Kent and Medway NHS and Social Care Partnership Trust (KMPT)

Mental Health Update

Report prepared for:

Kent County Council
Health Overview and Scrutiny Committee (HOSC)
20 July 2018

Version: 5.0
Date: 08 July 2018

Reporting Officer: Vincent Badu
Director Transformation and Partnerships, KMPT

Report Compiled By: Sarah Day, *Programme Manager, KMPT*

1. Introduction

1.1. This report has been prepared at the invitation[1] of Kent County Council's Health Overview and Scrutiny Committee (HOSC).

1.2. It will provide an update on the Care Quality Commission (CQC) inspection report and the Trust (KMPT) improvement plan to address issues raised in the inspection report. It will also provide a general update on KMPT current activities and priorities, new initiatives and opportunities.

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

2. CQC inspection report and improvement plan

2.1. The CQC, in January 2018, undertook a three-day unannounced inspection of three of KMPT's nine community mental health teams (CMHTs) for younger adults. This included the Canterbury and Coastal, and South Kent Coast CMHTs.

2.2. Since the inspection the CMHTs have been working in a focused way to resolve the serious concerns raised by the CQC and to significantly improve the consistency of the quality of care provided.

2.3. The CQC returned in May 2018 to revisit these three teams and test progress; the CQC confirmed they could see progress is being made and KMPT had addressed the concerns raised. At this May 2018 inspection the CQC also visited the Maidstone CMHT as they had identified from performance data that this is one of the higher performing teams in terms of meetings targets, recruitment, sickness absence rates and supervision support. Although this team received positive individual feedback, the CQC noted there were still inconsistencies across all teams.

2.4. In 2017 the CQC findings highlighted KMPT needed to improve its CMHT services across a number of elements. The January 2018 inspection was to test progress. The CMHTs had done an enormous amount of work and some really good progress had been made. However, the CQC were very clear, and were able to evidence, progress was not consistent across all required elements. The team of inspectors checked whether these services were safe, effective and responsive to people's needs. They also considered whether they were well-led. Their overall finding was that the quality of healthcare being provided required significant improvement. KMPT was consequently issued with a Warning Notice. This was immediately shared with the teams and an intensive work programme to resolve issues commenced. This included putting in place a comprehensive improvement plan and making some significant changes within the teams to ensure that they had sufficient support and strong, effective leadership.

2.5. Regular reporting is in place to the Executive Assurance Committee and Trust Board on the improvements made to safety and governance in CMHTs following the warning notice from CQC. In addition performance is scrutinised by internal operational service management teams, the Finance and Performance Committee and Quality Committee to ensure both the improvement plans and sustainability issues are progressed robustly.

2.6. Positively, the CQC's findings were not all focussed on areas needing improvement. They found several areas of good practice including staff having a good understanding of safeguarding and lone working, and CMHT staff being experienced, caring and hard working.

2.7. KMPT fully accepted the CQC's findings. The inspection and report have been instrumental in helping the teams focus and step up the pace of the improvements they are making. This work continues to progress and staff continue to be fully supported to ensure KMPT is consistently providing persons who use services with good quality care.

[1] Email to Sharon Tree (Senior Executive Assistant to Helen Greatorex, Chief Executive and Andrew Ling, Chairman, KMPT) from Georgina Little (Democratic Services Officer, KCC) dated 18 May 2018

2.8. The final CQC inspection report from the January 2018 inspection was published on the CQC website on 9 May 2018 and the warning notice remains in place until a further inspection is received by the CQC and improvement formally noted. The report can be found at https://www.cqc.org.uk/sites/default/files/new_reports/AAAH2785.pdf

2.9. Progress on delivery of all the key "must do and should do" recommendations highlighted by the CQC are now robustly underway. A summary of the key improvements delivered by the Trust to date include:

2.9.1 Continued reduction in care coordinator case loads, reasons for exceptionally high case loads are fully understood by service managers and there are plans in place for management and ongoing support.

2.9.2 Communications with people using services and referrers have been improved to ensure all new appointment letters contain details of how people can access help whilst waiting for formal assessment or treatment and the actions they can take if their condition deteriorates.

2.9.3 28 day referral to assessment performance has improved across all teams since January 2018. 28 day wait for assessment is on average 73.3%, with the lowest performing team at 62.3% (this equates to 20 patients not seen within 28 days for a routine appointment). The highest performing team is at 93.8% which equates to 2 people not being seen within the timeframe. Almost all teams are scheduling first appointments well within the 28 day window except for teams where slots are unavailable due to short term absence or vacancies.

