NHS
Kent and Medway
NHS and Social Care Partnership Trust

Quality Accounts 2016-17

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

Visit us at www.kmpt.nhs.uk

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Our commitment to you

Our values

respect
open
accountable
working together
innovative
excellence

Our vision

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

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

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22 02 2017 KM201

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Customer Care Charter

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

1. **Listen to your concerns and respect your views** – we will treat you as an individual and in the context of your whole life. We will listen to what you have to say and record it accurately.
2. **Involve you in planning your care** – you will be given the opportunity to determine the plan for your care, which will focus on your recovery. We will give you a copy of your care plan in a format acceptable to you.
3. **Be informative and engaged** – we will provide you with information about conditions and services and, if you agree, also communicate with those who care for you. We will answer your questions politely and carefully. If we do not know the answer we will tell you and get the information for you as soon as possible.
4. **Deliver best practice care** – we will learn from best practice and provide care that meets NICE guidelines. Our staff will be up to date and trained to deliver best practice in all that they do.
5. **Constantly improve** – we will ensure that service users and carers are able to influence service development. We will learn from your feedback and be accountable to you by making changes based on your concerns.

KMPT expects you to...

1. **Keep your appointments** – we ask that you attend, or advise us if you cannot meet an appointment given to you. If we have to change your appointment we will give you as much notice as possible and offer another date.
2. **Treat our staff with respect and without aggression** – while we appreciate that mental health problems can lead to frustration and anger, we ask that staff are treated with courtesy. We will be courteous and polite at all times.
3. **Be open about your views** – let us know your expectations and any concerns so that we can together plan the most appropriate care for you.

If you do not feel that we are meeting these commitments, we ask you to raise this with your key worker, the service manager, or write to: Patient Experience, Freepost RTCS-SBAL-KBUK, St Martin's Hospital, Canterbury CT1 1TD or email: patient.experience@kmpt.nhs.uk

Signed

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Introduction

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

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

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

The Quality Account comprises three sections, as required in the guidance set by the Department of Health in the Quality Account Toolkit. Part one is the statement from the Chief Executive on page 10. Part two reviews our progress on our quality improvement priorities in 2016-17 and contains statements about various aspects of the quality of our services in the format set for us. Part three contains our priorities for improvement in the year ahead and tells you who was involved in determining our priorities. For ease, the latter statement is on page 79.

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

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

Key achievements in 2016-2017

CQC Inspection

The care quality regulators the Care Quality Commission (CQC) have rated the quality of services provided by the trust as being `Good' after carrying out a detailed and comprehensive inspection of the trust over a week during January 2017. This is a significant improvement on the previous CQC rating of 'requires improvement' obtained by the trust in March 2015.

In the latest CQC Inspection the trust was rated as 'Outstanding' for the caring domain. This highlights the high level of compassion and care that staff provides for patients.

For more details about the CQC Inspection please see page 66.
The trust CQC inspection matrix, showing the ratings for each CQC quality domain is on page 68 and see appendix B for the trust CQC Improvement Plan.

Relocating Inpatients back to Kent and Medway

The trust has reduced the number of patients being placed in beds outside of Kent and Medway during 2016-2017.

Firesetting research Award

The Forensic and Specialist Services Service have won a prestigious 'Impact through knowledge Exchange Award' as part of the University of Kent's Innovation Awards 2016.

Working with staff from the Centre for Research and Education in Forensic Psychology (CORE-FP) at the University of Kent the Service Line's project is for the development, implementation, and evaluation of the Firesetting Intervention Programme for Mentally Disordered Offenders (FIP-MO). This is a specialist intervention developed for individuals with a history of deliberate firesetting who have a mental disorder or personality disorder.

The Impact through the Knowledge Exchange award seeks to recognise collaboration between academics and an external organisation on a project which has clearly demonstrated impact in the wider community, for example, multiple services adopting the outcome of the research.

Nursing Conference 2016

The KMPT Annual Nursing Conference was held on Thursday 12 May 2016 which was in conjunction with International Nurses Day; a day dedicated to celebrating all the fabulous work that nurses do around the world.

The theme for this year's conference was 'A force for change, improving health systems' resilience'. Over 115 people attended the conference, which consisted of local and national speakers sharing ideas, discussing issues, best practice and workshops.

Community Rehabilitation Pilot Project

A project designed to provide a recovery focused service for patients with complex mental health needs in order to reduce readmissions and avoid the breakdown of living situations reported in June 2016.

The project found that by focusing a range of interventions/activities based on patient need, through the application of Community Rehabilitation re-admissions to inpatient wards were reduced and patients experienced positive outcomes. The project also increased partnership working both across the trust and with a range of external providers such as housing providers and the voluntary sector.

Peer Support Week

The trust held a Peer Support Week in order to celebrate the important contribution that the trust's Peer Support Workers make to enhancing patient care.

Open Dialogue

A team from the trust, together with three other organisations within the UK, has received a financial award from the Health Foundation to put into practice and evaluate the Peer-supported Open Dialogue (POD) approach within KMPT. This involves consistent family and social network meetings, where members of the patient's family or peer group meet with a team of mental health professionals in their own home to talk and listen. Open Dialogue is already embedded in practice in Finland, Northern Europe and parts of America. The trusts involvement in this project will make it one of the first to implement POD in the UK.

Kent Mental Health Festival

The trust took part in the Kent's first Mental Health festival which was held at Folkestone Leas Cliff Hall. The aim of the event was to celebrate World Mental Health Day and to raise awareness about mental health. The KMPT Vocational Rehabilitation team were in attendance promoting the work of the job taster programme that offers service users work experience.

National Positive Practice In Mental Health Awards 2016

The Peer Supported Open Dialogue initiative was highly commended in the Care Pathway Category and the KMPT Mother and Infant Mental Health Service was highly commended in the Community Perinatal Mental Health Services category.

Kent's Dementia Friendly Awards 2016

The Kent Dementia Friendly Awards are organised by the Kent Dementia Action Alliance and are a chance to celebrate all of the work that communities across Kent support those living with dementia. The East Kent Forget Me Nots Group (Dementia service user involvement group) won the 2016 Partnership Project Award and Chris Norris, KMPT Dementia Service Envoy was awarded the Dementia Volunteer Award.

Chief Executive's Statement

Welcome to our Eighth Quality Account.

This year has seen a series of significant achievements for KMPT, as evidenced by the Care Quality Commission (CQC) rating the services we provide as 'Good' overall.

Most notable is the CQC rating of 'Outstanding' in the caring domain celebrating that we are compassionate, kind and respectful to those we serve. For more information on the CQC inspection see page 64. Our CQC inspection matrix can be seen on page 65 and details of our CQC improvement plan can be seen in Appendix B. It is this plan that will make sure that by the autumn of 2018 we are 'Outstanding'.

Helen Greatorex
Chief Executive Officer

We have continued to work on nine quality priorities that were set last year, progress on these priorities is set out on page 13. We have also set nine priorities for this year; they can be viewed on page 78.

Whilst we have come a long way, there is still a lot to do and we know that we are far from perfect. We are though, determined to get better and better, week by week so that our patients can rely on always having the best possible care.

Our Quality Account shows that a significant amount of good progress has been achieved. This is the result of the hard work and commitment provided from our staff and partners.

Trust objectives 2016-17

1. To enhance the quality and safety of services by maintaining or exceeding required standards of care

2. To enhance service user engagement and patient experience (5 year objective)

3. To maintain and further establish our position as the provider of choice for mental health services in Kent and Medway (5 year objective)

4. To ensure sound financial management without compromising quality of service (5 year objective)

5. To become an exemplary employer, enabling staff to reach their full potential (5 year objective)

6. To develop dynamic and innovative clinical models, enhancing the quality, safety and effectiveness of services (5 year objective)

7. To incorporate sustainability and environmental management as an essential element of healthcare delivery (5 year target)

Our Clinical Strategy

Our clinical strategy was first published in 2012, with the purpose of building a culture of excellence within every part of our organisation, ensuring staff are supported, developed and valued and that clinical leadership drives improvements. During 2015-2016 in order to take account of emerging challenges that have occurred since 2012 the four key objectives of our clinical strategy were refreshed as follows:

1. KMPT will develop and deliver a range of service models to support timely care in the least restrictive setting, ensuring urgent and acute needs can be met.
2. KMPT will ensure service users have clear, integrated pathways to recovery, including supported transfer to and from primary care.
3. KMPT will work with CCGs and partners to develop services, enabling more service users with complex needs to be cared for within Kent.
4. KMPT will ensure high quality clinical environments and the use of technology to support quality and clinical effectiveness.

Our services

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

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

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

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

People with drug and alcohol problems:
- Detoxification inpatient unit

Forensic mental health services:
- Medium-secure unit including specialist women's unit
- Low-secure unit
- Custody liaison service
- Street triage service

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

The trust has reviewed all the data available to it on the quality of care in all 24 of these NHS services.

The income generated by the NHS services reviewed in 2016-17 represents 100 per cent of the total income generated from the provision of NHS services by the trust for 2016-17.

