Merton Council

Healthier Communities and Older People Overview and Scrutiny Panel

Date: 17 March 2015

Time: 7.15 pm

Venue: Committee rooms B, C & D - Merton Civic Centre, London Road, Morden SM4 5DX

AGENDA

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6a	Quality Account - Executive Report	1 - 16

This is a public meeting – members of the public are very welcome to attend. The meeting room will be open to members of the public from 7.00 p.m.

For more information about the work of this and other overview and scrutiny panels, please telephone 020 8545 3390 or e-mail scrutiny@merton.gov.uk. Alternatively, visit www.merton.gov.uk/scrutiny

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Healthier Communities and Older People Overview and Scrutiny Panel membership

Councillors:
Peter McCabe (Chair)
Brian Lewis-Lavender (Vice-Chair)
Pauline Cowper
Mary Curtin
Brenda Fraser
Suzanne Grocott
Sally Kenny
Abdul Latif

Substitute Members:
Joan Henry
Najeeb Latif
Gregory Patrick Udeh
Jill West

Co-opted Representatives
Myrtle Agutter
Saleem Sheikh
Hayley James

Note on declarations of interest

Members are advised to declare any Disclosable Pecuniary Interest in any matter to be considered at the meeting. If a pecuniary interest is declared they should withdraw from the meeting room during the whole of the consideration of that mater and must not participate in any vote on that matter. If members consider they should not participate because of a non-pecuniary interest which may give rise to a perception of bias, they should declare this, .withdraw and not participate in consideration of the item. For further advice please speak with the Assistant Director of Corporate Governance.

What is Overview and Scrutiny?
Overview and Scrutiny describes the way Merton's scrutiny councillors hold the Council's Executive (the Cabinet) to account to make sure that they take the right decisions for the Borough. Scrutiny panels also carry out reviews of Council services or issues to identify ways the Council can improve or develop new policy to meet the needs of local people. From May 2008, the Overview & Scrutiny Commission and Panels have been restructured and the Panels renamed to reflect the Local Area Agreement strategic themes.

Scrutiny's work falls into four broad areas:

⇒ **Call-in**: If three (non-executive) councillors feel that a decision made by the Cabinet is inappropriate they can 'call the decision in' after it has been made to prevent the decision taking immediate effect. They can then interview the Cabinet Member or Council Officers and make recommendations to the decision-maker suggesting improvements.
⇒ **Policy Reviews**: The panels carry out detailed, evidence-based assessments of Council services or issues that affect the lives of local people. At the end of the review the panels issue a report setting out their findings and recommendations for improvement and present it to Cabinet and other partner agencies. During the reviews, panels will gather information, evidence and opinions from Council officers, external bodies and organisations and members of the public to help them understand the key issues relating to the review topic.
⇒ **One-Off Reviews**: Panels often want to have a quick, one-off review of a topic and will ask Council officers to come and speak to them about a particular service or issue before making recommendations to the Cabinet.
⇒ **Scrutiny of Council Documents**: Panels also examine key Council documents, such as the budget, the Business Plan and the Best Value Performance Plan.

Scrutiny panels need the help of local people, partners and community groups to make sure that Merton delivers effective services. If you think there is something that scrutiny should look at, or have views on current reviews being carried out by scrutiny, let us know.

For more information, please contact the Scrutiny Team on 020 8545 3390 or by e-mail on scrutiny@merton.gov.uk. Alternatively, visit www.merton.gov.uk/scrutiny

Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: **17th March 2015**
Agenda item:

Wards: ALL

Subject:

Lead officer:

Lead member: Councillor Peter McCabe, Chair of the Healthier Communities and Older People Overview and Scrutiny Panel.

Contact officer: Patricia Sanders, Corporate Affairs Assistant, Patricia.Sanders@swlstg-tr.nhs.uk

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Recommendations:

A. To note the proposed South West London & St Georges Mental Health NHS Trust Quality Account indicators 2015-16

B. To provide feedback to South West London & St Georges Mental Health NHS Trust on the proposed Quality Account indicators 2015-16

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

SOUTH WEST LONDON & ST GEORGES MENTAL HEALTH NHS TRUST REQUESTS THE HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL TO CONSIDER THE PROPOSED 2015-16 QUALITY ACCOUNT INDICATORS AT AN EARLY STAGE PRIOR TO THE FORMAL CONSULTATION PROCESS.

