway NHS and Social Care Partnership Trust Annual Clinical Audit and Service Evaluation Report 2012-13 available at www.kmpt.nhs.uk

Local Clinical Audits

### Local Clinical Audit and Quality Improvement Activities
The reports of 59 local clinical audits and service evaluation projects were reviewed by the Trust between 1st April 2012 and 31st March 2013

Case Study: Local Clinical Audit: Person-Centred Care Plan Audit

The purpose of this project is to further improve both the quality and patient focus of care planning within all trust inpatient units. This is done by ward staff comparing care plans produced on the ward against the following standards, all care plans must:

1. Clearly identify the service users problems
2. Identify interventions, actions and frequency for each problem
3. Have clearly identified anticipated outcomes and clients views recorded for each problem
4. Have service user involvement (in care planning) considered
5. Have clear start and end dates recorded for each problem
6. Have been signed by the service user to indicate that they agree with the care plan
7. Have evidence that the service users have been given a copy of their care plan
8. Have all clinical risk and risk management plans clearly identified
9. Be explicit in relation to MHA, capacity and rights
10. Be up to date and provide an accurate reflection on the patient's current well being
11. Be simple and straight forward avoiding any unnecessary and lengthy explanations or narrative
12. Have evidence of carers involvement explicit in the care plans

Five patient records are audited each month and the results are reported for each Service Line. Since the project started in April 2012, there has been a significant improvement in compliance across all 12 practice standards as shown in the graph below:

Compliance with Standards April 2012 to February 2013 (Total Compliance = 100%)
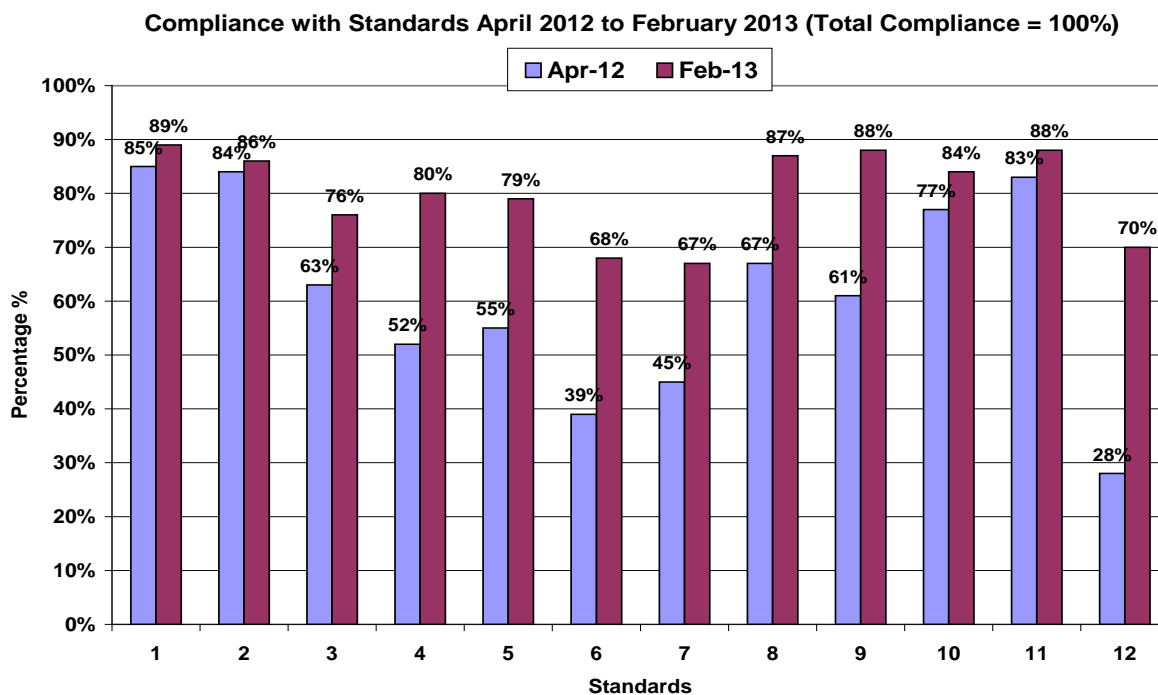
It should be noted that although the audit questionnaire was piloted before being implemented, some inter-rater reliability issues were identified, resulting in negative scores being recorded for some standards. The re-wording of some of the questions was agreed with staff and the revised questionnaire was implemented in December2012. Despite these changes, improvements in care planning practice have continued. The status of this project is ongoing.

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

- CPA Manager produced simple guidance with the aim of informing care coordinators and clinicians on what constitutes a CPA review, who should attend and the format of the review *(Care Programme Approach Service Evaluation)*

- Checklist for appointments devised to ensure that medication reviews are conducted *(Use of antipsychotic medication with people with a learning disability)*

- All patients' letters to GPs to be written in a standard format *(Assessment of GP satisfaction with Swale Access Team Service)*

- The antipsychotic dosage `ready reckoner' to be included in prescription cards *(Evaluation of high dose antipsychotic prescribing within inpatients)*

- Psychiatrist to ensure enough time is allocated to listen to patients during consultations *(Review of Service user experience of consultations with psychiatrists on a forensic in patient ward)*

- GPs requested to arrange for an ECG and send a copy with the referrals *(Clinical Audit of Memory Clinic Diagnosis Outcomes)*

- A simple proforma is to be designed, for use in medication clinic, listing all questions needing to be asked to help screen for cardiac side effects on AChEi drugs. The clinicians carrying out medication clinic have agreed to use a proforma and put the information on RiO (Patient information system) *(Clinical audit of anticholinesterase inhibitors: Are we monitoring the cardiac side effects?)*.