2.9.4 Teams now routinely book patients within 10 days of referral and there are a number of 'reminder' actions taken at regular points in order to reduce non attendance at appointments. These include reminder texts, telephone contact and letters.

2.9.5 Daily red board meetings are in place across all teams to enable multi-disciplinary discussions to take place around people who are assessed as high risk, those who did not attend (DNA) appointments and to ensure 7 day follow up is completed as planned following an episode of acute care.

2.9.6 Mandatory training is on average 88% compliant against a target of 85% with the exception of 3 courses that are below 85%.

2.9.7 Supervision improvements for all staff and significantly for clinicians has improved from an average of 31% in January to 89% in May 2018, set against a 95% internal target.

2.9.8 Clinical mitigations are in place for patients waiting for assessment and or specialist treatment.

2.9.9 Core assessment, care plans, risk assessments, Care Programme Approach (CPA) and Health of the Nation Outcome Scales (HoNOS) all show an improvement over the last 4 months.

2.9.10 Reduction of overall vacancies from whole time equivalent (wte) 58.9 (16%) in January 2018 to 45.6 (13%) in May 2018. However staffing pressures remain evident in some teams due to long term absence.

2.10. Appendix A sets out the focussed inspection improvement plan for all CMHTs as the 'must do' and 'should do' actions identified cover all teams.

2.11. Unannounced CQC inspections: The CQC visited the Older Adult Inpatient services at Jasmine ward on 18 April 2018 and The Orchards on 19 April 2018. The Care Group leadership team received feedback at the end of each visit and the feedback was overwhelmingly positive in relation to the clinical delivery of the service, with particular reference to the excellent handover process. The CQC inspectors identified a number of estate related issues on both wards, which were either immediately rectified or are being actioned. Publication of the final CQC inspection report is awaited.

3. Current activities and priorities

3.1. Care Pathways Delivery Programme:

3.1.1. KMPT's Care Pathways Delivery Programme aims to support the Trust evolve its brand over the coming years through the development and implementation of quality care pathways, expanding and developing the use of information management technology, and through a closer alignment of its built environment to the needs of services. These developments align with the national themes for the NHS as health and care systems are subject to increasing demand and downward financial pressure and will be taken forward through the development of a two year cost improvement plan (CIP), commencing in 2018/19 and being fully functional by the end of 2019. The programme will ensure that patient care remains the ultimate priority and focus and will draw on national work and pathways work completed in KMPT in 2016/17 to develop streamlined clinical care pathways affording efficacy and efficiency to meet a range of diagnoses. The programme is working with local clinicians, people that use services and local stakeholders to ensure developments meet local need in line with locality planning within the Sustainability and Transformation Partnerships (STP).

3.1.2. The Care Pathway Delivery Programme is being formally rolled out during July 2018. The work will be supported by a new Programme Management Office (when fully in place) and will deliver the Trust's Clinical Strategy through clearly describing the care the CMHTs and Acute services will provide. This is a two year programme in terms of full implementation and some aspects are beginning to progress now, including: the Active Review Programme, the Personality Disorder Programme and the Initial Interventions Programme. KMPT's Chief Operating Officer is the executive sponsor for this work and presented initial outline plans at the Joint Commissioning for Mental Health meeting on 6 July 2018 with commissioners positively responding to the idea of clearly described clinical interventions.

3.1.3. As part of the Care Pathway Delivery Programme, KMPT is seeking to build more robust links with partners. Scoping meetings are starting to take place with third sector providers, such as Porchlight, Live It Well Kent and Healthwatch, to ensure thinking is joined up and together KMPT and its partners deliver whole pathways that reduce the current fragmentation. This work is welcomed and positively supported by the Mental Health Commissioning Group.

3.2 Single Point of Access service:

3.2.1 On 23 June 2018 the Single Point of Access service reduced its hours of operation. The service will continue to operate 7 days a week, 08.00 to 22.00 hours rather than 24 hours a day. People on a caseload will continue to access the Crisis Home Treatment service, as they currently do, out-of-hours. The Police will continue to be able to access 24 hour advice and guidance as is required under the Policing and Crime Act 2017.

3.2.2 In terms of the future for the Single Point of Access, KMPT is working with commissioners to develop a mental health component into NHS 111 and Urgent Care Centre services. This work is supported by the Care Pathways Delivery Programme and Mental Health work stream of the Kent STP.

