APPENDIX 1

Kent and Medway NHS and Social Care Partnership Trust [KMPT]

Mental Health Update

Report prepared for:

Medway Council
Health and Adult Social Care [HASC] Overview and Scrutiny Committee
22 August 2017

Version:	3.0	**Reporting Officer:**	Helen Greatorex Chief Executive, KMPT
Date:	01 August 2017	**Report Compiled By:**	Vincent Badu Interim Director Transformation Older People's Services Sarah Day Programme Management Office [PMO] Programme Manager, KMPT

respect ◆ open ◆ accountable ◆ working together ◆ innovative ◆ excellence

1. Introduction

1.1 This report has been prepared at the invitation of Medway Council's Health and Adult Social Care Overview and Scrutiny Committee [HASC] to provide an update about the Trust.

1.2 This report aims to update Members on current activities and priorities, successes, challenges and opportunities and to provide a reminder to Members of the current service provision in Medway.

1.3 This report will be presented under the following set of headings:

i. Current service provision – a reminder.

ii. Current activities and priorities.

iii. New initiatives and opportunities.

1.4 The Committee is asked to note the content of the report and provide comment.

2. Current service provision – a reminder

2.1 The Trust is commissioned to provide a range of inpatient, community and specialist services to younger and older adult residents of Medway. Some of these services are based in Medway; others are based outside of Medway and offer an inreach provision to the residents of Medway. Appendix A provides an outline of those services based in Medway. Appendix B provides an outline of those services based outside of Medway that offer an inreach provision to the residents of Medway.

3. Current activities and priorities

3.1 **Care Quality Commission [CQC]:** The Trust is delighted to report the CQC has rated the Trust as 'Good' overall, and 'Outstanding' for caring. The rating followed the comprehensive inspection that took place in January 2017.

3.2 The CQC is the independent regulator of health and adult social care in England. It makes sure health and social care services provide people with safe, effective, compassionate, high quality care and encourage care services to improve.

3.3 On 17 May 2017 a Quality Summit took place. It was attended by all key stakeholders. The focus of the summit was to hear from the CQC about the outcome of the inspection and to discuss how stakeholders could work together with the Trust to support the delivery of quality improvements. The CQC noted the Trust is 'nearly there' and that the 'there' was referring to 'outstanding'. This is a huge improvement on the previous rating ('Requires Improvement' in 2015) and one that reflects the tremendous work staff, service users, carers and partners have put in to improve services.

3.4 The table below provides a summary of the CQC's ratings; it shows how very close the Trust is to achieving an overall rating of 'Outstanding':

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units[PICUs]	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Forensic inpatient / secure wards	Requires improvement	Good	Outstanding ★	Good	Good	Good
Long stay / rehabilitation mental health wards for working age adults	Good	Outstanding ★	Outstanding ★	Good	Outstanding ★	Outstanding ★
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Substance misuse services	Good	Outstanding ★	Outstanding ★	Outstanding ★	Outstanding ★	Outstanding ★
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Wards for people with ;earning disabilities or autism	Outstanding ★	Outstanding ★	Outstanding ★	Outstanding ★	Outstanding ★	Outstanding ★

3.5 The Trust is determined to achieve 'Outstanding' and with the continued passion and drive of its staff, service users, carers and partners is well on the way to achieving this target by autumn 2018. To ensure the delivery of these quality improvements a Quality Improvement Plan [QIP] has been developed. The plan sets out how the Trust, with partners, will meet the regulatory compliance standards identified during the inspection as requiring some improvement. It focuses on ensuring quality is at the very heart of everything the Trust does. It includes a number of initiatives and transformational projects such as the revised Quality Strategy that is just one of many initiatives the Trust is implementing over the next 18 months. Others include implementing a Personality Disorder Strategy and Estates Strategy, all of which feed into the Trust's overarching business plan. The Trust continues to review its care pathways and provide intensive support to those areas that are struggling, reorganising pathways and resources as required to ensure improved patient outcomes. Additionally the Trust continues to take forward its part of the system-wide 'case for change' to ensure mental health is very much included in the transformation work across Medway and Kent (Sustainability and Transformation Plan [STP]). All of this work will help ensure there is a greater consistency across services.

3.6 Appendix C provides a copy of the QIA – Quarter 2 update.

3.7 **Mental Health Strategy (Memorandum of Understanding):** Over the last year the Trust has been working closely with Kent Police to develop a shared approach to working with people who have or might have a mental health need. As a result of this, a *Mental Health Strategy (Memorandum of Understanding)* has been signed by the Chief Constable (Kent Police) and Chief Executive (KMPT).

3.8 To celebrate the partnership a joint event, hosted by the Police and Crime Commissioner took place on 20 June 2017 to launch the *Mental Health Strategy*. This was the first Mental Health Conference of its kind in Kent, with around 100 delegates from charities, local authorities, commissioning groups, and community safety and criminal justice partners represented. Parliamentary under-Secretary of State at the Home Office for Vulnerability, Safeguarding and Countering Extremism, Sarah Newton MP, was a key note speaker at the event. She praised the initiative and noted she is particularly encouraged that the strategy talks not only about crisis point resolution, but about work to prevent people from ever reaching that crisis point and that it talks about a range of services and interventions and joint working to achieve this - building on some proven good practice.

3.9 The *Mental Health Strategy* aims to provide the right care and support for people in crisis by:

- ✓ Reducing the number of people who reach mental health crisis in circumstances that require police intervention.
- ✓ Reducing the number of people who are detained under Section 136[1].
- ✓ Minimising the use of police custody as a place of safety except in exceptional circumstances where a person is violent, or has committed a crime or cannot be safely accommodated elsewhere in line with legislation and best practice.
- ✓ Reducing the time people spend in a police custody waiting for an assessment under the Mental Health Act [MHA] where one is deemed as being required.
- ✓ Reducing the time and resources utilised by police officers, health and social care staff spent with detained persons who require assessment.
- ✓ Improving the pathways and services available for people suffering from mental health crisis before, during and after a crisis occurs.

3.10 To achieve this, the Trust and Kent Police will work closely with local authorities and other NHS organisations in Medway and Kent to develop effective and economically sustainable services for those in mental health crisis. The Trust will continue to work with the *Crisis Care Concordat* to improve the service provided to those in mental health crisis.

3.11 **Community Street Triage:** Underpinning the work of the *Mental Health Strategy* and *Crisis Care Concordat* is delivery of two new community street triage service pilots, one in Medway, the other in Thanet, to enhance the existing county-wide service in Canterbury.

3.12 The Medway Community Street Triage Service, where mental health nurses join police officers on patrol at key times in Medway, was operationalised on 29 June 2017 following a joint training event and substantive recruitment to the team. In Medway it is estimated that 57% of police time is spent dealing with mental health issues, a position that is not sustainable for the police or in the best interests of those vulnerable people.