- Clinical staff have completed the R1 RiO update training which includes recording allergies and drug reactions in RiO (Patient information system) *(Health and Social Care Records Audit – All Services)*

The learning points and action taken from all local clinical audit projects and quality improvement activities reported during 2012-13 can be found in the Kent and Medway NHS and Social Care Partnership Trust Annual Clinical Audit and Service Evaluation Report 2012-13 available at www.kmpt.nhs.uk

Internal Audit Review of Clinical Audit

During the period the systems associated with the production and reporting of clinical audit projects within KMPT were subject to an internal audit. South Coast Audit, the orgainisiation that carried out the audit were able to give significant assurance that the systems for clinical audit within KMPT were effective. The internal auditors, who have carried out similar reviews of clinical audit systems and processes in other trusts, also stated that the processes for clinical audit in KMPT were one of the best they have seen.

Research and Development

The number of patients receiving NHS services by the Trust in 2012-13 recruited to participate in research approved by the Research Ethics Committee and adopted by the Mental Health Research Network (MHRN) was 247. This exceeded our target of 165. KMPT was the highest performing Trust in Kent and Medway in exceeding the recruitment targets set by the Comprehensive Local Research Network (CLRN).

KMPT was involved in recruiting 25 service users to MHRN adopted clinical research studies during this period. In addition a further 10 studies were undertaken by professional trainees and staff at the Trust. These were all approved by the Research Ethics Committee, but were small scale unfunded studies.

There were three multi-site portfolio studies undertaken that were led by KMPT. One of these was awarded 'Best User Service Involvement' by the MHRN. The CLRN have continued to undertake research governance scrutiny for all MHRN adopted studies, meetings and deadlines. Canterbury Christ Church University have undertaken research governance for all other studies.

KMPT is strengthening its research activity and is supported across the Trust. Each of the four service lines has a lead for R & D, with local research meetings occurring regularly. Academic links are strengthened with regular research meetings between Canterbury Christchurch University and KMPT.

Also KMPT has an active partnership with the University of Kent (UKC). The Forensic Service Line and UKC are jointly funding a PhD student to undertake research at KMPT. Professor Gannon, Forensic Psychologist from UKC continues to consult one day a week in the Forensic Service and has been integral in the service's increased research activity.

The Older Adults' Service is active in dementia research and strengthening links with the Dementia and Neurodegenerative Diseases Research Network (DENDRON). The Expert by Experience group is represented at the Trust Research Group. They held a workshop last year attended by the Chief Executive and the Executive Director of Operations.

Excellent care personal to you

Goals agreed with commissioners - use of the CQUIN payment framework

A proportion of the Trust's income in 2012-13 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The CQUIN payment framework aims to support the cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of discussions between NHS Medway, our lead commissioning Primary Care Trust for 2012-13 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 (2.5% of annual contract value in 2012-13 and 2013-14). The use of the CQUIN framework indicates that KMPT has been actively engaged in quality improvements with commissioners.

For 2013-14 CQUIN indicators agreed with commissioners aim to support tangible improvements in Quality and are linked to both the Quality, Innovation, Productivity and Prevention (QIPP) and Outcomes Framework, as well as the move to Payment by Results for mental health services from April 2014. The main CQUIN areas for 2013-14 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 details of the full CQUIN Payment Framework for 2012-13. Appendix B shows the other Quality Performance Indicators reported to our commissioners in 2012-13.

Registration

Quality Account – CQC Update

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 20 registered locations. The CQC carried out a number of unannounced visits at these locations between the 1st of April 2012 and the 31st of March 2013, under Section 46 of the Health and Social Care Act 2008; in line with other Trusts, in order to assess and monitor compliance with the essential standards.

Following a visit to the Birling Centre, a learning disabilities inpatient unit in December 2011 where the Trust was deemed to be non-compliant with outcome 4, the care and welfare of people who use services, a robust action plan was put in place to ensure that improvements to care were made. The CQC re-visited the unit in June 2012 and found that all of the essential standards reviewed were compliant. One of the improvements noted by the CQC were that the care records were now clear and more focused on individual needs.

The CQC also visited the following sites during 2012; the Arundel Unit – two younger adult wards and one older adults wards, Priority House – two younger adult wards and the crisis team, the Neuro-rehab unit – a specialist ward caring for patients who have experienced a head injury or neurological damage and the Frank Lloyd Unit – two continuing care older adult wards.

Where compliance was not granted following these visits, action plans have been put in place to ensure that the quality of care that people receive improves. These action plans are reviewed and monitored by the CQC and National Health Service Litigation Authority (NHSLA) Compliance Monitoring Group, a subgroup of the Patient Safety Group which is a board level committee.

The Trust has also received a series of internal compliance support visits and reviews conducted by the Compliance and Risk Team. At these visits, a mock assessment is conducted and evidence reviewed against a selection of the essential standards. Feedback is given at the time of the visit and following this a report is produced highlighting recommendations to be taken forward. The team/ward themselves are then responsible for producing an action plan for implementation. During 2013-14, the implementation of these action plans are to be monitored at each service line performance meeting to ensure that compliance is achieved.

Support information has been developed to ensure that staff have an awareness and understanding of the essential standards and how these link to day to day practices. An outcome evidence list has been developed as a tool for managers to use to benchmark the care they provide against the essential standards and where gaps are identified to ensure that these are rectified.

During 2013-14, the compliance and risk team plan to facilitate a number of CQC outcomes workshops for staff to increase understanding of the essential standards. Learning from both internal reviews and CQC visits is communicated to staff by the compliance pages on the Trust

intranet and is also shared widely via the learning from experience group a process which will continue in 2013-14. Key staff also meet regularly with the Trust's Lead CQC Assessor and the CQC Compliance Manager, ensuring that the Trust continues to develop a positive working relationship with the CQC.

- *The West Kent Neuro-Rehabilitation Unit in Sevenoaks works with brain-injury service users with the aim of helping them regain the ability to walk*

Data Quality

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

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

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

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

- 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.
- Further development of Business Intelligence reports to support operational services to improve data completeness and data quality on Rio
- Developing, implementing and embedding a Trustwide Data Quality Culture sponsored and monitored at senior management level
- Integrating data quality with the new Performance Management Framework as a key element of the Trust's reporting activities

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 2013-14. An additional data quality plan with a specific focus on the implementation of Payment by results has also been developed to address the improvements in data quality required.