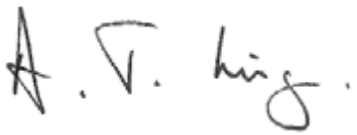
The information contained within this document is accurate. The Director's statement on page 11 further makes it clear that we have met the requirements for preparing this account. Furthermore, our auditors have reviewed the account and their report can be found in Appendix H.

Directors' statement

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

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

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



Andrew Ling
Chairman

Review of Quality Performance: Achieving our 2016-17 priorities

The nine priorities were:

Patient safety

- To increase the number of carers (if applicable) attending CPA Reviews
- To work with service users to increase the number of advance care plans/statements/directives recorded on the trust patient information system.
- To reduce harm from medication incidents.

Patient Experience

- Learning from the Friends and Family Test feedback
- Patient experience of the organisation of care
- Completion of the Triangle of Care self-assessment documentation.

Clinical Effectiveness

- Review of HoNOS outcomes
- To improve the quality of care plans
- To improve the provision and quality of clinical supervision.

2016-17 Patient Safety Priority 1
To increase the number of carers (if applicable) attending CPA Reviews

Approach

The purpose of this priority was to improve carer involvement within the care planning process, which is an issue that has been highlighted from serious incident investigations.

Action

A new RiO Care Plan was placed on RiO, which has a question about the carer's view, which encourages carer involvement.

Care plan training for care coordinators, which is now provided over a day, has been made mandatory for care coordinators working within the Community Recovery Service Line (CRSL). The training includes a section on carer involvement within the care planning process and advance care planning.

In the 6 monthly CPA Review audit carried out in the CRSL and the Older People Service, a question is asked "Did the carer attend the CPA Review?" The compliance for CRSL 2016 results stated carers attended 27% CPA reviews. The 2016 audit is currently being undertaken for adults, however the compliance for older peoples services (2015) was 29%.

Whether a carer attends a CPA Review is not easy to measure, as we have to determine if the service user has a carer and if they want them to come to a review.

To measure the number of carers attending CPA reviews, the following factors would need to be taken into account:-

a. If the service user has a carer
b. If the service user would like their carer to come to the review.

There is no place to accurately record this on RiO, as the carer is defined as next of kin (NOK), who may not be their carer.

The CPA Review re-evaluation project, carried out every 6 months, now includes the following questions in order to measure carer attendance at CPA reviews:-

a. From the RiO records, is it recorded that the service user has a carer/ NOK? Yes or No (target to be achieved = 100%)
b. If they do have a carer, was the carer invited to the Review? Yes or No (target to be achieved = 100% for service users with an identified carer)
c. Did the carer attend the CPA Review? (no target as attendance by the carer is voluntary)

Action taken to reach practice targets includes the introduction of an escalation procedure to be followed in order to report and take action on poor CPA review practice and the communication of project outcomes to service line governance groups.

Results

Results for CRSL

Data item	1 DC Cycle	2 DC Cycle	3 DC Cycle
Did the service user have a carer recorded within RiO?	N/A	N/A	54%
If the service user has a carer, they must be invited to CPA Reviews.	29%	51%	57%
If the service user has a carer did they attend the CPA Review?	N/A	27%	57%

Results for Older People Service

Data item	1 DC Cycle	2 DC Cycle	3 DC Cycle
Did the service user have a carer recorded within RiO?	N/A	N/A	51%
If the service user has a carer, they must be invited to CPA Reviews.	29%	51%	80%
If the service user has a carer did they attend the CPA Review?	N/A	N/A	100%

2016-17 Patient Safety Priority 2

To work with service users to increase the number of Advance Care Plans/statements/directives recorded on the trust patient information system

Approach

An advance care plan, sometimes also referred to as an advance statement or advance directive helps people to plan their care should they become unwell in the future and due to their illness they are unable to fully contribute to the planning of their care.

The advance care plan sets out the treatment that a person does not wish to receive, together with a statement of wishes and preferences that the person would like carried out.

Examples of such wishes might be a statement of what they would like to happen to their pet animal (such as kennelling arrangements) or who they would like to hold their house keys for them.

An advance care plan cannot be used to request certain treatments or to have particular medical staff involved in your care.

The use of advance care plans is necessary for the promotion and provision of person centred care. A number of Serious Incident (SI) investigations have highlighted that the need to increase the use and recording of advance care plans across the trust.

Action

- Advance Care Plan guidance has been revised to include specific instructions when Advance Care Plans are discussed with service users, for example during 7 day follow-up and in recovery groups
- The question ‘Is there an advanced care plan?’ has been included on the new CRSL Care Plan Audit Questionnaire, which started in July 2016.

Results

The number of CPA clients (7,856) in all clusters that have an advance care plan in place during 2016-2017 were 231; this is an increase of 13.5% when compared to 2015-2016 (200).

2016-17 Patient Safety Priority 3

To reduce harm from medication incidents

Approach

Nationally, medicines safety has been identified as a risk. The medication safety alerts issued by the NPSA in the last few years, and the DH Never Events cover several drugs and processes associated with a higher risk of harm. Most of these are not relevant in a mental health organisation, but the principles are the same.

Medication incidents are reviewed by the Medicines Safety Group (MSG), which meets every other month. This multi-disciplinary group is responsible for identifying trends, and ensuring that learning is shared across the organisation.

In order to have the most impact on reducing harm from medicines, the priorities are:

- Reducing omissions of critical medicines (indicated by blank boxes on prescription cards), in line with the targets set by the Patient Safety Collaborative
- Improve medicines reconciliation in line with targets set by the Patient Safety Collaborative, thereby reducing preventable adverse drug reactions due to incorrect drugs or doses being prescribed or administered
- Improve medication incident reporting to enable meaningful learning that can be shared across service lines.

Action

Reducing omissions of critical medicines – a monthly audit was undertaken on all the wards and the results reported to the drug and therapeutics group, the Trust wide Patient Safety Group, and the Quality Committee on a monthly basis. The wards introduced daily checks of the drug charts to identify and rectify any blank administration boxes.

Improve medicines reconciliation – the pharmacy department set themselves a target that 95% of all new admissions to adult and older people acute wards would receive a full medicines reconciliation within 24 hours or the next working day. Monthly results were published across the pharmacy department and lessons learnt from any patient's that were outside of the target.

Improve medication incident reporting – monthly analysis of incidents reported by the medicines safety group via the drug and therapeutics group, were published in a monthly report to the drug & therapeutics group, the Trust wide Patient Safety Group, and the Quality Committee.

Results

Reducing omissions of critical medicines – The percentage of reported blank boxes on prescription cards through the audit per month from November 2015 to March 2016 was 9%, and the average per month was 9 per cent. During the last year (April 16 – March 17) the percentage has reduced down to an average of 4% of charts containing blank boxes.

Improve medicines reconciliation – The percentage of patient's that received medicines reconciliation within the target set started at 79% at the beginning of monitoring. By March 2017 the pharmacy department have consistently achieved 95% of patients receiving medicines reconciliation for the last year.

Improve medication incident reporting – The number of incidents reported during the previous year (2015-2016) averaged 28 per month, for the financial year 2016-17 medication incident reporting has increased to an average of 33 incidents per month.

2016-17 Patient Experience Priority 1

Learning from the Friends and Family Test Feedback

Approach

The results of the Friends and Family Test can provide evidence of learning about services, which can be used to promote service improvements.
The Friends and Family Test is used to gather service user views of the service provided by KMPT. Monthly reports are provided to the service lines and individual wards and teams with the score for that month and a list of the written feedback.

Action

- Each service line is expected to provide evidence of 3 items of learning that have been implemented as a direct result of patient feedback received via the Friends and Family (F&F) Test
- The service lines are expected to discuss the F&F Test as a standing agenda item at the Service Line Patient Experience Groups
- The Service Line Patient Experience Groups report to the Trust wide Patient Experience Group (TWPEG) evidence of service changes implemented as a direct result of feedback from service users via the Friends and Family Test

Results

The following learning and action has taken place:

Acute Service -

- There has been a request for puzzles and board games on the wards; the ward will approach the 'Friends for Mental Health' to find out if this can be funded
- Issues around tea/coffee availability on the wards has been raised and the service line is investigating the request to have a vending machine installed
- The matter of 1-1 time on the wards is under discussion as a result of feedback and the service line is looking at providing some standards
- There was some very positive feedback about the use of STR workers in the Crisis Team in north Kent which was passed on to the staff involved
- Issues raised about the lack of consistency with the members of staff providing support from the crisis team are currently under review.