3.3 Inpatient bed occupancy:

3.3.1 Bed occupancy has increased since Easter 2018, in line with the national picture, and consequently on-call and out-of-hours services have been busy. Despite these challenges KMPT has not had a single person requiring an acute inpatient admission admitted to a bed out-of-area. This is likely related to a number of interventions supporting transformation to day-to-day operations including a high functioning Patient Flow Team and medical staff working over the weekends and on the wards at times of peak activity such as Bank Holidays.

3.3.2 KMPT has generally been able to meet its acute inpatient bed occupancy standard of 94%, whilst operating on 6 reduced beds for some time as a result of ongoing estate refurbishment works. KMPT is commissioned to provide 174 beds (with only 173 beds available) and currently uses c152.5 beds.

3.3.3 KMPT is conscious one of its Older Adult Inpatient wards (Cranmer) at Canterbury is at the end of its estate life cycle and the environment needs significant improvement. KMPT is currently considering how these beds will be re-provided on the St Martin's site in Canterbury to ensure good quality care for people using services in fit for purpose facilities. Proposals, which will aim to reduce any unnecessary change for people using services, their carers are under development.

3.3.4 NHS England is requiring KMPT to review its use of out-of-area placements for people who require an Acute Inpatient service with a view to cease out-of-area placements by 2021. At this point in time KMPT has no person who needs an acute inpatient bed out of area other than women requiring Psychiatric Intensive Care (PIC). Currently KMPT cannot fully comply as there is no Kent and Medway female PIC unit. To fully meet these requirements, over the next year, KMPT will work proactively with commissioners to find solutions.

3.4 Psychiatric Liaison service:

3.4.1 Currently KMPT is being asked by Acute General Hospitals to provide 24/7 Psychiatric Liaison services. KMPT does not have the resources to provide this level of service however the STP signed up to the provision of Core 24 Psychiatric Liaison services in all Kent (and Medway) hospitals. The work to deliver this ambitious programme will be challenging; the development of the Urgent Care Pathways will provide a means to support implementation. The delivery of this programme will need to be fully supported by commissioning colleagues and key stakeholders.

3.4.2 Additionally KMPT is pro-actively seeking to find ways to work differently within existing resource to better support partners, for example better utilising its Crisis Resolution Home Treatment (CRHT) resource. A 'test of change' project is currently running around the provision of liaison psychiatry at the William Harvey Hospital.

3.5 Urgent Care Pathway: Aligned to the overarching Care Pathways Delivery Programme, work to develop clearly defined Urgent Care Pathways is in progress. There are a number of opportunities to test both preventative interventions, as in preventing hospital admission, and alternative crisis response. The initial work is in partnership with Medway Foundation NHS Trust with project support provided by the Clinical Commissioning Group (CCG).

3.6 Section 136:

3.6.1 A key area of concern for KMPT is the high number of recommendations made under Section 136 of the Mental Health Act (MHA). In April 2018, 164 people were subject to the use of Section 136 powers by the Police. This is an increase overall with data indicating an upward trend. Use of Section 136 is, on occasion, an appropriate intervention however its use is not always the best therapeutic intervention for people in mental distress. The Police, KMPT and other key organisations are committed to reduce its use, where appropriate, working together to find solutions ensuring a partnership response.

3.6.2 A number of initiatives are in place including joint mental health awareness training with Kent Police and an evaluation of the former Street Triage pilots across Kent (and Medway) with commissioners, the Police and Ambulance services in order to agree a future service model based on 7 days a week operation.

3.6.3 Further work on the multi-agency response to supporting frequent presenters in mental distress is also being prioritised.

3.7 Dementia service:

3.7.1 Older Adult Community services are working in partnership with CCG colleagues to improve the dementia diagnosis rate across Kent. Funding has been secured for a new, time limited initiative commencing in September 2018 focusing on care home diagnosis rates for West Kent.

3.7.2 KMPT has been invited to join the Dementia STP forum. The forum aims are to streamline and standardise processes across Kent (and Medway) and to encourage greater partnership working.

3.7.3 There are a number of opportunities to develop new posts including a Dementia Primary Care Nurse. Early scoping discussions are taking place in East Kent around the possible development of Primary Care Dementia Coordinators.