Excellent care personal to you

NHS Number and General Medical Practice Code Validity

Kent and Medway Partnership Trust has submitted records within prescribed deadlines for 2012-13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data (April 12 - January 13).

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

- 99.8% for admitted patient care, and

- 100% for outpatient care

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

- 96.5% for admitted patient care, and

- 99.4% for out patient care

Information Governance Toolkit Attainment Levels

Information Governance attainment for the Trust in 2012-13 assessed using the Information Governance toolkit (IGT) was 91% up from 85% in 2011-12. 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 evidence and Information Governance processes were audited by South Coast Audit (SCA) at the beginning of 2013 and they gave the Trust 'Significant Assurance'. SCA also audited staff understanding of information matters through the SCA Staff Survey and the results showed that overall the level of IG understanding remained high.

Clinical Coding Error Rate

The Trust was not subject to the payment by results clinical coding audit during 2012-13 by the Audit Commission. However, the Trust did undertake its own audit of patient records and the discharge summaries, when present, were an excellent source of information, thus aiding the coding process.

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

	Total from episodes audited	Total correct	% correct
Primary diagnosis	50	48	96%
Secondary diagnosis	170	147	86%

Of the 50 episodes audited, there were a total of 50 primary diagnoses present: 96% of these were correct compared to 92% last year; and secondary diagnosis: 86% this year compared to 77.7% last year. Historic system constraints identified on previous audits prevent the recording of procedures codes.

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

- *Trust Admiral Nurse Celia Stamper (left) launches the National Time for a Cuppa campaign with Downton Abbey's Mrs Hughes, played by Phyllis Logan (centre). Madeline Armstrong (right) was the very first Admiral Nurse in Kent back in 1999.*

Excellent care personal to you

Review of Quality Performance: Achieving Our 2012-13 Priorities

The nine priorities were:

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.

2012-13 Patient Safety Priority 1

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

Approach

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

Action

100% of service users admitted to older adult wards have received a falls assessment as well as anyone admitted to an Adult Acute bed who was over the age of 65. All older adult wards have falls champions in place and use the productive ward's safety crosses to measure the incidents of falls. Falls assessments are part of the nursing metrics and monitored on a monthly basis through the modern matrons meeting and reported to the Trustwide patient safety group.

Results

Reported service user slips, trips and falls (STF) increased in 2012, both in the overall number and in the number resulting in harm. Factors that may account for the increase during this period are:

- Embedding of the Slip, Trip, Fall Policy which has increased staff awareness of the importance of this issue

- Local monitoring of falls as part of Productive Ward initiative

- Increasing staff awareness to report and investigate STF incidents as Serious Incidents (SIs) where these require medical attention

- Lack of clarity regarding the definitions of moderate and severe falls as defined by the National Safety Patient Agency (NPSA)

In older adult inpatient services, where the number of falls resulting in harm is a priority, there has been an increase of 22%

Older adult inpatient falls resulting in harm (incl sus falls)	2010-11	2011-12	2012-13	% change between 2011-12 and 2012-13
	354	360	438	22%

ALL OA inpatient falls resulting in harm (including suspected falls). This includes all levels of harm.

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

Through this collaborative we will be working closely with our older adult wards to address patient falls resulting in harm and aim to have a 25% decrease within 2013-14.

The NPSA definitions of falls will now be used for reporting purposes.

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.

Approach

It is important that the Trust maintains its work on preventing suicide and serious self-harm during an inpatient admission. The current climate is particularly challenging, considering the latest report by the National Confidential Inquiry into Suicide and Homicide indicating a nationally increasing rate of suicide for the first time for more than a decade.

Action

The Trust's Suicide Prevention Strategy for 2012–2015 is being rolled out. Within it, the Suicide Prevention Action Plan for 2012-13 identified priorities for Trust services, covering clinical risk assessment and management, communication of risk information, transitions in care, staff training and supervision and co-morbid substance misuse. It has a particular focus on the use of the Mental Health Act and the safety of inpatients, as well as highlighting the issue of patients in the community who refuse treatment and miss scheduled contacts with their clinical team.

The Suicide Prevention Toolkit has been implemented by inpatient wards within the Trust, the impact of which is being evaluated. Each service line has selected its priorities from the Suicide Prevention Action Plan, in order to improve its performance. There is an ongoing Trustwide Ligature and Ligature Point Audit that covers all inpatient wards, for which each service line has produced an Action Plan to remove or mitigate risks in this respect.

Regrettably, it has proved impossible to embed the use of a Department of Health approved risk assessment tool, the Galatean Risk Screening Tool (GRiST) being the favoured instrument following a scoping exercise. This is because the Trust's primary clinical record, RiO, which is used nationally, does not support the GRiST, but rather has its own risk assessment processes, which staff are required to populate. We consider the risk of having two risk assessments running in parallel - one within the primary clinical record and the other outside it - to outweigh the potential benefit of piloting the GRiST. Despite the Trust being represented at a meeting convened by those responsible for RiO to discuss opportunities to improve RiO risk assessment processes, this has not yet led to any improvement of the system.

Results

In 2012-13, one inpatient took their own life within a ward; two inpatients did so when absent (authorised or unauthorised) from a ward; 16 inpatients seriously harmed themselves.

In 2011-12, no inpatients took their own life within a ward. One inpatient did so when absent (authorised or unauthorised) from a ward; 14 inpatients seriously harmed themselves.

While the 2012-13 data show an increase in the number of these incidents, they cannot be inferred to represent a deterioration in patient safety standards, as the low statistical prevalence does not support such a conclusion to be drawn. Nevertheless, any such incident should be prevented wherever possible by implementing the highest standards of clinical care.

