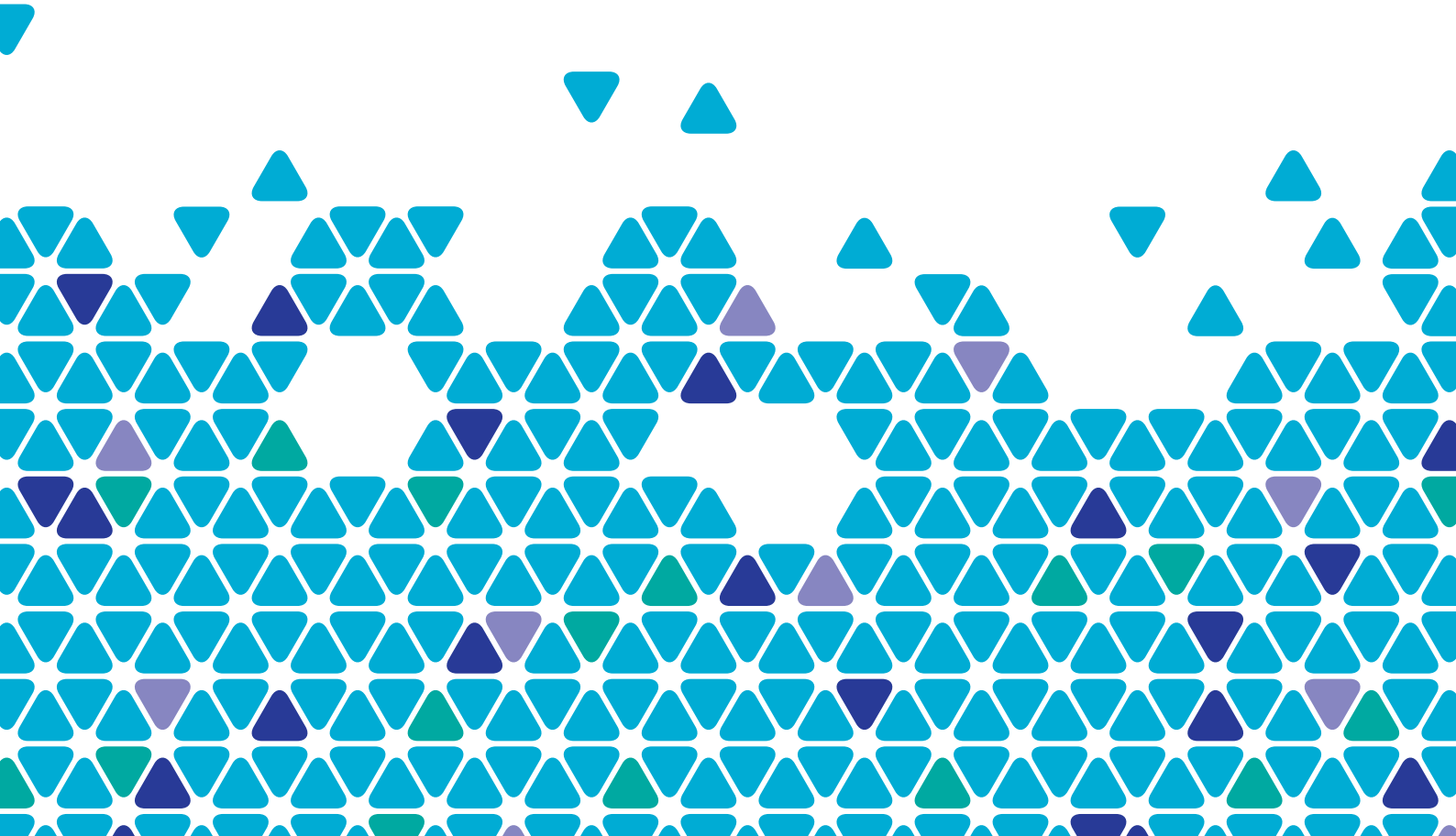
South West London and St George's NHS
Mental Health NHS Trust

Quality Account
2013/14



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Part 1

Chief Executive's statement on the quality of our services

I am delighted to present South West London and St George's Trust's Quality Account for 2013/14 – our fifth set to date.

The purpose of these accounts is to report publicly on what we have achieved over the last twelve months in terms of making tangible progress against our stated quality goals. They also look ahead to our quality priorities for the next twelve months and summarise how we expect to manage and monitor them.

The Trust has identified the Quality Account priorities in partnership with staff, service users, carers and Clinical Commissioning Groups (CCGs). The initial themes were discussed further at the Clinical Quality Commissioning Reference Group (CQRG) and then worked up into indicators using information provided by the Trust clinical leads. The draft report was sent out to CCGs, Health Overview and Scrutiny Committees (HOSCs), Local Healthwatch, the Service User Reference Group and sub committees of the Trust Board.

I am very pleased to report that we have beaten our targets for several quality improvement initiatives since we published our last set of Quality Accounts in June 2013. This does not mean we are becoming complacent, however. The pursuit of quality is an ongoing journey, especially as the current state of mental health in the UK is presenting us with so many challenging clinical and financial challenges. For example, according to the Centre for Mental Health Annual Report 2012:

- one in four of us has a mental health condition at any one time
- around half of people with lifetime mental health problems experience the first symptoms before the age of 14
- only a quarter of people with a mental health condition receive any treatment for it
- nine out of ten people in prison have at least one mental health problem. Almost a quarter of prisoners have a mental illness that requires specialist treatment
- mental ill health has an economic and social cost of £105bn a year
- mental illness accounts for 23% of the total burden of disease but only 13% of NHS spending
- untreated mental ill health adds around £10 billion a year to the cost of physical health care for people with long-term conditions
- people with severe and enduring mental health conditions die on average 20 years earlier than those without
- mental ill health is the biggest single cause of sickness absence and health-related reduced productivity losses in UK organisations - at any one time, one worker in six will be experiencing depression, anxiety or problems related to stress

In light of the severity of the national picture, delivering the highest possible quality across everything we do remains central to the way we work. Not only are we are committed to the provision of consistent, personalised, high quality services and a journey of continuous quality improvement. We are also committed to remaining a learning organisation, continually enhancing our competencies and capabilities and encouraging new and better ways of thinking. We consider our staff to be a key asset in the delivery of quality improvement and we continue to invest in their ongoing career development. We are also making a significant investment in expanding our core headcount by 70 whole time equivalent qualified nurses, for whom a proactive recruitment drive is already well under way. The upshot will significantly improve quality and safety of inpatient service delivery and ensure a higher quality inpatient experience. This will be achieved not only by as a result of changing the skill mix of staff via increasing the ratio of qualified to unqualified staff but by ensuring more consistency of care in that the nurses delivering it are likely to be permanent, as opposed to agency, members of staff.

In order to focus and co-ordinate our quality efforts we have recently put together a five year quality strategy which collates all our quality activities under three key main themes:

- **clinical effectiveness**
- **patient safety**
- **patient experience**

We have also ensured that these three themes align with the five high level national domains for improvement specified in The NHS Outcomes Framework 2014/15.

Our five year quality strategy for 2014 – 2019 will be available on our website a little later this year, and we will be following it up with regular updates on our progress on its implementation. Meanwhile, I am delighted to report that two of the Trust's significant quality achievements to date include the successful introduction of The 15 Steps Challenge and The Triangle of Care.

The 15 Steps Challenge

We have now established the 15 Steps Challenge, our Board programme of quality-oriented ward and community visits. We will continue to expand this programme with a view to:

- Devoting the majority of its time to discussing and acting on quality issues and the factors which determine quality - good financial management is essential to providing a quality service, but is not an end in itself.
- Monitoring the quality of care provided across all services - routinely measuring and benchmarking services internally and externally where this information is available. Proactively looking at any risks to quality and taking prompt mitigating action.
- Challenging poor performance or variation in quality and recognise quality improvement - honestly looking at the root causes of both poor and exceptional performance is the first step to making effective, as opposed to knee-jerk responses when things go wrong, and spreading good practice when things go right.
- Working with other health and social care organisations to ensure care is co-ordinated and personalised - health and social care systems are highly complex and therefore inherently risky. Partnership working and development of services that result in agreed care pathways can minimise these risks.

> "We are also committed to remaining a learning organisation, continually enhancing our competencies and capabilities and encouraging new and better ways of thinking."

- Building a culture of listening, transparency and accountability - listening to concerns from whatever source, but particularly service users, carers and staff, is a crucial element in detecting problems before they become serious failings. Being held to account for the quality of care provided as a public organisation keeps the Trust alert to the possibility of harm and sensitive to early signs of failure.
- Working to ensure everyone working for the Trust is motivated and enabled to deliver quality care - ensuring staff have well designed job descriptions within which performance expectations are explicit and achievable. Staff have a right to work in a setting that is safe, free from discrimination and bullying and where they have access to expert support and advice to improve the quality of care they provide.

The Triangle of Care

The Trust is now a committed member of the Carers' Trust 'Triangle of Care' Kite Mark Scheme. This commits us to using standardised audit and action planning tools provided by the Carers' Trust. Specifically, the scheme cites six key standards required to achieve better collaboration and partnership with carers in the service user and carer's journey through mental health services, as follows:

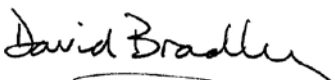
- carers and the essential role they play are identified at first contact or as soon as possible thereafter
- staff are 'carer aware' and trained in carer engagement strategies
- policy and practice protocols re: confidentiality and sharing information, are in place
- defined post(s) responsible for carers are in place
- a carer introduction to the service and staff is available, with a relevant range of information across the care pathway
- a range of carer support services is available

Originally launched in 2010, the Triangle of Care approach was developed by carers and staff with a view to improving carer engagement in acute inpatient and home treatment services. It received further validation when it was included in No Health without Mental Health, a cross-government mental health outcomes strategy, in February 2011.

These are just two examples of the enormous headway we are making at the Trust in terms of making a real and positive difference to the quality clinical outcomes for our patients, and in the quality of their experience – and that of their carers – while they are undergoing treatment with us. This time next year I anticipate being able to report on several more top level achievements of equal significance.

The Trust's sub-group to the Board, Quality Assurance and Safety Assurance Group has signed off these quality accounts. To the best of my knowledge the information presented in this report is accurate.

Thank you to everyone who is helping keeping quality at the top of our agenda, and for their unswerving commitment to turning our vision into positive action.



David Bradley
Chief Executive

Part 2

Looking forward - Priorities for improvement 2014/15

At South West London and St George's (SWLSTG), we want to demonstrate the highest possible standards of quality and professionalism in everything we do. This applies in all our interactions with service users and our wider stakeholders and, additionally, across all our day to day processes and procedures, be they clinical or non-clinical.

We want the exemplary calibre of our people and our performance to be apparent at all times – and where there are any aspects of our work that need improving, we want to strive to identify and enhance these as efficiently and cost effectively as possible.

Our definition of quality is what our service users say that it is. In short, it is our service users' judgement that decides whether the service they have received from us has met their identified needs.

In addition to our service users and their carers, the Trust serves numerous customers and provides services to many different stakeholders. These include CCGs, GPs, local authorities and our own staff. We make a point of constantly monitoring what our stakeholders think so we can act on what they say.

With all these aims and ambitions in mind, we have collated our strategic planning under three key quality themes:

- clinical effectiveness
- patient safety
- patient experience

These, in turn, accommodate the five overarching domains identified by the NHS Outcomes Framework 2014/15 setting out the high-level national outcomes that the NHS should be aiming to improve:

Domain 1: Preventing people from dying prematurely

Domain 2: Enhancing quality of life for people with long-term conditions

Domain 3: Helping people to recover from episodes of ill health or following injury

Domain 4: Ensuring people have a positive experience of care

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Looking forward - Quality Account priorities for 2014/15

This section of the Trust's Quality Account outlines the priorities identified by the Trust to improve the quality of our services in 2014/15. The Trust has identified these priorities in partnership with staff, service users, carers and Clinical Commissioning Groups (CCGs). The Trust commenced its consultation on the quality priorities for 2014/15 in December 2013 by seeking views on quality themes from each CCG, SWLSTG staff, service users and carers.

The themes identified by the CCGs were:

- Crisis Plans
- Physical Health, Falls and Diabetes
- Interface with Primary Care
- Learning Disabilities (LD)
- Service User and Carer Experience

These initial themes were discussed further at the Clinical Quality Commissioning Reference Group (CQRG) in February 2014 and then worked up into potential indicator ideas using information provided by the Trust clinical leads for Crisis Planning, Physical Health, Learning Disabilities, Feedback for Improvement and the Trust Commission for Quality and Innovation (CQUIN) Lead.

In summary the quality improvements for 2014/15 are:

Clinical Effectiveness

- Improving the quality of crisis planning for all Trust service users
- Improving the identification of service users with learning disabilities

Patient Safety

- Improving the physical health of hospital inpatients by monitoring Diabetes, Observations of Vital Signs and Falls

Patient Experience

- Improving the interfaces with primary care and providing education for GPs on Mental Health
- Using feedback systems to improve experience

For further detail on specific targets throughout the year please refer to **Appendix 1.**

Looking forward - CQUIN goals for 2014/15

The Trust's CQUIN indicators were agreed with our commissioners which sit under the three domains of quality: safety, effectiveness and patient experience. Each CQUIN goal must be measurable, using a defined indicator.

CQUIN Indicators for 2014/15 being pursued by the Trust:

1. Friends and Family Test (FFT) for staff and patients
2. Safety Thermometer
3. Improving diagnoses in mental health (physical health)
4. Feedback for Improvement – Community
5. 4 Factor Model
6. Crisis Plans
7. Safe, Managed Discharges

For further detail on each CQUIN please refer to **Appendix 2**.

Evaluation of current practice against the findings of the Francis Report

Following the publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry in 2013, the Trust conducted a baseline evaluation determining the current practice at South West London and St George's Mental Health Trust against the recommendations from the Winterbourne View Report and the Francis Inquiry. Findings were collated, analysed, and presented in a report to the Quality and Safety Assurance Committee (QSAC) in September 2013. Analysis of the baseline assessment revealed that many of the recommendations proposed by Winterbourne and Francis represent good practice and are already in place at South West London and St George's Mental Health Trust. A review of these recommendations in February 2014 indicates that in total 12 Francis and Winterbourne recommendations require further work.

A number of specific actions have been identified in **Appendix 3** against these recommendations where there was the need for some additional work. This work will be led and mainstreamed through the established governance structures and processes within the Trust.

The Trust is now paying sufficient and consistent attention to our governance systems, intelligence gathering, the management culture and building better direct relationships with service users and their families in order to mitigate the risk of the failures of care found in Mid Staffordshire and Winterbourne View. However, we need to maintain relentless attention to quality and increase our ability to listen to the experiences of people using services and of our staff if we are to continue to assure ourselves of sustained organisational effectiveness.

> "The overarching lesson from events at both Mid-Staffordshire and Winterbourne View is that a fundamental culture change is needed to put people at the centre of the NHS."

Implementing the Recommendations of the Government's Response to the Francis Report and its Winterbourne Review Report – NHS England, September 2013

Part 3

Looking back - Review of quality performance 2013/14

Review of Quality Account priorities 2013/14

Progress against quality priorities identified for 2013/14

This section of the Trust's Quality Account provides information on the quality of services provided in 2013/14 and reports on our progress against the 2013/14 quality account priorities. The Trust identified these priorities in partnership with staff, service users, carers and commissioners. The Trust selected priorities for safety, service user experience and clinical effectiveness.

Overview of Trust performance with 2013/14 Quality Account priorities

Indicator	April 2013 starting position	Target	Year-end performance 2013/14
Patient Safety			
Priority 1: Safeguarding Children	94.5%	95%	**Successfully Achieved** ✔
Priority 2: Safeguarding Adults	94.6%	90%	**Successfully Achieved** ✔
Service User/Carer Experience			
Priority 3: Real Time Feedback (RTF)	Information not previously collected	a) Access to both RTF kiosks and the Trust website to provide the Trust with feedback	**Successfully Achieved** ✔
		b) Quarterly reports on themed feedback and actions taken via the Trust website. Annual report to the Service User Reference Group (SURG) and the Carers Friends and Family Reference Group (CFFF).	**Successfully Achieved** ✔
		c) Review the changes as a result of feedback and set targets to reduce the recurrent themes.	**Successfully Achieved** ✔

Clinical Effectiveness			
Priority 4: HoNOS (Health of the Nation Outcome Scale) Matched Pairs	38%	95%	The Trust has undertaken extensive work in order to support staff in achieving this target, including producing a process map however despite this we have not been able to reach the targets set and only achieved 54%. Given the importance of outcome measures we have included this as a CQUIN next year using the Four Factor Model to demonstrate outcomes and areas where we can make the biggest improvements to service users' lives for the Trust and commissioners.
Priority 5: Crisis Planning	Information not previously collected	The review of crisis plans will be measured through audit standards set in Quarter 1.	**Successfully Achieved** ✔

For further details on each priority please refer to **Appendix 4.**

Review of CQUIN Goals 2013/14

A proportion of the SWLSTG's income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between the Trust and Commissioners for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework (CQUIN). The six CQUIN areas (and measures) for 2013/14 were:

- **Feedback for Improvement**
- **Safety Thermometer**
- **Crisis Plans**
- **Safe, Managed Discharges**
- **Smoking Cessation**
- **Physical Health**

CQUIN	Indicator	Year-end performance
Feedback for Improvement (Service User/ Carer Experience)	Recruit a Real Time Feedback (RTF) Coordinator	**Successfully completed** ✔
	Implement RTF systems on all inpatient wards and in all Home Treatment Teams	**Successfully completed** ✔
	Produce and submit a business case to commissioners for the implementation of RTF in community teams in 2014/15	**Successfully completed** ✔
	Produce and submit quarterly reports to commissioners including implementation progress updates, lessons learned and examples of ward action plans	**Successfully completed** ✔
	Commence RTF systems roll out (implementation) for community teams	**Successfully completed** ✔
Safety Thermometer (Patient Safety)	Collect and submit monthly Safety Thermometer screening data for falls, pressure ulcers and Urinary Tract Infections (UTI) (for those with catheters) for older people's inpatient wards	**Successfully completed** ✔
	Put in place improvement programmes to respond to any harms or hazards identified	**Successfully completed** ✔
	Submit a year-end report exploring if the Safety Thermometer work has had an effect on identified harms or hazards	**Successfully completed** ✔