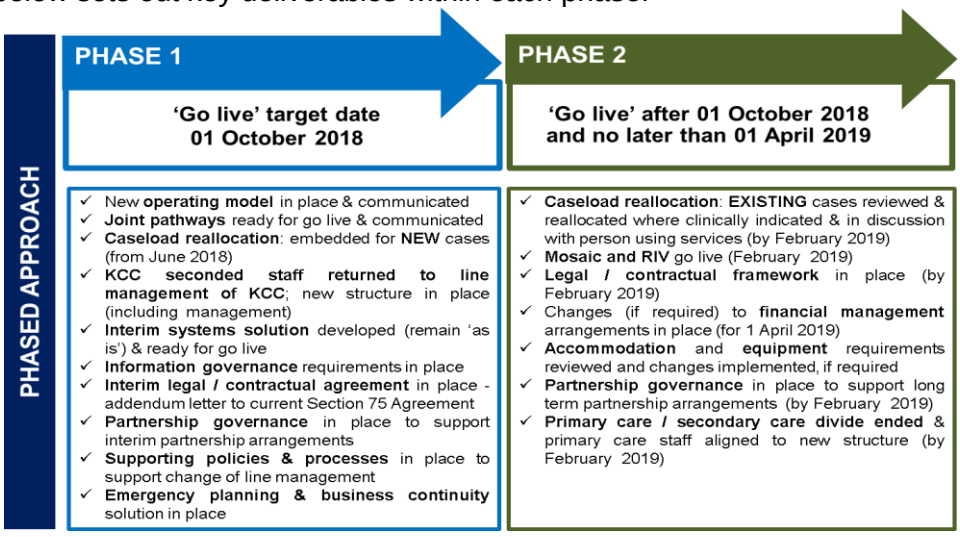
3.8 **Older Adult Community service:** Following an approach by West Kent CCG, KMPT's Older Adult Community service is piloting Kinesis - a secure web based solution that directly links general practitioners (GPs) to hospital specialists for rapid access to expert clinical advice. The tool enhances engagement and supports GPs in making the right decisions for "when and how to treat and when to refer" their patients. Enabling GPs to contact specialists via email provides a safer option for recording advice previously given over the telephone. It also enables improved monitoring of volume and nature of communications.

3.9 Partnership Transformation Programme:

3.9.1 In October 2017 the KCC / KMPT Partnership Board agreed, in principle, a new approach to the partnership which will ensure an integrated response within secondary care and the more robust delivery of both social care and health statutory responsibilities. A key element of this new approach will be to realign the management of seconded Adult Mental Health social work staff directly into KCC. This will move the day-to-day operational management of the KCC seconded staff in the CMHTs and Approved Mental Health Professionals (AMHP) service under the direct management of KCC. This is a significant change that will impact across the health and social care delivery functions of the CMHTs and will require the two organisations to ensure the shared vision to work in partnership remains intact.

3.9.2 KMPT and KCC have agreed a shared goal is for the new arrangement to commence by October 2018. To achieve this, a Partnership Transformation Programme was established in November 2018, led jointly by KCC's Corporate Director Adult Social Care and Health and KMPT's Director of Transformation and Partnership. A project management approach to delivering this work has been adopted and a number of workstreams established.

3.9.3 The programme is progressing to plan with engagement of clinicians and front line staff in developing future operational delivery models. A phased approach has been agreed for 'go live' in order to ensure safe and effective services are maintained including timely communications with key stakeholders. Phase 1 has a 'go live' target from 1 October 2018 with Phase 2 'go live' following after 1 October 2018 and no later than 1 April 2019. The diagram below sets out key deliverables within each phase.



4. New initiatives and opportunities

4.1 Mother and Baby Mental Health:

4.1.1 In April 2017 NHS England confirmed that KMPT had been successful with its bid to provide a new mother and baby mental health inpatient unit in the South East for patients from across Kent, Surrey and Sussex. The expansion in mother and baby unit capacity is part of

NHS England's work programme to improve the access and quality of perinatal mental health services across the country.

4.1.2 KMPT's existing Mother and Infant Mental Health service (MIMHs) already provides an excellent community service to mothers across Kent and Medway who need mental advice and treatment during pregnancy and up to one year after birth. However previously when admission to a specialist inpatient unit was needed, new mothers could face being placed in a unit up to 200 miles away from loved ones, or if no specialist bed was available to accommodate them with their new born, mother and baby would have to be separated.

4.1.3 The new specialist Mother and Baby Unit (MBU) will be located in Kent. The programme of work to develop the new facility and recruit to the multi-disciplinary team has progressed successfully and is on track for the new service to open during July 2018.