• *Chief Executive Angela McNab performs the 'topping out' ceremony at KMPT's new inpatient facility at St Martin's Hospital in Canterbury, aided by Phil Durigan, Managing Director of the building company, Kier.*

Excellent care personal to you

2012-13 Patient Safety Priority 3

To ensure all adults and children are effectively safeguarded.

Approach

In order to ensure the safety of patients and their children the organization has continued to emphasize the importance of accurate and effective data collection on patients who are parents in our care in order to deliver the best care possible whilst ensuring both child and adult is safeguarded. We have used the Common Assessment Framework (CAF) to assist in meeting the needs of families through appropriate information sharing.

To further safeguard our patients we have monitored the response to Deprivation of Liberty Safeguards (DOLs) Assessments conducted by our medical staff to ensure a timely approach to all requests.

Action

Having issued staff with a safeguarding checklist to guide them in information collation during assessments of patients who are also parents, the Named Nurses have conducted monthly audits to ensure standards of information collated are done so effectively and used to address concerns for those patients and their children.

Storage of information in the appropriate areas on RiO has also been monitored through the monthly audits. The named nurses have raised the profile of the Common Assessment Framework (CAF) with staff and its uses to share information and bring about the most appropriate intervention for families in need.

We have monitored our response to requests for DOLs assessments and we have used an external audit to review our compliance in practice with the Mental Capacity Act.

Results

1. CAFs Completed 2012/2013 = 17

2. DOLs assessments completed in 3-day deadline

Number of DOLs Assessments 2012-13	Number completed in 3 days	%
120	90	75%

3. Results of monthly case file audits of documentation held on patients who are parents.

Time period	Number of files audited	% meeting expected standards
2012-13	135 cases	80%

4. Safeguarding cases reviewed and deemed to have met Mental Capacity Compliance.

Time period	Number of case files audited by external auditor	% meeting MCA compliance
January 2013	12	91.6%

2012-13 Patient Experience Priority 1

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

Approach

During the year 2011-12 the Trust produced a 'Customer Care Charter', this was launched in April 2012 by the Board and was distributed through out the organisation with the aim that the charter would 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. During the year the Trust continued to monitor complaints particularly the percentage of complaints received relating to staff attitude.

Action

The Customer Care Charter was launched in April 2012 and was distributed throughout the Trust following some production difficulties. During the summer the physical copies of the charter were distributed across the organisation on going work is needed with teams and this is being addressed through the customer care week.

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

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

Results:

The percentage of complaints received by KMPT relating to staff attitude during 2012-13 remained static at 27% this translates into 78 complaints across the entire organisation in one year.

2012-13 Patient Experience Priority 2

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

Approach

The Trust is currently using the 'Friends and Family' question (previously called the Net Promoter) with a postcard system this gathers patient views at discharge and demonstrates a clear commitment from board to ward to improve patient experience.

Action

Trust staff provide each service user at discharge a post card which has 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?" printed upon it. The service user can return the completed questionnaire using a freepost address. The results are entered on a web-based survey system by volunteers and allow comparison from team to team. Quarterly reports are compiled in order to ensure that service lines are aware of the results of the questionnaire.

The Friends and Family question is scored by calculating the difference between the number of people surveyed who said they would recommend the local service and the proportion who said they would not using the %number of Promoters minus the % number of Detractors from a minimum survey size of patients discharged in a calendar month.

Results

KMPT has increased its overall net promoter score from 70 in November 2012 to 75 in March 2013 and therefore has been able to demonstrate an improvement in patient experience using the net prompter score.

2012-13 Patient Experience Priority 3

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.

Approach

There is a wealth of evidence documenting the increased risk of physical illness and complications for people with a range of mental health problems. Physical and mental health is also inextricably linked so in many instances by improving one you improve the other. 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.

People with serious mental illness (SMI) are up to five times more likely to develop type 2 Diabetes, almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease. Their life expectancy is 20-25 years less than the general population mainly due to poor physical health and improving physical health by health checks, monitoring and education within the KMPT is essential to redress the balance.

Action

Ensuring staff from all service lines within the Trust have an awareness of the importance of physical health in mental health is of paramount importance, therefore facilitated training courses with more emphasis on the physical health of our service users were reviewed over the past year and were updated accordingly.

The Physical Health in Mental Health training programme includes awareness and understanding of the KMPT Physical Health & Examination Policy and documenting physical health checks on RiO, normal ranges for blood pressure, pulse, temperature, O2 saturation and respiration, the modified early warning scoring system (MEWS), recognising the physically deteriorating patient, healthy diet, physical activity, venous thrombus embolism (VTE), coronary heart disease and chronic obstructive pulmonary disease (COPD), pressure injury prevention, diabetes, medication side effects management and smoking cessation (provided by the Kent Community Stop Smoking Service).

The Rethink mental health charity's e-learning package to train staff in physical health in mental health is available via the KMPT e-learning site.

Emails were sent to all service line managers to reiterate the importance of physical health assessments, examinations and monitoring to staff.

The wards and units within KMPT provide data on physical health examinations and assessments via the nursing metrics and once again scored 100%. The community teams have worked hard over the past year to provide physical health checks for their service users, providing innovative ways of doing this; for example providing health checks at depot clinics or memory clinics.

The data from East Kent stop smoking service for the past 12 months found that:

- 99 KMPT clients were referred to the generic community stop smoking service in the period
- 43% were taking medication for their mental health condition
- Quit plan: seven weeks quit support using an abrupt cessation model
- Success rate 53% (general population 57%)
- Six clients have agreed to be stop smoking champions

- *KMPT staff regularly work with service users to carry out physical health examinations and encourage healthier lifestyles, including giving up smoking.*

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 as an emergency within 28 days of being discharged from a ward.