Crisis Plans (Clinical Effectiveness) Crisis Plans (Clinical Effectiveness)	Establish a working group to include Service User Reference Group (SURG) representation, to co-produce what is considered to be an exemplar crisis plan, good practice standards and crisis planning process. Obtain sign off (approval) of these standards from the CQRG	**Successfully completed** ✔
	Train appropriate staff (doctors and care coordinators) on how to create co-produced crisis plans to the approved standard. This training programme will include the implementation of a suite of tools and resources to support staff, service users and carers. This will also include an understanding of the appropriate use of A&E services	**Successfully completed** ✔
	Q2 - Audit of a sample of Crisis Plans completed for people who have had a CPA review in the last quarter. Submit audit report to the CQRG	**Successfully completed** ✔
	Q3 - Re-audit crisis plans and report on results. Report to include: • Actions needing to be addressed, organised by themes and areas • Information on a sample of Crisis Plans of large enough statistical value to demonstrate improvement Examples of Crisis Plans and anecdotes from service users, carers, families and staff to be supplied	**Successfully completed** ✔
	Q3 - 40% of all Crisis Plans to be categorized as 'Adequate' or above following Q3 audit. *The audit revealed that where the new summary collaborative crisis plan template had been used (n=39, 13%) the quality of these was very good: • **n=3 (8%) were rated as adequate** • **n=16 (41%) as good** • **n=20 (51%) as excellent in quality.** However, where the new summary collaborative crisis plan template had not been used the quality was poor: n=249 (84%) of crisis plans were rated as poor in quality based on the audit framework.	The Q3 audit was completed and report submitted. A discussion was held with commissioners at the February CQRG to agree if the Q3 target has been fully achieved, unfortunately, the decision was that it had not*.
	Re-audit crisis plans and final report on results as above	**Successfully completed** ✔
	Q4 - 60% of all Crisis Plans to be categorised as 'Adequate' or above following final Q4 audit	**Successfully completed** ✔

Safe, Managed Discharges (Patient Safety)	Explore and report to commissioners on the feasibility of delivering a secure e-mail system to e-mail GP practices	**Successfully completed** ✓
	Produce a quality standard for inpatient discharge summaries. This should be achieved by: • Working with GP colleagues to establish what is useful/not useful in discharge summaries. This will be achieved by a discharge summaries workshop for GPs at the CQRG meeting in April 2013 • Consulting the latest Royal College of Physicians (RCP) discharge summary template	**Successfully completed** ✓
	Produce and implement a pre-populated discharge summary template in RiO for use by staff	**Successfully completed** ✓
	Report on the feasibility of providing service users with discharge summaries at the time of discharge from the ward	**Successfully completed** ✓
	Q2, Q3 and Q4 - Audit against the approved quality standard discharge summary template and report results to commissioners including any lessons learned	**Successfully completed** ✓
	Audit a sample (100) community discharge summaries and compare with approved inpatient standard. Based on the results of this audit, make recommendations for improvements to community discharge planning	**Successfully completed** ✓
	Agree an implementation plan for the roll out of a quality standard discharge summary template to community teams (this will be included as a CQUIN for 2014/15)	**Successfully completed** ✓
Smoking Cessation (Patient Safety)	Submit implementation plan for regular session feedback surveys to become part of the support package. This plan must include Feedback Survey form for approval by commissioners	**Successfully completed** ✓
	Implement session feedback survey	**Successfully completed** ✓

Smoking Cessation (Patient Safety)	Q2, Q3 and Q4 - Report on feedback surveys to show variations between different cohorts of service users. As well as demonstrating achievement of the above targets, the Trust should submit a report on feedback survey results. This report should include: • Evidence of changes/improvements to the support package that have been made throughout the year based on the feedback received from service users' surveys • Evidence that any changes/improvements to the support package have or have not improved the service user experience (this evidence can be quantitative, qualitative or a mixture of both depending on the change made).	**Successfully completed** ✔
	% of people referred to and who engage in and take up the smoking cessation service that complete the full 12 weeks support package	**Successfully completed** ✔
	Continuation of the 2012/13 reporting structures that report each quarter on: • Smoking status recorded • Referrals to Smoking Cessation Advisors (SCAs) • People setting quit dates	**Successfully completed** ✔
Physical Health (Patient Safety)	95% of inpatients to have a relevant Physical Health Assessment (PHA) within 48 hours of admission. If it is not possible to do a full physical health assessment within that time a rationale should be provided and assumptions outlined	**Successfully completed** ✔
	Quarterly information on exceptions (those people for whom it is not possible to complete a PHA within 48 hours of admission) to be collated into themes and reported to the CQRG for the August 2013 meeting. This information should include, where possible, vignettes from staff	**Successfully completed** ✔
	95% of inpatients to have it recorded that an attempt has been made to complete a relevant PHA every 6 months	**Successfully completed** ✔
	Quarterly physical health plan in discharge summary quality audits to be completed and reports submitted to commissioners	**Successfully completed** ✔

Further detail can be found in **Appendix 5**.

Progress against the core quality account indicators

The table below details the Trust's performance against the core set of indicators for 2013/14. All Trusts are required to report against these indicators using a standardised statement set out in the Quality Account regulations. Some of the indicators are not relevant to all Trusts, and we have therefore only included indicators that are relevant to the services that the Trust provides.

Data has been sourced from both the Health and Social Centre (HSCIC) and from the Trust internal data management system, Pulse, and will be referenced accordingly.

Indicator	Target	2013/14 performance
Care Programme Approach (CPA) seven day follow-ups *What is being monitored? The proportion of patients on CPA who were followed up within seven days after discharge from psychiatric inpatient care* The Trust has met this indicator for the last two years. Breaches are reviewed at the monthly Directorate Performance Review meetings.	95%	**Successfully Achieved** ✔ **96%** **Source: Trust Pulse**
Crisis Resolution and Home Treatment (CHRT) gatekeeping for inpatient admissions *What is being monitored? The proportion of admissions to acute wards that were gate kept by the CRHT teams* The Trust has met the gatekeeping requirement for two years now and there has been increasing numbers of people who can be treated at home, rather than having to come into hospital during a crisis. The Trust aims to invest further in the Home Treatment functions to ensure that there is greater access to this important clinical support. This requires all contacts be face to face for this measure "unless it can be demonstrated that face-to-face was not appropriate or possible".	95%	**Successfully Achieved** ✔ **98%** **Source: Trust Pulse**
30 day emergency readmissions *What is being monitored? The percentage of patients readmitted to a hospital which forms part of the Trust within 30 days of being discharged* The SWLSTG mental health trust intends to take the following actions to improve this percentage, and so quality of its services, by reviewing individual readmissions and reviewing the reasons for admission on an individual basis to assess to see if improvements can be made to the service user care pathway to avoid readmissions.	Less than 7.5%	**9.5%** **Source: Trust Pulse**

> “Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.” **NHS Choices**

‘Friends and family’ test *What is being measured? The proportion of staff that completed the staff survey that ‘agreed’ and ‘strongly agreed’ with the statement “If a friend or relative needed treatment, I would be happy with the standard of care provided by the Trust.”* The SWLSTG mental health trust intends to improve this percentage by engaging with staff around delivering better outcomes for our patients for improvement through the ‘Listening into Action’ initiative that is currently in operation across the Trust.	N/A	**49%** **Source: NHS Staff Survey 2013**
Patient experience of community mental health services *What is being measured? The weighted average of four of 2012 survey questions from the community mental health survey (score out of 100)* The SWLSTG mental health trust intends to take the following actions to improve this score, and so quality of its services, by reviewing the data from the survey and focusing our areas of weakness such as out of hours contact and crisis plans.	N/A	**1.5 out of 10** **Source: The “overall” score from the 2013 national community service user survey, taken from the CQC website**
Patient safety incidents resulting in severe harm or death *What does this mean> The proportion of safety incidents resulting in severe harm or death* SWLSTG continues to provide appropriate training and supports teams to learn from these incidents.	N/A	**0.97%** **Source: NRLS data 01/07/13 – 30/09/13**

Looking back - Statements of quality assurance from the Board 2013/14

Information on the review of services

During 2013/14 SWLSTG provided inpatient and community mental health services under four management teams: Kingston and Richmond, Sutton and Merton, Wandsworth and Specialist Services.

Our service areas include:

- adults of working age mental health
- older people's mental health
- child and adolescent mental health
- mental health services for people with learning disabilities
- drug and alcohol services
- prison services.

The Trust provides a number of specialist national services including obsessive-compulsive disorder (OCD) / body dysmorphic disorder (BDD), forensics services, eating disorder and deaf services for children, adolescents and adults.

The Trust reviews the data available on the quality of care in all of these NHS services as part of ongoing governance processes and will continue to do so as the Trust prepares to apply for FT status. The income generated by the NHS services reviewed in 2013/14 represents 100% of the total income generated from the provision of NHS services by the Trust for this period.

Participation in clinical audits

During 2013/14, seven national clinical audits and a national confidential enquiry covered NHS services provided by SWLSTG.

During that period SWLSTG participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

Appendix 6 outlines the national clinical audits and national confidential enquiries that South West London and SWLSTG participated in, or reviewed, during 2013/14.

SWLSTG reviewed four national clinical audits in 2013/14. Below are some of the actions the Trust has taken, or intends to take, to improve the quality of healthcare provided as a result of these findings.

The Trust reviewed the report from the Health and Work Development Unit on Promoting public health in the workplace. This was a follow up to the 2010 audit and the Trust has seen significant improvements, in particular the Trust's smoking cessation and physical activity programmes. Since the audit was conducted in October 2013, there has been a focus on engaging staff to improve their lives at work, through the work of the Trust's Listening into Action (LiA) Team. This includes working with Trust contractors to actively promote healthy food choices in the staff restaurants and vending machines, offering health and wellbeing programmes and exercise taster sessions for staff and adopting a case management approach targeting long term sickness absence.

Five health and wellbeing work streams have been developed to promote the positive aspects associated with health and wellbeing at work through LiA initiatives and other projects. The rationale behind this being that by improving attendance and performance within the Trust, the quality and safety of patient care will also improve.

The five health and wellbeing work streams are as follows:

- **Wellbeing programmes**
- **Management of Sickness Absence**
- **Staff Support**
- **Review of Trust policies**
- **Governance and Monitoring**

The Trust subscribes to membership of POM-H (UK) which supports the implementation of NICE guidelines to help clinical teams monitor

and improve the quality of their mental health prescribing. POMH-UK audit reports were reviewed by the Drugs and Therapeutics Audit sub-group and the findings and recommendations circulated Trust wide. The Trust performance with respect to POMH-UK audits was mixed, in that the Lithium audit findings showed that further work was required to maintain the improvements made last year. The audit on prescribing Attention Deficit Hyperactivity Disorder (ADHD) showed there was good adherence by Child and Adolescent Mental Health Services (CAMHS) and paediatric services to the audit standard regarding measurement of baseline height, weight, blood pressure and pulse before starting treatment. Both CAMHS and paediatric services also performed relatively well with respect to ensuring that early treatment monitoring (i.e. within the first three months of treatment) was undertaken. Action plans are in development to address any areas of improvement required.

Sutton and Merton IAPT and Wandsworth IAPT both participated in the National Audit of Psychological Therapies (NAPT) which was established to assess and improve the quality of NHS-funded psychological therapy provision for people with anxiety and depression in England and Wales. The baseline (2011) and the second round of NAPT evaluated the same aspects of quality - access, appropriateness, acceptability and outcomes. In general the Trust fared favourably against national standards. However findings were below the national average in standards relating to NICE guidelines and information provided to service users about their choice of treatment options. Action plans have been developed to address all areas of concern identified in the audit.

Participation in clinical research

The Trust is making steady progress with patient recruitment into clinical research, with a year to date total of 127. We continue to receive managerial support from the London (South) Clinical Research Network (CLRN) through local adoption of studies on the National Institute for Health Research (NIHR) portfolio. Trust Research and Development (R&D) has also maintained a steady position within the London (South) CLRN's performance metrics by consistently outperforming other acute Trusts within South London in governance, local approval and study set-up times. The increase in locally adopted clinical trials this year is expected to accrue substantially more income than previous years, despite a lower recruitment total compared to this time last year.

The R&D department has scored some recent successes and has made significant progress in expanding its research portfolio, particularly in the areas of hosting clinical trials and fostering strategically and operationally effective collaborative partnerships. The Trust portfolio currently comprises 51 studies, of which 33 were adopted from the NIHR portfolio through the London (South) CLRN. The remaining 18 studies are chiefly educational projects and locally generated unfunded research. At present there are 16 clinical staff participating in portfolio research across subspecialties such as Neuropsychiatry, Learning Disability, Child & Adolescent Psychiatry, Forensic Psychiatry and Personality Disorder and OCD.

Our renewed participation in clinical trials will also generate considerable income based on a' per patient' funding formula. The recruitment stage of our first commercially funded clinical trial in over four years, the Impact of Illness in Schizophrenia study led by Dr Aileen O'Brien has ended, with the Trust recording the highest level of recruitment within the country. On the back of this success, Dr O'Brien has already been approached to work on another clinical trial and is in the process of negotiating terms and conditions prior to study set-up.

Under the leadership of Dr Robert Lawrence, the Clinical Research Unit in Psychiatry of Old Age and Neuropsychiatry (CRU-POAN) is gaining momentum and the last three months have been particularly productive. In addition to the two amyloid imaging studies running at the Trust, negotiations are currently underway for Dr Lawrence to adopt a further six studies, subject to local feasibility review. This includes a joint grant application with St George's, University of London to examine whether vitamin supplements can delay cognitive decline in Mild Cognitive Impairment (MCI). The outline application has been accepted for further review by the NIHR's Efficacy and Mechanism Evaluation (EME) Programme and is expected to go to full submission.

Other studies currently under review for local adoption include:

- Alcohol Related Brain Damage (ARBD) – a possible collaboration with Kent & Medway Trust
- Lundbeck – Protocol 14863A Phase III study into Alzheimer's Disease
- Astra Zeneca – Protocol (AZD3293) Phase II-III into Alzheimer's Disease and Mild Cognitive Impairment
- AFFECT – a randomised controlled trail of calcium channel blockade (ccb) with Amlodipine for the treatment of subcortical ischaemic vascular dementia.

This body of work will undoubtedly bolster the Trust's reputation for hosting innovative research, whilst contributing substantially to the Trust ledger by accruing more research income. This includes a joint grant application with St George's, University of London (SGUL) to examine whether vitamin supplements can delay cognitive decline in MCI. The outline application has been accepted for further review by the NIHR's EME Programme and is expected to go to full submission.

The Patient & Public Involvement (PPI) in Research consultation process is operating smoothly, with input from researchers at St George's, University of London. The overriding aim of the initiative is to promote active involvement in research among service users and carers, to raise awareness and identify any potential barriers to recruitment into local research. Currently the R&D Office is working in partnership with SGUL to plan the main consultation day which is scheduled for May 2014. There is expected to be an impressive turnout, with representatives from the Trust's clinical body, voluntary and community organisations, service users, carers and researchers. Service users and carers have played an intrinsic role in the planning stages and will also act as facilitators at the main consultation event.

The R&D department has successfully appointed three new research nurses to work on industry, dementia and a pending clinical trial (Optimal Treatment for OCD). Inductions are due to start imminently and the R&D Co-ordinator will also apply for additional contingency funding from the CLRN to maximise the Trust's financial investment in these posts as well as sustainability.

**The CLRN recruitment year runs from October-September.*

Statements from the Care Quality Commission

South West London and St George's Mental Health NHS Trust is required to register with the Care Quality Commission (CQC). The Trust was registered with the CQC without compliance conditions on registration. South West London and St George's Mental Health NHS Trust has been registered to carry out the following regulated activities (activities undertaken by the Trust that require registration):

- treatment of disease, disorder or injury
- assessment and medical treatment of persons detained under the Mental Health Act
- diagnostic and screening procedures

Between April 2013 and November 2013, the CQC conducted unannounced inspections under the old inspection process at the following registered Trust sites; Springfield University Hospital, Tolworth Hospital, Queen Mary's Hospital, Hayden House and Westmoor House. The CQC has not taken enforcement action against South West London and St George's Mental Health NHS Trust during 2013-14. However, a number of compliance actions were identified by the CQC which the Trust has taken action to address.

The Trust has one outstanding compliance action relating to a lack of understanding and non-compliance with the Mental Capacity Act at Tolworth Hospital. The CQC found that further work was required to ensure that, where people did not have the capacity to consent, the provider consistently acted in accordance with legal requirements and consequently raised a compliance action against the Trust. Work is in progress to address these concerns.

In March 2014, South West London and St George's Mental Health Trust was a pilot site for the new CQC inspection and regulatory process for mental health trusts. The Trust is awaiting the report from this inspection.

Further information about the Trust's performance against the CQC Essential Standards for Quality and Safety is available at: http://www.cqc.org.uk/directory/RQY. South West London and St George's Mental Health NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data quality

The Trust has unified most of the data collection processes, to ensure that almost all clinical information we use is derived from the electronic clinical record (RiO). The information can therefore be easily monitored for accuracy, helping to ensure that the information is current, comparable and correct.

This coherent system is the cornerstone of efforts to assure data quality and means by which the information used to plan, monitor and control the quality of services is as accurate as possible.

The performance measures are based on the electronic clinical record, with no need for additional data entry. Therefore the quality of information is directly linked with the quality of the clinical record and the provision of care and support.

South West London and St George's Mental Health Trust will be taking the following actions to improve data quality:

- The Trust benchmarks strongly on inpatient data quality in comparison to many other mental health Trusts, but will focus on ensuring the information in the Mental Health Minimum Data Set (MHMDS) is prioritised, especially the new data required for the mental health tariff.
- Data quality is reported by team and individual on an ongoing basis but is reviewed at the monthly performance meetings and is reported to the Board.
- A new, easy to use personal dashboard will be developed in the year to support the management of data quality throughout the organisation. Each clinician will be able to easily see how their data quality supports the provision of an accurate and reliable clinical record.
- Work will be carried out with teams to identify who should record what information on the clinical record. At the moment, there is some duplication of effort and the roles of each profession and team will be clarified to improve the efficiency of data capture.
- A clinical audit on data quality is completed annually to check that the information is accurate. The Trust can easily check the information contained in an individual data field, but it is more difficult to ascertain the quality of the record or whether the necessary information is contained in free text fields.