CRSL

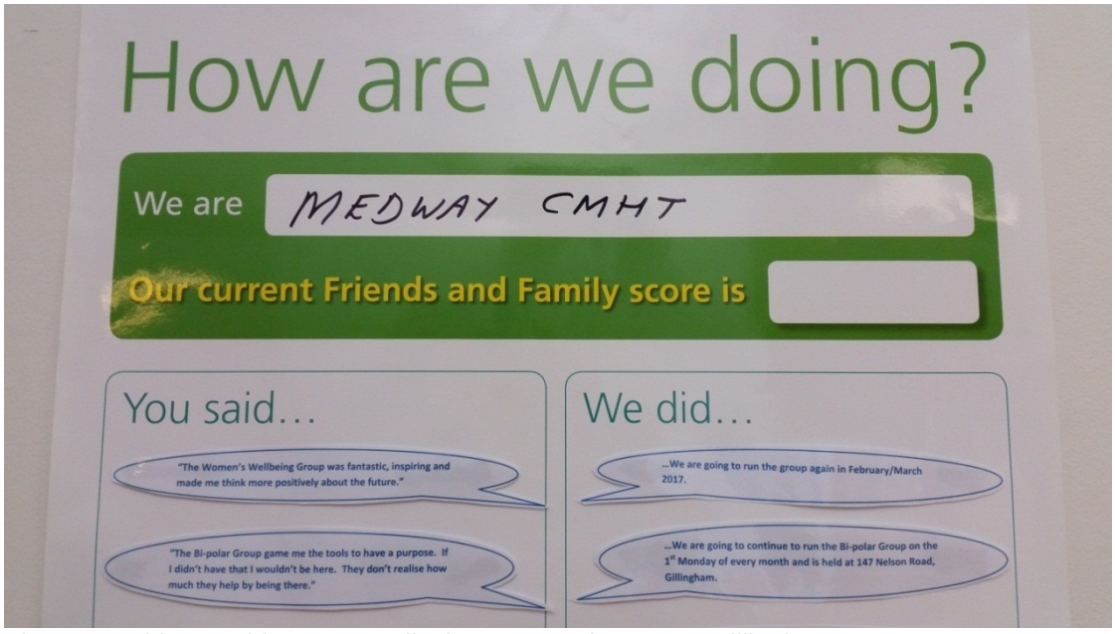
- Teams are being encouraged to forge stronger links with local third sector support. This has been helped recently as Live Well Kent has produced leaflets detailing the specific support available in each area. These will be available in all our reception areas and staff will be able to signpost people with more ease
- Improving care plan training to help staff reflect on the importance of working with individuals to find an occupation and activity that will support their wellbeing
- A specialist occupational therapy group will be run in each locality with a focus on occupation to enable recovery.

Forensic and Specialist Services Service Line

- Requests for gym equipment at Bridge House
- More practical groups
- To include an occupational therapist at Ash Eton, Personality Disorder service
- Importance of privacy and dignity at prosthetic services; Staff reminded and training for staff available
- Service line notified about additional resource requests

Older Adult Service Line

- The keypad on the inside of the door in Gregory House has been replaced with a button allowing people to leave without a member of staff opening the door for them after feedback was received. People felt as though they needed 'permission' to leave the building, this is also being done in Thanet
- The introduction of dedicated telephone 'slots' for doctors to call clients in Canterbury
- In Thanet it was reported that the reception area was too warm and there was no access to water, plans are in hand to purchase blinds and there is now a water cooler in place
- In Swale there was feedback that there was nothing available after a diagnosis of dementia: currently improving the provision of post diagnostic counselling, arranging training for all staff
- A YOD support group has started in Swale taking place in the evening after feedback pointed out that that the provision was not suitable for younger people with dementia
- In Medway following a comment that better information was required a leaflet covering '5 things that you should know' following a diagnosis of dementia has been developed.



The You Said, We Did Poster on display at Canada House, Gillingham

2016-17 Patient Experience Priority 2
Patient Experience of the organisation of care

Approach

The purpose of this was to improve the feedback of patients relating to their experience of how their care coordinators' organise their care. In the 2015 National Patient Survey (NPS) KMPT made significant improvements in most areas however question Ten '*How well does this person (care coordinator) organise the care and services you need?'* KMPT achieved a score of 7.7 and the highest score achieved was 8.9 (out of a total of 10*).* A target was set to achieve *a* 5 per cent improvement (score of 8.2) in the 2016 NPS score for question10.

Action

This issue has been included in the 2016-17 service line patient experience action plans and is monitored by the Trust wide Patient and Carer Experience Group (TWPCEG) throughout the year.

Results

The score that the trust achieved in the 2016 NPS for question Ten was 7.6, which was a 1.3 per cent decrease when compared to the score for the same question when asked in 2015.

2016-17 Patient Experience Priority 3
Completion of the Triangle of Care self-assessment documentation

Approach

The aim of this priority is to ensure that KMPT is working to the principles of carer involvement in order to improve the experience of carers whose loved ones are in receipt of services from KMPT. The Triangle of Care (ToC) is an accreditation scheme managed by the Carers Trust. KMPT has been involved with the ToC initiative for several years and has now fully committed to completing the accreditation self-assessment documentation.

Action

All the wards of the Acute Service, Forensic and Specialist Services and Older People Service have completed the self-assessment process.

The CRSL have undertaken a mapping process of carer involvement across all the Community Mental Health Teams (CMHT) and taking action where required. This is in preparation of undertaking the self-assessment process for all CMHTs during 2017–2018.

Results

The process of the trust being a member of ToC and carrying out the self-assessments has resulted in the following service developments:

- Carer Champions. There is at least one per ward. These individuals are key in promoting carer awareness to a wider staff group, develop awareness of resources/support available for carers, point of contact for carers and often facilitate local carer groups for those who have loved ones who are current inpatients. Extensive work is underway to develop carer champions within the community as they start to prepare for phase 2 of the ToC.
- Training and awareness for staff: whilst we are still pursuing mandatory training for all staff, there is an increase in local training utilising carers. Family awareness training also provided and has been rolled out to teams.
- Change of name of Trust wide Patient and Experience Group to Trust Wide Patient and Carer Experience Group. Across localities there are Patient Consultative Committees and Carer Consultative Committees.
- Ongoing carer conferences – where staff are actively talking about ToC and carer involvement/engagement, prior to ToC membership carers were often asking what was happening re ToC/seeking greater involvement.
- Development of carer handbooks to be given at point of admission.
- Improved focus on Friends and Family Test (FFT).
- Development of carer champion networks to improve sharing of good practice; this has included the development of a shared drive.
- Review and revision of the Carers Charter – this has been developed and reviewed with carers.
- Feedback session to Care Quality Commission providing carer perspective on KMPT.

- Communication to all teams regarding confidentiality, emphasising that confidentiality is not a barrier to listening.

2016-17 Clinical Effectiveness Priority 1
Review of HoNOS outcomes

Approach

HoNOS (Health of the Nation Outcome Score) is the trust's main Clinician Rated Outcome Measure (CROM) which is used to measure the clinical and social outcomes of patients at a particular point in time. HoNOS when used at the start, at points during and at the end of episodes of care can indicate if improvement or stability has occurred in a patient's clinical and social condition. HoNOS Scores are also used in the process of patient clustering, which ensures that patients are in the appropriate care pathway to meet their clinical and social care needs. During 2016-17 a local CQUIN project was agreed to formulate the data collected from HoNOS scores into four well-being indicators (Personal, Emotional, Social and Severe Disturbance). This Four Factor Model (Speak, 2013) summarises the original HoHOS scores into a meaningful format, without losing any of the original collected HoNOS data. The information produced from the Four Factor Model, for each patient cluster, would then be discussed by each of the service lines through their governance groups and then to report back to the Clinical Effectiveness and Outcomes Group regarding their evaluation of the outcomes for patient clusters and services, together with how the Four Factor HoNOS information has informed service development.

Action

A trust wide Action Learning Set (ALS) group, with representation from the service lines, Performance Team and Information Team, has been established in order to manage the requirements of the CROM CQUIN. Training on how to interpret the Four Factor HoNOS data was provided by the Performance Team to each of the four service lines. The Acute Service, CRSL and Older People Service established outcomes groups in order to discuss the Four Factor HoNOS data that related to their respective patient clusters. For the Forensic and Specialist Services the data is not applicable or available given the diverse nature of services (LD services, specialist services), who may not all use clustering. A member of the service line is a member of the ALS Group and reports to the service line governance group. The CQUIN has remained a standing agenda item on the Clinical Effectiveness and Outcomes Group monthly meetings throughout 2016-17.

Results

A number of issues have been identified that need to be addressed before a meaningful use of the HoHOS data, reformatted into the Four Factor Data, can be used for service development. A requirement to define the outcome expectations for each patient cluster was identified, so that variations in HoNOS Four Factor scores could be clearly identified. Feedback from professionals and teams has highlighted that there are inconsistences in knowledge and application of clustering and that this contributes to data quality issues in the HoNOS Four Factor outcome data. The current clustering e-learning package was felt to be insufficient and that the training should be provided face to face by a practicing clinician. The development of a cluster algorithm is being considered, which will support clinical decision making around clustering.

2016-17 Clinical Effectiveness Priority 2

To improve the quality of care plans Year 1

Approach

In April 2016 a new electronic care plan proforma was introduced. This has had a positive impact on the quality of care planning across the trust. All service lines have embraced the recovery approach and person centred thinking in the formulation and use of care plans by developing service specific frameworks to apply the common principles of person centred care planning.

The introduction of the new Care Plan format required each service line to review and update their approaches taken in obtaining assurance of the quality of person centred care planning. This also provided service lines the opportunity to develop their own variations of Person Centred Care Planning Audit to meet the specific need of their service users and carers

Action

Acute Service
In May 2016 a new Acute Service Care Planning Group was set up to drive the person centred care planning agenda forward in the service line. Audit submissions from all areas were made a priority as this can be sporadic at times. The group have also been instrumental in developing new framework and guidance to assist staff in the formulation of care plans. This went live on 1 December 2016. From this work a new Acute Service Care Plan Audit was designed and approved, the new audit is expected to be implemented by April 2017.