Approach

The following key performance indicators were used as a proxy measure of this priority, these included:

- Patients re-admitted to hospital as an emergency within 28 days of being discharged from hospital

- Monitoring the delayed transfer of care (DToC) of patients who are ready to be discharged from hospital but cannot be due to various factors which are prohibiting this discharge.

- Patients being followed up in the community within 7 days of being discharged from hospital.

- Crisis Resolution Home Treatment Teams (CRHT) undertaking home treatment visits as an alternative to being admitted to hospital

Action

- Ad-hoc audits took place when performance exceeded expected levels of 28 day emergency re-admissions. On average there were around 4 emergency re-admissions within 28 days per month. Guidance regarding what qualifies as an emergency re-admission was widely circulated to teams and also forms part of the Inpatient Standard Operating Policy. The Acute Service Line Programme Manager has also undertaken an audit of patients that have had 5 or more re-admissions within 12 months, following the outcome of this audit an action plan will be produced and any learning shared across Service Lines.

- The Trust put in place a number of initiatives to review the DTOCs across Service Lines on a weekly basis and this resulted in reducing the DTOC %, ensuring that patients identified as DTOCs were moved on as soon a possible. The Acute Service Line also put in place Discharge Co-ordinators across the sites who monitor and action the discharge of patients, including those identified as being delayed, those with a long length of stay and any patient that has an issue regarding moving on. Through weekly validation and flash reports, escalating cases where required and the establishment of the Discharge Co-ordinator roles there has been increased confidence that discharge planning is timely and effective.

Excellent care personal to you

• It is recognised that patients are at a greater risk within the immediate period after discharge from hospital. Therefore any patient discharged will have a follow-up visit in the community within 7 days; any patients that have not been follow-up within 7 days are investigated within the Community Recovery Service Line to see if there is a valid reason for this or if there is any learning. Performance continues to be monitored regularly to ensure a high compliance with this standard.

• CRHT monitor all patients admitted to the ward and where possible will facilitate early discharge through home treatment, working in collaboration with the care coordinator to provide effective post discharge care.

• CRHT were set monthly targets for home treatment episodes, these were monitored within the Service Line to ensure the target was met. There has been an increase in the number of Support Time Recovery (STR) Workers to further enhance the home treatment element of CRHTs that will assist in treating people in their home as oppose to being admitted to hospital.

Results

• In 2012-13, 2.3% of people were re-admitted to Younger Adult Acute beds as an emergency within 28 days of discharge. This is a reduction from 4% the previous year.

• DTOC for Younger Adult Acute in 2012-13 was 9.6%, this is above the Monitor Target of 7.5%, however performance in February and March were below target and early indications show April 2013 performance at around 2%.   Overall the Trust achieved the target at 6.1%

• The Monitor target of above 95% of people having a 7 day follow-up in community for Younger Adults was achieved.

• The number of CRHT Home Treatment episodes for 2012-13 was 2882, this is an overachievement of 196 episodes against the national target.

7-day follow up - The Trust has achieved in excess of the 95% target in 2012-13 with 97.2% of all discharges followed up within the seven days, a further improvement on the level attained in 2011-12. The Trust has been above target consistently for each individual month of the year.

	Discharges	Followed up	Achieved
Q1	283	276	97.5%
Q2	296	289	97.6%
Q3	301	294	97.7%
Q4	309	297	96.1%
2012-13 YTD	1189	1156	97.2%

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 2012-13.

In younger adult reviews, 2.4% of people were re-admitted within 28 days and in older adults, 0.9%. This is a reduction in the percentage of patients undergoing an emergency readmission compared to 2011-12.

2012-13 Clinical Effectiveness Priority 2

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

Approach

The aim of the NICE Reference Group for 2011-12 was to focus on improving the general provision of training for staff in key NICE clinical guidelines. The intention was to achieve this by initially holding a multidisciplinary event for staff to come together and agree a trustwide training plan.

Action

KMPT's first NICE best practice event was held on 5th July 2012. The event was well attended by a range of staff from various disciplines and levels throughout the Trust, in addition to service user and carer representatives.

There was a selection of presentations showcasing how NICE recommendations are being implemented around the Trust. This was followed by a lively panel discussion about how training provision for staff covering NICE recommendations could be improved. When consideration was given to available time and resources, it was agreed that e-learning was the most efficient method for improving staff access to training in NICE guidelines.

A business case was written on 26th July requesting funding from commissioners to support staff in development of e-learning modules. It was agreed that key topics would be selected. A plan was drawn up to complete all nine e-leaning modules and publish them by 31st March 2013.

KMPT staff from a range of disciplines from across the Trust volunteered their time to work on developing the course content. The Trust Learning and Development team then used specialist software to convert the content into e-learning courses available to all staff, which have been published on the KMPT staff e-learning pages.

Results

The following e-learning courses based on NICE clinical guidelines have been produced and made available to staff:

- bipolar disorder
- borderline personality disorder
- depression
- medicines adherence
- obsessive compulsive disorder
- post traumatic stress disorder
- schizophrenia
- long term management of self-harm

Within the first few weeks of availability, data from the Learning and Development team showed that these courses had been accessed a total of 193 times.

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.

Approach

The Trust has continued its commitment to recovery focused services in 2012-13. This is a stated aim in our Clinical Strategy, which all our activities are tested against.

Action

This year the clinical focus on recovery within KMPT was developed and supported in the following ways:

- Over 300 staff attended recovery training sessions, co-delivered by experts by experience and focussing on tools and techniques for supporting service users to achieve meaningful individual recovery.
- Over 300 Recovery Stars were completed with service users to help them identify their own recovery goals and priorities .
- The 'Live it Library' was set up in partnership with other local agencies. This provides an opportunity for local service users to record their own recovery stories which others can then access online to give them hope and ideas to support their own recovery journey through and beyond mental health services.
- New recovery groups were set up in community mental health teams, increasing the opportunities for service users to gain support from peers in using the KMPT recovery pack to guide their recovery journeys.
- A peer support worker strategy was introduced, detailing how KMPT will work alongside local partners to significantly increase the number of peer support worker employed by KMPT over the next two years.
- Recovery Packs – all service users are offered their own recovery pack in loose leaf printed format, in which they can record progress, care plan and their personal recovery plan.