NHS number and general medical practice code validity

South West London and St George's Mental Health NHS Trust submitted records during 2013/14 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which publish information on data quality. The percentage of records in the published data at Month 10 2013/14:

- Which included the patient's valid NHS number was:
  - 99.7% for admitted service user care (compared to a national average of 99.1%)
- Which included the patient's valid General Medical Practice Code was :
  - 100%for admitted patient care (compared to a national average of 99.9%)

Information governance toolkit attainment levels

SWLSTG met the deadline for submission of its annual Information Governance Toolkit score for 2013/14. The Trust achieved an overall score of 'satisfactory' for the third year running. The Trust scored Level 2 or higher in all of the 45 requirements.

Information governance personal data loss

Personal data loss risk is managed by the Trust's Information Governance Group and overseen by the Senior Information Risk Officer. During 2013/14, 36 minor incidents were reported to the Information Governance Group. Only one was recorded as a Serious Incident in which a list of contact details of circa 20 service users were inappropriately included in a distribution list to all of the others. This was fully investigated and appropriate action taken.

Clinical coding error rate

SWLSTG was not subject to a formal Payment by Results clinical coding audit during 2013/14 although the procedures were reviewed. The Trust has continued to focus on the coverage of clinical coding of primary diagnosis for inpatient episodes of care. By December 2013, the figure was 80.6%, against a national average of 98.8%.

On the quality of Clinical Coding, in 2013/2014 the Trust was audited for the accuracy of Clinical Codes for inpatient episodes, The Trust scored over 95% accuracy for primary diagnosis, and over 80% for secondary diagnosis. This was translated to Level 3 in the respective annual Information Governance Toolkit, which is the highest possible score in this category for that particular requirement.

Complaints

We take all our complaints very seriously and consider them to be a valuable feedback mechanism. Listening carefully to the concerns, we endeavour to everything possible to resolve them and respond to complainants. We aim to learn from what has happened and make demonstrable improvements to the service where appropriate.

During 2013/14 the Trust has changed the way it conducts its complaints handling. Prior to September 2013, complaints were investigated by managers and clinicians in the boroughs who prepared responses for review by the Complaints Department. Since September 2013, additional resources have been allocated to the Patient Experience Team (previously the Complaints Department) and comprise a Patient Experience Manager, four Patient Experience Leads and a Patient Advice and Liaison Service (PALS) and Complaints Administrator.

These adjustments have led to a number of improvements in quality:

Independence and investigations:

As the team are managerially separate to the Directorates and work in a corporate context, investigations are independent to the service, the team are able to challenge information received during the course of the investigation and reach conclusions that are objective and impartial. This is not a replacement to a completely independent investigation from outside the Trust but represents considerable improvement. Clinical advice is also sought by the team about practice and learning issues from a clinician within the team.

Responses:

The Patient Experience Department have a quality review structure in place to ensure that all responses cover all points raised; all responses are reviewed and signed by the Chief Executive.

Learning and embedding learning:

The Patient Experience Team ensures that learning from cases is reported to the Board. The Board is made of aware of complaints and themes of particular note in monthly Patient Stories. This is in addition to a monthly report which sets out the learning and themes as well as statistics which is provided to the Directorate's Clinical Governance Group and also feeds into the Trust wide action plan.

PALS Advice Line and Surgeries:

The team also run PALS surgeries in selected service areas where concerns are resolved quickly at a local level. This is in addition to a PALS telephone advice line.

Care Connect and Patient Opinion:

The Trust is piloting Care Connect a new web based system where service users, carers, friends and families can report a problem, ask a question or share an experience and the Patient Experience Team will respond within two working days. A similar system applies for Patient Opinion where posts about experiences are responded to. The team has also begun posting blogs about complaints handling and learning.

Timeliness and Responsiveness:

The Team has two Key Performance Indicators (KPIs) and has made substantial improvements to achieve these.

Complaints Indicator	Target	Oct	Nov	Dec	Jan	Feb	Mar
75% all written responses will be sent to the complainant within 25 working days	75%	65%	100%	100%	100%	96%	97%
75% all complaints will be acknowledged with 3 working days	75%	88%	81%	90%	96%	88%	97%

During the period 1 April 2013 to 31 March 2014 we received 403 complaints which is a reduction from the previous year figure of 415. We continue to improve the quality of resolution and our responses to complainants and of the 403 complaints received in the year, nine were referred to the Ombudsman for independent review which is a significant reduction from 24 referrals last year. Three remain open for a decision, one was withdrawn by the complainant, two were not upheld, one was partially upheld, one was upheld and one was closed as the Trust agreed to send a further response.

Whilst the number of complaints has decreased overall, there is an increase in certain categories. This is owing to changes in the way complaints are categorised and have therefore reduced the number categorised under General Procedures. Communication of Information to Patients and Attitude of Staff remain the highest categories for the Trust and there are a number of strategies developed to address these issues:

- A framework for all inpatient wards to make visible and store information about services so that patients, carers and visitors can access it easily
- All outpatient correspondence relating to appointments now includes an offer to discuss any correspondence that has been sent to clarify any points of misunderstanding
- Work has been done to enhance 'customer service', working with service users on the ward to jointly define compassion, care and etiquette with the aim of improving the experience of our service users and carers.

A Complaints Annual Report will be prepared in accordance with Regulation 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulation 2009.

Compliments

Compliments received about the Patient Experience Department:

> A thank you from a challenging complainant who thanked the Complaints Officer for listening, saying that people usually hang up on him.
>
> *"Thank you for your help. I am happy with this outcome and it is a relief to me especially at this difficult time"*
>
> *"Thank goodness for you!"*
>
> *"Thanks so much… Very sorry to keep coming back to you, but you seem to be the most efficient source of knowledge"*
>
> *"Anyways - a massive thank you for all the help and support that has been available here, you really do have a substantial impact"*
>
> *"Great that there is now a PALS department at Springfield and you are one of the best PALS people I have spoken to"*
>
> *"Great to have you manage complaint responses"*
>
> *"Thank you… for your support of my service"*

The Trust values positive feedback and received 564 compliments this year were received via letters, emails, cards and Real Time Feedback Kiosks on the Trusts wards.

Wisteria ward

"The first thing to say is our heartfelt thanks to all doctors, therapists, nurses, HCA's, for taking care of our child for 15 months, you made life affirming and lifesaving changes to the state of our child. We thank you for the bottom of our hearts"

Adult Eating Disorders (Outpatients)

"I really just wanted to drop you a line to say thank you... thank you for not turning me away, for not chastising me... for not judging me and for giving me the help and encourage and access to all of the amazing professional services that have enabled me to recover and move on with my life… I don't think at the time I realised just how good the services and facilities available to me were, so I would like to repeat my gratitude once more... It has made me understand just how lucky I was in terms of the service available."

Twickenham and Hampton Community Mental Health Team

"I'm sure I would not have done it without your help and advice. We will be forever grateful to you. We would like to give you a big thank you; you always seem to go that extra mile."

Serious Incidents

Since 2011, the Trust has made significant changes to the systems and processes around serious incident reporting with a view to improving the timescales and quality of reporting. From December 2012 the Trust has had no overdue (Strategic Executive Information System) STEIS reports and has met the KPI relating to the quality of reports submitted to Kingston CCG.

The Trust has worked collaboratively with Kingston CCG to improve the quality of the reports submitted and to maintain a strong relationship by discussing incidents of concern on a weekly basis which has led to a joint approach in deciding which incidents are added to STEIS and those that can be investigated at a local level.

Overall in 2013/14 36 incidents were added to STEIS. Wandsworth reported the highest number of incidents which is consistent with its population size. The Trust is not an outlier in the number of Serious Incidents reported in the year when compared to other mental health Trusts. The Trust however does report within the lowest 25% of Trusts in terms of National Patient Safety Agency (NPSA) data. Only 11.8 incidents are reported per 1000 bed days between 1st October 2012 and 31st March 2013, however the Trust has made significant improvements in the way incidents are reported and our internal figures demonstrate a significant increase in the number of no harm and low level incidents reported. Awaiting publication of latest patient safety information, due to be published at the end of April 2014.

In 2013/14, South West London and St George's Mental Health Trust have focused on developing organisational learning and embedding the learning through to all staff. This included three Trust wide learning events held in 2013/14, a business case to increase the number of Risk Assessment Training and Education (RATE) Training Trust wide and two risk alerts being circulated. The Trust also commissioned Niche Consultancy to complete a review on the Trust's learning structures, this review has been completed, the Trust has demonstrated achievement past level C (bureaucratic) and much of the systems, processes and practice in place meets level D (the 'proactive level') in the Manchester Patient Safety (MaPSaf) framework.

Trust wide actions arising from incidents, safeguarding cases and complaints continue to be monitored by the Serious Incident Governance Group and The Quality Tracker which is a risk tool that is noted at the Trust Board. The Trust has also developed its structures to ensure that local actions are monitored at the Directorate Clinical Governance Groups.

The top 4 reported categories for 2013/14 were Suicide by Outpatient (7), Unexpected death of a Community patient (in receipt) (6), Slips, Trips and Falls (3), Attempted Suicide by an inpatient (4).

There was one reported homicide in 2013/14 for which the Trust investigation has completed and is currently under a Domestic Homicide Review.

There were no reported Never Events.

What else have we done?

- Updated and reviewed all Trust wide Clinical Policies
- Launched an Incident Reporting Campaign to increase the number of incidents reported.
- Developed a Trust wide Action Plan to address re-occurring themes
- Produce a quarterly report on themes and learning
- Review incidents on a daily basis to provide support to staff and encourage a proactive approach to risk management.

Comments from stakeholders

To ensure transparency and partnership involvement SWLSTG sent the draft Quality Account for comment to key stakeholders including local Healthwatch, Health Overview and Scrutiny Committees (HOSCs) and Clinical Commissioning Groups (CCGs).

Carer Representative, QSAC

Content

The key themes (which are partly dictated by NHS and or CQUIN priorities) focus on issues which really matter to service users, carers, family and friends (CFF).

The document presents a huge amount of detail, and it is good that this is all in the public domain. Planned and desired outcomes are clearly stated and there are measurable performance indicators against which we can hold the Trust to account.

There is a great deal of information on process, performance indicators, actual or anticipated outputs, but I would like to see more on the outcomes all this produces for service users and CFFs

I am very pleased that the Chief Executive has chosen to highlight the Triangle of Care in his statement, as this demonstrates a strong commitment to families and carers.

There are clear indications that the Trust is making progress on important issues of quality and safety, which is reassuring to service users and CFF.

But the document's presentation presents a huge problem for the reader. It is very repetitive (including unnecessary repetition of some of the performance indicators etc.) and the strong message about improving services – which deserves to be publicised, often becomes blurred and lost within all the detail.

Presentation

Who is the QA intended for? Who – apart from a small number of commissioners, CQC and NHS officials – is going to read it, and who actually needs this amount of detail? I assume it has to meet the requirements of the NHS, CQC and Commissioners as well as the "general public" – whoever they are, and that these are incompatible.

As a fairly well-informed general reader I find the information in the QA interesting and much of it reassuring. But the presentation is confusing and repetitive and in places the document feels impenetrable. It jumps about from next year, to last year, then back to next year, which makes it very hard to follow, or to see a coherent narrative. For example, one area I am particularly interested in – crisis planning – seems to say the same things at least three times, and the important message about service improvement and about how it is being achieved becomes diluted.

Healthwatch Wandsworth (HWW) will be making some suggestions with regard to presentation of the document in their response, and I hope these can be addressed in future QA documents, if not in this one.

It would be helpful to have a summary report, perhaps targeted primarily at the general reader, including Service Users and CFFs, which presents a clear narrative and draws out key achievements (something more substantial than the usual "executive summary"). Clearer signposting within the document might be helpful eg making VERY CLEAR all the places where there is a switch from 2013/14 to 14/15.

It might also help if the contents page is set out in more detail to help signpost readers to particular issues or areas which interest them.

Although it is very hard to track the narrative, and progress on priorities across 13/24 and 14/15, I found the actual language used, and the layout of the various tables and charts, clear and reasonably easy to follow, though in places it is rather "wordy". It might be worth asking someone in the comms team to do some editing.

I am sure a full glossary will be provided with the final document.

Getting the message across to service users and CFF

All the issues covered in the QA are important to SUs and CFFs and many people will want to consider and discuss them in detail. However, I think many people might be put off by such a bureaucratic document. And it is very hard to take in the whole range of the document at one reading! I hope we can think

about better, more user-friendly ways to put these important issues across (though QSAC et al probably need a separate discussion about this).

Crisis Planning

I am very pleased that the Trust is developing a clear understanding of collaborative crisis planning and that the QA gives the issue a high priority setting out clear aims and indicators, all of which can be measured and audited. This is a sensible, realistic way of addressing the weaknesses which were identified in 2012.

The document appears to focus mainly on in-patient and HTT. I would like more information about links with CMHTs where crisis planning is also managed, and with GP services, as part of managed discharge.

A key point to emerge from the recent "Delphi" research by Miles Rinaldi was that 90% of service users and 75% of CFFs thought that crisis plans will not work because services will not honour them. The QA provides some welcome evidence that this situation is changing, with the introduction of collaborative crisis plans. This will only work effectively if crisis plans are understood, renewed and acted upon across the whole system, which includes CMHTs and primary care/GP services. I would like to see more in the document about crisis planning in CMHTs, and stronger cross references between the sections on crisis planning and GP services. I think this will help to demonstrate that crisis plans actually are starting to be honoured. This will help to provide some assurance which is still badly needed.

I am pleased that the QA (and the collaborative crisis planning template itself) acknowledge the role of CFFs

Recovery-focused care planning, including crisis planning (p 52). The QA makes the important point that SUs carers and families all need to be involved. Just to note that Family work training for staff (psycho-social interventions) can make a big contribution to this. A session on collaborative crisis planning was very well received by staff at a recent family work training course. We need more of this.

Improving physical health of hospital in-patients… falls, diabetes, monitoring etc.

Although the inpatient services are the focus, I would like to see something about how the management of Diabetes care in particular is maintained after the person has left hospital – can we include something about "handover" or signposting to community services, with, perhaps again a cross-reference to primary care and GPs?

Improved interface with primary care

Again – could we include a link / connection with crisis planning. SUs and CFFs are always very anxious about getting a "fast track back" if they experience a crisis or relapse after discharge to primary care, and a statement about the importance of this – and of honouring crisis plans – would be helpful and reassuring.

Physical health – specific achievements and improving diagnosis in mental health (physical health)

I would like to see more clarity about the role of GPs and primary care – and how this links to the Trust's responsibility. People with a severe mental illness still have the same physical healthcare needs after they have been discharged from CPA and/or CMHTs. What more can the Trust do to ensure that these needs are fully understood and followed through in primary care – and can the QA say anything to give more assurance to carers like me?

Safe, managed discharges

I am pleased that this important area is included in the QA. This section seems to be mainly about communication between clinicians. I would like to see more about families including recognition that family members often have to take on and manage potential risk, should the service user start to relapse. Family members are often very concerned about this. I want to know how family members are involved and supported, in secondary and primary care, in the management of risk. This important issue needs to be included in the QA. (These points could also be covered in the sections on safeguarding)

I hope you will find my comments useful, either in revising the QA, or – even more important – in the actual delivery of services.

Healthwatch Wandsworth

Healthwatch Wandsworth is grateful for the opportunity to comment on the fifth annual Quality Account of the Mental Health Trust. But this poses something of a conundrum. On the one hand the document contains a mass of detailed information which bears witness to the Trust's corporate commitment to sustained quality improvement despite the prevailing financial stringency and, to those who have been engaged with the Trust for some time, presents clear signs that comments made on previous years' accounts have been heard and attended to. But on the other hand as an attempt to communicate with the general public the document falls a long way short.

Taking the latter point first, it is hard realistically to imagine a lay member of the general public or indeed many service users, carers or family members getting much beyond the Chief Executive's opening statement. For the rest of the Account much of the content, the way it is presented and the order in which it is presented reflect a mainly bureaucratic approach and are quite confusing for a lay reader. HWW are submitting some specific ideas on how to overcome some of these problems but perhaps the Quality Account deserves a thorough rethinking for next time.

Approaching the draft Quality Account 2013-4 on its own terms, however, HWW see many things to welcome. In particular, this year's version makes significant progress towards aligning the annual Quality Account with the Trust's wider ongoing quality strategy. We also welcome the Chief Executive's statement that the Trust's five year quality strategy for 2014 – 2019 will be available on the website a little later this year, and that this will be followed up with regular updates on progress.

In addition the draft Quality Account provides encouraging evidence of constructive collaboration with the commissioning CCGs on the use of the CQUIN framework (incentive payments) to set clear, measurable and progressive targets for specific quality initiatives contributing to strategic goals.

We gladly acknowledge the considerable amount of hard work by a wide range of Trust staff which has led to the successful completion of 4 out of 5 of the Quality Account priorities for 2013-4 together with the near-totality of the CQUIN targets. For us the achievements which stand out are the co-production of a collaborative form of crisis plan which seems to have met with a high level of satisfaction among those who have so far used it; and the consolidation of the Real Time Feedback system into a useful tool of responsive management in a good number of inpatient units. But even these are arguably "process" changes: it would be good to see more evidence of improved outcomes for service users and their families.

For the coming year the Quality Account singles out 5 priorities as before but for the first time helpfully situates them against the wider strategic framework. Two of the priorities, improving the quality of crisis planning and using feedback systems to improve the experience of patients and carers, friends and family, usefully aim to carry forward the good work done under previous accounts. The other 3, dealing with identification of learning disabilities, improving inpatients' physical health and improving interfaces with primary care, are all new to the Quality Account and in our view represent important areas deserving priority attention at this stage.