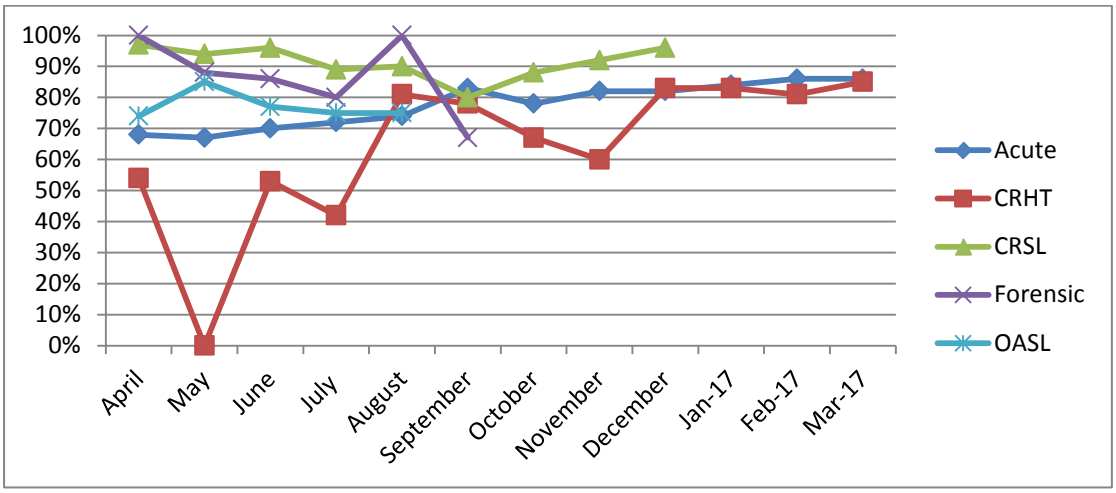
Community Recovery Service Line
The CRSL implemented a new care plan audit in July 2016 for Community Services. Rehabilitation Services continued to audit their care plan practice using the monthly Person Centred Care Planning Audit used by the Acute, Older People and non-NHS England commissioned Forensic and Specialist Services. In January 2017 it was agreed by the service line that Rehabilitation Services should be included in the new Care Plan Audit.

Older People Service Line
Prior to September 2016 inpatient care plans were audited monthly via the Person Centred Care Plan Audit and community care plans via the Community Older Person Centred Care Planning Audit. From September 2016 both inpatients and community services were audited via a single Older Person Centred Care Plan Audit.

Forensic and Specialist Services
Care Planning is audited via My Shared Care Audit, it should be noted that the service line does not use the new care plan but a service line specific My Shared Care Plan.

Results

Person Centred Care Planning Audit (Inpatient) total of Yes% responses each month since April 2016 for each service line



Please note that the PCCP Audit (inpatients) is the only care plan audit which uses the same questions across all of the service lines, all the other service line specific care plan audits have variations in their questions, which have been developed to make each audit more responsive to the care plan needs of service users within each service line

The CRSL rehabilitation units moved from the PCCP Audit (inpatients) to the CRSL New Care Plan audit in January 2017.

The Older People Service inpatient services transferred to the new combined Community and Inpatient Older People Service PCCP Audit in September 2016.

The reason why the Forensic PCCP Audit results stop in September is that all Forensic Services came under the My Shared Care Plan Audit which is facilitated by the Forensic and Specialist Services.

The following are examples of learning points discussed and disseminated from PCCP Audit reports during the above period.

1. Ensure the care plan has clearly identified goals (what do I/we want to achieve) and next steps for each need.
2. Ensure the extent of service user involvement is clearly stated in the care plan.
3. Ensure physical health needs of the service user are clearly addressed within the care plan.

2016-17 Clinical Effectiveness Priority 3
To improve the provision and quality of clinical supervision

Approach

The provision and quality of clinical supervision across KMPT was identified as an issue in the CQC inspection report published in July 2015, thus resulting in the following actions being taken.

Action

The CRSL had undertaken a staff survey on clinical supervision during February/March 2016. An action plan has been produced in order to improve the provision and quality of clinical supervision within the service line. The Acute Service has completed a staff survey on clinical supervision and the data from the survey is currently being analysed. The Forensic and Specialist Service has also carried out a survey and is in the process of drafting and implementing an action plan. The Older People Service is in the process of carrying out their staff clinical supervision survey.

Results

The following actions have been implemented as a result of the CRSL staff survey on Clinical Supervision:

- An additional statement has been added to the Supervision Policy that outlines the process for the handover of supervision records and responsibility to the new service manager
- From December 2016 Team Leaders have been given instructions to complete managerial supervision returns on a monthly basis for submission to their service manager. Any concerns to be addressed through the team leaders' managerial supervision. Service managers provide a monthly report to the business manager
- All staff informed that they must have a supervision agreement in place.

The following actions are in the process of being implemented.

- Service managers to spot check the quality of supervision at least once every six months
- Figures from the service managers returns to be submitted to the WFOD Committee (February 2017)
- Meet with workforce development to agree when the training programme will be completed. Set timeline for training.
- All Service Managers and Team Leaders to complete the supervision module training.

From the Forensic and Specialist Services survey, 50 staff responded, and the results were generally very positive. All but three staff had regular supervision, the majority had time to review their performance against their PDP, discuss Continuing Professional Development, and reflect on work with patients.

The disciplines where supervision was less consistent were healthcare and nursing staff. The survey elicited largely positive comments ("my supervision is excellent and I wouldn't change anything"), and constructive criticism ("providing protected time (for supervision) / better preparation / more focus on clinical practice and work with

patients."; “sometimes it is rushed due to staffing levels etc.; you don't always have a lot of time to fully complete a supervision and talk at length”).

An action plan is being drafted to ensure protected time is provided for healthcare and nursing staff to receive regular supervision, with space to discuss their direct work with patients. Reflective practice groups for staff are also being implemented within Forensic Services.

Memorybilias Q&A session leaves lasting impression

Honest and inspirational are two of the words that captured this week's Memorybilia group's 'Question Time'.

The event was organised for those who have questions about how people can live well with dementia, face their diagnosis and cope with the condition by speaking with both professionals and those with lived experience as part of a question and answer session.

The panel consisted of Allan Newby, Tom Coppins, Lorraine Brown, Jackie Swapp, Alzheimer's Society and Margaret O'Shaughnessy, Clinical Psychologist, KMPT who invited questions from members of the public, healthcare professionals and charities.

Left to right: Allan Newby, Tom Coppins, Lorraine Brown, Jackie Swapp, Alzheimer's Society and Margaret O'Shaughnessy, Clinical Psychologist, KMPT

Allan spoke about how he had to overcome the initial shock of being diagnosed with dementia, describing it like being "knocked off your feet" and "the fear of the unknown". He said that it is only once you accept the diagnosis that you are able to create a world in which you can live and live the best you can.

Lorraine spoke about her experience of being diagnosed with Alzheimer's and how keeping a diary and photographs on her mobile phone are her only way of recalling events.

Allan, Tom and Lorraine shared the difficulties they have experienced in accessing information that is available all in one place and how memory clinics, carers support programmes are vital in offering them and their carers ongoing support.

Speaking about the event, Margaret O'Shaughnessy said: "This event was organised for Dementia Awareness Week and the aims were to raise awareness about dementia and to reduce the stigma that gets in the way of people talking about their own experiences of dementia."

The Memorybilia group are all people living with dementia, who come together once a month to discuss both local and national issues involving those living with dementia.

For more information on the Memorybilia group visit: **https://www.kmpt.nhs.uk/get-involved/memorybilia.htm**

The trust signed up to the NHS England Sign up to safety campaign in 2014 which has the vision of making the NHS the safest healthcare system in the world by aiming to deliver harm free care for every patient every time.

KMPT Sign Up to Safety Pledges

In order to work towards the above aim all health care organisations have been invited to make pledges on the action they will be taking within each of the following domains:

- Put safety first
- Continually learn
- Honesty
- Collaborate
- Support

The KMPT pledges can be seen in Appendix E:

Safety Improvement Plan

The KMPT Safety Improvement Plan identifies the patient safety improvement areas, building on and enhancing the KMPT Patient Safety priorities. The trust will be focusing on the following topics during the next 3 to 5 years:

- Clinical Risk Reduction (Suicides and Management of Violence)
- Safer Discharge
- Medication
- Patient Safety Culture and Risk Assessment Transformation
- Physical Health Care

Please see Appendix F, for further details

Statements Relating to Quality of Services

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

Mandatory Quality Indicators

KMPT has achieved the target levels of these indicators consistently throughout 2016-17 and have performance levels above national average in most cases. Robust procedures are embedded within the trust to ensure continued compliance against these indicators; additionally there is constant review of any instances of non-compliance to ensure lessons are learnt to further improve our performance in the future.

7 day follow up

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

KMPT has taken the following actions to improve this percentage and so the quality of its services, by: the CRSL ensuring that all patients are contacted by their care coordinator, or a nominated person in their absence, within 7 days of discharge from acute services.