4.2 Recovery and Wellbeing Learning Community Partnership:

4.2.1 The Recovery and Wellbeing College will offer educational courses to support mental, physical and emotional wellbeing in shared learning environments in the community. It will support people to identify and build on their own strengths and make sense of their experiences. This helps people take control, feel hopeful and become experts in their own wellbeing and recovery. Whether you are experiencing health challenges yourself, are a family member, friend or carer, or work in associated services, the Recovery and Wellbeing College will be open to all. Recovery Colleges were introduced following a recommendation by Implementing Recovery through Organisational Change (ImROC) programme in 2010. There are over 83 colleges across the country and the economic evidence suggest that for every £1 invested over £16 of benefit is achieved for the health and social care economy.

4.2.2 Preparation for roll out of first Kent programme of the Recovery College courses commencing in September 2018, in Thanet, is progressing well. The whole course programme has been developed through extensive consultation with people who use services and key stakeholders. Sixteen co-facilitators with a mix of lived and learned expertise are now fully trained to co-design and co-deliver the educational courses between September 2018 and December 2018. All sessions follow a strengths based approach, supporting people to recognise their own strengths, develop skills and make best use of community resources. An evaluation team has been established to ensure the pilot is well evaluated and that qualitative, quantitative and cost benefit data are produced.

4.2.3 Work is progressing with a diverse range of external stakeholders to develop the Kent-wide cross-boundary Recovery and Wellbeing Partnership. This will widen the learning community provision across Kent, thus diffusing the innovation and creating resources which are transformative and sustainable.

5. Conclusion and Recommendation

5.1. The KCC HOSC is requested to note the content of this mental health update report.

APPENDIX A : KMPT ADULT CMHTs FOCUSSED INSPECTION ACTION PLAN – June 2018 v4

This action plan has been developed in order to urgently address patient safety issues identified during the unannounced CQC] focussed inspection conducted on 22-24 January 2018 at three adult CMHTs (Canterbury and Costal [C&C], Medway, & South Kent Coast [SKC]). Improvement will be monitored & tracked at a fortnightly meeting to be chaired by the Executive Director of Nursing & Quality which includes operational colleagues involved in the delivery of the plan. Onward reporting consists of the Executive Assurance Committee, Quality Committee & to the Board. The action plan now includes all of the Enforcement Actions following the report publication.

Improvement plan owner:	Chief Operating Officer (COO)
Implementation monitoring:	CQC Oversight Group / Care Group Senior Management Team (SMT)
Executive approval:	Executive Assurance Committee (EAC)
Executive sponsor:	Executive Director of Nursing and Quality
Reporting to:	Quality Committee and Trust Board

RAG KEY:	
Purple	**Embedded**
Green	**Complete**
Amber	**In progress**
Red	**Overdue**
Requirements:	
Must do	
Should do	
Further improvement / supportive actions	

STAFF KEY:

AMD	Assistant Medical Director	EDoN	Executive Director of Nursing & Quality	HRBP	Human Resources Business Partners
COO	Chief Operating Officer	ER Manager	Employee Relations Manager	MD	Executive Medical Director
DCOO	Deputy Chief Operating Officer	HoN	Head of Nursing	QM	Quality Manager
DoF	Executive Director of Finance	HoS	Head of Service	DWOD	Director of Workforce and Organisational Development