It is important however in our view that these Quality Account priorities are seen as the tips of a much larger iceberg of quality improvement work being pursued under the wider quality strategy. In that connection it is helpful to find in the Chief Executive's statement his references to the 15 Steps Challenge and the Triangle of Care, important quality initiatives which run across the Trust's work. We would have liked to have seen rather greater prominence given to the Trust's planned efforts to improve its performance in the CQC's patient satisfaction survey of community mental health services, which is touched on only once near the end of the draft account (p. 54). It is also a little surprising to find no explicit reference to the Trust's decision to invest in improving certain key staffing ratios following the recent nursing review of inpatient services.

The Quality Account makes a number of references to specific audits to be carried out and reports to be written. In a few cases, particularly where feedback from service users and carers, friends and family is concerned, the commitment is given, and rightly so, to publish the material on the Trust's website. It may not be practical or worthwhile for every audit report to be published in full in this way but it could be helpful to include more signposts to ways people might keep track of progress in quality improvement over the course of the year.

Kingston HOSC

We appreciate the opportunity of providing comments on the Trust's Quality Account for 2013/14 and the proposed Objectives for 2014/15.

We are pleased to note the excellent progress made on last year's objectives and that the Trust continues to host innovative research. In particular we welcome the studies under review for local adoption on Dementia and Alzheimer's. This is particularly important going forward. The Panel considered a presentation from Kingston Hospital about Dementia care for in-patients and we will look during the coming year at approaches in the community and would like to see evidence of steps towards a holistic joined up approach enabling a commonality of professional practice and best approaches where possible and appropriate.

We are pleased to see that the Trust has been successful in achieving virtually all of the CQUIN targets set last year but wonder whether these are sustainable in the longer term when CQUIN funding may no longer be badged against these areas.

We also welcome both the Triangle of Care and the 15 Step challenge initiatives as they are good practice and we look forward to learning more about progress with these.

In terms of the **Objectives for 2014/15** we would like to make the following comments:

In January 2014 the Health Overview Panel received a detailed presentation on Crisis Planning. One of the suggestions we made was around ensuring carers are more involved in care as well as in the actual crisis planning process. We welcome the objective to involve patients' social networks where ever possible in crisis planning and the intention to draw up crisis plans for those patients who are not on the CPA.

Physical health, falls and diabetes

We note that people with serious mental health conditions often die 20 years earlier than those without these conditions. We suggest that as well as strengthening health checks, screening and advice within inpatient settings, that stronger relationships are forged with primary care to ensure that GPs are more vigilant in providing health interventions and advice for people in the community with enduring mental health problems and that there is a good communication between secondary and primary care about identification of physical health issues. We suggest that there may be a need for GPs to adopt more proactive approaches to encourage people with mental health problems to engage on physical health issues.

Kingston Hospital NHS Foundation Trust has undertaken work on falls, and this is a continuing KHT objective for 2014/15. Some of the KHT inpatient approaches for elderly medical patients may be appropriate for SWLSTG.

Interface with GPs

We are pleased to learn about the availability of some secondary care services in a limited number of GP practices and hope that this can be extended and link fully with the Kingston Wellbeing Service (KWS). The Panel has requested an update in 2014/15 on how the KWS and secondary care services are accessed in primary care settings.

We welcome the use by acute trusts in Wandsworth of the Kinesis GP system, the plans for the pilots for mental health and hope that this can be introduced in the near future to Kingston.

Learning Disabilities

We welcome the Trust's approach to focus on improving services for people with learning disabilities, including producing a protocol about LD, Autism and Asperger's awareness and we would like to draw attention to what could be relevant work undertaken by RBK. The Panel has had two presentations about the individual strategies for Children's and Adults' Autism in the past few months and we would commend this work to the Trust.

Service User, Friends and Family Feedback

The Panel has also heard about the Real Time Feedback and the benefits that this has brought about, and we welcome the wider involvement of friends and family who can bring a different perspective and can have a very important role in supporting patients. We would suggest that the Trust also looks at ways to gather primary health care professional views to triangulate with patients' views.

2014/15 CQUIN

We particularly welcome the proposed audit of discharge summaries to ensure that information to GPs is as comprehensive as it can be. We would be most interested to learn about the proposed Cluster Assessment process during 2014/15. Again we would question how these approaches can be sustained going forward if CQUIN incentives are not badged to these in future years.

What others said about the Trust

Whilst it can be difficult to discuss some of negative findings of the CQC we consider it is important to give a flavour of these. They are public documents and some information should be made available.

Quality Performance

Looking back on 2013/14 it is very encouraging to note that the Trust has successfully achieved all the targets which were largely focused on progress in getting robust systems in place, particularly for safeguarding and crisis planning.

We note that serious Patient Safety Incidents details are awaited and we would request that details are included in the final Quality Account. We would be grateful if the Trust could confirm whether information is included for those services which are commissioned by non-NHS commissioners such as Local Authority Public Health Teams.

Other comments

There appear to be some omissions in the report. We cannot see any reporting on health care associated infections and how these are handled and there does not appear to be a summary of how the Trust benchmarks nationally on quality issues.

Healthwatch Richmond

Healthwatch Richmond welcomes this report and the opportunity to comment. It is pleasing to see that the Trust has achieved 4 of the 5 targets it set for the previous year, and promises ongoing commitment from the Trust to continue improving quality in these areas. We acknowledge the final priority was not achieved for reasons outside the Trust's control.

We welcome the achievements made with crisis planning targets; these are positive steps to build on over the coming year. The results of a patient experience survey we conducted in early 2014 reinforce this by showing that patients experience difficulties in accessing the crisis management teams. We feel that the current priority does not go far enough to address wider issues, and further development of the crisis response services is needed. Indeed the Trust notes that feedback from service users stated that much more could be done collaboratively to develop crisis plans with people using services.

Whilst we recognise that the priority for improving interfaces with primary care is an important long-term step for the Trust, such priorities should be Trust wide. As the priority focuses on Wandsworth, the benefit of this target for Richmond residents is unclear. With the current re-design of the Community Mental Health services in Richmond, the opportunity should be taken to extend the benefits of this pilot beyond Wandsworth.

It is encouraging to see the Trust's commitment to improve and broaden the mechanisms for patient feedback being expressed in its priorities. However it is unclear from the priorities whether the Trust has set any targets for measuring achievements. More systematic reporting is needed, as is evidence of actions taken in light of the feedback.

It is promising to see improving the identification of users with learning disabilities as a target. It would be positive to see the Trust gather service user and carer feedback on progress, with this measured and incorporated into future planning. Regarding the focus on physical health, it would be beneficial to have an indication of the way in which this target will inform work to enhance the physical health of those served by community mental health services, as this is also an important area of work.

Healthwatch Richmond's patient experience survey received patient feedback that raised concerns about staffing issues, levels of occupancy on wards and patient safety within the Trust that have not been addressed by the Quality Account. We hope that the Trust are committed to making improvements in these areas and we look forward to working with them, particularly regarding our recent survey, after the publication of the upcoming CQC report.

Healthwatch Kingston

Healthwatch Kingston very much welcomes the opportunity to comment on South West London & St George's Mental Health Trust Quality Account 2013-14.

In the past year, much has changed for Healthwatch Kingston. In April 2013 it transformed from the Local Involvement Network (LINk) to a local Healthwatch. As well as continuing the LINk's work to engage with patients and service users on health and social care issues, it now has statutory powers to hold health and social care providers to account.

It can do this through Enter & View (visiting a service and observing what takes place), by writing reports about evidence we receive and making recommendations to service providers, and by reporting services to its commissioners or a body such as the CQC.

As a user-led organisation, Healthwatch Kingston represents the voice of local people, and focuses on patient experience. It offers service providers the opportunity to get meaningful feedback to help improve and change their services to meet the need of patients and service users.

Mental Health remains a priority for Healthwatch Kingston and its affiliates, and the Mental Health Task Group has continued to monitor mental health services as well set priorities for the group to focus on.

We would like to see more engagement with Healthwatches in South West London, particularly as we represent a large group of people with experience of mental health services and issues.

Priorities

We are pleased to see that the Trust has met most of its expected outcomes for 2013-14.

Priority 1

We appreciate that it is vital for the Trust to develop multi-agency communications in terms of safeguarding children, and we hope that this means that Looked after Children are both known to the Trust and better protected. We feel that this priority says little about any safeguarding children cases the Trust has dealt with and their outcomes.

Priority 2

Healthwatch Kingston recognises the importance of safeguarding, and we are pleased that the targets of allocating a Safeguarding Adults Manager and a strategy meeting/ discussion have been met.

We noted that the target was 90% but the starting position in April 2013 was 94.6%. It would be interesting to find out what the end position was in March 2014. It is also a shame that target B is not measured; perhaps an explanation why it is currently not measured would be helpful here.

Priority 3

As an organisation of and for patients, service users and their carers, Healthwatch Kingston is pleased to see that service user/ carer experience is a priority. Services cannot improve unless service users and carers are consulted in a meaningful way. It is therefore disappointing that targets B and C (quarterly reports and themed feedback and actions on the Trust, and reviews of these changes respectively) are currently not provided.

We would also preferred to have seen some data on the feedback provided in this section, rather than separately later on in the report (p. 55-58).

Priority 4

We realise that this priority was not met due to a change in the system and the way the HoNOS was recorded. Although the target reached is significantly lower than the expected target, we believe that making it a CQUIN for next year means that the Trust has put in place adequate measures to ensure the target can be met next year.

Priority 5

Carers are one of the priorities for Healthwatch Kingston's Mental Health Task Group, and we feel that carers need to be included in a better and more effective way in crisis planning. This has benefits for the both the patient and their carer.

We are pleased to see that the Trust rolled out training courses on recovery focused care and crisis planning for staff. We also noted that crisis plans have significantly improved over the year with far fewer rated as poor.

It is good to see that service user feedback has contributed to this work, and that the training has helped staff dealing with difficult issues.

Progress against core quality account indicators

The targets have been met for only two of the six indicators. Three indicators have no target figures and some data has not yet been published which means that we cannot comment on these.

The two indicators that have been met are encouraging however as it shows that the Trust followed up on 96% of patients on CPA (Care Programme Approach) and that it is providing more care at home for patients.

Final comment

We feel that the report has a confusing layout and that certain sections that ought the together are reported on in separate sections. For instance, Priority 3 would make more sense if the section on complaints and feedback was added to this.

Although we realise that this report must contain clinical terms, we feel not enough has been done to make it user friendly enough.

Service Users Reference Group (SURG)

General feedback was positive and were thankful to have been involved in the document. Two specific questions were asked about the CQUIN indicators.

Friends and Family Test

- How will this be implemented?
- Can this be included as part of other feedback mechanisms?

Safe, Managed discharge

- Should ensure that all discharges are co-produced with the service user

Executive Management Committee (EMC)

EMC asked that the introduction should reflect the process for developing the report, including who was consulted in the priorities.

Compliance and Clinical Practice Standards Group

Physical health, vital signs priority should include:

- Routine scoring of observations using of National Early Warning System (NEWS) scores for hospital inpatients
- Checking for level of consciousness
- Making these changes will ensure we are compliant with standards from the Resuscitation Council.

Learning Disability Group

The Clinical noted the importance of stressing that the standards must clarify that the Quality Account priority is about improving the services for those clients with learning disabilities who access mainstream mental health services (not those who currently sit within our specialist Mental Health Learning Disability services).

These amendments reflect the national policy and elements of the Green Light Tool Kit ; the trust must concentrate our resources on this group not those who have already been identified by the specialist MHLD services that we have.

Amendments following comments from stakeholders

The Trust welcomes the statements received and thanks stakeholders for their comments. The Trust will be responding to those who provided a statement.

The following changes have been made to the Quality Account as a result of the feedback received:

- A number of textual changes have been made and the format of the report has been amended to improve readability.
- Amendments were made to the Learning Disability Quality Account priority for 2014/15 to change the focus to improving the services for those clients with learning disabilities who access mainstream mental health services.
- A summary document has been produced to summarise the documents key findings to simplify reading for service users and carers.
- Amendments were made to the Physical Health Quality Account priority for 2014/15 following feedback from the Resuscitation Training Officer in order to comply with standards from the Resuscitation Council.
- We checked the regulations to report on health care associated infections, these standards only apply for Acute Trusts.
- We have confirmed that safe and managed discharges are co-produced with service users and carers.
- We have confirmed that we have included comments from the CQC (see page 24).
- Following Kingston HOSC's comments we will provide a summary on how SWLSTG benchmarks nationally on quality issues for next year's report.

Feedback

South West London and St George's Mental Health Trust would welcome feedback on our Quality Account 2013/14.

If you would like to provide feedback or make suggestions for the content of future reports, for example, possible priorities for 2015/16, please contact Harriet Hicken, Quality Account Lead, **harriet.hicken@swlstg-tr.nhs.uk**

Glossary

Abbreviation	Definition
A&E	Accident and Emergency
ACF	Acute Care Forum
ADHD	Attention Deficit Hyperactivity Disorder
ARBD	Alcohol Related Brain Damage
BDD	Body Dysmorphic Disease
BP	Blood Pressure
CAMHS	Child and Adolescent Mental Health Services
ccb	Calcium Channel Blockade
CCGs	Clinical Commissioning Groups
CFF	Carers Friends and Family
CHD	Coronary Heart Disease
CLRN's	Comprehensive Clinical Research Network
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQC	Care Quality Commission
CQRG	Clinical Quality Commissioning Reference Group
CQUIN	Commission for Quality and Innovation
CRHT	Crisis Resolution and Home Treatment
CROM	Clinician rate outcome measure
CRU-POAN	Clinical Research Unit in Psychiatry of Old Age and Neuropsychiatry
DenDRoN	Dementias & Neurodegenerative Diseases Research Network.
DOF	Diabetes, Observations of Vital Signs and Falls
DOH	Department of Health
EDT	Electronic Data Transfer
EMC	Executive Management Committee
EME	Efficacy and Mechanism Evaluation
FFT	Friends and Family Test
HoNOS	Health of the nation outcome scales.
HOSCs	Health Overview and Scrutiny Committees
HSCIC	Health and Social Centre
HTT	Home Treatment Team
IAPT	Improving access to psychological therapies
IGR	Integrate Governance Report
KPIs	Key Performance Indicators
L(S)CLRN	London (South) Comprehensive Local Research Network

LD	Learning Disability
LiA	Listening into Action
LINks	Local Involvement Networks
LSCB	London Safeguarding Children Board
MaPSaf	Manchester Patient Safety
MHMDS	Mental Health Minimum Data Set
NAPT	National Audit of Psychological Therapies
NAS	National audit of Schizophrenia
NEWS	National Early Warning System
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
OCD	Obsessive Compulsive Disorder
PALS	Patient Advice and Liaison Service
PHA	Physical Health Assessment
POM-H	Prescribing Observatory for Mental-Health
PPI	Patient and Public Involvement
QIP	Quality, Innovation, Productivity and Prevention
QOF	Quality Outcome Framework
QSAC	Quality and Safety Assurance Committee
R&D	Research and Development
RATE	Risk Assessment Training and Education
RCP	Royal College of Physicians (RCP
RiO	The Trust's electronic clinical and patient record system.
RTF	Real Time Feedback
SAM	Safeguarding Adult Manager
SCA	Smoking Cessation Advisor
SIRO	Senior Information Risk Officer
STEIS	Strategic Executive Information System
SURG	Service User Reference Group
SUS	Secondary Uses Service
SWLSTG	South West London and St George's Mental Health NHS Trust
UTI	Urinary Tract Infection
VTE	Venous Thrombosis

Annex

Statement of Directors Responsibility in Respect of the Quality Account

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

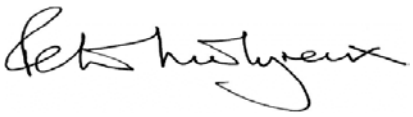
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

The Quality Accounts present 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 had been prepared in accordance with Department of Health guidance.

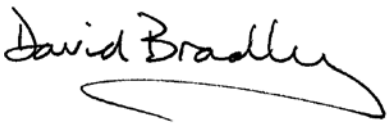
The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board



Chairman

Date: 05/06/2014



Chief Executive

Date: 05/06/2014

Independent Auditors' Limited Assurance Report

Independent Auditors' Limited Assurance Report to the Directors of South West London and St George's Mental Health NHS Trust on the annual quality account.

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

Scope and subject matter

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

- the percentage of patients on Care Programme Approach (CPA) who were followed up within seven days of discharge from psychiatric inpatient care during the period, as reported on page 53 of the Quality Account; and
- the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the period, as reported on page 53 of the Quality Account.

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

Respective responsibilities of Directors and auditors

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February 2014 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Trust's Commissioners and Local Healthwatch organisations;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated June 2014;
- the latest national patient survey dated 17 September 2013;
- the latest national staff survey conducted in 2013;
- the Head of Internal Audit's annual opinion over the trust's control environment dated April 2014;
- the annual governance statement for 2013/14 dated 5 June 2014; and
- the draft report on the Care Quality Commission inspection which took place on 17-21 March 2014.

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 South West London and St George's Mental Health NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. 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 South West London and St George's Mental Health NHS 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 South West London and St George's Mental Health NHS Trust.