3.13 Recognising it is early days, the service is delivering a better service for vulnerable people in Medway. It is ensuring the needs of vulnerable people are put first, and that those people get the most appropriate and professional support they require. It acknowledges police custody is the last place vulnerable people experiencing a mental health crisis should be, but police are often the first point of contact in these circumstances. The partnership working has already helped the Trust to reach people who may not have even realised they needed help.

[1] A section 136 is a power under the 1983 Mental Health Act [MHA] that allows a constable to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours for the specified purposes. The place of safety could be a police station or hospital (often a special section 136 suite).

4. New initiatives and opportunities

4.1 The Trust continues to welcome the opportunity to develop new initiatives and opportunities to deliver its vision[2]. To achieve this, the Trust is involved in a number of initiatives in partnership with other agencies. These include:

4.2 **Criminal Justice and Liaison Diversion Service [CJLDS]**: The Trust welcomed Lord Keith Bradley (Lord's Select NHS Sustainability Committee) and Jenny Talbot OBE (Director, Care not Custody, Prison Reform Trust) to meet members of its CJLDS on 29 June 2017.

4.3 The visit commenced with a welcome meeting at Kent Police headquarters where Lord Bradley met with representatives from the Trust, Kent Police, local authorities and the criminal justice system. Presentations and round table discussion took place around current services, future plans and areas ripe for development. All agencies agreed that clear and regular communication is as crucial to each service as it is for those going through the criminal justice system. Speed and efficiency in overcoming barriers was highlighted as increasingly important, particularly with the introduction of new technology such as the virtual court system.

4.4 Lord Bradley then went on to see a custody suite in action at Medway Police Station. Lord Bradley was welcomed by Inspector Trevor Keeble who gave him a tour of the facilities. He was particularly interested in the virtual court capabilities as well as the bright lights of the smart water technology. Lord Bradley spent time talking with custody and liaison practitioners from both Kent Police and the Trust's CJLDS, who spoke candidly about what it was like to work in the team, the positive work they do and the potential for future improvements. Seeing the service as particularly worthwhile, and impressed by the very evident strong partnership between agencies, Lord Bradley was keen to find ways he could help the group move forward with improvements.

4.5 **New self care health app for service users:** A new self-care health app has been launched. The free innovative app has been designed to support the sharing of experiences and connect together people with the same health conditions, in a helpful way. Service users are directed to it for additional support in managing their health condition.

4.6 Downloading the app, users can join online support communities that will provide support to anyone with a health condition, directly from other people who have the same health condition. It additionally connects people with the relevant charity for the disease who moderate and support the community.

4.7 The app is based on the free HealthUnlocked social network. There are many different online communities across 180 health conditions and wellbeing needs. Use of the network has been shown to improve self-management and increase confidence a person has around their own health condition. For more information on HealthUnlocked, please visit: https://healthunlocked.com/about

4.8 **Government announcement for mental health workers:** The Trust welcomes the Government's announcement on 31 July 2017 regarding the expansion plans for the mental health workforce and £1.3 billion to transform mental health services.

[2]KMPT's vision is to create an environment within Medway and Kent where mental health is everyone's business, where every health and social care contact counts, where everyone works together to encourage and support children, their parents, young people and adults of all ages with a mental health problem or at risk of developing one to live in their own community, to experience care closer to or at home and to stay out of hospital and lead a meaningful life.

4.9 The Trust will be working closely with Health Education England [HEE], NHS Improvement [NHSI], NHS England [NHSE], Royal College of Psychiatrists [RCPsych] and other key stakeholders to look at how the plan can be taken forward to create new posts in priority growth areas to support and deliver the improvements set out in the 5 Year Forward View For Mental Health.

5. Conclusion and Recommendation

5.1 The Medway HASC is requested to note the content of this mental health update report.

APPENDIX A : SERVICES BASED IN MEDWAY

Type of service	Description of service
Acute (younger adult) services	
Crisis resolution and home treatment [CRHT]	Based at A Block, Medway Maritime Hospital (Gillingham), the Medway and Swale CRHT provides support at home 24 hours 7 days a week to those individuals aged 18 years and over experiencing mental health crisis and whom without support would require hospital admission.
Liaison psychiatry	Based at Medway Maritime Hospital, the Medway Liaison Psychiatry service operates 24 hours a day 7 days a week and aims to provide mental health support to people admitted to Medway Maritime Hospital. The service works very closely with staff at Medway Maritime Hospital to allow a patient's mental health to be treated effectively alongside any physical health problems. The service is available to anyone over the age of 18, regardless of address, who attends the emergency department or is an inpatient at Medway Maritime Hospital and needs advice, assistance or a mental health assessment.
Community recovery services	
CMHT	Based at Canada House (Gillingham) the Medway and Swale CMHT provides services to adults of working age (18 to 65 years) with severe long term mental health needs.
Mental health learning disability [MHLD]	Based at Canada House, the Medway and Swale MHLD team provides services to adults of working age (18 to 65 years) with a mental health learning disabilities.
Early intervention for psychosis [EIP]	Based at Canada House, the Medway and West Kent EIP service works with people aged between 14 and 35 years old who are experiencing their first episode of psychosis, and who have been experiencing symptoms for less than three years.
Inpatient rehabilitation	Based at Newhaven Lodge, Medway Maritime Hospital, the 8 bedded Newhaven Lodge Rehabilitation Unit is a mixed gender inpatient adult mental health rehabilitation unit. The rehabilitation team work with men and women who have experienced a relapse in their mental health, to promote recovery and support them to develop or regain skills for every day living.
Older adult services	
Inpatient older adult	Based at A Block, Medway Maritime Hospital, the 14 bedded Ruby Ward is a female only inpatient older adult unit for people suffering acute mental health challenges and experiencing dementia, depression, anxiety and psychotic conditions.
Community mental health	Based at Elizabeth House (Rainham), the Medway CMHSOP

service for older people [CMHSOP]	provides a service for people age over 65 years with both organic and functional presentations.
Forensic and specialist services	
Criminal justice liaison and diversion service [CJLD]	Based in the Medway Custody Suite, the Medway CJLD service[3] provides screening and assessment of individuals, of all age groups and vulnerabilities within the criminal justice system.
Chronic fatigue syndrome CFS] / myalgic encephalopathy [ME] (pain clinic)	Based at Medway Maritime Hospital the pan-county service offers multidisciplinary assessment and treatment programmes for adults from 18 years with a diagnosis of CFS / ME.
Disablement services (prosthetics and orthotics) and environmental control services	Based at the DSC the pan-county Disablement and Environmental Control teams provide services to people with a permanent medical condition or severe physical disability by providing suitable equipment that can help with every day life. This includes providing electronic assistive technology equipment, on loan, to severely disabled people to enable them to live more independently in their homes.
Community brain injury	Based at Medway Maritime Hospital the Medway and Swale Community Brain Injury team supports people with non-progressive brain injuries between the ages of 18 and 65 years.
Community street triage	Based out of the Medway Custody Suite, the service operates Wednesday, Thursday and Friday 11.30 hours to 00.00 hours. The police and a nurse patrol the local area in an unmarked police vehicle and respond to section 136 call outs to provide assessment and clinical expertise as an alternative.