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
1. SAFE CARE AND TREATMENT Regulation 12 (HSCA 2008)						
	1.1 The Trust must ensure that staff assess the risks to patients' health & safety or respond appropriately to meet people's individual needs to ensure their welfare & safety during any care or treatment.	1. Develop & deliver clinical risk assessment & management training to all 9 younger adult CMHTs 2. Ensure all patients receiving care coordination have a valid risk assessment in place & that this is reviewed & updated as & when risks change.	**HoN CRCG**	1. End July 18 2. Ongoing	1. Attendance sheets 2. Performance reports / CliQ checks	1. Training dates in the diary – to be fully delivered by 03/07/18 2. CliQ checks in place - 2 weekly reporting to monthly Quality Care Group meeting 3. Weekly performance report to all managers demonstrating compliance 4. Compliance monitored through Care Group Performance meeting & Integrated Quality & Performance Review (IQPR) chaired by Executive
	1.2 The Trust must ensure that staff provide safe care & treatment to patients' receiving, or awaiting to receive, a service from the adult community mental health teams.	1. Develop an Active Review programme Standard Operating Procedure (SOP) 2. Roll out Active Review methodology to all teams with a current waiting list 3. All patients on care coordinator case loads should have a relevant & up to date care plan 4. All people waiting for psychological therapies to be transferred to psychological therapies colleagues caseload 5. Administrative staff to ensure all patients waiting for a service receive a waiting list letter / Keep Safe plan 6. Administrators to audit 20 case files a month of people waiting to ensure: □ People receive the waiting list letter □ Receive a Keep Safe plan □ Have been reviewed at 28 days & 56 days wait (part of Active Review programme) 7. All persons waiting 56 days to be reviewed & allocated 8. Review & action any did not attends (DNAs) at Red Board meetings 9. Audit adherence to DNA policy	**COO supported by DCOO, HoS, HoN & Director of Therapies**	5. 31/07/18	1. Case loads transferred to therapies staff 2. Audit results 3. Performance reports 4. Audit results 5. SOP	1. 2. 3. 4. Psychological therapies services have clearly defined wait lists for therapies proactively managed 5. Teams instructed to action waiting list letter & review process. To be audited in June 18 & July 18 to evidence safe plan 6. Waiting list project group reviewing this data in June 18. 7. Adherence to the DNA policy to be audited by Quality Managers across June 18 and July 18. 8. SOP for Active Review in place & rolled out in SKC & Medway end of July 18. Active review in place as necessary in psychological therapies teams

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	1.2 The Trust must ensure that staff provide safe care & treatment to patients' receiving, or awaiting to receive, a service from the adult community mental health teams.	10. Develop an Active Review programme Standard Operating Procedure (SOP) 11. Roll out Active Review methodology to all teams with a current waiting list 12. All patients on care coordinator case loads should have a relevant & up to date care plan 13. All people waiting for psychological therapies to be transferred to psychological therapies colleagues caseload 14. Administrative staff to ensure all patients waiting for a service receive a waiting list letter / Keep Safe plan 15. Administrators to audit 20 case files a month of people waiting to ensure: □ People receive the waiting list letter □ Receive a Keep Safe plan □ Have been reviewed at 28 days & 56 days wait (part of Active Review programme) 16. All persons waiting 56 days to be reviewed & allocated 17. Review & action any did not attends (DNAs) at Red Board meetings 18. Audit adherence to DNA policy	**COO supported by DCOO, HoS, HoN & Director of Therapies**	6. 31/07/18	6. Case loads transferred to therapies staff 7. Audit results 8. Performance reports 9. Audit results 10. SOP	9. 10. 11. 12. Psychological therapies services have clearly defined wait lists for therapies proactively managed 13. Teams instructed to action waiting list letter & review process. To be audited in June 18 & July 18 to evidence safe plan 14. Waiting list project group reviewing this data in June 18. 15. Adherence to the DNA policy to be audited by Quality Managers across June 18 and July 18. 16. SOP for Active Review in place & rolled out in SKC & Medway end of July 18. Active review in place as necessary in psychological therapies teams

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	1.3 The Trust must have systems in place to ensure patients are aware of any changes in their care provision & alternative plans that have been put in place to ensure their safety. This would include long or short term change of care coordinator & discharge to primary care.	**Handover of care** 1. Embed the CMHT SOP for use in the follow up of patients in case of staff planned & unplanned absence known as 'handover of care' process. 2. Audit a sample of letters to patients, indicating where changes to care coordinators have been made. 3. Continue to grant CMHT new administrators rights to input to electronic records at the request of the clinician. All RiO entries to be validated by the clinician to confirm that they have checked the record.	**DCOO**	1. Completed 2. & 3 Ongoing	1. Daily planning meeting actions points 2. List of administrators granted rights	1. DGS model known as "handover of care" across the teams was rolled out to service managers on 19 February 18. This is now embedded in all teams. The procedure has been added to the 'a day in the life of CMHTs' guidance disseminated to all teams & to the CMHT Operational policy that is currently being reviewed. An audit of compliance with take place in June 18. 2. 3. Administration can now document in RiO, with clinicians being responsible for validated entries (agreed at Trust-wide Patient Safety and Mortality Review Group).
		Communication with general practitioners (GPs) 1. Revise the CMHT Operational policy to clarify access criteria to CMHT & good discharge processes 2. Continue communication to GPs through Local Medical Committee (LMC) & Clinical Commissioning Groups (CCGs) including briefings on progress with Choice and Partnership Approach (CaPA) implementation 3. All staff to use standardised letters to GPs on discharge & following assessments signed by assessing clinician. Where a patient is not accepted for ongoing care by CMHT, a letter must be sent to GP, clearly indicating reasons for not accepting a patient on CMHT caseload & signpost to services where patient might be able to get help & support	**COO, MD & Director Communications**	1. 31/07/18 2. Ongoing 3. Ongoing	1. Flowchart / checklist for CMHT criteria 2. Briefing sessions, dates & attendees 3. Audit of letters	1. The CMHT Operational policy has been revised to include some of the process changes that have occurred & reference to CaPA implementation. This has been updated with ratification by end of June 18. 2. Communication & briefings continue via the local medical committee & via CCGs. Discussion to be had with the communications team regarding the production of a formalised briefing. 3. An audit to ensure that they are being used consistently will be conducted in June 18 to check that the process is embedded in practice.
2. GOOD GOVERNANCE Regulation 17 (HSCA 2008)						