Indicator	Performance	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
7 day follow up	KMPT	96.5%	94.8%	95.0%	95.0%
	National average	96.2%	96.8%	96.7%	96.7%
	Highest nationally	100%	100%	100%	99.4%
	Lowest nationally	28.6%	76.9%	73.3%	84.6%

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

CRHT Gatekeeping

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

KMPT has taken the following actions to improve this percentage and so the quality of its services, by ensuring every referral for admission is reviewed by the CRHT team prior to the decision to admit to determine if intensive home treatment can be provided as an alternative to admission wherever possible.

Indicator	Performance	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
CRHT Gatekeeping	KMPT	100%	100%	100%	100%
	National average	98.1%	98.4%	98.7%	98.8%
	Highest nationally	100%	100%	100%	100%
	Lowest nationally	78.9%	93.2%	92.3%	92.7%

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

28 day readmission Rates

KMPT considers that this data is as described for the following reasons: this is a locally produced percentage based on the agreed methodology of readmissions within 28 days as a percentage of all admissions. No national benchmarking has been possible as there is no recent data published. It should be noted that the increase in this rate may be caused by KMPT inpatients that had been transferred to an acute hospital and then transferred back to a KMPT inpatient facility being included in the data. Similarly, those patients who are transferred from a KMPT ward to an external bed placement and back to a KMPT ward will show as a readmission.

KMPT has taken the following actions to improve this percentage and so the quality of its services, by improving discharge planning and community treatment following discharge to minimise the chance of a readmission being required.

	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
28 day readmission rate YA acute	15.0%	16.4%	16.4%	19.6%
28 day readmission rate OP acute	9.4%	14.0%	14.1%	5.1%

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

KMPT considers that this data is as described because it is taken from responses to the National NHS Staff Survey 2016. It is taken from responses to the question:

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

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

We have calculated the average for mental health and learning disability trusts by adding together the 'agree' and 'strongly agree' responses for each trust, adding all these trust scores together and then dividing them by the 28 mental health and learning disability trusts who took part in the survey.

In response to this question, the trust is working on the following areas:

- An engagement plan has been written, with regular events run for staff across the trust with members of EMT
- HR2U days, where members of the team go out and spend time in the trust, listening and responding to issues that matter to staff
- Embedding the fundamentals of engagement through management and leadership development – supervision, appraisals, objectives and regular feedback
- A different approach to the staff survey outcomes, with a focus on key themes and identifying 3 top priorities at local level
- Greater emphasis on health and well-being across the trust.

Indicator	Performance	2015	2016
If a friend or relative needed treatment, I would be happy with the standard of care provided by this trust	KMPT	53%	53%
	National average	58%	59%
	Highest nationally	82%	82%
	Lowest nationally	38%	44%

http://www.nhsstaffsurveys.com

Additional information requested to be included in all NHS trusts' Quality Accounts 2016–2017 (NHS England letter, Gateway Reference 06251)

NHS Staff Survey KF 26 Staff experiencing harassment, bullying or abuse from staff in the last 12 months.

KMPT considers that this data is as described because it is taken from responses to the National NHS Staff Survey 2016. It is taken from responses to the question:

'In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from:… managers….other colleagues'.

The figure has been arrived at by adding the responses to 1-2 times, 3-5 times, 6-10 times and >10 times for each part of the question (managers section and other colleagues section), adding them together and then dividing them by two. The same method was used to calculate the national average (and dividing by the 28 other mental health and learning disability trusts) and the highest and lowest scores.

During 2016/17 KMPT has taken the following actions:

- Reporting of 'Green Button' and employee relations cases to Workforce and OD Committee on bi-monthly basis
- Introduction and communication of Freedom to Speak Up Guardian
- Introduction of 'HR2U sessions', where senior members of the Workforce and OD Committee visit sites, working alongside the KMPT 'Listen Up' campaign
- Equality and Diversity Steering group also assessing in more detail the outputs of the WRES reporting, with action plans, including further roll-out of 'Respect' campaign
- Triangulated the data with employee relations data on formal bullying and harassment complaints. The number of formal complaints did not equate to the staff survey percentage, but the decreasing trend does replicate the formal complaints recorded.

Indicator	Performance	2015	2016
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from:… managers….other colleagues	KMPT	17.5%	15%
	National average	15%	14%
	Highest nationally	21%	21%
	Lowest nationally	10%	11%

http://www.nhsstaffsurveys.com

Additional information requested to be included in all NHS trusts' Quality Accounts 2016–2017 (NHS England letter, Gateway Reference 06251)

NHS Staff Survey KF 21 Staff believing that their trust provides equal opportunities for career progression or promotion

KMPT considers that this data is as described because it is taken from responses to the National NHS Staff Survey 2016. It is taken from responses to the question:

'Does your organization act fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age'

The figure reported relates to the 'yes' responses to the above question. The average was calculated by adding all the 'yes' responses and dividing by the 28 other mental health and learning disability trusts

The trust has taken the following actions:

- Equality and diversity data is captured routinely as part of attendance on training and development events
- All vacancies are advertised on NHS jobs following consideration as redeployment opportunities
- All staff have an annual appraisal at which development needs and career ambitions are discussed and agreed
- Internal and external secondments are supported to facilitate future career progression and promotion

Indicator	Performance	2015	2016
Does your organization act fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	KMPT	59%	59%
	National average	59%	59%
	Highest nationally	75%	71%
	Lowest nationally	49%	52%

http://www.nhsstaffsurveys.com

Patient experience of community mental health services

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

In order to monitor the action plans resulting from the improvement areas highlighted in the results of the National Patient Survey (NPS) KMPT uses a variety of different methods. These include Community Services Evaluations (conducted by members of trust Experts by Experience group): the Friends and Family Test (FFT) to gather the views of service users; engaging with mental health action groups (MHAGs) to receive feedback of patients experience; issues relating to patient satisfaction are also raised and discussed at the Patient Consultative Committees that meet across Kent and Medway.

Indicator 2014	Performance	2015	2016
Patient experience of contact with health and social care workers	KMPT	7.4	7.6
	National average	7.4	7.6
	Highest nationally	8.2	8.1
	Lowest nationally	6.8	6.8

http://content.digital.nhs.uk/article/6966/Domain-4---Ensuring-people-have-a-positive-experience-of-care

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

KMPT considers that this data is as described for the following reasons; the data for National figures is taken, where available, from the National Reporting and Learning System (NRLS). We have calculated the national average by using the total figures for mental health trusts and also determined the highest and lowest trusts from the same set of data. Up to date KMPT Total figures for 2016-17 are taken locally from the incident reporting system (Datix) as this provides a more accurate position of the trust against the National figures. The local figures have been reported to the Quality Committee, the Patient Safety Committee and trust Board (public part) bi-monthly throughout the year.

KMPT has employed a Serious Incident and Complaints Facilitators to support investigations that cut across complaints and serious incidents. This model supports operational services with a degree of independence in the investigation process. All service lines have meetings that review patient safety and serious incidents and ensure learning is shared with practitioners. The trust is regularly reviewing how best to share learning across the trust. This work is supported by the trust's on-going involvement in the south of England Improving Safety in Mental Health Collaborative and the Kent, Surry and Sussex Patient Safety Collaborative.

Trust wide reporting of serious incidents continues to improve to ensure accuracy and compliance with national. KMPT full year data for severe harm, death and all reported patient safety incidents for 2016/17 were 68 out of a total of 3827 incidents. This equates to 1.8% sever/death harms which compares to 84/3151 (2.7%) in 2015-16.

It is important to note that with the new NRLS CCS2 codes 33 reported deaths have been recorded under "Requires investigation to be completed to establish if an incident occurred", whilst having been reported as patient safety incidents further information could confirm natural causes.

Indicator	Performance	2016-17 Total KMPT*	2016-17 Q1/Q2	2015-16 Q1/Q2	2015-16 Q3/Q4
		Internal data	Data from NRLS		
	KMPT	68 (1.8%)	1.8% (37)	3.8%(47)	1.7% (30)
Severe harm/death	National average %	--	1.1%	1% (1484)	1.1% (1668)
	Highest nationally %	--	6%(86)	3.8%(47)	3.9% (60)
	Lowest nationally %	--	0.3%(3)	0.1% (1)	0.6% (3)

*Local data – KMPT incident reporting system, patient safety incidents
National data –
https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-28-september-2016/

Trust wins innovation award to improve quality of health care

(Sitting-Left to right) Yasmin Ishaq - Manager of the Mental Health Primary Care Social Work Service. Kirsty Lee - relative of patient experiencing Open Dialogue, Rosarri Harte - Deputy Medical Director, Teresa Barker - Liaison Psychiatry Service Manager
(Standing Left to right) Dr James Osbourne - Consultant Psychologist, Brett Lee - patient experiencing Open Dialogue, Paul Roberts - Community Psychiatric Nurse, Dr Catherine Kinane - Medical Director

A team from KMPT, has been selected by the Health Foundation, an independent health care charity, to be part of its £1.5 million innovation programme, Innovating for Improvement.

The fourth round of the Innovating for Improvement programme is supporting twenty health care projects in the UK with the aim of improving health care delivery by testing and developing innovative ideas and approaches and putting them into practice.