[3]The Medway CJLD team is one of seven operating pan-county; in addition to the team operating out of the Medway Custody Suite, teams operate from six other suites outside Medway.

APPENDIX B : SERVICES BASED OUTSIDE MEDWAY THAT OFFER AN INREACH PROVISION TO THE RESIDENTS OF MEDWAY

Type of service	Description of service
Acute (younger adult) services	
Section 136 suite	Based at Priority House (Maidstone), the 2 roomed suite offers a place of safety for those individuals on a section 136 awaiting assessment. Should the Maidstone suite be full, individuals can be taken to the 1 roomed suite at Little Brook Hospital (Dartford).
Inpatient acute	Based at Little Brook Hospital, the two 17 bedded (Amberwood and Cherrywood) and one 16 bedded (Pinewood) acute younger adult admission wards provide inpatient care with intensive support for patients in periods of acute psychiatric illness.
PICU	Based at Little Brook Hospital, the pan-county 12 bedded (Willow suite) PICU provides mixed gender facilities designed for short-stay treatment of patients with mental health problems requiring intensive treatment, care and observation.
Older adult services	
Inpatient older adult	Based at Darent Valley Hospital, the 16 bedded Jasmine Ward is a mixed gender older adult unit for people suffering acute mental health challenges and experiencing dementia, depression, anxiety and psychotic conditions.
Inpatient continuing healthcare [CHC]	Based at the Frank Lloyd Unit (Sittingbourne), the two 20 bedded wards, Hearts Delight and Woodstock, and the one 16 bedded Littlestone ward based at Little Brook Hospital provide CHC bed stock for all North Kent localities. Patients with a diagnosis of dementia and associated needs are admitted to the most suitable bed for the individual's need.
Forensic and specialist services	
Street triage	Based within the Kent Police Force Control Room and South East Coast Ambulance NHS Foundation Trust [SECAmb] Emergency Room, the pan-county service operates between 16.00 and 00.00 hours Sunday to Tuesday. Currently the night service comprises one band 4 nurse within the Control Room; this is increasing to one band 6 nurse who will respond in person and two band 4 nurses who will be based in the Control and Emergency Rooms to provide advice. In addition as an extension to the Criminal Justice Liaison and Diversion Service based within the Kent Police Northfleet custody suite (Gravesend) the pan-country day service will operate between 09.00 and 17.00 hours Monday to Friday. This service will comprise one band 7 senior practitioner who will respond in person.
Inpatient forensic (medium	Based at the Trevor Gibbens Unit (Maidstone) the pan-county

secure)	service provides medium secure care for men and women. .
Inpatient forensic (low secure)	Based at the Greenacres site (Dartford) the 20 bedded pan-county Tarentfort Centre consists of two wards for male patients with a learning disability whose offending behaviour and mental health needs require that they are detained under the MHA in secure conditions. In addition, the 20 bedded pan-county Allington Centre offers holistic person centered care packages for male patients between the age of 18- 64 years detained under the MHA, whose mental health and offending / criminal behaviors puts them and / or others at significant risk.
Inpatient forensic (rehabilitation)	Based at the Greenacres site the 10 bedded pan-county Brookfield Centre provides a rehabilitation and recovery inpatient service for forensic male patients with a learning disability. The service helps to reintegrate this patient group into the community, and acts primarily as a step down service for patients from the Tarentfort Centre.
Personality disorder	Based at The Brenchley Unit (Maidstone) this service provides a therapeutic community and range of services for patients diagnosed with a severe or borderline personality disorder. .
Inpatient addiction	Based at Fant Oast (Maidstone) the pan-county 10 bedded Bridge House Service provides inpatient detoxification treatment in a high quality environment.
Neuropsychiatry	Based at Darent House (Sevenoaks) the West Kent and Medway tertiary neuropsychiatry service offers outpatient assessment and treatment to individuals with a psychological / psychiatric disorder that manifest as neurological / organic conditions.
Eating disorder services [EDS]	Based at Oakapple Lane (Maidstone) the pan-county EDS provides services to people with eating disorders and works mainly with people who are experiencing anorexia or bulimia nervosa.
Mother and infant mental health services [MIMHS]	Based in Canterbury and Maidstone the pan-county MIMHS is for women with mental health difficulties who are considering pregnancy, are currently pregnant, or have given birth and the baby is under a year old. The team also provides inreach services at Canada House.

APPENDIX C : QIP – QUARTER 2

KMPT QUALITY IMPROVEMENT PLAN (QIP) FINAL – Q2 update v1

This quality improvement plan has been developed in order to address the regulatory compliance standards identified during KMPT's comprehensive inspection undertaken by the CQC in January 2017.

Improvement plan owners:	Service Line Directors/Corporate Leads
Implementation monitoring:	CQC Oversight Group
Executive approval:	Executive Assurance Committee
Executive sponsor:	Executive Director of Nursing and Quality
Reporting to:	Quality Committee and Trust Board

RAG KEY:	
Green	**Complete**
Amber	**Work in progress but not overdue**
Red	**Overdue**
SW-MD	**System wide must do**
SW-SD	**System wide should do**

Requirements:
Must do
Should do
Further improvement

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
1. PERSON CENTRED CARE – Regulation 9 HSCA						
	1.1 The trust must take action to ensure all patients, where appropriate, have access to psychological assessment and interventions (Acute wards)	1. Review and recruit to psychology posts to cover all acute sites 2. Monitor progress of recruitment at Performance Management Team	**ASL Service Line Director**	1. End Q2 2. End Q4 3. End Q2 4. End Q2	1. Review of staffing 2. ASL staffing report 3. Draft KMPT Personality Disorder Strategy and clinical model	1. Recruitment for psychologists to joint the team is underway. The acute wards at Canterbury currently have 1.47 WTE Band 7 Psychologist vacancies which will increase to 1.87 WTE in August