Results

As at 31.03.13 - RID 626b from April 12 - March 13

	Discharges from Team	Discharges from Trust	% D/C from Trust
Access Service	14,677	13,135	89%
Recovery Service	1289	1114	86%

Feedback from service users who attended KMPT's Recovery Group Programme

"The Recovery Group that I have been attending is finishing after eight weeks. It helps you plan your own recovery. It deals with problem solving instead of ignoring them – hoping that they'll go away. At first I thought that a two hour session would be too long – far from it. We all sit around a table enjoying tea and biscuits and having an informal chat amongst friends – who we know we can trust. It's a fun environment looking at colourful worksheets – the time now goes fast. It took me time to become ill… It will take me time to get better, but I will get better."

"Found a new sense of worth."

"The group has helped me to feel and be more positive. I feel I could have benefitted from parts of the pack sooner in my recovery process."

"Discharge me from service please so other more needy people can benefit from the programme."

"Would be keen to be involved in future Recovery Groups."

"The group offers mutual support."

"Found new friends."

"Try to be positive about things. I can cope if I manage things properly."

"I'm more self-aware."

"I will be sharing my recovery journey at my next discharge from services."

"I have the knowledge that I can go back to / dip into the pack when I need, and to have a plan should I face crisis again."

"My friends and family have noticed positive changes."

"I am owning compliments."

"I feel more grounded."

"I am considering coming off my medication."

"I feel inspired and keen to consider other goals/dreams."

"Have a clearer vision about my future."

Comments on 2012-13 Performance from Local Healthwatch and Local Authorities

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

We are required to ask Kent County Council Health, Overview and Scrutiny Committee, Medway Council Health, Overview and Scrutiny Committee, Kent Healthwatch, Medway Healthwatch and the CCG who have referred the most patients to us in 2012-13. From the table below, you will see this is West Kent CCG.

Access and CMHTOP Referrals in 2012-13

Practice Consortium / Practice Name	All Referrals
Ashford Locality Commissioning Group	1432
Canterbury and Coastal CCG	3784
Dartford, Gravesham and Swanley Locality	3155
Medway Consortium	3160
Outside Kent	320
South Kent Coast CCG	3275
Swale Locality Group	1598
Thanet GP Consortium	2826
Unknown	204
West Kent CCG	4941
GRAND TOTAL	24695

Source RID755 as at 16/04/13

Response received from Kent County Council Health Overview and Scrutiny Committee

Dear Angela

Quality Accounts

In recent weeks, the HOSC has received a number of draft Quality Accounts from Trusts providing services in Kent, and may continue to receive more. I would like to take this opportunity to explain to you the position of the Committee this year.

Given the large number of Trusts which will be looking to the HOSC at Kent County Council for a response, and the standard window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Through the regular work programme of HOSC, and the activities of individual Members, we hope that the scrutiny process continues to add value to the development of effective healthcare across Kent and the decision not to submit a comment should not be interpreted as a negative comment in any way.

As part of its ongoing overview function, the Committee would appreciate receiving a copy of your finalised Quality Account for this year and hope to be able to become more fully engaged in next year's process.

King regards

Robert Brookbank
Chairman

Response received from Medway Council Health Overview and Scrutiny Committee

Dear Dr White

Quality Account

I am writing to thank you for inviting the Health and Adult Social Care Overview and Scrutiny Committee to comment on your Quality Accounts.

As the Quality Accounts are often received outside of the business cycle for the Committee the Assistant Director, Adult Social Care and the Assistant Director, Customer First, Leisure, Democracy and Culture have a delegated authority, along with the Chairman and spokespersons of the Committee to respond.

Set out below is the response on behalf of the Committee:

- Page 4 – the commitment to work with users (patients), carers, staff and partners to improve patient experience is particularly welcomed
- Page 7 – application for Foundation Trust status – the Committee would welcome an update on the timetable for this to take place
- Page 13 – it is concerning that the incidents of suicide in community teams amounted to 50 taking their life and 106 incidents of serious self harm being recorded compared to one patient who took their own life in an inpatient setting. This seems to confirm the view taken by the JHOSC that there is a high level of risk remaining in the community and a higher degree of safety in inpatient provision
- Page 14 – reference is made to at least `two deep dive exercises in Medway and the East of the organisation' in relation to safeguarding children and young people. This is welcomed and Medway Council's officers will work with your Trust on this

- Page 48 refers to an increase in the number of serious untoward incidents. It would be useful to know whether these occurred in Medway, whether there were particular `hotspots' for instance and for our mental health team to know the details
- General observation would be that there are more references to `patients' than 'service users' which gives rather an 'inpatient focus' as opposed to a community service ie the chapters on 'Patient' Experience Priorities
- A second observation would be that it was difficult to gauge by reading the Quality Account what progress had been made over the past year and where real inroads in quality of service provision had been made
- It would be interesting for the Committee to have the results of the latest service user survey and any action points arising from that

Kind regards

Rosie Gunstone
KMPT will be responding to these questions from Medway Council.

Response received from Local Healthwatch Kent

Dear Prue

Apologies for not having responded sooner to your request. I have raised this with my fellow Directors and I hope you can appreciate that, as a very new organisation, at this stage we cannot offer any comment that would reflect patients' experiences over the past year.

With this in mind we would like to thank you for the opportunity to comment and would hope to receive your document next year.

I have also copied in our external representative Jim Hancock for information.

Kind regards

Caroline

No responses have been received from Local Healthwatch Medway or West Kent CCG.