Basis for qualified conclusion

For both of the indicators covered by our opinion, the Trust is required by the Department of Health *Mental Health Community Team Activity Return Guidance* dated August 2010 to exclude patients transferred to or from other NHS hospitals for psychiatric treatment. Our testing of both indicators identified that not all patients transferred in this way have been excluded from the reported indicators, as required by the guidance. The Trust has therefore failed to meet the 'relevance', 'accuracy' or 'validity' dimensions of data quality in relation to both indicators reviewed.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

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

Grant Thornton UK LLP

Grant Thornton House,
Melton Street,
Euston Square,
London

26 June 2014

Appendix 1

Quality Account Priorities 2014/15

Clinical Effectiveness	
Theme	Improving the quality of **Crisis Planning** for all Trust service users.
Intended Outcome	To ensure that service users who experience a crisis in their mental health receive appropriate, tailored treatment that they have been involved in planning.
Rationale	The development of an individually tailored crisis plan for each service user is essential to enable healthcare providers, working within different services, to be able to deliver cohesive and appropriate care. For example, should a service user present in A&E, a member of the psychiatric liaison team would immediately be able to access and implement the service user's crisis plan and ensure personalised, effective care despite having no prior knowledge of the individual. Wherever possible, it is important that service users and mental health professionals work together to develop crisis plans in order to ensure that service users' views are properly reflected. It also facilitates more autonomy for service users and improves their collaborative partnership with mental health professionals. *National Institute for Health and Care Excellence (NICE) guidance (2011)* and *the Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis (2014)* both outline important quality measures indicting whether, and to what the degree families and/or carers should be involved. In a recent audit of care plans for SWLSTG (March 2014), findings indicated that some 21% of care plans involved the service users' social support network to a 'great extent', while the majority of care plans were created without any involvement from the service users support network. Where appropriate, we want to ensure that friends and family are involved more closely in decisions about the services provided to those they care about.
Action	We will link with the CQUIN target for 2014/15 to increase the number and the quality of crisis plans to ensure that during treatment in Home Treatment Teams or acute inpatient wards the crisis plan is accessed and followed. We will improve the quality of our crisis plans by working with the Trust wide Care Plan Steering Group to audit care plans and crisis plans of service users who have had a Care Programme Approach (CPA) review in the previous quarter. We will complete quarterly audits of crisis plans and of clinical progress notes/care plans to determine if there is evidence that the crisis plan was accessed and followed during treatment spells in Home Treatment Teams or acute inpatient wards.

Target	**Q1** **Indicator 1** a) 30% of people on CPA to have a collaboratively developed crisis plan uploaded onto RiO b) 15% of people NOT on CPA to have a collaboratively developed crisis plan uploaded onto RiO c) Trust to complete quarterly quality audit of crisis plans. Audit report to be submitted to commissioners d) 60% of new, collaboratively developed crisis plans to be categorised as 'adequate' or above following Q1 audit **Indicator 2** Trust to complete quarterly audit of crisis plans and of clinical progress notes/care plans to demonstrate evidence that the crisis plan was accessed and followed. Audit report to be submitted to commissioners and should include any reasons for not following certain aspects of a person's crisis plan during treatment spells in HTT or inpatient wards. **Q2** **Indicator 1** a) 40% of people on CPA to have a collaboratively developed crisis plan uploaded onto RiO b) 25% of people NOT on CPA to have a collaboratively developed crisis plan uploaded onto RiO c) Trust to complete quarterly quality audit of crisis plans. Audit report to be submitted to commissioners d) 70% of new, collaboratively developed crisis plans to be categorised as 'adequate', of which 40% are to be categorised at 'good' following the Q2 audit **Indicator 2** Trust to complete quarterly audit of crisis plans and of clinical progress notes / care plans to demonstrate evidence that the crisis plan was accessed and followed. Audit report to be submitted to commissioners and should include any reasons for not following certain aspects of a person's crisis plan during treatment spells in HTT or inpatient wards.

Target	**Q3** **Indicator 1** a) 50% of people on CPA to have a collaboratively developed crisis plan uploaded onto RiO b) 40% of people NOT on CPA to have a collaboratively developed crisis plan uploaded onto RiO c) Trust to complete quarterly quality audit of crisis plans. Audit report to be submitted to commissioners d) 80% of new, collaboratively developed crisis plans to be categorised as 'adequate', of which 50% are to be categorised at 'good' following the Q3 audit **Indicator 2** Trust to complete quarterly audit of crisis plans and of clinical progress notes / care plans to demonstrate evidence that the crisis plan was accessed and followed. Audit report to be submitted to commissioners and should include any reasons for not following certain aspects of a person's crisis plan during treatment spells in HTT or inpatient wards. **Indicator 3** CAMHS to look at how to incorporate the collaboratively developed crisis plans process into CAMHS. Implementation recommendations to be submitted to commissioners. **Q4** **Indicator 1** a) 60% of people on CPA to have a collaboratively developed crisis plan uploaded onto RiO b) 45% of people NOT on CPA to have a collaboratively developed crisis plan uploaded onto RiO c) Trust to complete quarterly quality audit of crisis plans. Audit report to be submitted to commissioners d) 90% of new, collaboratively developed crisis plans to be categorised as 'adequate', of which 60% are to be categorised at 'good' following the Q4 audit **Indicator 2** Trust to complete quarterly audit of crisis plans and of clinical progress notes / care plans to demonstrate evidence that the crisis plan was accessed and followed. Audit report to be submitted to commissioners and should include any reasons for not following certain aspects of a person's crisis plan during treatment spells in HTT or inpatient wards.
Reporting	Progress for this target will be monitored by the Quality Improvement Programme, who will provide quarterly updates to the Director of Transformation and the Trust Integrated Governance Group. This project has been assigned a Senior Responsible Officer, Clinical Lead and Project Manager.

Clinical Effectiveness	
Theme	Improving the identification of service users with mental health issues who have a learning disability (LD) within local mainstream services
Intended Outcome	To improve trust wide understanding of Mental Health & Learning Disabilities LDs which in turn will improve the identification of this group and the support offered to those service users who have a LD.
Rationale	The Department of Health policy 'Protecting Patients from Avoidable Harm' (March 2013) details that actions should be taken to learn from mistakes made with particular reference to the Winterbourne View scandal: 'People with learning disabilities (LD), autism or mental health problems will get more support in the community rather than in hospital, where appropriate.' Mental health services do not always provide good services for people with LD. Progress against the Monitor standards to facilitate access of people with learning disabilities into mainstream mental health services has been slow. Staff generally have limited LD knowledge and awareness. In light of this, the Trust aims to improve the service that is received by mental health service users with LD in mainstream services as per 'Closing the Gap: Priorities for essential change in Mental Health (Department of Health).
Action	The Trust will initiate a two year action plan to improve the experience of people with mental health issues and LD and make adjustments to treatments currently available. The membership and the terms of reference of the current Trust Mainstreaming LD Group will be revised to ensure that this important theme has appropriate leadership within the Trust. In addition to this, wards and teams will identify a LD champion to promote awareness & good practice locally. The Trust will produce a protocol on LD, Autism and Asperger's syndrome increase awareness and identify service users with Learning disabilities within mainstream services. The Trusts will develop an eLearning awareness training package and resource materials in conjunction with St George's Hospital Medical School. Teams will have access to key information for service users in an Easy Read format.
Target	**Q1** a) Identify an Executive Lead for mental health & learning disabilities b) Revise the membership and terms of reference for the Mainstreaming LD Group. c) Produce LD Awareness Protocol (to include awareness of Autism and Asperger's) to increase identification of individuals with learning disabilities who use mainstream services. d) Trust's Medical Director and Director of Nursing and Quality Standards to commission a Trust wide baseline audit using an audit tool based on the Green Light Toolkit. This audit should establish: • how many service users in mainstream services have already been identified as having LD • how many of these identified service users have been referred to the Trust's LD service for a) consultation / advice or b) assessment or c) intervention. • how many of these identified service users have management strategies that relate to their learning disabilities recorded in their clinical record.

Target	**Q2** a) Develop eLearning training package This training package will include: • basic awareness of learning disabilities • screening questions • referral pathways • basic knowledge of reasonable adjustments • information on how mainstream mental health services can be adjusted for LD service users. • Information on resources including easy read b) Wards and teams to identify LD Champions. **Q3** a) Launch of eLearning package to all staff b) LD Champions to have completed LD eLearning package c) The Trust to hold an LD Learning Event to promote awareness, embed learning across the Trust, and support the training. **Q4** a) For those service users in mainstream mental health services that have been identified to have LD: • 25% to have a clear, co-produced LD management plan recorded in their clinical record and have their care plan in an accessible format. • 25% to have evidence in their clinical record of liaison / consultation with the Trust's LD services. b) Trust's Medical Director and Director of Nursing and Quality Standards to commission a year-end audit using the audit tool developed in Q1. c) Audit report to be produced. This report should include: • lessons learned • recommendations for improvement • uptake of eLearning training d) Gaps identified by the Q4 audit to be worked into year two of the two year action plan to improve the identification process for service users with mental health issues and learning disabilities within the Trust.
Reporting	Progress for this target will be monitored by the Quality Improvement Programme, who will provide quarterly updates to the Director of Transformation and the Trust Integrated Governance Group. This project has been assigned a Senior Responsible Officer, Clinical Lead and Project Manager.

Patient safety	
Theme	Improving the physical health of hospital inpatients by monitoring Diabetes, Observations of Vital Signs and Falls.
Intended Outcome	To better integrate mental health and physical health care at every level.
Rationale	The document issued by the Department of Health; *Closing the Gap: Priorities for essential change in Mental Health*, specifically focuses on integrating physical and mental health. It is essential that service users who have been admitted to our wards feel, and are, safe and that they receive a high quality of care to optimise both their mental and physical health.
Action	Working in line with CQUIN we will produce a two year strategy to improve the monitoring and treatment received by our service users in regards to: • Diabetes • Observations of vital signs • Falls **Diabetes** To improve the support service users receive for managing their Diabetes, we will screen on admission for this condition. Diabetic service users will be given a care plan that includes a management plan designed specifically to support their needs, including information on lifestyle, diet, nutrition, medication advice and access to primary care. **Observations of vital signs** To improve the monitoring and electronic recording of vital signs we will work towards the daily observation of vital signs, using the National Early Warning System (NEWS) format for all inpatients. **Falls** The Trust will work to prevent measure and reduce harm from falls and put in place improvement programmes to respond to any identified harm or hazards caused by falls. We will ensure the Trust's Falls Policy is in line with NICE guidance and includes: • a strategy to prevent falls • the reduction of any harm caused by falls • the management of care post falls • the management of hazards regarding falls

Target	**Q1** **Diabetes** a) The Trust will complete a quarterly audit of diabetes management plans. These audits will seek to demonstrate evidence that 10% of service users with identified Diabetes have a care plan including a support management plan including information on lifestyle, diet, nutrition, medication advice and access to primary care. The audit reports will be submitted to commissioners and will aim to record demonstrable progress. **Observation of vital signs** a) The Trust will develop a plan to monitor and electronically record inpatients' vital signs using the NEWS format on a daily basis **Falls** a) The Trust will update the Falls policy to in line with NICE guidance b) The Trust will audit incident data on falls and submit a report to include: • numbers of falls • level of harm • practice • against standards and recommendations for improvement **Q2** **Diabetes** a) The Trust will complete a quarterly audit of Diabetes management plans. These audits will seek to demonstrate evidence that 20% of service users with identified Diabetes have a care plan including a support management including information on lifestyle, diet, nutrition, medication advice and access to primary care. The Trust will submit these audit reports to commissioners. **Observation of vital signs** a) The Trust will produce a 'Daily Observation of Service Users' Vital Signs' training package for staff b) The Trust will agree an appropriate recording process for daily vital signs data and will include these in the training package **Falls** a) The Trust will develop a Falls eLearning package b) Inpatient wards will identify a Falls Champion c) The Trust will audit incident data on falls and submit a report to include: • numbers of falls • level of harm • practice against standards and recommendations for improvement

	Q3 **Diabetes** a) The Trust will complete quarterly audits of Diabetes management plans. These plans will set out to demonstrate evidence that 30% of those with identified Diabetes have a care plan including a support management plan including information on lifestyle, diet, nutrition, medication advice and access to primary care. The Trust will submit these audit reports to commissioners. b) The Trust will develop an eLearning package on Diabetes management. **Observation of vital signs** a) The Trust will roll out 'Daily Observation of Service Users' Vital Signs' training to staff **Falls** a) Trust wide learning event on falls will take place to educate staff about risks, prevention, common hazards and good practice using incidents subject to Root Cause Analysis as examples from which to learn. b) The Trust will audit incident data on falls and submit a report to include: • number of falls - it is expected that the number of falls should reduce throughout the year as a result of this Quality Account indicator and evidence should be included to demonstrate that the number of falls has fallen from Q1 • level of harm • practice against standards and recommendation for improvement **Q4** **Diabetes** The Trust will complete quarterly audits of Diabetes management plans. These plans will set out to demonstrate evidence that 40% of those with identified Diabetes have a care plan including a support management plan including information on lifestyle, diet, nutrition, medication advice and access to primary care. The Trust will submit these audit reports to commissioners. **Observation of vital signs** a) Staff to monitor and electronically record inpatients' vital signs using the NEWS format on a daily basis **Falls** a) Trust to audit incident data on falls and submit a report to demonstrate: • a reduction in the number of falls reported for the year • reduced levels of harm • lessons learned
Reporting	Progress towards this target will be monitored by the Quality Improvement Programme, who will provide quarterly updates to the Director of Transformation and the Trust Integrated Governance Group. This project has been assigned a Senior Responsible Officer, Clinical Lead and Project Manager.

Service user/carer experience	
Theme	Improving **interfaces with primary care** and providing education for GPs on Mental Health.
Intended Outcome	To streamline services provided to service users by improving communication between primary and secondary care.
Rationale for this priority	To ensure high quality patient care, it is important to improve communication between primary and secondary care services. To ensure that GPs are provided with information they need, when they need it, it is essential that communication between clinicians is more personalised, timely and joined-up. Kinesis GP is a web based software system that directly links GPs to hospital specialists for rapid access to expert advice. This system has been in operation in Wandsworth for over 18 months built around acute Trusts. Kinesis GP allows hospital specialists, covering a wide range of clinical specialities to provide education and feedback to GPs. Requests are running at 5-10 per day from 30 active GP practices users with 80% of these requests answered within 24 hours.
Action	We will seek to improve liaison and engagement with GPs and provide advice and education to increase access to mental health services. To do this we will: • Pilot the Kinesis GP system in Wandsworth and review the performance to produce a proposal for piloting Kinesis GPs in the other 4 Boroughs • Conduct a GP satisfaction survey to audit GPs' satisfaction with the liaison systems
Target	**Q1** **Kinesis** a) Commence Kinesis pilot in Wandsworth Community and Rehabilitation Services and Wandsworth Home Treatment Team. **Q2** **Kinesis** a) Continue pilot in Wandsworth Community and Rehabilitation Services and Wandsworth Home Treatment Team b) Commence pilot in Wandsworth Age Related Services. **GP Satisfaction survey** Electronic survey (e.g. Survey Monkey or similar) for GPs to be designed and produced to establish GPs' level of satisfaction with the service and contact information provided, communication and liaison, the advice received from our services and any mental health related educational requirements. **Q3** **Kinesis** a) Continue pilots in Wandsworth Community and Rehabilitation Services, Wandsworth Home Treatment Team and Wandsworth Age Related Services. **GP Satisfaction survey** Send out satisfaction survey to GPs.

	Q4 **Kinesis** a) Produce and submit year-end report to commissioners on Kinesis GP system. This report should include information on: • system usage figures • benefits realisation • cost effectiveness of the system • lessons learned **GP Satisfaction survey** a) Analyse the results of the GP satisfaction survey. b) Produce a survey results report. This report should include information on: • any gaps identified by GPs relating to their satisfaction of the service and contact information provided, communication, liaison structures, the advice received from our services or any mental health related educational requirements, recommendations for improvement.
Reporting	Progress for this target will be monitored by the Quality Improvement Programme, who will provide quarterly updates to the Director of Transformation and the Trust Integrated Governance Group. This project has been assigned a Senior Responsible Officer, Clinical Lead and Project Manager.

Service user/carer experience	
Theme	Using feedback systems to improve the experience of service users and carers, friends and family.
Intended Outcome	To encourage service users and carers, friends and family (CFF) to comment on their experience of mental health services in order for the Trust to identify areas for improvement.
Rationale for this priority	Understanding the experience of service users and CFF is crucial in informing the Trust about areas of good practice and areas for improvement for its services to meet the needs and expectations of those using them. This is outlined in 'Closing the Gap: Priorities for essential change in mental health (Department of Health (DoH)). By ensuring the voices and views of patients and CFF are heard we can learn about potential service improvements. Use of feedback mechanisms can drive change and continuous improvements in the quality of the care that mental health service users receive. Options for people to provide feedback in the Trust include Real Time Feedback (RTF), the Family and Friends Test (FFT) Care Connect and Patient Opinion. RTF and the FFT are CQUIN indicators for 2014/15 and Care Connect is now in operation. However, Patient Opinion, which is an important new feedback source to enable honest and meaningful conversations between service users and staff, has only recently been implemented and requires further promotion.

Action	The CQUIN for RTF will report quarterly and these reports will be made available on the Trust website. These reports will include: • updates on the progress of the implementation of RTF systems across the Trust's community teams • examples of RTF action plans (formed in response to feedback received) from community teams • themed feedback (from both RTF and FFT) • lessons learned The CQUIN for FFT will report to commissioners in Q1 and Q4. These reports will be made available on the Trust website. The Quality Account will focus on the promotion of Patient Opinion, the implementation of a new Patient Experience Strategy and the integration of all feedback systems.
Target	**Q1** a) Develop communications plan to promote Patient Opinion Trust wide. This should include: • The production and rollout of Patient Opinion 'starter' training for staff • Internal and external publicity • A press launch b) Co-produce and launch a Patient Experience Strategy **Q2** a) RTF CQUIN Q1 report to be made available on the Trust website b) FFT Staff CQUIN Q1 report to be made available on the Trust website c) Implement communication plan for Patient Opinion. d) Progress report on the promotion of Patient Opinion. This report should include: • Examples of feedback received and appropriate action plans • Examples of changes made in response to feedback and their outcomes • Figures on the number of people posting feedback on the site regarding SWLSTG • An update on the success of the promotion work and recommendations/ideas for improvement going forward e) Patient Experience Strategy implementation plan to be signed off

	Q3 a) RTF CQUIN Q2 report to be made available on the Trust website b) Continue to implement communication plan for Patient Opinion c) Progress report on the promotion of Patient Opinion. This report should include: • Examples of feedback received and appropriate action plans • Examples of changes made in response to feedback and their outcomes • Figures on the number of people posting feedback on the site regarding SWLSTG • An update on the success of the promotion work and recommendations/ideas for improvement going forward d) Patient Experience Strategy implementation to begin **Q4** a) RTF CQUIN Q3 report to be made available on the Trust website b) RTF CQUIN Q4 report to be made available on the Trust website during Q1 of 2015/16 c) FFT Patient CQUIN Q4 report to be made available on the Trust website during Q1 of 2015/16 d) Report on progress of Patient Experience Strategy implementation e) Year-end feedback report to be produced to demonstrate service user and CFF satisfaction with Trust services. This report should be co-produced by the project managers for RTF, FFT and Patient Opinion and include: • Quotations and vignettes from service users, carers, friends and family members gathered using all the Trust feedback systems • Quotations and vignettes from staff on the feedback systems and changes that have been made as a result of feedback received from all systems.
Reporting	Progress for this target will be monitored by the Quality Improvement Programme, who will provide quarterly updates to the Director of Transformation and the Trust Integrated Governance Group. This project has been assigned a Senior Responsible Officer, Clinical Lead and Project Manager.