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	2.1 The Trust must have effective audit & governance systems & / or processes in place that ensure care & treatment is provided in line with their policies.	**Policies** 1. Ensure compliance audits are conducted against key policies to include DNA policy & Transfer Discharge policy & results reported through relevant Trust-wide group & committee 2. Ratify & implement updated CMHT Operational policy 3. A named administration manager to review all audits in place to ensure fit for purpose & assure / provide evidence against policy compliance 4. Check the quality of clinical documentation via CliQ checks	**DCOO, AMD & HoS**	1-4. 30/07/18	1. Audit results 2. CMHT operational policy 3. Report 4. CliQ checks	1. Compliance is audited within each team. Audits of DNA activity & transfer activity are scheduled for end of June 18. 2. Draft policy has been reviewed, final amendments, due for ratification end of June 2018. 3. CliQ checks are conducted every 2 weeks.
		Audit / performance 1. Revise the available performance data to ensure it is fit for purpose. 2. To ensure performance data distinguishes those persons on active caseload & those persons waiting for services 3. To ensure data provides greater detail on waiting lists (what people are waiting for) 4. Ensure data can pull out people on depot clinic caseloads, on doctor only caseloads seen in outpatient department, out of area caseloads & in other alternative care	**Director of Contracting supported by DoF, COO, Head of Performance & Head of RiO**	1-4. 09/07/18	Improved data set available to team level	

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
3. Operations						
	3.1 The Trust should ensure that staff follow consistent criteria for deciding whether a patient requires care coordination following initial assessment.	1. QMs to lead on audit to demonstrate a consistent approach to management of caseloads through daily & weekly team meetings 2. Develop a brief summary guide for Care Programme Approach (CPA) which will be shared with all CMHT staff. CliQ checks to incorporate a review of CPA.	**DCOO supported by QMs** **HoN, QMs**	1. 31/08/18 2. 31/07/18	1. Report to be provided by QMs 2. CPA brief guide & CliQ checks	1. DCOO has instructed QM to commence audit with a report due August 18. 2. To be developed & implemented.
	3.2 The Trust should ensure that staff follow up clients who did not attend appointments appropriately	1. Audit compliance with DNA policy. 2. Performance team to routinely provide data on patients attending Depot Clinics & to audit attendance & follow up against DNA policy. 3. Develop & implement a Depot Clinic SOP.	**DCOO supported by HoS, QMs & Performance Team**	1. 31/07/18 2. Ongoing 3. 31/07/18	1. Audit results 2. Data set identifying people attending depot clinics 3. Depot Clinic SOP	1. Audits of DNA activity are scheduled for June 18.
	3.3 Ensure consistency in practice across of CMHTs	1. Implement & embed all SOPs included in the 'day in the life of CMHT' pack. 2. Audit compliance against the SOPs within the above.		1. 31/07/18 2. 31/08/18	1-2. Audit results & performance reports	1. To be monitored at weekly meeting with service managers & at Care Group Governance meetings.
4. Workforce						
	Overarching workforce actions to meet the should do's in 4.1, 4.2 and 4.3 below:	1. HRBP to complete a monthly workforce dashboard to include information regarding 4.1, 4.2 & 4.3 2. DWOD to continue to develop relevant policies to support positive recruitment & retention processes	**CRCG HRPB with support from DWOD**	1-2. 31/07/18 & ongoing	1-2. IQPR Report	1. Review at weekly Care Group SMT meeting & review at July 18 Care Group Quality Performance Review meeting 2. The Human Resource Dashboard has been improved to include appraisals & supervision compliance & is updated on a monthly basis & taken to the Care Group Performance meeting on the 1st Friday of the month & to the Human Resource Clinics that are held with the service managers for monitoring.