Open Dialogue, pioneered by Professor Jaakko Seikkula, is already embedded in parts of Finland, Northern Europe and parts of America, and KMPT is leading the way, with three other organisations in the UK to be adapting the model for widespread use in the NHS. The basis of peer-supported Open Dialogue (POD) involves consistent family and social network meetings where members of the patient's family or peer group meet with a team of mental health professionals in their own home to talk and listen.

Over the course of the programme the team will develop its innovative idea and approach, put it into practice and gather evidence about how the innovation improves the quality of health care.

The team will be led by Professor Catherine Kinane, Executive Medical Director and Dr James Osborne, Consultant Psychologist. Dr. Kinane said: "It is absolutely fantastic news to have been selected to develop the approach. With our second cohort of students now going through training, the benefits of POD are really cascading throughout the trust and being part of the Health Foundation's Innovating for Improvement programme will enable us to continue to embed the approach at pace. We have a super team of staff involved in Open Dialogue in KMPT and their commitment is key to our success, as is the involvement of patients, families and carers."

Dr Osborne commented that "Winning this prestigious innovation award and having the programme support of The Health Foundation represents a major step forward for KMPT to bring about the first UK Peer Supported Open Dialogue team in Secondary mental health care. We are delighted to have this opportunity to really

challenge the shape of mental health services by giving truly equal voice to service users, their families and the clinician."

Sarah Henderson, Associate Director from the Health Foundation said, "We are very excited to be working with such a high-caliber of teams, who all have great innovative ideas. As an organisation we are keen to support innovation at the frontline across all sectors of health and care services, and I am pleased that we will be able to support these ambitious teams to develop and test their ideas over the next year.

"Our aim is to promote the effectiveness and impact of the teams' innovations and show how they have succeeded in improving the quality of health care, with the intention of these being widely adopted across the UK."

The programme will run for fifteen months and each project will receive up to £75,000 of funding to support the implementation and evaluation of the project.

Find out more about the Innovating for Improvement programme:
www.health.org.uk/innovatingimprovement

Participation in clinical audit and quality improvement activities

Participation in clinical audit and quality improvement activities

National clinical audit and quality improvement activities

During the period 1 April 2016 to 31 March 2017 KMPT was actively involved in 10 National Clinical Audits/Quality Improvement projects and Two National Confidential Enquiries that were relevant to the services provided by the trust.

During the above period the trust participated in **100%** of the national clinical audits and national confidential enquires which it was eligible to participate in, see table below for a list of projects that the trust was eligible to participate in.

National Confidential Enquiry Into Suicide and Homicide by People with mental illness
National Confidential Enquiry Into Patient Outcomes and Death (NCEPOD)
National Audit of Early Intervention in Psychosis (Action Planning)
Prescribing Observatory Mental Health (POMH) – UK: Prescribing topics in mental health services (3 topics)

The national clinical audits and national confidential enquires that KMPT participated in, and for which data collection was completed during 2016-2017 are listed below alongside the number of cases submitted to each audit and where appropriate the number of cases required to be submitted.

Topic	No of cases required to be submitted	Cases submitted (%)
National Audit of Early Intervention in Psychosis	100	100 (100%)
POMH-UK Topic 11c Prescribing antipsychotic medication for people with dementia	NA	86
POMH-UK Topic 7e: Monitoring of patients prescribed lithium	N/A	25
POMH-UK Topic 1g and 3d Prescribing high dose and combined antipsychotics	N/A	230
NCEPOD: Mental Health Conditions in Young People	Number of patients admitted meeting study criteria	9 (100%)
National Confidential Enquiry Into Suicide and Homicide by People with mental illness	N/A	96%

KMPT also participated in the following National Quality Improvement activities during 2015-2016:

KMPT currently has five Memory Clinics registered with **The Memory Services Accreditation Programme:**

- Ashford Memory Clinic: Accredited until 2018,
- Dover Memory Service: Accredited, until October 2019.
- Thanet Memory Clinic: Accredited until January 2018,
- Shepway Memory Assessment Service: Accredited as Excellent until February 2017.
- Canterbury CMHSOP: In review Stage

The memory clinics in Swale, Medway, Dartford and West Kent are due to be registered imminently and complete accreditation within the next two years.

Two ECT Clinics Registered with **ECT Accreditation Service** :

- **Margate ECT Clinic:** Accredited to June 2019,
- **Priority House, Maidstone Clinic** Accredited to December 2019

Two Units registered with **Community of Communities Network**

- **The Brenchly Unit:** Accreditation Member (Accredited)
- **Ash Eton**: Full Member , Registered 2012 and working to accreditation,

Maidstone Crisis Resolution and Home Treatment Team Registered with **Home Treatment Accreditation Scheme**

Accredited to September 2019

The Forensic Quality Network for Forensic Mental Health Services is divided into two arms, Medium Secure and Low Secure

Medium Secure: TGU, Maidstone, Accredited Cycle 9, registered for Cycle 10

Low Secure Allington and Tarenfort Centres Dartford, Accredited Cycle 4, registered for Cycle 5

The reports of 8 national clinical audits and quality improvement activities were reviewed by the trust between 1 April 2016 and 31 March 2017

Case study: National Clinical Audit

854/15 National Early Intervention in Psychosis Audit 2015

Improving access to evidence-based care for people with first episode psychosis is a national priority. A new Access and Waiting Time Standard has been set and additional funding has been made available to deliver better services. As part of this initiative, NHS England commissioned an audit to establish a baseline position regarding services' ability to provide timely access to NICE recommended interventions across England.

The following standards were measured:

Standard 1: Allocation and engagement

Patients with first episode or suspected psychosis allocated and engaged within two weeks

Standard 2 – Cognitive Behavioural Therapy for psychosis (CBTp)

Patients with first episode or suspected psychosis are offered CBTp

Standard 3 – Family Intervention (FI)

FI is offered to those in contact with their families

Standard 4 – Clozapine prescribing

Clozapine is prescribed to patients for whom this treatment is indicated (or valid reason is given for not prescribing clozapine)

Standard 5 – Offer of supported employment programmes

Patients looking for work are offered supported employment programmes

Standards 6 – Physical health assessment

Screening is offered for all seven physical health measures

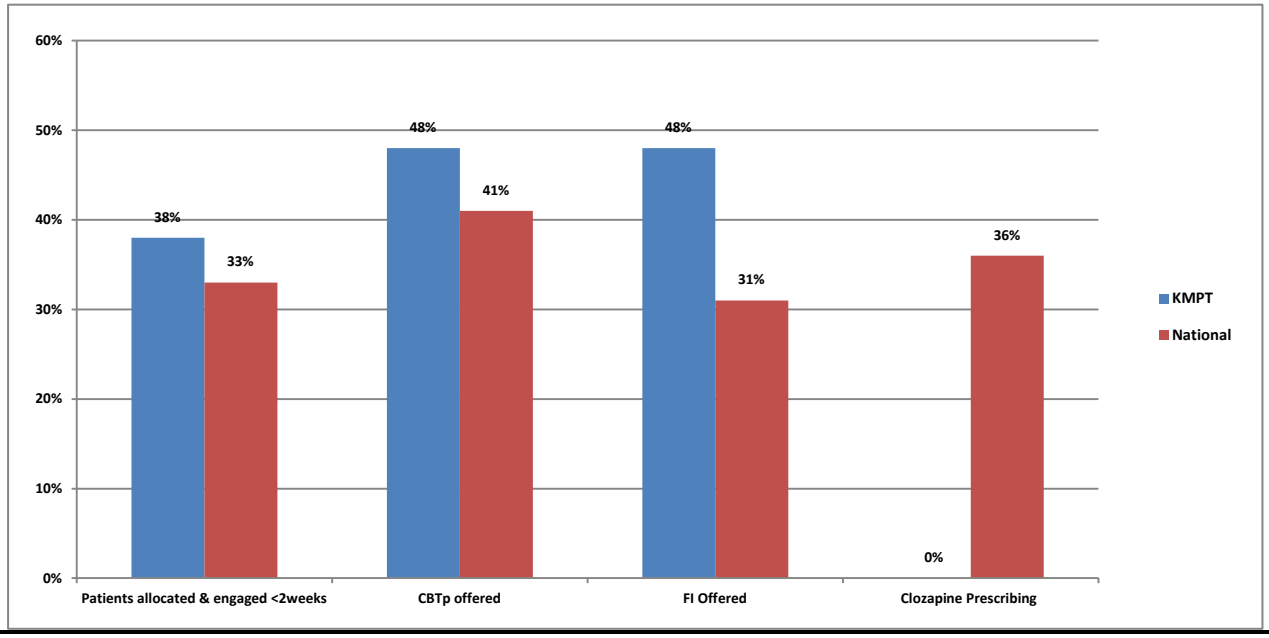
Standard 7 – Physical health interventions