Excellent care personal to you

Appendices

A: CQUIN framework 2012-13

B: Quality Performance Indicators

C: Glossary and Abbreviations

D: Auditor's Report

Appendix A: CQUIN framework 2012-13 with RAG rating of attainment at year end:

RAG rating headings: **Green = attained; Amber = partly attained; red = not attained**

Ref No	Indicator name	Value £	RAG Status	Outcome
1	**Goal 1: Redesign and continued improvement of Community Mental Health pathways (ongoing)**			
1.1	Reducing A&E attendance for MH patients with non-acute needs	£129,000	Green	The target of 20% reduction in attendance was achieved
1.2	Collaboration with acute hospitals to improve MH pathways - A&E and inpatients (DVH)	£225,750	Green	Data at year end indicated improvement in 5 out of 8 indicators
1.3	Collaboration with acute hospitals to improve MH pathways - A&E and inpatients (MTW)	£225,750	Green	Data at year end indicated improvement in 5 out of 8 indicators
1.4	Community MH Redesign (ongoing) - continue development of Recovery-oriented practice	£96,750	Green	Target numbers of staff trained and recovery stars recorded were exceeded.
1.7	Improve missed appointments and non-attendance	£80,625	Green	Significant reduction in DNAs achieved to less than 20% for all teams.
2	**Goal 2: Redesign and improvement of Acute pathways**			
2.1	Acute pathway redesign (using care clusters) - focus on 5,14,15	£580,500	Green	First draft of urgent care pathway developed.
3	**Goal 3: Increase personalisation of support to patients**			
3.1	Increase self-directed support	£80,625	Red	Despite improvement in year the Service Line did not achieve the target number of personal social care budgets
4	**Goal 4: Improving patient safety and experience**			
		£741,750		
4.1	Measuring patient and carer experience (by recommendations)	£145,125	Green	Improvement demonstrated in patient experience from local surveys
4.2	Improving responsiveness to patient needs	£112,875	Green	Report provided to meet all requirements.
4.3	Patient and carer communications	£129,000	Green	Patient and carer information on care clusters produced and published.
4.4	Implementation of national 'safety thermometer'	£154,800	Green	Data submitted throughout the year as required for all eligible services.

Excellent care personal to you

4.5	Improve physical health assessments and care	£87,075		Overall the Trust was slightly below the 60% target at 59.3% which represented a significant increase in the number of people with a Physical Health Check.
4.6	Improve physical health assessments and care	£112,875		Of the 524 open pathways to the EIS, 82% of the total number of people on an EIS pathway offered a Nutrition Assessment (achieving the agreed target) by end of Q4.
5	**Goal 5: Deliver National / Regional EQ Dementia improvements**			
	Improving care provided to people with dementia. Achieve improvement in the EQ anti-psychotic prescribing measure and 'assessment and diagnosis' pathway Patient and Carer Information measure in Dementia: Development of the Patient Experience measure Participate in data quality assurance audits Successfully engage in shared learning opportunities	£387,000		All indicators and targets were achieved including development of KMPT Library Reminiscence Collection that can be used by Memory Services and new patient survey that focuses medication and information, CPA reviews and care co-ordination, and service user's experience of accessing psychological services.

6	**Goal 6: High impact interventions (HIIs) and trajectories**			
	Deliver threshold level activity on High Impact Innovations (HIIs)	£161,250		Commissioners agreed that the CQUINs were met overall in 4 projects to improve the use of digital technology.

7.0	**Forensic CQUIN**			
7.1	Shared Pathway – Recovery and outcomes	£65,430		Target indicators achieved for the year 2012/13.
7.2	Service User Defined CPA Standards	£65,430		Awareness training delivered to all staff and service users in the 20 standards.
7.3	Implementing a standard Secure Pathway	£43,620		Target indicators achieved
7.4	High Dependency Unit Environment Improvements	£109,050		Target indicators met
7.5	Improving responsiveness to patient needs	£43,620		Patient satisfaction surveys completed
7.6	Secure Forensic Care Pathway Feasibility Project	£43,620		The data entry collection worksheet provided as per CQUIN requirements.
7.7	Specialised Clinical Dashboard	£43,620		Data has been returned electronically for Q3 and Q4 as per CQUIN requirements
7.8	NHS Safety Thermometer			All data submitted

Appendix B: Quality Performance Indicators

QPI	On Target	Freq of Report	11/12 Actual	"YTD Actuals/ END OF YEAR 12/13"
Risk assessment and Management Plan within 24 hours of admission to acute inpatients	100%	Qtrly	100%	100%
Percentage of patients admitted who had a physical health check at admission	95%	Qtrly	100%	99%
Nutrition - % of nutritional assessments completed	95%	Qtrly	99%	98%
% Spiritual needs recorded	95%	Qtrly	100%	99%
Never Events - inpatient suicide using non-collapsible rails.	Nil	Qtrly	0	0
Incidents of serious self harm by inpatients	Actual	Qtrly	10	13
Percentage of acute inpatients (all age) experiencing one or more incidents of control and restraining (MH02) - Quarterly reported		Qtrly	11.4%	16%
Percentage of acute inpatients (all age) experiencing one or more incidents of seclusion (MH03) - excludes forensics		Qtrly	5.8%	9%
Number of all patients who had recorded incidents: physical assault on the patient (MH10)	Actual	Qtrly	713	754
The proportion of detained acute inpatients who have absconded in last three months (MH14)		Qtrly	125	59
Clostridium difficile - actuals	Actual	Mthly	2	1
MRSA Bacteraemia - actuals	Actual	Mthly	1	0
Audits of Hand Hygiene (All inpatient sites listed)	Y	Annually	100%	98%
Falls - OPMH inpatients over 65 - Assessments of risk within 24 hours of admission to acute inpatients	100%	Qtrly	100%	100%
Number of incidences of patients experiencing mixed sex accommodation	Nil	Mthly	0	0
Number of incidences reported of patients using the wrong gender bathroom	Nil	Mthly	0	5
Hand Hygiene Training - All staff (3 yearly)	95%	Qtrly	100%	92%
Hand Hygiene Training - Clinical (2 yearly)	95%	Qtrly	84%	90%
Number of Serious incidents - reported on STEIS, trends, ethnicity & actual	Actual	Mthly	55	91
Number of patient safety incident related deaths reported to NPSA	Actual	Qtrly	11	27
Number and % of Grade 1 SIS that are over 45 days		Mthly	9	13 (54%)
Number and % of Grade 2 SIS that are over 60 days		Mthly	1	1 (100%)