THE FULL QUALITY ACCOUNT DOCUMENT WILL BE SENT TO YOU BY THE 30 APRIL 2015 SEEKING A RETURN WITHIN 30 DAYS OF RECEIPT OF THE QUALITY ACCOUNT TO ALLOW TIME FOR US TO PREPARE THE REPORT, WHICH WILL INCLUDE YOUR STATEMENT, FOR PUBLICATION BY THE 30TH JUNE 2015.

2 DETAILS

2.1. The consultation to date on the Quality Account proposed indicators 2015-16 has been coordinated through the Clinical Quality Reference Group (CQRG) with the CCGs in Sutton, Merton, Wandsworth, Kingston and Richmond. This consultation commenced in December 2014.

2.2. Further consultation with Health Overview and Scrutiny Panels, HealthWatch, service users and carers on the Quality Account proposed indicators 2015-16 is being progressed by South West London & St Georges Mental Health NHS Trust.

2.3. Quality Account Indicator Theme number 1 – Co-ordinated Discharge Planning is a two year theme aiming to improve the quality and coordination of discharge planning for inpatient service users.

2.4. Quality Account Indicator Theme number 2 - Service Responsiveness and Web Consultations has been designed to promote innovative methods of communication to improve service responsiveness for service users in the community and for GPs when contacting the Trust.

2.5. Quality Account Indicator Theme number 3 and 4 are Physical Health and Learning Disability Quality Account indicators for 2014-15 in the second year of a two year indicator. The focus in year two will include obesity for Physical Health and Autistic Spectrum Disorders (ASD) for Learning Disability.

3 ALTERNATIVE OPTIONS

N/A

4 CONSULTATION UNDERTAKEN OR PROPOSED

SOUTH WEST LONDON & ST GEORGES MENTAL HEALTH NHS TRUST REQUESTS THE HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL TO CONSIDER THE PROPOSED 2015-16 QUALITY ACCOUNT INDICATORS AT AN EARLY STAGE PRIOR TO THE FORMAL CONSULTATION PROCESS.

FOLLOWING THIS, THE FULL QUALITY ACCOUNT WILL BE SENT TO YOU BY THE 30 APRIL 2015 SEEKING A RETURN WITHIN 30 DAYS OF RECEIPT OF THE QUALITY ACCOUNT TO ALLOW TIME FOR US TO PREPARE THE REPORT, WHICH WILL INCLUDE YOUR STATEMENT, FOR PUBLICATION BY THE 30TH JUNE 2015.

CONSULTATION TO DATE ON THE QUALITY ACCOUNT PROPOSED INDICATORS 2015-16 HAS BEEN CO-ORDINATED THROUGH THE CLINICAL QUALITY REFERENCE GROUP (CQRG) WITH THE CCGS IN SUTTON, MERTON, KINGSTON AND RICHMOND. THIS CONSULTATION COMMENCED DECEMBER 2014

FURTHER CONSULTATION WITH HEALTH OVERVIEW AND SCRUTINY COMITTEES, HEALTHWATCH, SERVICE USERS AND CARERS ON THE QUALITY ACCOUNT PROPOSED INDICATORS 2015-16 IS BEING PROGRESSED BY SOUTH WEST LOINDON & ST GEORGES MENTAL HEALTH NHS TRUST.

5 TIMETABLE

THE HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL IS REQUESTED TO CONSIDER THE PROPOSED QUALITY ACCOUNT INDICATORS AND PROVIDE FEEDBACK TO SOUTH WEST LONDON & ST GEORGES MENTAL HEALTH NHS TRUST BY THE END OF MARCH 2015.

THE FULL QUALITY ACCOUNT WILL BE SENT TO YOU BY THE 30 APRIL 2015 SEEKING A RETURN WITHIN 30 DAYS OF RECEIPT OF THE QUALITY ACCOUNT TO ALLOW TIME FOR US TO PREPARE THE REPORT, WHICH WILL INCLUDE YOUR STATEMENT, FOR PUBLICATION BY THE 30TH JUNE 2015.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

NONE

7 LEGAL AND STATUTORY IMPLICATIONS

SOUTH WEST LONDON & ST GEORGES MENTAL HEALTH NHS TRUST HAS A LEGAL DUTY TO SEND OUR QUALITY ACCOUNT TO YOU TO INVITE COMMENTS ON THE REPORT PRIOR TO PUBLICATION. THIS PROVIDES YOU WITH THE OPPORTUNITY TO REVIEW THE INFORMATION CONTAINED IN THE REPORT AND PROVIDE A STATEMENT ON YOUR VIEW OF WHAT IS REPORTED