All interventions are offered where required

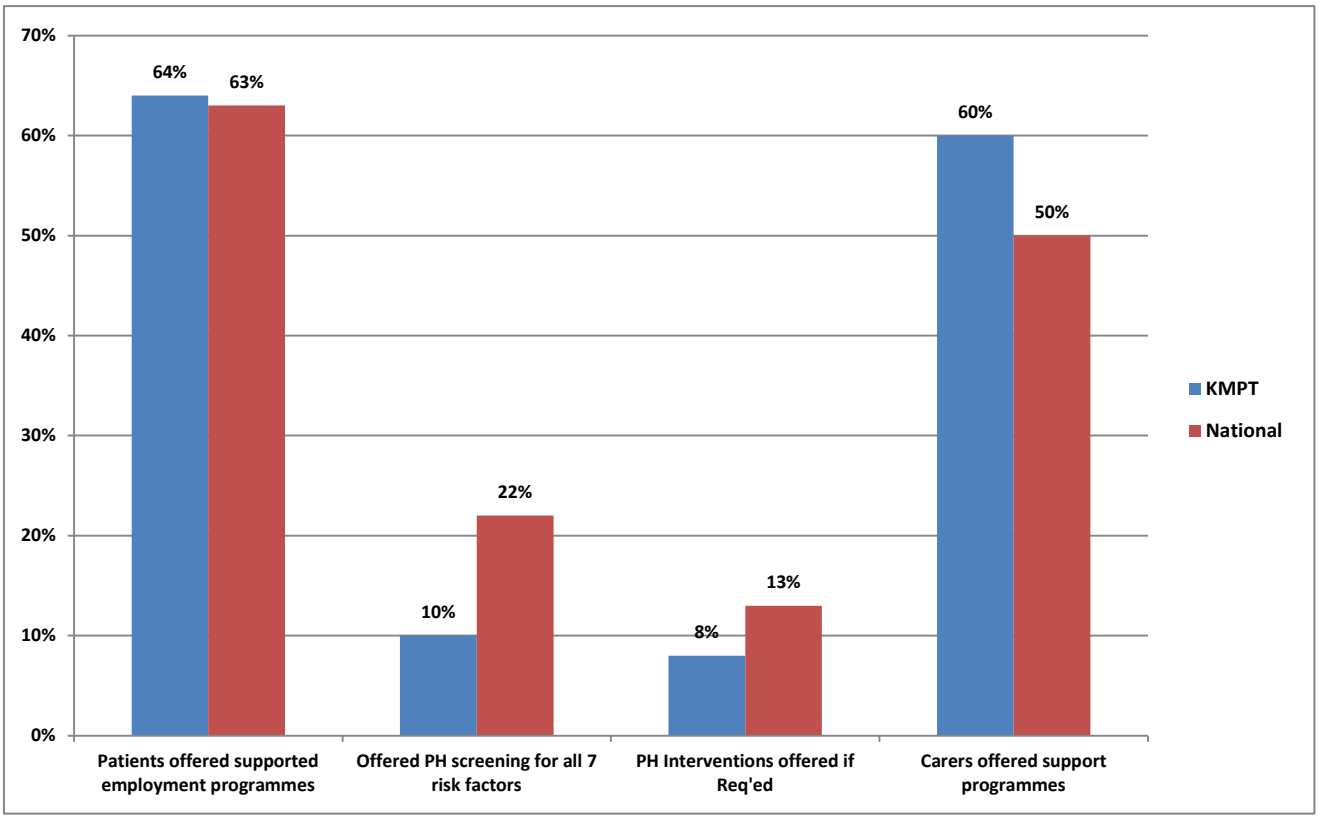
Standard 8 – Carer-focused educational and support programmes

Carers are offered support programmes

Please see the graph below which shows KMPT and Total National Sample compliance with Standards 1 to 4



Please see graph 2 below which shows KMPT and Total National Sample compliance with Standards 5 to 8



An Action Plan has been drafted which includes the following actions:

- Referrals to team reviewed daily in order to improve allocation and engagement of patient within to weeks of referral
- Bid for funding in increase the number of EIP team members that are CPTp training
- Review of team caseloads in order to increase time for EIP team members to provide family interventions
- Review of medical input into team
- Training of Peer Support Workers and STR workers in individual employment placement support
- Well-being practitioner employed and Health Care Assistants posts being planned to assist in physical health screening and interventions
- Improvements in access to Carer support groups specific to EIP being planned
- For the trust to participate in the 2nd round of the National EIP Audit during 2017/18

The learning points and action taken from all national clinical audit projects and quality improvement activities reported during 2016-17 can be found in the KMPT Annual Quality Improvement Projects (Clinical Audit and Service Evaluation) Report 2016-2017, please email clinicalaudit@kmpt.nhs.uk for further details.

Local Clinical Audit and Quality Improvement Activities

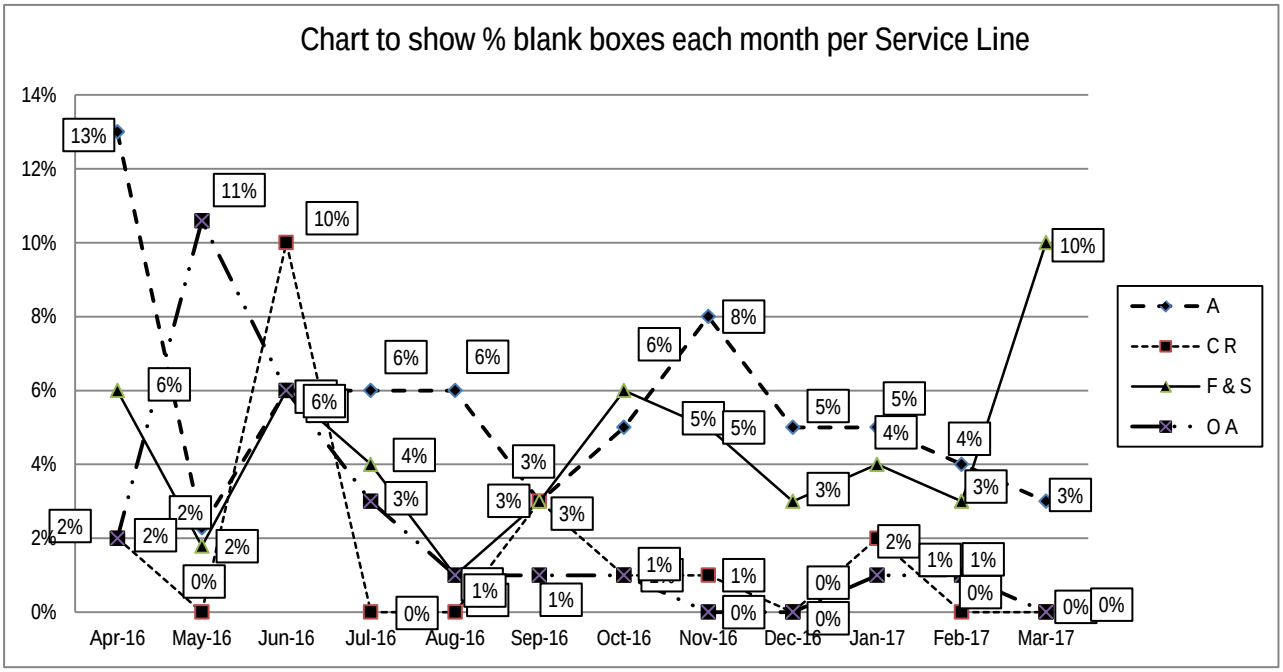
The reports of **131** local clinical audits and service evaluation projects (including the reports of project reported on a monthly basis) were reviewed by the trust between 1 April 2016 and 31 March 2017

Case Study: **Local Clinical Audit**

803/14 Medication `Blank Box' Audit (On-going project which reports monthly)

The aim of the above project is to reduce the number of Blank Boxes on In-patient Medication Charts

The chart below shows the percentage of medication charts that contained blank boxes, by month, since and including April 2015. When the audit started in November 2015 the percentage of medication charts with blank boxes across all service lines was 37%.



Action taken to reduce blank boxes includes the following:

- Speak to nurses individually, discussing in supervision, ensure induction process with bank and agency nurses and look at competency tests.
- Identify the administering nurse and contact to ascertain if they gave the aforementioned medication. Offer support and supervision to minimise the chance of this happening again.
- Inform ward manger and email the nurse who was doing the medication ward round

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

The implementation of service line learning logs in CRSL and in other services lines when available will be monitored to insure that learning from complaints is recorded and where required action is taken to promote improvements (792/14 Complaints Audit Final Report (re-audit)

A protocol for the escalation of poor practice has been developed and agreed between the CPA compliance manager and the Older People Service and CRSL (687/13 CPA Reviews Re-evaluation OASL and CRSL Reports (3rd cycle)

It is recommended that medication reconciliation be carried out within the Medway CRHT team across the trust because starting the medication reconciliation process at or soon after admission of patients to crisis team may ultimately save time and reduce potential adverse drug events and risks for unnecessary subsequent care. (851/15 Audit on medication reconciliation carried out in Medway and Swale CRHT team)

All recording of physical health activity now combined into one single form on OpenRio (patient information system), which includes Lester tool guidance, refusal box and text boxes for clinical decisions, (867/15 Cardio Metabolic Assessment and Treatment for Patients with Psychoses in the Early Intervention Service)

Continuing interface between old age and forensic services to ensure that all patients above 65 years referred to forensic services have a cognitive assessment. (730/14 Clinical audit of the evidence of cognitive assessment in patients over the age of 65 referred to forensic services at initial assessment)

To improve the interaction between the Forget-Me-Nots (FMNs) and twitter one-on-one sessions or workshops were seen as the best option (881/16 A service evaluation which will investigate a dementia service user involvement group's interaction with Twitter)

Information about MCI will be available to all service users who received diagnosis of MCI. (911/16 An evaluation of support provided by Shepway Memory Assessment Service for those with Mild Cognitive Impairment (MCI)

The learning points and action taken from all local clinical audit projects and quality improvement activities reported during 2016-17 can be found in the KMPT Annual Quality Improvement Projects (Clinical Audit and Service Evaluation) Report 2016-2017, please email clinicalaudit@kmpt.nhs.uk for further details.