Appendix 2

CQUIN Goals 2014/15

CQUIN and description	Indicators	Intended outcome
Staff and Service user Friends and Family Test (FFT) The goal of the Friends and Family Test is to improve the experience of service users in line with Domain 4 of the NHS Outcomes Framework.	1. Implement staff FFT to all Trust departments, teams and wards 2. One off report to commissioners by 31 July 2014 on responses and necessary actions plans 3. Implementation of Patient FFT 4. Achieve a response rate, in line with expected national guidance, by 31 October 2014 5. Achieve a response rate, in line with expected national guidance, by 31 January 2015 6. Produce a year-end report including: • Examples of action plans, based on feedback received in response to FFT follow-up question, to improve service user experience of services • List of feedback themes • Lessons learned (implementation and stakeholder engagement).	The FFT aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of the care received by NHS mental health service users (DoH National guidance Oct 2012).
Safety Thermometer This indicator is to be based on the National NHS Safety Thermometer. To monitor falls, pressure ulcers, Venous Thrombosis (VTE) and urinary tract infections (for those with indwelling catheters) for older people who are on an Inpatient ward under the care of the Trust and to put in place improvement programmes to respond to any harms or hazards identified.	1. Collect and submit data by completing monthly Safety Thermometer screening on Older Peoples Inpatient wards under the care of the Trust 2. Audit incident data on falls and submit an audit report to commissioners. Report to include recommendations on how to: • reduce harm caused by falls • reduce the number of falls occurring • (Q3) confirmation that NICE guidance has been implemented or submission of an action plan in respect of this with timetable • (Q3) Confirmation that NPSA Rapid Response guidance has been implemented or submission of an action plan in respect of this with timetable. 3. Submission of year-end report exploring if the Safety Thermometer and falls audit work has had an effect on identified harms or hazards.	To measure and reduce harm. This CQUIN will drive behavioural change regarding the physical health of mental health service users on inpatient wards.

Improving diagnosis in mental health (Physical Health) To support NHS England's commitment to reduce the 15 to 20 year premature mortality in people with psychosis and improve their safety through improved assessment, treatment and communication between clinicians. For 2014/15 this CQUIN focuses on all patients with psychoses, including schizophrenia, in all types of inpatient beds, intensive community teams in all sectors i.e. early intervention teams, assertive outreach and community forensic teams. However, providers are encouraged to extend the processes developed to meet this CQUIN for the benefit of all patients.	**Indicator 1** Cardio Metabolic Assessment for patients with psychoses, including Schizophrenia Demonstrate, through the National Audit of Schizophrenia, full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with psychoses, including schizophrenia. The results recorded in the patient's notes/care plan/ discharge documentation as appropriate, together with a record of associated interventions according to NICE guidelines or onward referral to another clinician for assessment, diagnosis, and treatment e.g. smoking cessation programme, lifestyle advice and medication review. 1. Collect audit data. The following cardio metabolic parameters (as per the 'Lester tool' and the cardiovascular outcome framework) are assessed: • Smoking status • Lifestyle (including exercise, diet, alcohol and drugs) • Body Mass Index • Blood pressure • Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate) • Blood lipids • Hepatitis C. The audit sample must cover all relevant services provided by the provider **Indicator 2** Completion of a programme of local audit of communication with patients' GPs, focusing on patients on the CPA. Audit CPA Review Letters, Discharge Summaries and other correspondence with GPs to ensure that the holistic CPA components have been communicated. 1. Demonstrate that for 70% (Q2) and 90% (Q4) of patients, an up-to-date summary of care (communicated via CPA Review Letters, Discharge Summaries and other correspondence) has been shared with the GP. This should include the holistic components set out in the CPA guidance:	This CQUIN will incentivise providers to ensure that service users have recorded comprehensive physical and mental health diagnoses, communicated between primary care and specialist mental health clinicians and with the service user. The primary aim is to reduce premature mortality, improve patient safety, patient experience and quality of life, through shared communications and reconciliation of treatments. This CQUIN also supports and facilitates closer working relationships between specialist mental health providers and primary care. It has the capacity to lead to reductions in length of stay through addressing the impact of untreated physical morbidity on recovery.

	a) ICD codes for primary and secondary mental and physical health diagnoses. b) Medications prescribed and monitoring and adherence support plans. c) Physical health condition(s) and ongoing monitoring and treatment needs. d) Recovery interventions including lifestyle, social, employment and accommodation plans where necessary for physical health improvement.	
Feedback for improvement – Community Use (RTF) systems to improve overall service user and carer, friends and family (CFF) experience of Trust community services.	1. Trust to submit RTF systems community implementation plan to commissioners as part of the Q1 report. This should include dates of: • Technical system implementation • Staff and service user training on how to use the RTF systems • Go live dates for each community area included in the implementation • Process for review and improvement • Lessons learned and improvements made to date by any community teams / services already using RTF systems. 2. Submit a progress report on use of RTF systems in Home Treatment Teams (following implementation in Q2 2013/14). Report to include a list of themed feedback received to date. 3. Submit quarterly progress updates on implementation. These should include action plan for any community team / service that has successfully completed their implementation of the RTF systems. Action plans should include: • List of themed feedback from service users and CFF • Planned actions to address any issues or reasonable requests • Target dates and named responsible person for completion of each action • Lessons learned	The use of RTF systems in the community will be a primary vehicle / driver for the systematic improvement of quality and service user, CFF experience within the organisation

Cluster Assessment Mental Health is the only health or social care speciality that currently has no outcome measures.	1. Submit Q1 and Q3 reports to clinical and classical commissioners on cluster assessment within the Trust. Reports should: • Set out details of the Four Factor model and its use • Reviews the effectiveness of the Trust's care packages for a quarter for each cluster to demonstrate: i) The % of service users where changes in their total Health of the Nation Outcome Scales (HoNOS) score met the criteria for reliable, clinically significant change (reliable improvement and deterioration) following a cluster episode i) The % of service users where changes occurred but they did not meet the criteria for reliable change (improvement and deterioration) following a cluster episode i) The % of service users where there was no change at all in their total HoNOS scores following a cluster episode. *The Four Factor Model is a clinician rated outcome measure (CROM) which can be used across all the payment by results clusters for working age and older adult mental health service. 2. Q2 - Trust to host a cluster assessment (HoNOS) event for staff and commissioners to feedback the initial findings of the cluster assessment outcomes. 3. Q4 - Submit final report to commissioners including: • Implications for commissioners • Variance (between teams) and its causes • Aspects of outcomes that are more able to be affected by changes in practice • Next steps	Using the Four Factor Model* is our first attempt to demonstrate outcomes and areas where we can make the biggest improvements to service users' lives for the Trust and commissioners.

Crisis plans Crisis planning was identified as an area of weakness in the 2012 community service user survey.	**Indicator 1** Continuation of quarterly quality audits as per 2013/14 but also having a target for the number / proportion of collaboratively developed crisis plans for each quarter - rising baseline i.e. significantly increase the number without compromising quality. Training for staff to continue throughout the year. 1. 30% (Q1), 40% (Q2), 50% (Q3), 60% (Q4) of people on CPA to have a collaboratively developed crisis plans uploaded onto RiO 2. 215% (Q1), 25% (Q2), 40% (Q3), 45% (Q4) of people NOT on CPA to have a collaboratively developed crisis plans uploaded onto RiO 3. Trust to complete quarterly quality audit of crisis plans. Audit report to be submitted to commissioners 4. 60% (Q1), 70% (Q2), 80% (Q3), 90% (Q4) of new, collaboratively developed crisis plans to be categorised as 'Adequate' or above following Q1 audit **Indicator 2** Audits to be undertaken on a quarterly basis of clinical progress notes / care plans to demonstrate evidence that the crisis plan was accessed and followed with any reasons for not following certain aspects of a person's crisis plan during treatment spells in HTT or inpatient wards. There could also be feedback systems developed for service users (e.g. RTF) at discharge from HTT / inpatient wards to assess satisfaction levels with how their crisis plan was followed or not. 1. Trust to complete quarterly audits of crisis plans of clinical progress notes / care plans to demonstrate evidence that the crisis plan was accessed and followed. Audit reports to be submitted to commissioners and should include any reasons for not following certain aspects of a person's crisis plan during treatment spells in HTT or inpatient wards. **Indicator 3 (one-off report submission)** 1. (Q3) CAMHS to look at how to incorporate the collaboratively developed crisis plans process into CAMHS. Implementation recommendations to be submitted to commissioners.	The aims of this indicator are: 1. To increase the number and the quality of collaboratively developed crisis plans for people on CPA. 2. For people who are referred into Home Treatment Teams and or inpatient wards for there to be evidence that the crisis plan has been accessed and followed as much as is possible

Safe, Managed Discharges Adequate and timely communication will ensure safe, managed discharges from community services. It will support high quality care and patients' safety in both secondary and primary care settings.	Trust to improve communication of community discharge summary information between primary and secondary care. This work will ensure that GPs receive appropriate information and the process of discharge summary production is made more efficient for clinicians. This work will also act as a precursor for the electronic data transfer (EDT) of information to GPs and summaries being pre-populated directly from data held in RiO. This will involve a change in the way that information is input into RiO (moving away from text being entered into progress notes in the current format. 1. (Q1) - Produce a quality standard for community discharge summaries. This template should include a section for completion when people disengage with services. This should be achieved by co-producing with GPs, service users, carers and Trust staff and taking into consideration recommendations made in the 2013/14 Q3 Community Discharge Summary Audit Report 2. Produce and implement a pre-populated discharge summary template in RiO for use by staff 3. (Q2, Q3 and Q4) - Audit the quality standard discharge summary template produced in Q1 and report results to commissioners including any lessons learned.	To ensure that GPs are provided with timely discharge summaries which contain only the information they want and need

Appendix 3

Francis Report action plan

Action plan to address the recommendations outstanding from Francis Report		
Recommendation	**Action**	**Timescale**
All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into contracts of employment.	Amended Contracts of Employment to be agreed. Trust values are to be reviewed in light of the NHS constitution.	**May 2014**
Implementation of a single-inpatient consultant model on older people's wards to ensure effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient.	This is in place in Azaleas and a plan is being developed for Crocus	**May 2014**
Roll out of Real Time Feedback to community teams and 'You said, We did' monitoring to improve quality following service user comments. Francis recommended a proactive system for following up patients shortly after discharge and that results be made available to all stakeholders in as near "real time" as possible	Roll out planned between April and June 2014	**June 2104**
As part of a mandatory annual performance appraisal, each Nurse, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	A Continuing Professional Development portfolio for registered nurses is being developed to complete as evidence towards their NMC annual registration. Pending guidance from the Nursing and Midwifery Council (NMC).	**May 2013**

Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff thodology, such as the "cultural barometer".	Following a restructure within the Human Resources Directorate and the appointment of an Assistant Director of Education and Workforce Transformation post, work is underway to develop a robust Education and Training Strategy to develop the nursing workforce. Discussions are also underway with the South West London Academic, Health & Social Care System to develop an integrated health and social care leadership programme.	**May 2014**
Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust me	A cultural barometer framework has been drafted based on the Department of Health's interpretation of the Chief Nursing officer six C's for Mental Health Nurses. A plan to pilot this will be developed.	**June 2014**
There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	The plan to Implement the Single Inpatient Consultant Model supports the development of a single Clinical Leader on the ward and the ability to develop a multi-disciplinary team	**May 2014**
Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	Current systems for receiving feedback to be integrated e.g. Care Connect, Patient Opinion and Real Time feedback, responding quickly and identifying changes as a result.	**June 2014**
A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	Current systems for receiving feedback to be integrated e.g. Care Connect, Patient Opinion and Real Time feedback, responding quickly and identifying changes as a result.	**June 2014**

Appendix 4

Review of Quality Account Priorities 2013/14

Priority 1: Safeguarding Children	
Priority	To improve the percentage of all adult secondary mental health service users to have recorded (using Safeguarding children form) whether they have responsibility for or regular contact with children under the age of 18 years.
Target	a) 95% of all adult secondary mental health service users to have recorded whether they have responsibility for or regular contact with children under the age of 18 years. b) Sample audit where safeguarding alerts have been raised (F2s). To identify what further actions and outcomes were taken following the alert. c) Develop systems for the collection of data in IAPT services for 2014/15.
April 2013 starting position	94.5% of adult services users on CPA had the safeguarding children form completed
Rationale for this priority	This was a development from the priority 2012/13. The Trust is moving from recording this information for those service users on CPA to all service users. Safeguarding children continues to be the "highest priority to patient safety" and by continuing with this priority the Trust will be able to further develop multi agency communications.

For 2013/14 the Trust extended the recording of this priority to include all adult service users whether under CPA or general care. The Trust set a challenging target of 95% completion by the end of March 2014. This was successfully reached with the support of all teams and services and access to advice and supervision from the Trust Named Nurse for Safeguarding Children. This priority is embedded in all 4 Levels of the Trust mandatory Safeguarding Children training and forms part of the data set provided by the Trust to the 5 local London Safeguarding Children Boards (LSCB).

The sample audit has been completed and the number of Looked after Children identified through the completed forms. The aim for 2014/15 will be to benchmark the Trust figure against similar mental health trusts.

The system for adding adult IAPT service users who have responsibility for or regular contact with children under the age of 18 years has been piloted during February/March 2014 for introduction in April 2014.

NB: Once a child safeguarding alert has been raised the process is then overseen by the respective local authority. The Trust is provided with an overview of the process and a Trust representative should be sent to attend any related meetings.

Priority 2: Safeguarding Adults	
Priority	To improve the percentage of all safeguarding adult cases that meet the timescales for the allocation of a Safeguarding Adult Manager (SAM) and strategy discussion/ meeting as set out in local policy documents (excluding Sutton cases as these are managed externally). To improve the percentage of service users who are offered the opportunity to feedback on their case after a strategy meeting or case conference and gather qualitative data.
Target	a) 90% of safeguarding adult cases to meet timescales for the allocation of SAM (within five working days) and strategy discussion/meeting (within five days) as set out in local policy documents (excluding Sutton cases as these are managed externally). b) To ensure 90% of service users who have had a case conference, and 30% of those subject to a strategy discussion/meeting are offered a feedback interview and/or feedback form to fill in. This offer will be made dependent on the service users' wishes and their capacity to participate. Use this qualitative data to improve services. Audit compliance quarterly.
April 2013 starting position	a) In April 2013 94.6% of cases Trust wide were allocated to a Safeguarding Adult Manager within five days. b) Not currently measured.
Rationale for this priority	Safeguarding adults was a theme identified by Trust stakeholders in November 2011 and acknowledged, alongside safeguarding children, as "the highest priority to patient safety" by Wandsworth Overview and Scrutiny Committee. Following further stakeholder engagement throughout 2012/13, safeguarding adults as a theme still continued to be of high importance. Stakeholders fed back that as the Trust had installed a new central reporting system, Ulysses Safeguard, to capture and monitor data, that they were now keen to see the Trust continue to progress against the original indicators that were set. Phase 2 of the Ulysses Safeguard development will be focusing on reporting all. The prompt allocation of a SAM is a key part of the safeguarding adults' process. SAMs provide the lead coordinating role and have overall responsibility for the safeguarding adults' process. SAMs ensure that actions undertaken by organisations are coordinated and monitored, the adult at risk is involved in all decisions that affect their daily life and those who need to know are kept informed. Valuable information can be learned from service users who provide feedback on their experiences of the safeguarding adults' process that can be used to improve services. This offer of feedback will be made dependent on service users' wishes and their capacity to participate.

The introduction of the use of the electronic incident reporting system to report safeguarding 'adults at risk' concerns has provided the means for collation of the performance data used to measure results. The local and corporate governance groups have ensured all cases have management oversight to maintain compliance with policy, and meeting Quality Account targets.

The Quality Account measures were monitored throughout the year on a rolling three month basis. This chosen method of monitoring reporting levels was successful in supporting the achievement of the year end targets. The figures for March 2014 are reported here and show that all targets were met.

Target A has been highly effective in embedding the SAM role throughout the Trust: all wards and teams were made aware of the SAM's pivotal role in the safeguarding adults' process. The SAM's knowledge, skills and training is used to make a timely decision on the most appropriate and effective response to the alleged abuse or neglect. Within the Trust, Team Managers and Principal Social Workers have taken up the role, and provided a focal point for others to refer to. Even where cases are managed externally (e.g. by the local authority) it has clarified where the responsibility for a case lies.

Part of Target A was a measure of compliance with policy on the timescale in convening a strategy meeting; where professionals decide the process to be followed after considering all the information available. Having this as a Quality Account measure has standardised the formal recording of the first stage under safeguarding process.

It is important to note that the successful adoption and embedding of these actions, will allow the SAMs to continue to move away from process-led interventions, and increase focus on the service user, and meet the requirement to enact the 'personalisation' of the safeguarding procedures.

In 2013/14 there were a total of 84 cases closed involving 74 service users. 43 were closed following case conference and 41 were closed at strategy meeting.

Care coordinators or SAMs were contacted to assess any potential risk that may have been triggered by sending a letter (e.g. in cases of allegations of domestic abuse and it could not be confirmed that service user would open letter). An introductory letter and feedback forms were sent to all qualifying cases during March 2014.

At the time of reporting two replies have been received. Collation of the quantitative and qualitative data was completed in April 2014, and results will be submitted to the Safeguarding Adults Quality and Compliance group in June 2014.