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	Patients will have access to psychological therapy as part of their treatment plan where this is identified as a need	meetings 3. Finalise and launch Personality Disorders pathway 4. Develop and implement a referral process for use across all teams to ensure that where there is recommendation for psychological therapies, this is shared within the daily conference calls between acute and community services			4. Standard operating procedure for referrals	when an employee leaves(current vacancy rate is 0.87 when a WTE person leaves this will increase to 1.87WTE). These are out to advert and should these posts be recruited to, the current Qualified Psychology posts will be fully established. In Dartford, a 0.8 WTE Band 8a has been recruited; there are no further vacancies for qualified psychology and are therefore currently fully established. In Maidstone, a 0.4 Band 7 Psychologist post is out to advert. If recruited to the current Qualified Psychology posts will be fully established in this area. There are 2 WTE vacancies for Band 4 Assistant Psychologist posts covering the acute service line. A therapeutic staffing review is underway to assess whether these posts are still required or if further qualified psychology provision would be more suitable. 2. Senior Matron, Director and Assistant Director, looking at staffing and configuration to support better recruitment strategy across the board 3. & 4. Personality disorders strategy has been approved by the Board and the clinical model

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
						and pathway is in development. This will include the referral pathway. Where there is a need for psychological intervention this is picked up as part of the care pathway review.
2. SAFE CARE AND TREATMENT – Regulation 12 HSCA						
SW-MD	**2.1 The trust must address the high caseload numbers allocated to individual staff to ensure that all patients are appropriately monitored (CMHTs)** All adult community teams will have robust standard operating procedures for the management of caseload in order to ensure patient safety, improve patient experience and clinical outcomes	1. Deliver target of maximum of 40 caseloads per full time care coordinator by August 2017 2. Set and monitor trajectories at performance management meetings 3. Implement the agreed CMHT eligibility criteria and standard operating model 4. Re-issue team level status reports complete with recommendations for improvement	**CRSL Service Line Director**	1. End Q2 2. Q1 onwards 3. End Q2 4. Q1 onwards	1. Standard operating model/Eligibility criteria 2. Team level status reports/dashboards 3. Performance dashboard 4. Caseload numbers per team and care coordinator	1. The CAPA model is being implemented across CRSL, it is projected this will take up to 12 months 2. Draft trajectories have been set up and will be monitored in PMM. 3. Eligibility and SOP going to CEOG in July. This has been delayed as awaiting KCC feedback. 4. Review of Insight dashboard to support teams in delivering trajectories is underway.
SW-MD	**2.2 The trust must review the waiting lists for those patients waiting for initial assessment and those patients waiting for allocation to a named worker to ensure patients receive a service in a timely way (CMHTs)** All adult community teams will have systems and processes	1. Set and manage trajectory for patients on waiting lists for assessment and allocation to care coordinators/key worker 2. Continuously monitor waiting lists and unallocated lists at service line and Trust Performance Management Meetings and take corrective action accordingly	**CRSL Service Line Director**	1. End Q2 2. Q1 onwards	1. CMHT performance dashboard	1. The CAPA model is being implemented across CRSL which will help with demand and capacity. This model will ensure there is a standardised system and process in place to review waiting list.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	in place for the management and allocation of new patients.					
	2.3 The trust must ensure that all patients have risk assessments that are reviewed regularly and updated in response to changes (Acute wards) Risk assessments will inform risk management plans for individual patients to ensure safe care is provided	1. Clinical staff to attend service specific risk assessment training (STORM and SafeT) 2. Conduct clinical audits of documented risk assessments on Rio to ensure they are of good quality and reflect patients' needs 3. Monitor training attendance figures and ensure that compliance targets are met.	**ASL Service Line Director**	1. End Q3 2. End Q4 3. End Q4	1 and 2. Audit results and action plans 3. Training data	1. Risk assessment audit is complete, with report due to be published in July, this will be taken to the service line quality meeting, and to the patient safety meeting in order to support action planning to allow the service line to improve standards and manage risks in a governed manner. 2. All areas are improving their 3 tiered risk assessment training figures, and have provided assurance of this to the senior matron, advised that there needs to be 100% compliance with this. Target set was to be 50% by June 2017 and 100% for October 2017, as of 05/06/2017, the service line is 57% compliant so in house target is met
	2.4 The trust must ensure that systems in place to monitor patients using their Section 17 leave are used correctly (Acute wards) There is clear process being followed across all services in relation to Section 17 leave.	1. Review and launch Section 17 policy across the Trust, including new documentation templates. 2. Signing in and out audits to continue across the service line with results taken to the monthly quality meeting	**ASL Service Line Director**	1. End Q2 2 and 3. Ongoing 4. End Q4	1. New section 17 policy and forms have been developed and are in use. 2. Signing in and out audits are continuing and	1. Section 17 form has been reviewed and agreed that this will remain in place. 'MHA Top Tips' Guidance on how to use the s.17 Leave Form has been produced and is available on i-connect. 2. Signing in and out audits are submitted monthly and these are

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		3. Review signing in and out audits bi-monthly at Trust Wide Patient Safety and Mortality Group meetings 4. Provide on site training inpatient staff for staff that are using the Section 17 process	**MHA Policy and Training Manager**		improvements are being addressed 3. Training attendance and /course content	analysed in the form of a report, also submitted to the QC. There is evidence to suggest that there is some embedded good standards with regard to the process of recording the service user leaving the wards. Across the 10 wards reviewed the average compliance rate is 75%. 3. Mental Health Act team are ensuring that sufficient training and guidance is available to staff, with each locality being supported to organise bespoke packages for their staff. The trust figure for the MHA mandatory training compliance rate is 57%, ASL have achieved 71%. The Target for the service line is to achieve 100% by the end of Q3.
3. PREMISES AND EQUIPMENT - Regulation 15 HSCA						
	3.1 The trust must ensure that the service is providing accommodation that adheres to guidance on same-sex accommodation. This related to Cherrywood ward (Acute wards) All service users are cared within safe environments and where their privacy and dignity is maintained in line with Delivering Mixed Sex	1. Re-designate sleeping accommodation on Cherrywood Ward to meet mix sex accommodation standards. 2. All operational services to update their bed management templates to reflect gender specific issues to be addressed during site escalation meetings.	**Executive Director of Nursing and Quality**	Actions 1-4 completed in January 2017 5. Completed Q1 6. Q1 onwards 7. End Q2	1. Bed management templates 2. Delivering same sex accommodation policy 3. Trust register showing gender status of all wards 4. Revised Policy 5. DSSA Board declaration	1.The daily patient flow conference calls continue, these manage both the use of the out of area beds, for which we aim at zero, and the single sex occupancy standards. 2. Capital funding has been agreed to install a door entry system to all the bedroom corridors in the acute mental health unit at Littlebrook Hospital. This will provide greater flexible to