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

NONE

9 CRIME AND DISORDER IMPLICATIONS

NONE

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11 NONE

12 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- South West London & St Georges Quality Account Proposed Indicators 2014-15

13 BACKGROUND PAPERS

13.1. None

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Proposed 2015-16 Quality Account Indicators v 1.1
27th February 2015

Theme and rationale	Indicator description(s)	Target Achievement
1. **Coordinated Inpatient Discharge Planning (2 Year indicator)** **Year 1** **Rationale** The CQC raised coordinated discharge planning as an issue for concern for the Trust in the Intelligence Monitoring Report December 2014. The Acute Care Project Group (part of the Trust's Transformation Programme) conducted an evidence scan that identified a lack of pro-active planning of discharge arrangements and oversight of the discharge process as a whole. Facilitated discharge is considered a key element that needs to be addressed in order for the Trust to safely ensure all adult acute wards are 18 bedded wards as recommended by the RCN and Royal Collage of Psychiatrists. National initiatives such as the 'Triangle of Care' approach increasingly promote family and carer involvement as a central component of effective and coordinated discharge. This is a 2015/16 CQUIN. **Intended Outcome** This two year theme aims to improve the quality and coordination of discharge planning for inpatient service users. This indicator aims to: • Ensure that best practice standards of discharge planning are applied across	**Indicator 1: Discharge Standards (Q1 only)** To refine and improve Trust inpatient discharge standards to ensure standardisation and learning from best practice across Trust wards **Indicator 2: Ward Information Packs** To develop and implement a comprehensive discharge support and information element in ward packs for Adult Acute wards to facilitate discharge **Indicator 3: Task Management System** Publicise and engage staff with the Discharges Task List and Task Management System on My Dashboards. Refine processes and systems to ensure staff are able to make best use of the systems available.	**Q1** **Indicator 1** • Review the Trust inpatient discharge standards for Adult Acute wards. The process of updating the standards should include appropriate staff, service user and CFF input • Co-produce updated Trust inpatient discharge standards for Adult Acute wards. These standards should include a standardised ECR recording process at discharge for staff • Launch the updated inpatient discharge standards for Adult Acute wards **Indicator 2** • Co-produce, with appropriate staff, service users and CFF from Adult Acute wards, a discharge support and information element for ward packs to support discharge in Adult Acute wards **Indicator 3** • Produce usage guidelines for staff for the Discharges Task List and Task Management System on My Dashboards • Launch and implement usage guidelines in Adult Acute wards **Q2** **Indicator 1** • Conduct an audit of ECR discharge recording and submit an audit report. This report should include: - A review of ECR data for patients discharged in Q2 - Lessons learned - Recommendations for improvement **Indicator 2** • Distribute and implement the usage of the discharge element of ward packs across Adult Acute wards at the start of Q2

Theme and rationale	Indicator description(s)	Target Achievement
inpatient settings • Provide high quality and comprehensive information and support for service users leaving inpatient settings • Make best use of electronic systems to support discharge processes.		• Collect feedback during Q2 on the discharge element of ward packs from Adult Acute wards (staff, service users and CFF) • Collate feedback and submit a progress report at the end of Q2. This report should include recommendations for improvement based on the feedback collected **Indicator 3** • Monitor and review uptake of the Discharges Task List (DTL) and Task Management System (TMS) processes on Adult Acute wards. Produce and submit a report, to include: - DTL and TMS usage - Lessons learned - Recommendations for improvement
		Q3 **Indicator 1** • Implement recommendations for improvement from Q2 ECR audit **Indicator 2** • Refine/update the discharge element of ward packs based on feedback collected in Q2 and distribute updated versions to adult Acute wards • Produce plan to expand ward pack discharge element work to other Trust wards • Commence design work for discharge support and information element of ward packs for other Trust wards. The design process should include input from relevant stakeholders (staff, service users and CFF) from these other wards **Indicator 3** • Implement recommendations for improvement from Q2 review of DTL and TMS usage