Priority 3: Service user/care experience using Real Time Feedback (RTF)	
Priority	To provide service users and carers with the opportunity to provide feedback using RTF on kiosks/tablets and via the Trust website. To provide stakeholders with access to the results of feedback and action plans e.g. what we have done as a result of the feedback – "You said… We did" boards being developed and used in wards and team areas. Demonstrate changes as a result of the feedback.
Target	a) To ensure that service users and carers have access to both RTF kiosks and the Trust website facility to provide the Trust with feedback. b) To provide quarterly reports on themed feedback and actions taken via the Trust website. Corporate themes/actions are to be reported in an Annual Report to the Service User Reference Group (SURG) and the Carers Friends and Family Reference group (CFF). c) To review the changes as a result of feedback and set targets to reduce the recurrent themes.
April 2013 starting position	1. At year end 2012/13 the RTF kiosks had been installed in all ward areas and service users are now able to provide feedback via the Trust's website 2. Not currently provided via quarterly reports 3. Not currently provided
Rationale for this priority	One of the main outputs from the stakeholder engagement event in January 2013 was communication. Stakeholders were keen for the Trust to develop the service user experience priority from collecting the data from services users to include the collection of feedback also from carers. Stakeholders commented that it would be useful for both service users and carers to be able to give feedback from the privacy of their own homes using the Internet. This led to the development of access to feedback via the Trust website. Linked with the Trust website, it was also viewed by stakeholders that it would be informative to have a summary of the changes that have taken place as result of RTF to be summarised on a regular basis, hence the introduction of the quarterly report. The quarterly report will provide stakeholders with access to a summary of the "You said… We did" information including actions taken to resolve any concerns raised.

RTF Quality Account update 2013/14:

"Not only does it allow service users and carers to share ideas, but it encourages them to be part of the family in the recovery journey through team work and future progression. It has allowed me as a manager to see things from a different perspective and understand the things that matter most to them in the triangle of care. It is the compass leaning towards Care and Compassion!"

Ward Manager, Lavender Ward, Kingston & Richmond

Implementation

Since April 2013 RTF devices were rolled out to all wards, HTTs and pilot community teams. Moving forward RTF will be rolled out to all community teams and accessed using the devices already in place from the pilot and the online version of the surveys.

New Dashboard

Staff and service user training on how to use RTF systems

The RTF Coordinator started in post in July 2013 with the remit to support wards and teams to share compliments and develop action/improvement plans as identified by service users, carer's family and friends in the feedback. Support is provided in face to face sessions, meetings, by phone, by email and at stakeholder events.

Using the principle of the "You Said, We Did board" the RTF coordinator has taken feedback from staff on ways to streamline the RTF process and make it less time consuming. This includes: updating of the ward packs to include flow diagrams for device maintenance, templates for Community Team Meetings and "You Said We Did" boards and a protocol on actioning free text comments. The free text dashboard page has also been updated so that Ward Managers (or staff designated to action RTF comments) can categorise their feedback and add a comment in response to it. An email alert has also been devised to advise wards of new feedback.

RTF Device maintenance process

Your kiosk/tablet is displaying the desktop	**Try pression the Reset viewpoint icon initially** **Contact the IM&T Service Desk on 020 351 35454 for guidance on, rebooting the device if it doesn't work a call will be logged**
Your kiosk/tablet screen is blank	**Contact the IM&T Service Desk on 020 351 35454 for guidance on, rebooting the device if it doesn't work a call will be logged**
Your kiosk/tablet has been broken/smashed	**Contact the IM&T Service Desk on 020 351 35454. The Service Desk will then coordinate the removal/ installation of your new device facilities**
Any other kiosk/tablet issue **e.g. You said we did board, feedback results support with training and improvement plans**	**Contat the RTF Coordinator on 020 3513 6637 or Realtimefeedback@swlstg-tr-nhs.uk**

Service users and carers fed back through the RTF Forum on what was good about RTF, what did not work so well and what could be improved. As a result, the New Surveys were co-produced to include an easy read version and launched service users, carers, family and friends more choice on the questions they wanted to answer. The development of the online survey has meant carers, friends and family can give feedback from the comfort of their home at a time that suits them.

Feedback flow chart

Easy Read Survey

"You Said We Did"....

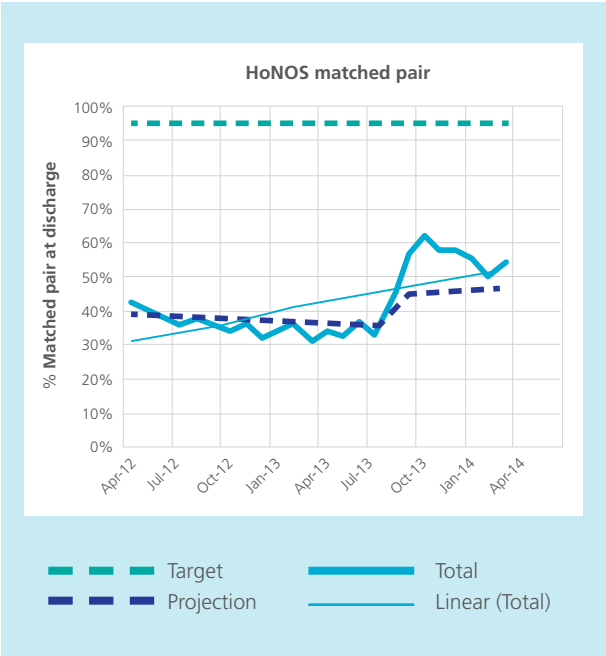
Feedback Themes

The main themes arising from feedback relate to care planning, relationsips with ward staff, activites and catering. Compliments and concerns raised are shared with ward/ team managers and the Patient Experience department.

The information on themed feedback and actions will be shared with the RTF Steering Group, Trust Service User Reference Group (SURG) and Trust Carers, Friends and Family Reference Group (CFF), Acute Care forum (ACF) Care Plan Audit and Integrated Governance Report (IGR) as part of the Trust Quality Account indicators for 2013/14.

Priority 4: Paired Health of the Nation Outcome Scales (HoNOS)	
Priority	Service users discharged from services should have paired HoNOS. HoNOS is a clinical outcome measure used by mental health services. The scales measure the health and social functioning of people with severe mental illness. The initial aim of HoNOS was to provide a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people'. A paired HoNOS refers to a score both on admission and discharge.
Target	95% of service users discharged from services to have paired HoNOS.
April 2013 starting position	At year end 2012/13 38% of service users had a paired HoNOS completed.
Rationale for this priority	In previous years the Trust has measured the percentage of service users who had HoNOS completed at assessment. Wandsworth Health Overview and Scrutiny Committee (HOSC) and Sutton LINks both proposed an indicator that supported the active use of paired HoNOS. Paired HoNOS was a theme identified by Trust stakeholders in November 2011 and was agreed as a priority for 2012/13. At the end of 2012/13 the Trust was some way from achieving the target set at 95%, although there has been a steady improvement throughout the year. In order to continue with this improvement this target will remain as a CQUIN priority for 2013/14.

The HoNOS instrument was developed for use in routine clinical practice. It is a clinician-rated scale which measures 12 dimensions on a 5-point (0-4) scale of severity. It is mandated within the National Health Service (NHS) in England as part of the minimum mental health dataset. The initial aim of HoNOS was to provide a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people'.



A paired HoNOS refers to a score both on admission or referral to a trust service and discharge. The chart below demonstrates progress towards meeting this target. Despite a significant increase in Matched HoNOS pair's recording in October 2013, the numbers have subsequently dropped to 54%.

There have been some considerable challenges impacting on our ability to meet this target. Clinicians enter a HoNOS score using the electronic case note system RiO. This system was reconfigured in autumn 2013; this London wide change resulted in the removal of the HoNOS as an outcome measure. Guidance was released informing clinicians of these changes, and a work-around solution was found involving the part completion of a cluster assessment form. However this guidance was complex, and has impacted on the completion rates, which have declined since October 2013.

The Trust is committed to improve this target. HoNOS is now analysed using the four factor model, and it has been agreed that completion and analysis of the HoNOS four factor model will be a CQUIN for the next financial year.

Priority 5: Crisis Contingency Planning	
Priority	To review the crisis plans of people on CPA and where a carer is stated to identify carer involvement in the crisis plan.
Target	The review of crisis plans will be measured through audit standards set in quarter one.
April 2013 starting position	For 2013/14 the Trust has a CQUIN payment framework indicator to look at crisis plans for service users, as a specific development, this priority will benefit from work that was completed during 2012/13.
Rationale for this priority	Stakeholders from the engagement event in January 2013, highlighted that carers, where identified, should have agreed plans in the event of a crisis. These plans should be developed in conjunction with the service user, the carer and the team.

Crisis plans are a key part of care planning. Feedback from service users, carers and families told us there was a lot more we could do at the Trust to collaboratively develop crisis plans with people using our services. CQC community surveys identified that the Trust had the lowest score in London for the experience of crisis planning and what to do in a crisis. As a result of this feedback the Trust wanted to radically improve the experience and satisfaction of crisis plans and the crisis planning process.

The first stage to improving the quality of crisis plans and the crisis planning process began by coproducing with service users, carers, families, friends and health and social care staff an exemplar crisis plan and good practice standards for collaborative crisis planning. Through the coproduction exercise, two crisis plans were developed: a full collaborative crisis plan (advance directive) and a summary collaborative crisis plan. Both were signed off by the CQRG.

The second stage to improving the quality of crisis plans and the crisis planning process was to provide training and support to staff to be able to collaboratively develop crisis plans with service users and their families, friends and carers.

Training sessions were held for doctors which explained the CQC community mental health survey results in contrast to other Trusts in London, the policy context in terms of NICE guidance on service user experience in adult mental health and the Mental Health Act code of practice, the research evidence on joint crisis plans, the practical challenges for implementing collaborative crisis plans in our organisation and the clinical leadership needed to support implementation. A total of 66 doctors attended these sessions.

A training course on recovery focused care planning and crisis planning was coproduced through the Trust's Recovery College and is being rolled out to all Bands 5 – 7 staff who are involved in care planning and crisis planning. To start, the training was targeted at Band 7 staff (ward and community team managers) so they are clear about the quality expected of care plans and crisis plans. In 2013/14, a total of 370 staff received this training.

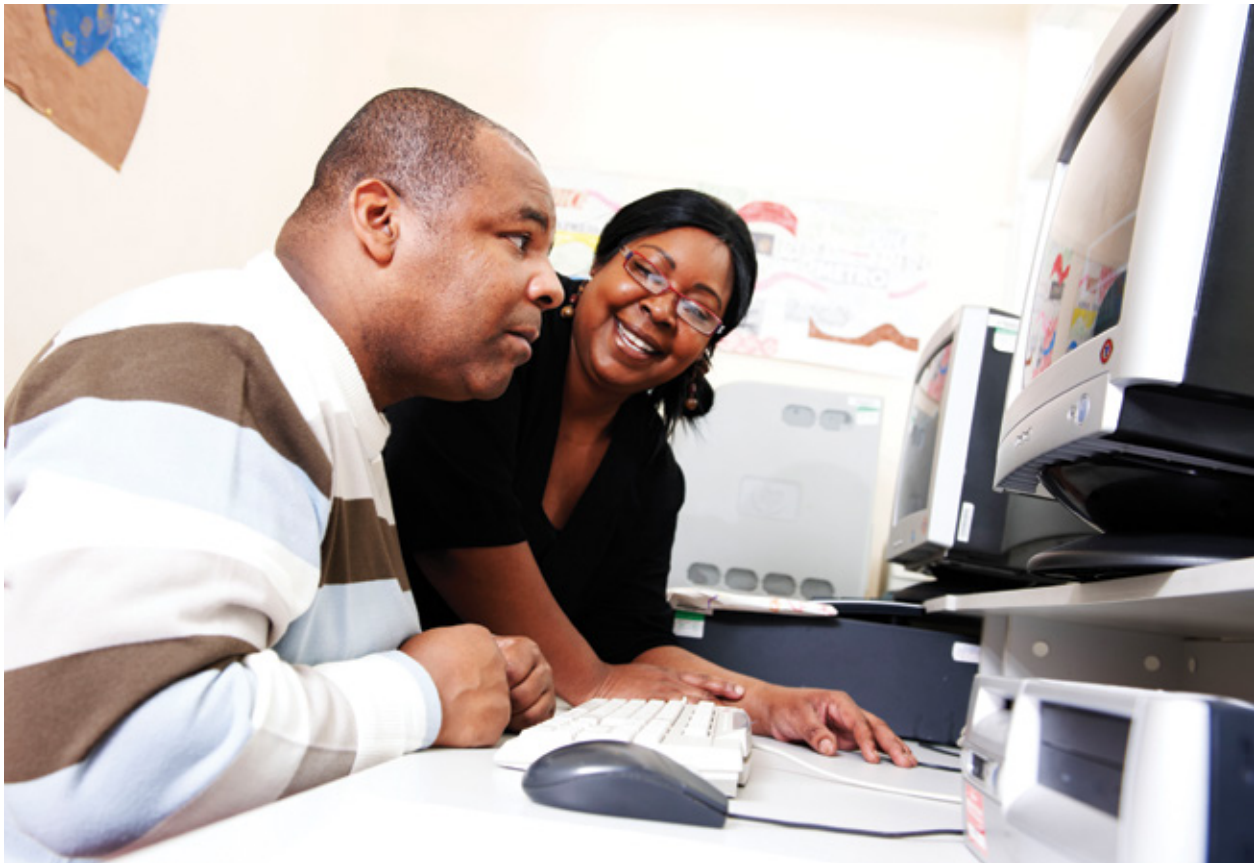
A training session for ward managers was delivered explaining the role of crisis plans when a person is admitted to wards and to ensure ward managers were aware of the good practice standards that were developed.

The crisis plan work has also been discussed with the HTT leads across the Trust along with Liaison Psychiatry colleagues who have all been very positive about the new collaborative crisis plans.

The third stage to improving the quality of crisis plans and the crisis planning process consisted of carrying out audits of the quality of the new collaborative crisis plans. The audit framework consists of 10 audit questions each with a five point rating scale. During 2013/14, based on the audits there was a significant increase in the quality of collaborative crisis plans developed with service users and their families, friends and carers:

- In quarter 2, the audit found that n=278 (97%) of the audited crisis plans were rated as poor in overall quality based on the new audit framework for collaborative crisis plans
- In quarter 3, the audit found that where the new collaborative crisis plan had been used the overall quality of these was very good: 8% were rated as adequate, 41% as good and 51% as excellent in quality.
- In quarter 4, the audit found that where the new collaborative crisis plan had been used the quality of these was very good: 3% were rated as poor, 10% as adequate, 40% as good and 47% as excellent in quality.

To date the feedback from service users, and carers and families continues to be positive about the new collaborative crisis plan. Service users like the paper based format, the zoning (red, amber and green) system for identifying trigger and warning signs of a crisis and the anecdotal feedback is that staff are listening to what is important to them at a time of crisis. Feedback from staff is they like the new summary collaborative crisis plan but are finding that it is not always easy to discuss and complete with service users – service users don't want to be reminded about previous times of when they were unwell and, some staff appear to be struggling with how to have these 'difficult' conversations with service users. The recovery focused care planning and crisis planning course at the Recovery College appears to be helping staff with these issues.
The other main theme from staff is the summary collaborative crisis plan is taking a long time to complete – because it needs service users, carers and family involved which is taking time. Feedback from GPs has to date been positive.



Appendix 5

Review of CQUIN Goals 2013/14

CQUIN	Indicator	Year-end performance
Feedback for Improvement	Recruit a Real Time Feedback (RTF) Coordinator	**Successfully completed** ✔
	Implement RTF systems on all inpatient wards and in all Home Treatment Teams	**Successfully completed** ✔
	Produce and submit a business case to commissioners for the implementation of RTF in community teams in 2014/15	**Successfully completed** ✔
	Produce and submit quarterly reports to commissioners including implementation progress updates, lessons learned and examples of ward action plans	**Successfully completed** ✔
	Commence RTF systems roll out (implementation) for community teams	**Successfully completed** ✔

Feedback for Improvement – specific achievements

RTF systems have been successfully implemented in all inpatients areas of the Trust. Action plans are now routinely formed by wards in response to the feedback received and changes are being made to improve service user, carer, friends and family experience.

A suite of tools and resources has been co-produced and implemented to support all stakeholders in giving, collecting, analysing and monitoring feedback in order to make the process of feedback for improvement as easy to access and effective as possible.

For more detailed information, please refer to the Service User Experience section of the Quality Account.

Safety Thermometer	Collect and submit monthly Safety Thermometer screening data for falls, pressure ulcers and Urinary Tract Infections (UTI) (for those with catheters) for older people's inpatient wards	**Successfully completed** ✔
	Put in place improvement programmes to respond to any harms or hazards identified	**Successfully completed** ✔
	Submit a year-end report exploring if the Safety Thermometer work has had an effect on identified harms or hazards	**Successfully completed** ✔

Crisis Plans	Establish a working group to include Service User Reference Group (SURG) representation, to co-produce what is considered to be an exemplar crisis plan, good practice standards and crisis planning process. Obtain sign off (approval) of these standards from the CQRG	**Successfully completed** ✔
	Train appropriate staff (doctors and care coordinators) on how to create co-produced crisis plans to the approved standard. This training programme will include the implementation of a suite of tools and resources to support staff, service users and carers. This will also include an understanding of the appropriate use of A&E services	**Successfully completed** ✔
	Q2 - Audit of a sample of Crisis Plans completed for people who have had a CPA review in the last quarter. Submit audit report to the CQRG	**Successfully completed** ✔
	Q3 - Re-audit crisis plans and report on results. Report to include: • Actions needing to be addressed, organised by themes and areas • Information on a sample of Crisis Plans of large enough statistical value to demonstrate improvement Examples of Crisis Plans and anecdotes from service users, carers, families and staff to be supplied	**Successfully completed** ✔
	Q3 - 40% of all Crisis Plans to be categorized as 'Adequate' or above following Q3 audit. *The audit revealed that where the new summary collaborative crisis plan template had been used (n=39, 13%) the quality of these was very good: • **n=3 (8%) were rated as adequate** • **n=16 (41%) as good** • **n=20 (51%) as excellent in quality.** However, where the new summary collaborative crisis plan template had not been used the quality was poor: n=249 (84%) of crisis plans were rated as poor in quality based on the audit framework.	The Q3 audit was completed and report submitted. A discussion was held with commissioners at the February CQRG to agree if the Q3 target has been fully achieved, unfortunately, the decision was that it had not*.
	Re-audit crisis plans and final report on results as above	**Successfully completed** ✔
	Q4 - 60% of all Crisis Plans to be categorised as 'Adequate' or above following final Q4 audit	**Successfully completed** ✔

Crisis Planning – specific achievements in 2013/14

Following co-producing 'What makes a good crisis plan?' with service users, carers, families and friends and Trust health and social care staff, good practice, gold standards for collaborative Crisis Planning were developed and approved by the CQRG. In addition, based on feedback during the co-production process, two Crisis Plans were being developed: a full Crisis Plan (Advance Directive) and a summary Crisis Plan.