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	Accommodation standards	3. Update the Delivering Same Sex Accommodation policy to reflect changes. 4. Public Board declaration of compliance with DSSA standards 5. Re-issue standard operating procedure for front line staff and on-call managers to support decision making within the acute service line. 6. Conduct further bed usage review and according to gender split, reconfigure the acute wards in Dartford. 7. New doors to be installed to provide flexibility for zoning patients within corridors across the Dartford inpatient wards.	**ASL Service Line Director**			the Trust bed stock and to ensure same sex accommodation standards are continuously adhered to.
	3.2 The trust must protect patients and staff against the risks associated with unsuitable premises and equipment, including a review of the bed frames used in the service to reduce the risk of ligatures (Forensic/secure wards) Environmental patient safety risks are assessed and fully mitigated	1. Ligature risk assessments and mitigations updated and learning disseminated during the comprehensive inspection 2. Review and recommend to the Executive Assurance Committee (EAC), options for mitigating risks associated with current bed design 3. Implement a replacement programme where indicated	**Executive Director of Nursing and Quality** **Director of Estates and Capital Planning**	1. Completed January 2017 2. Completed Q1 3. End Q2 4. End Q4	1. New beds in place 2. Audit report and associated action plan	Capital group has approved the replacement of 110 beds. The beds are currently under order and will be installed by end of Q2

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		4. Repeat the annual Ligature risk assessment across all inpatient as part of Trust audit plan				
4. GOOD GOVERNANCE – Regulation 17 HSCA						
	4.1 The trust must ensure the governance systems provide sufficient oversight and responsive action around the Mental Health Act (Trust) The Board discharges its responsibility and accountability in relation to the MHA.	1. Review and further strengthen the current governance arrangements for MHA. 2. Establish a formal MHA sub-committee to be chaired by a NED. 3. Update the Trust's governance structure chart. 4. Schedule regular reports on MHA activity to be received and discussed by the Trust Board and its sub-committees.	**Executive Director of Nursing and Quality**	1. Completed January 2017 2. Completed Q1 3. Completed January 2017 4. End Q4	1. New governance structure chart 2. Terms of reference 3. Minutes of MHA Sub-Committee 4. Board reports	Committee established and now operational and reporting schedule agreed.
5. STAFFING – Regulation 18 HSCA						
	5.1 The trust must ensure that staff have completed mandatory training in line with their targets (Acute wards, forensic/secure wards, CMHTs)	1. Monitor mandatory training compliance at monthly Service line/Trust wide performance management meetings and Workforce and OD Committee.	**ASL Service Line Director/ FSSL Service Line Director /CRSL Service Line Director/Executive Director for Workforce & OD**	1. End Q4	1. 85% compliance target completed for all mandatory training courses	Ongoing monitoring within in each service line. Target is to meet trust compliance target for all mandatory training courses of 85% compliance.
	5.2 The trust must ensure that all staff have sufficient understanding of the Mental	1. Set trajectory and monitor training figures to ensure they meet the target	**ASL Service Line Director**	1. End Q4 2. End Q4	1. Training data 2. Quality visits reports 3. Audit results	1. Senior matron monitoring – currently compliant at 92%. 2. Each locality has an action

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	Capacity Act and its guiding principles (Acute wards)	requirement in all teams 2. Deliver team based training and question and answer sessions in relation to MCA 3. Develop MCA champion roles per team 4. Continue with MCA snapshot audits and provide immediate feedback to teams	**Head of Safeguarding**			plan from MHA monitoring visits – which are owned by the locality matrons. 3. TIAA audit conducted and the trust received reasonable assurance – action plan in place.
6. 136 Pathway						
	6.1 Designated places of safety care pathway There was variability in the operation of crisis teams and the management of patients. Data around S136 was incorrect. *from escalation plan	1. Strengthen monthly countywide Section136 MDT meetings to ensure good communication and escalation processes 2. Continue to attend Police and Crime Bill discussions in order to address the Section 136 pathway on the new timeframe 3. Lead discussions on different commissioning and ways of working with the CCGs via the Crisis Concordat meetings	**ASL Director, MHA Policy and Training Manager, Police**	1. Complete 2. Complete 3. End Q3	1. Section 136 MDT meeting minutes 2. Police and Crime Bill review documentation 3. Crisis Concordat meeting minutes and new ways of working in place	1. Monthly S136 cross agency meetings continue 2. Quality officer in temporary post specifically to cover the 136 pathway and care within the places of safety 3. Learning regarding pending changes to the police and crime bill distributed to the service line, and the Trust through lessons bulletins and staff forums. Information has also be added to i-connect 4. Recruitment underway to create substantive place of safety staff at each site. 5. Clear protocols have been approved and are in use.
7. Workforce						
SW-SD	**7.1 The trust should ensure there are sufficient systems to monitor the training,**	1. Review appraisal system and seek approval from Executive Assurance	**Director for Workforce & OD**	1. Ongoing monitoring	**1.** Revised appraisal system	Workforce: Supervision policy is currently being reviewed by Head of Employee Relations. There are

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	appraisal and supervision of staff working across the services to ensure staff receive the appropriate level of support in their work (Trust and acute wards)	Committee 2. Recommended actions to be implemented and monitored by HR Business Partners. 3. Develop a system to consistently monitor supervision uptake across the Trust 4. Report supervision uptake at monthly Service line and Directorate performance meetings and address under performance 5. Setup trustwide 'task force' to inform quality and consistency of supervision across the trust. 6. Continue to roll out Management Essentials for all line managers 7. Team managers within the acute service line to ensure that this is of priority among their workloads	**ASL Service Line Director**	2. Ongoing 3. Ongoing 4. Ongoing 5. End Q2 6. Ongoing programme 7. Q1 onwards	**2.** Revised supervision policy **3.** Supervision uptake performance data **4.** Mandatory Training performance dashboard **5.** Improvement noted in quality of supervision records **6.** Training attendance records **7.** Monthly returns for the acute service line	plans to introduce an online appraisal form when the new version of ESR is available. Work will need to be undertaken to scope out whether this can be extended to supervision. The new appraisal window and process will commence between April 2018-July 2018. A communications plan has been formulated so that staff are fully briefed on the forthcoming changes. ASL: 1 & 2 Supervision data now held on a central log, with all localities required to submit a monthly return to that end, thus allowing monitoring 3. 4& 5 Plans to provide better engagement pathways for staff to support quality improvement. Innovations such as the quality improvement group which is showing excellent levels of attendance having been relaunched. 6. Monthly training figures monitored via PMMs Monthly audits monitored through PMMs and the Quality & Compliance team.
	7.2 The trust should look at	1. Accelerate and continue	**ASL Service**	1. End Q3	1. Agency programme	1. Agency programme board