QPI	On Target	Freq of Report	11/12 Actual	"YTD Actuals/ END OF YEAR 12/13"
Number of medication errors	Actual	Mthly	153	169
Complaints - number - report trends & actual	Actual	Qtrly	236	294
Complaints - ratio to contacts - report actual		Qtrly	0.10%	N/A
% of the eligible staff that are actively and regularly working with children subject to a child protection plan who have accessed supervision bi- monthly		Qtrly	97%	98%
% eligible staff receiving child safeguarding training at level 1	95%	Mthly	66%	89%
% eligible staff received adult safeguarding training at level 2 = KMPT Level 1	95%	Mthly	60%	93%
% eligible staff who have received an enhanced CRB check	100%	Mthly	100%	100%
% of the eligible staff that are actively and regularly working with adults subject to an adult protection alert who have accessed supervision bi-monthly		Qtrly	98%	98%
Number of Medical Locums in place >1 yr	Actual	Mthly	6	7
Number of suicides while in KMPT care - inpatient or community	Actual	Mthly	33	51
% of eligible staff who have had HoNOS PbR training	95%	Qtrly	Not measured	80%
Violence against MH Staff (community) assaults (MH11) - actual	Actual	Qtrly	36	19
Violence against MH Staff (inpatient) assaults (MH11) - actual	Actual	Qtrly	1449	1181
CPA clients in all clusters who have advance care plans in place	Actual		Not measured	165 (3.3%)
Number and % of service users in PbR clusters 4 and 8 & 10 who a designated care co-ordinator		Qtrly	Not measured	82.87% (3668/4426)
Number and % of service users in PbR clusters 4,8 and 10 receiving a comprehensive assessment. Definition agreed was those who had a Care Plan, Honos (under 12 months old) and risk assessment (under 12 months old)		Qtrly	Not measured	62.7% (2777/4426)

Appendix C: Glossary and Abbreviations

A & E	Accident and Emergency
AfC	Agenda for Change
AGM	Annual General Meeting
AIMS	Accreditation for Acute Inpatient Mental Health Services
ALE	Auditors Local Evaluation
ALOS	Average Length Of Stay
BME	Black Minority Ethnic
BPPC	Better Payment Practice Code
CAB	Citizen's Advice Bureau
CAF	Common Assessment Framework
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CIPs	Cost Improvement Programmemes
CMHTs	Community Mental Health Teams
CNST	Clinical Negligence Scheme for Trusts
CoG	Council of Governors
COPD	Chronic Obstructive Pulmonary Disease
CQUIN	Commissioning for Quality and Innovation
CQC	Care Quality Commission
CRES	Cash Releasing Efficiency Savings
CRHT	Crisis Resolution Home Treatment Team
CSFF	Community Services Feedback Form
CSIP	Care Services Improvement Partnership
CRS	Care Records Service
DGH	District General hospital
DOH	Department of Health
DOLs	Deprivation of Liberty Safeguards
DRE	Delivering Race Equality
DToC	Delayed Transfer of Care
EBITDA	Earnings Before Tax Depreciation Amortization
EFL	External Financing Limit
EMT	Executive Management Team
EPEX	Effective Project Executive Programme
ESR	Electronic Staff Record
EWTD	European Working Time Directives
FT	Foundation Trust
FTE	Full Time Equivalent
GIS	Geographical Information System
GP	General Practitioner
GRiST	Galatean Risk Screening Tool
HCC	Health Care Commission
HIS	Health Informatics Service
HR	Human Resources
IAPT	Improving access to Psychological Therapies
IBP	Integrated Business Plan
ICT	Information and Communication Technology

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

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

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

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

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

Advocate
An advocate is a person who can support a service user or carer through their contact with health services. Advocates will attend meetings with 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: Independent Auditor's Limited Assurance Report to the Directors of Kent and Medway NHS and Social Care Partnership Trust on the Annual Quality Account

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

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Kent and Medway NHS and Social Care Partnership Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death (page 31); and
- 100 per cent enhanced care programme approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital (page 28).

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

Respective responsibilities of Directors and auditors

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

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:
- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2012 to June 2013;

- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;

- feedback from the Commissioners (response not received);

- feedback from Local Healthwatch dated (31/05/2013);

- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 20/07/2012 and 2012/13 draft report dated 13/06/2013;

- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;

- the latest national patient survey dated 27/09/2012;

- the latest national staff survey dated 28/02/13;

- the Head of Internal Audit's annual opinion over the trust's control environment dated 10/04/2013;

- the annual governance statement dated 06/06/2013; and

- Care Quality Commission quality and risk profiles dated 31/03/13;

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

This report, including the conclusion, is made solely to the Board of Directors of Kent and Medway NHS and Social Care Partnership Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Kent and Medway NHS and Social Care Partnership Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

- making enquiries of management;

- testing key management controls;

- analytical procedures;

- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;

- comparing the content of the Quality Account to the requirements of the Regulations; and

- reading the documents.

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

Limitations

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

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

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

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Kent and Medway NHS and Social Care Partnership Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Andy Mack
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

Grant Thornton House, Melton Street, Euston Square, London, NW1 2EP

25 June 2013

Your Views

We want to know what you think. Therefore, if you have any comments to make about this Quality Account, 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: 01622 724100.

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

Bengali

ট্রাস্ট, 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 ਟ੍ਰੱਸਟ 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
2012/13

www.kmpt.nhs.uk