A new mandatory care planning and crisis planning course has been developed through the Trust's Recovery College and is now being rolled out to all Bands 5 – 7, staff who are involved in care planning and crisis planning.

To date the feedback from service users, and carers and families has been positive about the new collaborative crisis plan. Service users like the paper based format, the zoning (red, amber and green) system for identifying trigger and warning signs of a crisis and report that staff are listening to what is important to them at a time of crisis.

The Recovery College has also implemented a series of courses for service users and staff that support this year's CQUIN targets:

- Introduction to recovery
- Recovery focused care planning
- Taking back control
- Understanding self-harm
- Learning to be more assertive
- Living with psychosis and schizophrenia
- Returning to work or stuffing
- Pursuing your dreams and ambitions
- Introduction to relaxation and medication
- Five ways to wellbeing
- Problem solving
- Future focus
- Gaining confidence with effective communication

Safe, Managed Discharges	Explore and report to commissioners on the feasibility of delivering a secure e-mail system to e-mail GP practices	**Successfully completed** ✔
	Produce a quality standard for inpatient discharge summaries. This should be achieved by: • Working with GP colleagues to establish what is useful/not useful in discharge summaries. This will be achieved by a discharge summaries workshop for GPs at the CQRG meeting in April 2013 • Consulting the latest Royal College of Physicians (RCP) discharge summary template	**Successfully completed** ✔
	Produce and implement a pre-populated discharge summary template in RiO for use by staff	**Successfully completed** ✔

Safe, Managed Discharges	Report on the feasibility of providing service users with discharge summaries at the time of discharge from the ward	**Successfully completed** ✔
	Q2, Q3 and Q4 - Audit against the approved quality standard discharge summary template and report results to commissioners including any lessons learned	**Successfully completed** ✔
	Audit a sample (100) community discharge summaries and compare with approved inpatient standard. Based on the results of this audit, make recommendations for improvements to community discharge planning	**Successfully completed** ✔
	Agree an implementation plan for the roll out of a quality standard discharge summary template to community teams (this will be included as a CQUIN for 2014/15)	**Successfully completed** ✔

Safe, Managed Discharges – specific achievements in 2013/14

The quarterly audits of inpatient discharge summaries have demonstrated that there has been a vast improvement in the quality of the discharge information which is being sent out to GPs.

The lessons learned from these audits and the recommendations for improvement which have been successful will be applied to the 2014/15 CQUIN work to improve the quality of community discharge summaries.

New Trust guidelines and a staff tool were created and implemented by the Pharmacy Department at the start of Q3 on Physical health monitoring for specific medication. These now enable staff to copy and paste relevant information from the guidelines directly into discharge summaries, thus greatly facilitating the process and helping to improve performance in this vital area.

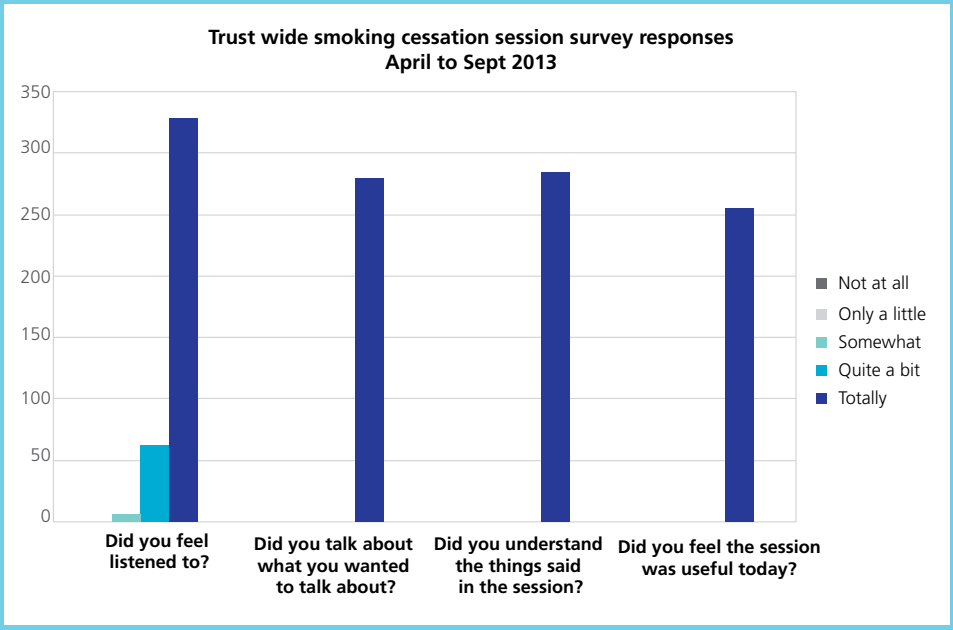
Smoking Cessation	Submit implementation plan for regular session feedback surveys to become part of the support package. This plan must include Feedback Survey form for approval by commissioners	**Successfully completed** ✔
	Implement session feedback survey	**Successfully completed** ✔
	Q2, Q3 and Q4 - Report on feedback surveys to show variations between different cohorts of service users. As well as demonstrating achievement of the above targets, the Trust should submit a report on feedback survey results. This report should include: • Evidence of changes/improvements to the support package that have been made throughout the year based on the feedback received from service users' surveys • Evidence of changes/improvements to the support package that have been made throughout the year based on the feedback received from service users' surveys	**Successfully completed** ✔

	% of people referred to and who engage in and take up the smoking cessation service that complete the full 12 weeks support package	**Successfully completed** ✔
	Continuation of the 2012/13 reporting structures that report each quarter on: • Smoking status recorded • Referrals to Smoking Cessation Advisors (SCAs) • People setting quit dates	**Successfully completed** ✔

Smoking Cessation – specific achievements in 2013/14

Since the start of the smoking cessation session feedback pilot and subsequent full implementation of the Smoking Cessation Session Feedback Survey at the end of Q1, 394 surveys have been completed by service users and the data recorded by the Trust's SCAs.

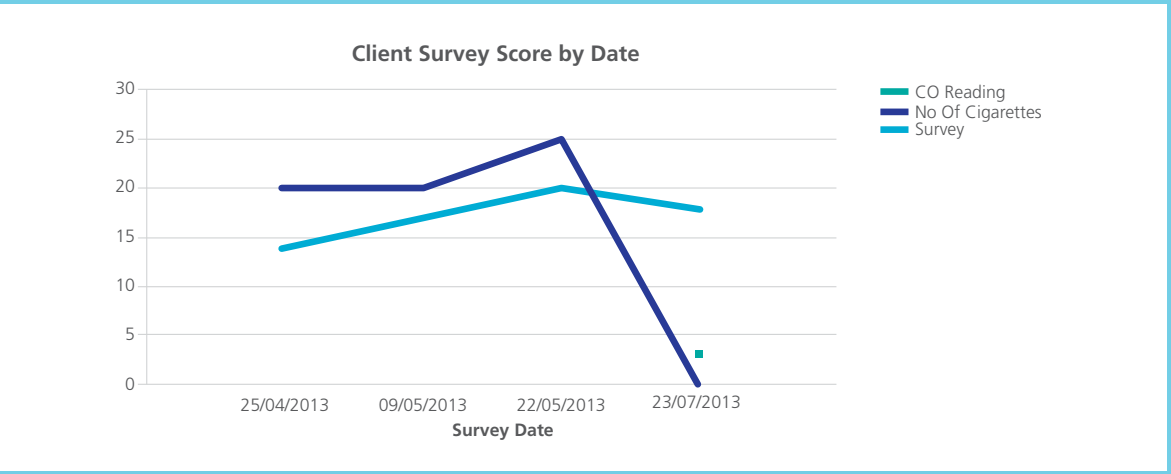
Feedback from service users has been extremely positive throughout the year



An important development in 2013/14 has been the way that the SCAs are now able to use the data collected from the session surveys to chart the progress of individual service users.

The graph below shows the progress of a Wandsworth service user in terms of overall satisfaction with the sessions along with a vast drop in the number of cigarettes smoked from 20 in April to zero in July.

Smoking Cessation – specific achievements in 2013/14



This year, the SCAs have also been monitoring the number of service users who have completed the full 12 weeks expert support package they offer. Figures for each quarter (see Figure 3 below) were higher than expected the percentage of service users who completed the full 12 weeks support package improved quarter on quarter:

Q1 – 27.6% **Q2 – 44.8%** **Q3 – 58.6%**

By using conditional probabilities, this data also allowed us to determine that there is a link between completing the 12 weeks support package and an improvement of smoking outcomes. Put simply, by attending the full 12 week expert support package, a person has a 75% chance that they will either see a reduction in the number of cigarettes they smoke by 25% or more, or succeed in quitting completely.

"Your sessions are very helpful. Cigarettes no longer exist to me. I look at them and I don't want them anymore."
Service user, Sutton & Merton

"I couldn't ask for more support!"
Service user, Wandsworth

"The stop smoking sessions were really good. I've never smoked anymore. You've always given me great advice. Thanks for the help."
Service user, Sutton & Merton

"Session already exceeded my expectations, no improvement required."
Service user, Wandsworth

"The appointment was very helpful. Can't fault the woman who helped me. Extremely excited at being helped to give up."
Service user, Kingston & Richmond

"The help and support given has made me feel more confident about staying off cigarettes."
Service user, Wandsworth

Physical Health	95% of inpatients to have a relevant Physical Health Assessment (PHA) within 48 hours of admission. If it is not possible to do a full physical health assessment within that time a rationale should be provided and assumptions outlined	**Successfully completed** ✔
	Quarterly information on exceptions (those people for whom it is not possible to complete a PHA within 48 hours of admission) to be collated into themes and reported to the CQRG for the August 2013 meeting. This information should include, where possible, vignettes from staff	**Successfully completed** ✔
	95% of inpatients to have it recorded that an attempt has been made to complete a relevant PHA every 6 months	**Successfully completed** ✔
	Quarterly physical health plan in discharge summary quality audits to be completed and reports submitted to commissioners	**Successfully completed** ✔

Physical Health – specific achievements in 2013/14

As part of the CQUIN 2013/14 Physical Health indicators, the Trust was required to include a clear physical health care plan in the discharge summary for those people on a Quality Outcome Framework (QOF) register and/or on antipsychotic medication. The quality of these physical health plans was then audited each quarter and the results presented to commissioners.

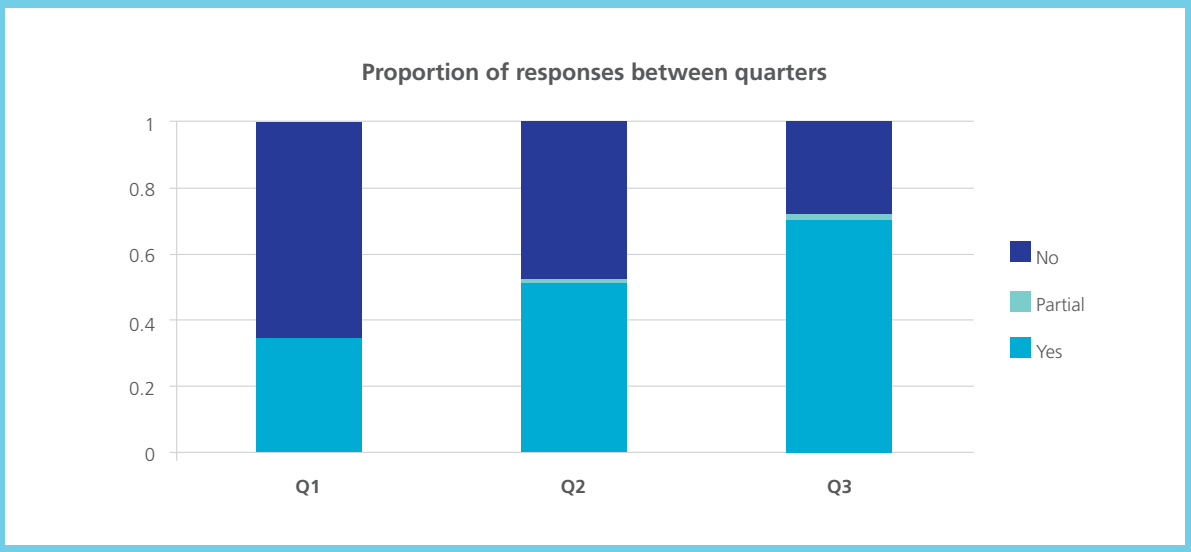
The following audit questions were asked:

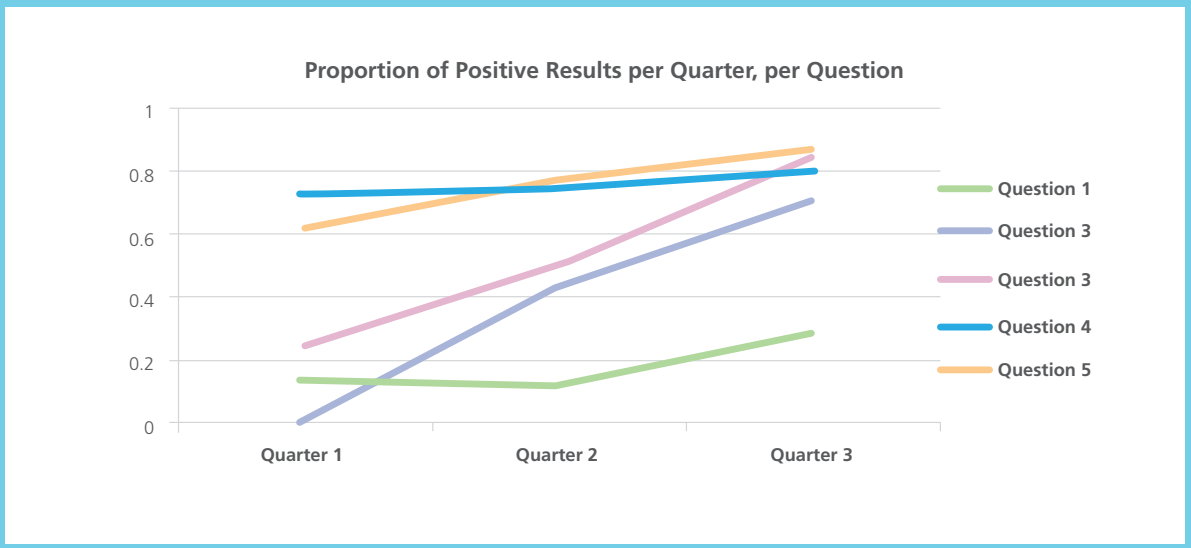
1. Is the service user on a QOF register (for obesity, Diabetes, Coronary Heart Disease (CHD), Chronic Obstructive Pulmonary Disease (COPD), Hypertension)?
2. Is the service user on antipsychotic / mood stabiliser medication?
3. If service user is on a QOF, is follow up of the physical health condition mentioned?
4. If service user is on an antipsychotic and/or mood stabiliser medication is there any mention of physical health monitoring?
5. If service user is on an antipsychotic and/or mood stabiliser medication is there any specific guidance recorded as per Trust policy?

The data collected each quarter was compared to determine whether there had been a significant change in results; i.e. had the recommendations from the previous audit been implemented, and had this resulted in improvement.

Physical Health – specific achievements in 2013/14

The graph below indicates that the quality of the audited data steadily improved over the year:





The graph above shows the change in the proportion of positive results for each question during this year. Questions 1 and 2 are statements of fact about the number of patients on a QOF or taking antipsychotics and as such we expect the numbers to remain approximately the same. Questions 3, 4 and 5, which address the quality of physical health monitoring information, have all seen an improvement over the period, with Question 5 (medication specific guidance) improving the most. Therefore, the implementation of revised guidance by the Pharmacy Department for physical monitoring of psychotropic medication proved to be very effective, as indicated by the significant improvement in performance since quarter one.

Appendix 6

Participated audits 2013/14

National Clinical Audits	Coordinating Body	Number of Cases Submitted	Number of Registered Cases Required
National Clinical Audits participated in and for which data collection was completed during period 2013/14:			
National Audit of Psychological Therapies	Royal College of Psychiatrists	1543 (Sutton and Merton Improving Access to Psychological Therapies (IAPT)) 1182 (Wandsworth IAPT)	N/A
National Audit of Schizophrenia	Royal College of Psychiatrists	85	85/100
Promoting Public Health in the Workplace	Health and Work Development Unit	N/A	N/A
Prescribing Observatory for Mental Health (POMH-UK) Topic 13a - Prescribing for ADHD in children, adolescents and adults	Royal College of Psychiatrists	44	N/A
POMH-UK Topic 7d - Monitoring of patients prescribed lithium	Royal College of Psychiatrists	284	N/A
POMH-UK Topic 10c - Prescribing antipsychotics for children and adolescents	Royal College of Psychiatrists	73	N/A
POMH-UK Topic 4b - Prescribing anti-dementia drugs	Royal College of Psychiatrists	258	N/A

National Clinical Audits reviewed during 2013/14:			
Promoting Public Health in the Workplace	Health and Work Development Unit	N/A	N/A
National Audit of Psychological Therapies	Royal College of Psychiatrists	1543 (Sutton and Merton IAPT) 1182 (Wandsworth IAPT)	N/A
POMH-UK Topic 13a - Prescribing for ADHD in children, adolescents and adults	Royal College of Psychiatrists	44	N/A
POMH-UK Topic 7d - Monitoring of patients prescribed lithium	Royal College of Psychiatrists	284	N/A
National Confidential Inquiries:			
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	University of Manchester – The Centre for Suicide Prevention	Last available response rate received March 2014 was 95%	

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