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	ways to reduce the service's reliance on bank and agency staff (Acute wards)	with implementing actions from the Agency Board programme. The Programme Board's objectives address recruitment and retention across the Trust 2. Conduct the six monthly inpatient establishment review to ensure staffing is appropriate for service need	**Line Director**	2. End Q2	Board work plan and outputs 2. Six months establishment review report	continues 2. Agreed patterns of working and mandatory clinical shifts for management team 3. Establishment review underway and due to Board in July. 4. Vacancy rate in April 2017 was at 16.6% for the acute service line.
	7.3 The trust should ensure that sufficient numbers of permanent staff are recruited and retained to enable the teams to operate effectively (CMHTs)	1. HR BP to identify all vacancies across CRSL, including social care 2. Develop time line for recruitment with service managers 3. Implement recruitment strategies to enhance application 4. Implement retention strategies already agreed by the Trust	**CRSL Service Line Director**	1. Completed 2. Completed Q1 3 & 4. Ongoing	1. Team level status reports/dashboards 2. Performance dashboard 3. Reduction in vacancies	1. Completed and maintained on a monthly basis 2. Recruitment timelines have shown some improvement in Medway, Maidstone and SKKC 3. Recruitment Project pilot has been appointed to, they will support the managers in future recruitment plans 4. HRBP's are working jointly with the Recruitment Manager on retention strategies work which is ongoing
	7.4 The trust should ensure that all staff receive individual supervision at regular intervals as per the trust's supervision policy (CMHTs)	1. Ensure compliance monitoring spreadsheet in place for all teams 2. Line managers to schedule supervision, 6 weekly and report on non compliance 3. Monitor compliance at performance management	**CRSL Service Line Director**	1. Completed 2. End Q2 3. Ongoing - quarterly	1. Team level status reports/dashboards 2. Performance dashboard 3. Improvement in frequency of supervision	1. Completed spreadsheet is in place 2. Supervision data is included on the performance dashboard for monitoring. An example for May 2017 can be seen below.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		meetings and resolve				3. Further work with managers to improve data recording and address actions locally with non-compliance
	7.5 The trust should ensure that its target for staff to receive an annual appraisal is met in all community mental health teams (CMHTs)	1. Compliance monitoring spreadsheet in place for all teams 2. Line managers to schedule annual appraisal in advance 3. Monitor and manage compliance at performance management meetings	**CRSL Service Line Director**	1. Completed 2. End Q4 3. Ongoing - monthly	1. Team level status reports/dashboards 2. Performance dashboard 3. Improvement in number of appraisals	1. Completed, spreadsheet is in place and is monitored 2. A trustwide approach to appraisal is being implemented. 3. Ongoing for current system process will change moving forward due to new trustwide approach
	7.6 The provider should consider the skill mix of qualified and non- qualified posts as staff commented that there is little career progression opportunity from Band 5 to Band 6 nurses and from Band 3 to Band 4 support workers (Rehab)	1. Rehab senior management team to review nursing skill mix within rehab services with nursing directorate 2. Identify recommendations for skill mixing, to take for discussion at EAC (Executive Assurance Committee)	**CRSL Service Line Director**	1. End Q2 2. End Q3	1. Agreed skill mix in place	Task and Finish group is underway which is reviewing the skill mix required in the rehab teams.
	7.7 The trust should ensure that the quality of supervision notes is consistent across the service (Forensic/secure wards)	1. To conduct a supervision audit to provide assurance of the quality of supervision notes.	**FSSL Service Line Director**	1. End Q3	Audit results and action plans	Meeting held in June 2017 to complete audit proposal and agree standards. Initial data to be collected by end July.
	7.8 The trust should ensure that band four staff receive appropriate training to allow them to be competent in	1. Identify and assess individual staff competencies against the set criteria	**FSSL Service Line Director Executive Director of**	1. Completed 2. End Q2 3. End Q2 4. End Q2	1. Band 4 defines competencies 2. % of completed competency	Competencies set in JD person specification. PCCP & Report writing training has taken place. 50% of staff has

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	their role (Forensic/secure wards)	2. All band 4 staff to be provided with report writing training by an allocated qualified colleague by the end of June 17 3. Provide person centred care planning training or all band 4 staff by the end of June 17 4. Complete a training needs analysis for current band 4 staff will be completed	**Workforce and OD**		assessments 3. Training data/course registers 4. Training needs analysis	attended so far. A further training session is booked for 15.08.17 Training needs analysis is currently being produced following consultation with Band 4 staff and will be completed by end of July.
	7.9 The provider should ensure the continuation of staff recruitment drive and strategies to address the staff shortages (OA wards)	1. Review the staffing establishments on the wards and implement strategies to reduce the reliance on agency staff 2. Appoint a band 3 administrator to each ward 3. Increase band 6 staff clinical shift work 4. X2 WTE OT recruitment on every ward – pre and post discharge work	**OASL Service Line Director**	1. Completed 2. End Q2 3. Completed – ongoing 4. End Q4	Staffing establishment levels and shift plans	Recruitment is underway.
	7.10 The Provider should ensure that training for agency staff is current and up to date (OA wards)	1. Review the current training programme offered to agency staff who work regularly in each team 2. Ensure regular agency staff have access to Trust training 3. Seek assurance from agencies on the level of training provided for each	**OASL Service Line Director** **Director of Workforce and OD**	1. Q1 onwards 2. End Q4 3. End Q4	1. Training packages for wards 2. List of training offered by different agencies before staff are sent on assignments	Agencies provide all required mandatory training apart from PSTS (some provide breakaway though this is not sufficient for working on wards). The wards provide a local induction but no formal training. Requested list of training from Pulse and Sanctuary.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		role type before they are sent on assignment				
	7.11 The provider should ensure that targets for supervision are consistently met (CMHSOP)	1. Set clear targets and monitor supervision uptake 2. Supervision uptake is included as a standard agenda item to all locality meetings	**OASL Service Line Director**	1. Ongoing 2. Q1 onwards	1. Supervision completion reports	This is being monitored within the service line.
8. Seclusion						
	8.1 The trust should ensure that documentation relating to patients being secluded is in line with their seclusion policy (Acute wards). **8.2 The trust should ensure that seclusion paperwork is relevant and allows staff to complete contemporaneous records (Forensic/secure wards)**	1. Implement new seclusion paperwork across all services where this is applicable 2. Include new seclusion forms as part of RiO templates 3. Audit documentation used following seclusion 4. Monitor the use of seclusion at the positive and Proactive Care Meeting	**Executive Director of Nursing and Quality**	1. End Q1 2. End Q1 3. End Q2 4. Q2 onwards	1. Seclusion audit	New form has been devised and is being piloted on Willow suite and Penshurst. Final version to be reviewed and agreed at the Open RiO Change Group
9. Mental Health Act						
	9.1 Trust managers should ensure that the Mental Health Act is consistently implemented in accordance with the Code of Practice; and that staff working on the acute and PICU wards have sufficient understanding of the Mental Health Act and its Code of Practice to ensure	1. Deliver team or site based training for staff in acute and PICU 2. Continue with regular documentation audit and escalate concerns immediately 3. Distribute appropriate leaflets across all of the acute and PICU wards.	**ASL Service Line Director MHA Training and Policy Manager**	1. End Q3 2. Q1 onwards 3. Q1 onwards	1. Training data 2. Audit results 3. Rights leaflets available across all sites	1. Mental Health Act training compliance currently at 59% - to be escalated to matron for action 2. Service line to look at the results of the regular Mental Health Act administrator audits which will enable us now to start planning bespoke training per locality