Theme and rationale	Indicator description(s)	Target Achievement
		Q4 **Indicator 1** • Conduct an audit of ECR discharge recording and submit an audit report. This report should include: - A review of ECR data for patients discharged in Q4 - Lessons learned - Recommendations for improvement **Indicators 1, 2 and 3** • Produce and submit a year-end report. This report should include progress to date based on feedback from key stakeholders, lessons learned and recommendations regarding the implementation of: - Ward packs - Updated discharge standards and implementation of standardised ECR recording - Changes to DTL and TMS processes. • Gaps identified by the year-end report will be used to inform the focus for Year 2 of this two year action plan to improve quality of coordinated discharge planning in the Trust

Theme and rationale	Indicator description(s)	Target Achievement
2. <u>Service Responsiveness and Web Consultations</u> **Rationale** The March 2014 CiH Inspection found that some people served by the adult community teams had raised concerns about the responsiveness of the service. Service users said they sometimes found it difficult to contact staff and would not always receive a call-back when they requested one. This has also been raised by clinical staff as a key line of enquiry. There are new and innovative methods of communication that have been piloted in Trust teams and externally, including the use of web based consultations, which could be refined and developed further to support improved responsiveness. A priority for the Trust, as outlined in the clinical strategy (2015-2020) is that by 2020 the Trust will be working more effectively with GPs. The GP satisfaction survey carried out as part of the 2014/15 Quality Account indicator for GP interfaces showed that 75% did not feel they received sufficient information from the Trust. **Intended Outcome** This indicator has been designed to promote innovative methods of communication to improve service responsiveness for service users in the community and for GPs when contacting the Trust.	**Indicator 1: Trust standards** Update and refine Trust standards and procedures for responsiveness in Trust teams, to include: - Expected time frames for returning calls when service users contact community teams - Appropriate methods of communication **Indicator 2: *Web consultations** Co-produce, pilot and implement web consultations for service users, and for clinicians and GPs ***NB: There is currently a Trust pilot underway for the use of Skype with service users until July 2015 at which point it will be reviewed whether the pilot continues. There are no current plans for the use of web consultations with GPs.**	**Q1** **Indicator 1** • In collaboration with community team staff, service users, carers, friends and families (CFF) and the Patient Experience Team, review and update Trust standards for responsiveness in Trust teams as part of community teams' operational policies • Launch, implement and promote updated responsiveness standards for community teams **Indicator 2** • In conjunction with the IT Web Consultations Pilot project manager, produce user guidelines and support materials for staff and service users for web consultations • Provide group and 1:1 training sessions for staff, as required, on the usage of web consultations • Pilot the use of web consultations between community team staff and service users in Jubilee Health Centre (Sutton) and in Deaf services • Collect feedback throughout the quarter from service users and clinicians on the effectiveness and usability of web consultations using a survey method. **Q2** **Indicator 1** • In collaboration with the Patient Experience Team, obtain feedback from service users and staff to establish adherence to the new responsiveness standards. This should be done by reviewing any related complaints. • Produce and submit a report including recommendations for improvement **Indicator 2** • Provide on-going support for staff in pilot teams regarding web consultations • Collate and write up feedback from service users and staff on pilot use of web consultations. Submit an interim report to commissioners to include: - Usage figures

Theme and rationale	Indicator description(s)	Target Achievement
		- Benefits, challenges and solutions found - Lessons learned - Recommendations for improvement • Incorporate recommendations for improvement from Q2 feedback report into Trust policy and protocol for web consultations • Produce an implementation plan to extend the web consultations pilot to include other community teams and GPs • Produce web consultations usage guidelines and support materials for GPs • Start engaging other teams and GPs in preparation for pilot extension to commence in Q3
		Q3 **Indicator 2** • Hold a session in Q3 with staff and service users to share learning and explore the barriers and facilitators to engagement for web consultations. This event should also serve as an engagement opportunity for GPs invited to join the pilot • Produce an event summary write up and submit report to commissioners at the end of Q3 • Commence web consultations in additional teams and GPs, providing support as required • Collect feedback from service users, clinicians and GPs as to the effectiveness and usability of web consultations using a survey method.
		Q4 **Indicator 1** • In collaboration with the Patient Experience Team, obtain feedback from service users and staff to establish adherence to the new responsiveness standards. This should be done by reviewing any related complaints. • Produce and submit a report including recommendations for improvement