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	4.1 The Trust should ensure that sufficient numbers of permanent staff are recruited & retained to enable the CMHTs to operate effectively.	1. Recruit substantively to the CRHT HoS post for East Kent 2. Recruit substantively to CMHT service manager posts in line with cost improvement programme (CIP). 3. Continue with centralised nursing recruitment	**COO**	1. 31/07/18 2. 31/07/18 3. 31/08/18	Both posts are recruited to & start dates confirmed.	1. Agreed at EAC to recruit to HoS post 2. Agreed with DCOO to progress with SKC and Medway service manager recruitment by end of June 18.
	4.2 The Trust should ensure that staff meet the Trust's target for completion of their mandatory training courses.	1. Monitor mandatory training compliance at monthly Care Group / Trust-wide Quality and Performance Review meetings and Workforce and Organisational Development Committee.	**HoS CRCG & DWOD**	1. Ongoing	1. 85% compliance target completed for all mandatory training courses	All training reviewed at monthly IQPR meetings – currently the Care Group has achieved 88% compliance rate for mandatory training with 2 teams outstanding, discussions have taken place with Learning & Development Team regarding the outstanding elements & they are currently working with the teams to provide additional sessions to improve the compliance levels.
	4.3 The Trust should ensure that all have regular access to supervision & that these sessions are recorded & stored appropriately.	**Staff supervision** 1. All staff to schedule management supervision 4-6 weekly on a quarterly basis 2. All CMHTs to display supervision tree & supervision monitoring form in staff team areas 3. Monitor management supervision uptake on monthly basis & report performance to HRBPs 4. All CMHT clinical staff to complete a case file audit as part of supervision 5. Each CMHT to keep a log of group / reflective supervision or case discussions dates & attendees & case discussed 6. Audit a random sample of the quality of supervision notes & actions	**DCOO, H0S, QMs, Service Managers & HRBP**	1. Completed & ongoing 2-7. Ongoing	1. Booked supervision dates 2. Audit of supervision tree on display 3. Supervision uptake reports 4. Audit reports 5. Supervision log, dates & attendees 6. Audit report	Supervision trees are in place for each team & dates have been scheduled for the whole year. Supervision uptake is being monitored & an improvement seen from 37% in January 18 to 78% end of April 18 .

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		Supervision policy & process 1. Relaunch revised Supervision policy 2. Develop an electronic supervision recording system which includes an escalation process 3. Identification of managers requiring additional support in their roles	**ER Manager, Head of Workforce Information & HRBP**	1. Ongoing 2. 31/08/18 3. 30/06/18 ongoing	1. Revised supervision policy in place with supporting managers guides 2. Electronic supervision 3. Training course attendance / records of support offered	The electronic system is moving forward, this will enable managers to directly report their supervisions at the time they are completed & a report can then be generated. In the meantime, teams update an agreed Trust template spreadsheet, if any teams are either low or do not submit any returns then this is picked up by the HRBP who escalates to the HoS for the area Monitoring & oversight is at Care Group and Trust IQPR . A new Human Resource Dashboard has been devised & supervision completion rates form part of the key performance indicators. Human Resource Clinics with service managers as a way of supporting recruitment processes & those staff. 3 service managers are exploring NHS Leadership Coach / Mentor courses.
5. Additional areas for improvement						
	5.1 Staff development	1. Develop an outline Practice Improvement programme plan based on cultural audit 2. Develop a middle management leadership course (including developing capable teams, 'PIP') 3. Conduct a gap analysis for middle management course (band 7 and all 8s = 599 staff) 4. Deliver middle management course (prioritised) 5. Review need for external support or intervention to deliver practice improvement programme.	**DWOD, COO, EDoN**	1. Ongoing 2. Ongoing 3. Ongoing 4. 30/04/19 5. Ongoing	1-2. Improvement programme 2. Gap analysis 3. Programme outline & attendees 4. Recommendation from review	1-4. Met with Enable East to look at the Developing Capable Teams programme & also researching work that Wrightington & Wigan Trust has done on improving teams. DWOD & COO are meeting w/c 18 June 18 to discuss & agree away forward.
	5.2 Culture	1. Explore external support to undertake a cultural audit & make recommendations for improvement	**DWOD**	1. End June 18	Audit report	Specification for creating a just learning culture has been finalised & is with procurement to send out to 4 organisations. An organisation will then be selected to work with & the work plan will be formalised. This also links to 5.1 above.