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	patients are given correct information about their rights and to ensure medication is administered lawfully under the Act (Acute wards)					3. Rights leaflets in place in all sites. Link added to i-connect so that staff have access to MHA information.
	9.2 The trust should ensure that Mental Health Act documentation is completed in line with the Code of Practice (Acute wards)	1. Deliver training to registered staff in receiving and scrutinising documents	**ASL Service Line Director**	1. End Q2	1. Training data 2. Audit reports	1. & 2. Training figures and audit outcomes has been added to each localities quality improvement plans so that this can be closely monitored via PMM as a specific heading. Q1 compliance rate was 87%.
	9.3 The trust should ensure that staff receive regular ongoing training on the Mental Health Act (LD wards)	1. Implement objectives of the MHA mandatory training strategy on induction and 2 yearly updates 2. Staff on LD wards to book onto the course	**Executive Director of Nursing & Quality** **FSSL Service Line Director**	1. Q1 onwards 2. End Q1	1. MHA training figures 2. MHA audit reports	Monitored via L & D reports – June report: overall 94%
10. Estates/capital works						
	10.1 The trust should ensure that outside areas accessible to patients offer comfort and therapeutic benefit (Acute wards)	1. Develop capital bid to address shortages for outside space 2. Implement protocols for the least restrictive use of outside space	**ASL Service Line Director**	1. End Q1 2. Immediate effect	1. Capital business case documentation 2. Protocols for use of outside space	1. There are business cases in development for the provision of outside space. 2. There are clear protocols in place in all areas – these have been reviewed and updated where applicable.
	10.2 The trust should enable more outdoor space for patients on Penshurst ward (Forensic/secure wards)	1. Review and update the previously submitted business case to include linking the tennis court to Penshurst courtyard	**FSSL Service Line Director**	1. End Q4	1. Improved outside space	Initial bid submitted and approved. Additional information being added and re-submitted on in July

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	10.3 The trust should enable the patients on the intensive care unit on Penshurst ward to have access to an outside area that demonstrates dignity and respect (Forensic/secure wards)	1. As above 2. Seek external advice regarding the use of outside space	**FSSL Service Line Director**	1. End Q4 2. End Q4	1. Improved outside space	Initial bid submitted and approved. Additional information being added and re-submitted in July
	10.4 The trust should continue implementing the capital works programme for anti-ligature at both the Trevor Gibbens Unit and Allington Centre (Forensic/secure wards)	1. Expedite existing plan to Director of Estates and Capital Planning for programme to commence	**FSSL Service Line Director**	1. End Q4	1. Ligatures mitigated	SL Non clinical risk lead/TB have started to visit wards to update the ligature inventory & list works that are required Walmer inventory completed & local works in hand. Following local works a review will take place regarding the need for any named ward to be moved up the Trust ligature works list
	10.5 The trust should ensure easy access to the fire escapes in the therapy room at the Allington Centre (Forensic/secure wards)	1. Ensure staff keep the fire escapes clear at all times 2. Continue with spot checks as part of environmental audits	**FSSL Service Line Director**	1. Completed 2. Q1 onwards	1. Notice placed on doors 2. Environmental audits	Spot check completed and found to be compliant.
	10.6 The provider should look at garden access and explore ways they may be able to address ease of access for three wards (OA wards)	1. Review and update the capital business case for garden access for the Woodstock, Woodchurch and Ruby wards. 2. Continue with individual risk assessments will for patients who wish to access the garden area 3. Continue monitoring of related incidents and update	**OASL Service Line Director**	1. End Q2 2. Ongoing 3. Ongoing	1. Clear garden access	Business cases being drafted for Woodstock and Ruby wards. PCD for Woodchurch ward was not approved as Estates team will visit the site to assess what can be put in place. An audit has been conducted on Ruby ward of patients' use of the garden area. This is to be rolled out across all wards in the service line.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		the Service Line risk register accordingly.				
11. Risk management						
	11.1 The provider should ensure that all blind spots within the 136 suites have been identified and mitigated (136 Suites)	1. Review the options available in relation to the blind spots in the 136 suites. 2. Implement actions to mitigate the risks of blind spots	**ASL Service Line Director**	1. End Q2	Convex mirrors installed	Blind spots identified at each site, and products ordered. Due to be installed in July
	11.2 The provider should ensure that all staff adhere and follow the requirements in the organisational Lone Working Policy (CRHT's)	1. Ensure all teams are aware of the CRHT Operational Policy and have a locality lone working protocol 2. Ensure new staff are fully inducted to Lone working policy 3. Matrons will manage this process to ensure that it is robustly adhered to across all sites 4. Include as part of Health and Safety Audit around lone working practices	**ASL Service Line Director**	1. Complete 2. Ongoing 3. Ongoing review 4. End Q4	1. CRHT operational policy and locality lone working protocols 2. Induction records 3. Service line audit results undertaken by matrons 4. Health and safety audit data	1. Lone working protocols at each site have been audited, and checked against the Trust policy 2. Induction records are held at each site 3. All sites have lone working protocols in place, and staff have been issued with learning via the bulletins. Conducted a mystery shopper shift in East Kent and this has identified some learning to be built into practice.
	11.3 The trust should ensure that any building work causes as little disruption as possible for patients and staff (Forensic/secure wards)	1. Continue to consult with patients/staff/ affected people prior to any future building work. There was site consultation with patients and staff completed for the Penshurst extra care area/seclusion works. Activities were able to	**FSSL Service Line Director**	Completed	1. Building works protocol 2. Record of consultation	