Theme and rationale	Indicator description(s)	Target Achievement
		Indicator 2 • Submit a year-end report and recommendations for commissioners around the use of web consultations in improving service responsiveness and engagement with service users and GPs. Report to include: - Levels of uptake - Benefits and disadvantages - Feedback from clinicians, service users and GPs - Links to national findings and policy recommendations, and the Trust's clinical strategy 2015-2020
3. **Physical Health (Year 2 of a two year indicator commenced in 2014/15)** **Year 2** **Rationale** The national mental health strategy 'No Health without mental health' (2011) outlined good physical health as one of six key objectives to improve outcomes for people with mental health problems. 'Parity of esteem' is outlined in the Trust's clinical strategy as a key priority for the next 5 years (2015-2020). It is essential that service users receive a high quality of care to optimise both their mental and physical health. People with severe mental illness are in some cases 3-4 times more likely to die prematurely from the key physical health diseases compared with the population as a whole (RCP report 2013: Whole-person care: from rhetoric to reality- Achieving parity between mental and physical health). **Intended Outcome** To continue the Trust's work on integrating	**Indicator 1: **Physical health handbook** This indicator will focus on co-producing a physical health handbook for inpatient service users. **NB: **Physical health handbook There will need to be a budget to develop the handbook (printing and graphic design costs)** **Indicator 2: Diabetes** Following the development of the diabetes e-learning package in 2014/15, the Trust will roll out the package amongst appropriate Trust clinical staff (target group to include staff RN and doctors CT1&2). **Indicator 3: ***Obesity, food and nutrition** The indicator will focus on refining the obesity pathway, educating staff and updating the methods for	**Q1** **Indicator 1** • Establish a physical health steering group to oversee development of the physical health handbook and undertake a review of existing patient information and leaflets created to date • Undertake a consultation exercise with service users and key staff regarding the requirements for the handbook and feedback on existing patient information **Indicator 2** • Plan and deliver coordinated launch of e-learning diabetes package developed during Year 1. This will be developed in line with a communications strategy to promote and educate staff around the package, using online and offline promotional materials • Commence roll out of e-learning package to appropriate clinical staff **Indicator 3** • Establish a review group to refine and improve the Obesity Pathway, in line with the updated Nutrition and Food Policy. • Produce recommendations to improve the recording of information on the ECR • Implement changes to Obesity pathway and make updates to food record charts • Undertake a baseline audit of the quality of recording for a subset of patients identified as being obese.

Theme and rationale	Indicator description(s)	Target Achievement
mental and physical health care at every level to ensure 'parity of esteem'. The physical health theme will follow the second year of its two year strategy to improve the monitoring and treatment received by our inpatient service users with regards to physical health.	supporting patients with dietary plans. **NB: **Subject to suitable capacity within relevant Trust teams**	• Submit audit report to commissioners. This report include evidence of: - Dietary plans - Height, weight and BMI recording - Lifestyle advice and links to support in the community **Q2** **Indicator 1** • Produce first draft of the physical health handbook based on consultation with key stakeholders and send out for feedback **Indicator 2** • Continue roll out of e-learning package to appropriate clinical staff • Audit the number of staff who have completed the e-learning package during Q1 and Q2 • Produce and submit report to commissioners. This report should include: - Feedback received on the package - % of relevant staff who have completed the package - Recommendations for future developments **Indicator 3** • Hold training and awareness sessions on obesity, food and nutrition for relevant staff to increase skills and co-working between therapy and nursing staff • Collect feedback from sessions and produce and submit a session summary report • Incorporate learning from initial training sessions into refining plans for delivery of sessions in Q3 **Q3** **Indicator 1** • Produce updated version of the physical health handbook based on feedback received from key stakeholders in Q2 **Indicator 2** • Continue the roll out of e-learning package to appropriate clinical

Theme and rationale	Indicator description(s)	Target Achievement
		staff • Audit the number of staff who have completed the e-learning package. • Produce and submit a report to commissioners. This report should include: - Feedback received on the package - % of relevant staff who have completed the package - Recommendations for future developments **Indicator 3** • Continue to hold training and awareness sessions for relevant staff to increase skills and co-working between therapy and nursing staff. • Collect feedback from sessions and produce and submit an event summary report • Update system recording processes on the ECR for height, weight and BMI
		Q4 **Indicator 1** • Launch handbook and distribute to all inpatient wards • Promote handbook and encourage distribution to all inpatients **Indicator 2** • Continue the roll out of e-learning package to appropriate clinical staff • Conduct year-end audit of the number of staff who have completed the e-learning package. • Review the quality of diabetes recording against a baseline from 2014/15 to demonstrate improvements. Submit a report to commissioners **Indicator 3** • Undertake a year-end audit of the quality of recording and interventions for patients with obesity. • Submit audit report to commissioners to show the improvements to quality and interventions for people with identified obesity. This audit

Theme and rationale	Indicator description(s)	Target Achievement
		report should include evidence of: - Dietary plans - Height, weight and BMI recording - Lifestyle advice and links to support in the community
4. <u>Learning Disabilities</u> **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.' Local progress against the Monitor standards to facilitate access of people with learning disabilities into mainstream mental health services requires improvement, and 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). Under the Autism Act (2010) and the Think Autism Strategy (2014), the Trust has a legal requirement to ensure clear pathways of care for people diagnosed with Autism, which should include involvement of friends and family. The Trust must also ensure that staff are provided	The Trust will continue the two year action plan to improve the experience of people with mental health issues and LD and make adjustments to treatments currently available. **Indicator 1: Resource Development** We will build databases and online resources to support staff and service users and ensure best practice learning. This will include Hospital Passports for people with Learning Disabilities going into hospital. **Indicator 2: Training and Engagement with staff, family and friends** With a focus on ASD, events and engagement activities will take place for staff, CFF and service users, including a targeted Trust-wide LD Awareness Week.	**Q1** **Indicator 1:** • The mainstreaming learning disabilities in mental health group will meet to review the LD protocol and amend screening criteria to reflect use with specific sub-groups such as CAMHS / Deaf services. • Review and update the LD Hospital Passport based on feedback from staff, CFF and service users, to reflect needs of service users within the Trust • Produce an audit tool that assists in identifying individuals who are not being recorded under disabilities section and submit tool to commissioners for information. • Build a database of reasonable adjustments to serve as a repository for good practice examples. **Q2** **Indicator 1:** • Develop an online resources page / learning forum for the LD Champions to be included as part of the new Trust website. Online resources page to include: - Database of reasonable adjustments - Audit tools for screening LD

Theme and rationale	Indicator description(s)	Target Achievement
with suitable training and resources to improve awareness. **Intended Outcome** To build upon on the foundation of good practice achieved in year 1 of the Quality Account; to continue to improve the identification of service users with mental health issues who have a learning disability (LD) within local mainstream services, with a specific focus on sub-groups such as CAMHS and deaf services. To continue to improve Trust wide understanding of Mental Health & Learning Disabilities which in turn will improve the identification of this group and the support offered to those service users who have a LD. In year 2 to have specific targets around the identification and support for individuals who have Autistic Spectrum Disorders (ASD), to ensure continuous improvements to care in line with the Autism Act (2010) and the Think Autism Strategy (2014).		- LD pathways and protcol - Easy read information - Resources on Autism awareness **Indicator 2:** • Hold a session for LD Champions to specifically look at: - Support for individuals with ASD - Easy read care plans - Launch of updated Hospital Passports, to ensure they are used when an individual meets the screening criteria in the Trust protocol • Submit a write up of the Q2 events and submit the event summary to commissioners. The report will include: - Numbers attended - Feedback from staff - Feedback from carers and family - Recommendations for future engagement and training sessions
		Q3 **Indicator 1:** • Plan, coordinate and deliver a re–launch of the Trust's LD e-learning package to all clinical staff to increase numbers of staff who have completed basic awareness package. • Submit a progress report regarding the uptake of the Hospital Passport in the Trust. Include feedback from staff, CFF and service users. **Indicator 2:** • Produce a summary of QA progress to date, to be published in Trustwide article for staff, service users and external stakeholders. • Hold an ASD awareness session for Trust staff • Hold a Trust-wide LD Awareness Week: - Include service user stories

Theme and rationale	Indicator description(s)	Target Achievement
		- Feature interviews with LD Champions making a difference and showing they have improved their practice in response to the needs of people with autism / LD - Accounts from carers, friends and family
		Q4 **Indicator 1:** • Monitor the number of clinical staff Trust wide that have completed the LD e-learning package. Compare with baseline against previous year. **Indicators 1 and 2:** • Audit and submit a report of the number of individuals who have LD recorded as a disability on the ECR against baseline from previous year: - Of the identified individuals monitor the proportion who have had reasonable adjustments offered - Audit the numbers who have been offered easy read care plans - Identify whether there has been an increase / decrease of numbers identified who have LD & MH issues • Submit a summary report of the two year LD quality account theme. The report will include key audit findings, progress areas, activities and events, lessons learned and recommendations for continuous improvement. Include a plan for integration of quality account work into Trust business as usual from 2016 onwards.

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