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		continue as normal but in alternative venues. Where issues were raised (e.g. use of Groombridge courtyard) these were listened to and changes made 2. The service will continue to plan for the least disruption possible when completing works. 3. Ensure appropriate equipment and furniture is available				
	11.4 The trust should ensure that incidents are recorded correctly so that they can be monitored and to share learning (Forensic/secure wards)	1. Develop and disseminate learning flyer for incident reporting on Datix 2. Provide training on how to complete a Datix form 3. Monitor incident reporting at local and Trust Wide patient safety meetings	**FSSL Service Line Director**	1. Completed Q1 2. End Q2 3. End Q2	1. Learning flyer 2. Training data 3. Datix reports	1. Trust Datix flyer amended and shared within service line. 2. Revised and simplified Datix forms developed and launched 3. Datix team will be providing remote access to help users from 17 July 4. Incident reporting continues to gradually increase as seen in incident data
	11.5 The provider should address outstanding risk register items that may pose a risk to staff and people using the service (CMHSOP)	1. Continue to review Team/Ward risk registers at monthly meetings 2. Maintain and regularly review risks and mitigations at service line meetings.	**OASL Service Line Director**	1. Ongoing 2. Completed Q1 and ongoing for monitoring	1. Patient safety service line meeting minutes **Service Line, Team registers.**	Newly established Patient safety and Risk DTM has been put in place where risk registers will be presented, updated and agreed. Following the meeting held on 23.05.17, further risks have been added to the risk register which will be reviewed and monitored at this meeting.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
12. Medicines						
	12.1 The trust should ensure that out of date stock is removed from the clinic room and that appropriate checks take place (Forensic/secure wards)	1. Immediately complete audit of the clinical room and monthly thereafter	**FSSL Service Line Director/Pharmacy**	1. Q1 onwards	1. Monthly medication audit results/formal clinical audit re medication 2017 results	Formal audit proposal completed – data for April being collected
13. Safety						
	13.1 The provider should consider whether all staff should wear personal alarms at all times on the wards (Rehab)	1. Discuss consideration for wearing personal alarms at rehab service development day 2. Communicate way forward at the Trust Wide Health and Safety Meeting (TWHSM)	**CRSL Service Line Director**	1. End Q2	1. Agreed decision noted at (TWHSM)	1 & 2 Briefing completed for discussion at TWHSM on 20th July 2017
	13.2 The provider should ensure completion of the review of alarms and address the lack of alarms for staff on Jasmine ward (OA wards)	1. Review alarm provision for Jasmine Ward staff 2. Develop a business case for alarm supplier	**OASL Service Line Director**	1. Completed Q1 2. End Q2	1. Preferred devices in use across relevant teams. 2. Identified alarm system for Jasmine	Alarm provision has been reviewed. Quotes are currently being obtained.
	13.3 The provider should review the decision to put locks on bedroom doors so not to compromise the safety and security of the patients' belongings (Bridge House)	1. Provide locks for all bedroom doors at Bridge House	**FSSL Service Line Director**	1. Completed	1. Locks in place	Locks installed 31/07 and 01/08.
14. Service line specific						
	14.1 The trust should put systems in place to ensure	1. Review and provide guidance of the care	**ASL Service Line**	1. End Q2	1. Quality Account quarterly report on	Quality priority for the service line is included in 2017/18 Quality

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	that, following incidents of aggressive behaviour or restraint, the care plans for the patients involved are updated to describe how to prevent, manage and de-escalate potential future incidents (Acute wards)	planning process following incidents of violence and aggression or restraint 2. Conduct an audit of care plans following episodes of violence and aggression or restraint	**Director,/PSTS Lead**	2. Ongoing	this safety objective	Account. Safe Wards and Positive Behaviour Support interventions being piloted in Acute wards. ,
	14.2 The trust should ensure that all patients have care plans that are individualised, incorporate their views and are recovery focused (Acute wards)	1. Continue with monthly person centred care planning audits 2. Review specifically the role of non-professionally affiliated staff in supporting practical and recovery focused interventions 3. Provide skills training and review levels of quality within care plans and discuss at service line quality meeting 4. Obtain feedback from service users	**ASL Service Line Director**	1. Ongoing 2. End Q2 3. End Q3	1. Audit results 2. Training data 3. Service user feedback	1. Monthly audits are conducted against the care plans for each team, results are published and monitored at TWPCEG 2. Care planning training is ongoing 3. PREM being used as outcome measure and this includes feedback from friends and family.
	14.3 The trust should address the waiting times for access to psychological therapies for patients at the South West Kent team (CMHTs)	1. Develop dashboard for waiting times and effectiveness of service delivery 2. Complete workforce benchmarking 3. Complete demand and capacity exercise	**CRSL Service Line Director**	1. End Q2 2. End Q2 3. End Q3	1. Dashboard used in teams 2. Workforce report 3. Demand and capacity report	1. Performance team to complete dashboard by 30th July
	14.4 The trust should implement the new	1. Relaunch standard operating model following	**CRSL Service Line Director**	1. End Q2	1. CMHT standard operating procedure	Draft operational policy discussed at Leadership Forum. Awaiting

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	operational policy for the community mental health teams and monitor its impact on the effective operation of the teams in relation to access criteria, caseloads and appropriate discharges of patients (CMHTs)	consultation in the service line			in use	feedback from teams and KCC before proceeding through KMPT governance processes.
	14.5 All relevant documentation about care planning should be filed in the care planning section of the electronic care records and not in the progress note section (MHLD)	1. Reissue guidance on filing of care plans 2. Monitor performance via care plan audits	**CRSL Service Line Director**	1. Completed Q1 2. Ongoing - monthly	1. Filing guidance 2. Audits	Audit process has begun, results will be shared in Q2 report
	14.6 Work should continue to ensure that people commence psychology treatment within the trust target of 18 weeks (MHLD)	1. Continue with the system in place to monitor referral to treatment target with clinicians on a monthly basis and with commissioners quarterly. 2. Demand and capacity analysis	**CRSL Service Line Director**	1. Ongoing 2. End Q2	1. Commissioners performance and quality meeting minutes 2. Demand and capacity report	Demand and capacity analysis begun with leads. Skill mix plans being considered
	14.7 The provider should review which team is responsible for uploading care programme approach review meeting minutes on to the electronic care record system. Currently the community mental health teams are responsible and	1. Rehabilitation team to continue to upload the minutes of CPA meetings onto RiO 2. Monitor CPA upload via performance dashboard	**CRSL Service Line Director**	1. Ongoing - monthly	1. Uploaded minutes 2. Performance dashboard	Rehab teams continue to schedule CPA and upload care plans. Any breaches in outcoming CPA are highlighted to care co-ordinated & local CMHT admin team.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	the compliance % is under target. The staff at the rehabilitation units have expressed an interest in taking this task over to ensure the target is met (Rehab)					
	14.8 The trust should ensure that capacity to consent documentation is attached to prescription cards (Forensic/secure wards)	1. Implement the standard practice for managing capacity to consent documentation across the service line	**FSSL Service Line Director**	1. Completed	1. Monthly medication audit results 2. Formal clinical audit re medication 2017Audit	Formal audit proposal completed – data for April being collected
	14.9 The provider should ensure that care plans for people using the service are accessible within the electronic care notes system (CMHSOP)	1. Distribute learning bulletin to all staff which includes information about use of letters as a formal care plan 2. Complete two monthly clinical documentation for people who are on CPA.	**OASL Service Line Director**	1. Completed Q1 2. Ongoing	1. Learning bulletins 2. Audit results	Improvement has been noted. Some teams still need some support. Learning bulletin produced and disseminated.