KMPT Quality Improvement Conference

Excellent, excellent, excellent wrote one delegate on their conference evaluation form, after a day packed with presentations and workshops on a wide range of quality improvement topics.

The day started with a welcome from Helen Greatorex, KMPT Chief Executive and the morning section of the conference programme was chaired by Professor Catherine Kinane, who introduced the three projects that had been selected by the Clinical Audit and Service Evaluation Group for a Clinical Audit and Service Evaluation Project Award for 2016.

After the projects had been presented delegates were invited to vote for the project they considered was the best. The project in first place was the audit of letters following consultations with doctors in a learning disability unit, presented by Dr Rebecca Gove and Dr Sidney Htut. The re-audit of documentation of falls assessment within Older Persons Inpatient Services presented by Dr Guy Muller was awarded second place and the service user re-evaluation of the West Kent Neuropsychiatry Service, presented by Kate Bispham was awarded third place.

Each presenter was awarded a medal and the presenters of the project awarded first place also received the CA&SE Award Shield.

(Left to Right) Dr Sidney Htut and Dr Rebecca Gove receiving their First Place Medal and the CA&SE Awards Shield from Dr Catherine Kinane Executive Medical Director

Professor Jane Reid, Regional Lead for Sign up to Safety (South) in her presentation highlighted the impact of human errors on patient safety and how such errors can be reduced through standardisation of processes and improved design.

In the presentation on using Lean Quality Improvement System to inform service reconfiguration given by Dr Pratish Thakker and Steven Bartley from Tees Esk and Wear Valleys NHS Trust an overview of how the Lean has been embedded within the culture and systems of the trust, together with a practical example of how the Lean processes have transformed a service through re-design and the reduction of waste.

The first parallel workshop session then took place, which included a work shop on Datix reporting including medication incidents and restraint, which included an overview of the use of Datix in incident reporting and a practical demonstration of how to report an incident on Datix given by Samantha Chalmers, Risk Manager and

Health and Safety Lead. Angie Lehman, Medicines and Safety Officer presented on how the information on medication incidents recorded on Datix is used.

The Physical Health and Mental Health: Cardio metabolic CQUIN workshop which was facilitated by Dr Soundararajan Munuswamy, consultant Psychiatrist and chair of the Clinical Audit and Service Evaluation Group, Andrew Dickers, Lead Nurse, Community Recovery Service Line and Vicky Boswell, Director of Performance, discussed a number of issues concerning the provision and recording of physical health screening and interventions.

After lunch there followed another workshop parallel session, which included a research workshop facilitated by Sarah Dickins, Research and Development Manager that provided an introduction to research within KMPT.

The other workshop was focused on activities being carried out in support of the KMPT Sign up to Safety Improvement Plan, these included a discussion on Root Cause Analysis provided by Steve Norman , Patient Safety Manager and Carrie Mclean, Complaints/SI Facilitator, presentations were also given on Patient Safety Culture by Dr Karan Singh and Transforming Clinical Risk Management by Malcolm Brown, Clinical Risk Training Lead Practitioner.

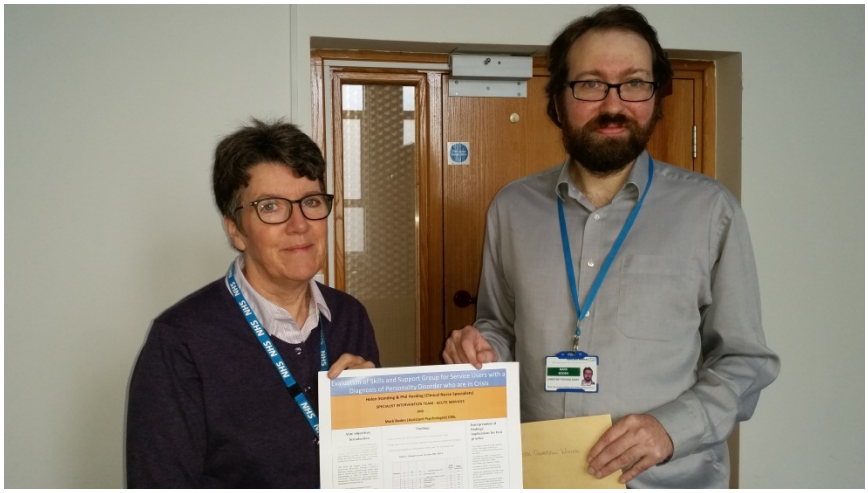
The conference continued with the afternoon key presentations in the main conference hall, which was chaired by Andrew Dickers, Lead Nurse for CRSL. James Osborne, Lead for East Kent Psychological Services in the CRSL gave an informative presentation on Open Dialogue which is an approach to working with individuals with mental distress in which a multidisciplinary team of professionals respond to acute crisis by holding meetings which bring together the person in distress and any members of their family and social networks as chosen by the service user.

Will Cartwright, Peer Support Worker then addressed the conference on his experiences gained from being a peer support worker, together with a vision for the future innovation for the role.

Will Cartwright, Peer Support worker addressing the Conference (Far Left, Andrew Dickers, Lead Nurse CRSL)

Professor Catherine Kinane then led a discussion on the KMPT Quality Account Priorities and the Clinical Strategy Objectives and their importance in improving the quality of trust services.

The Conference was concluded with the presentation of the CA&SE Awards and the Poster Award, which was won by Helen Standing, Phil Harding and Mark Boden for their poster entitled ***Evaluation of skills and support group for service users with a diagnosis of personality disorder who are in crisis.***



Helen Standing and Mark Boden with their award winning poster and prize

Research and Development

KMPT is clearly demonstrating success in its strategy to increase National Institute of Health Research (NIHR) Portfolio activity, as well as begin to develop our own home-grown research profile.

We exceeded our 2016-17 recruitment target of 410, recruiting 873 service users, their family members and our staff to NIHR Portfolio studies. Our target set by the Clinical Research Network: Kent Surrey Sussex (CRN: KSS) was 410.

This resulted in KMPT currently being ranked 20th out of all 51 mental health trusts in England. This is an increase from 42nd in 2011/12 and 30th in 2015/16). It is our ambition to reach the top 10 and remain there, within 5 years.

Figure 1*: NIHR Portfolio Recruitment by Month - 1 April 2016 to 31 March 2017*

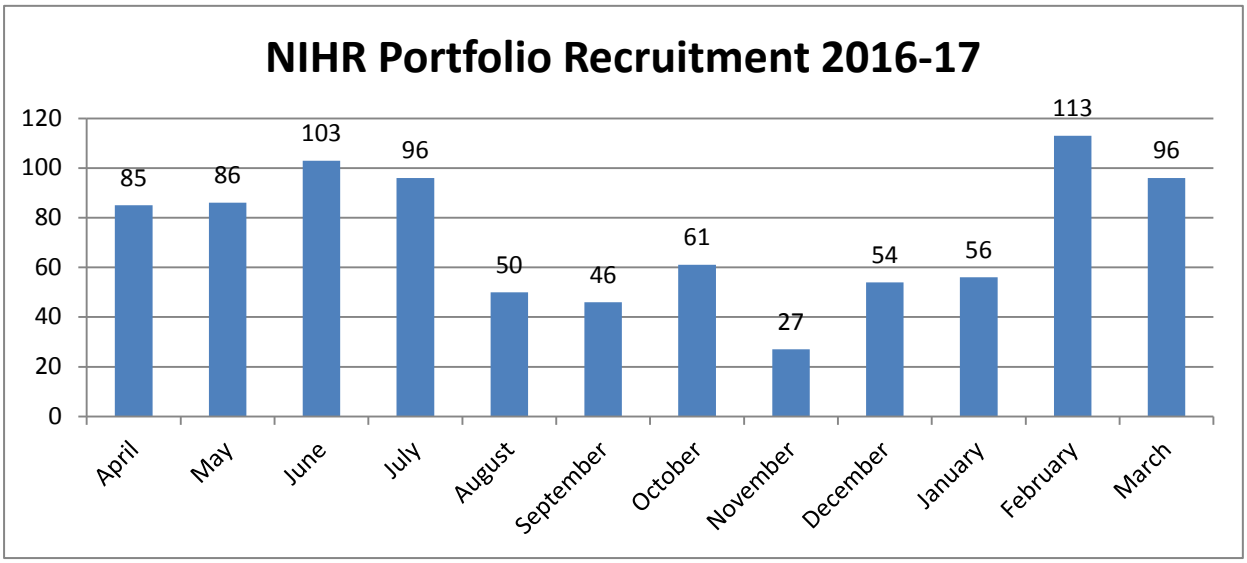
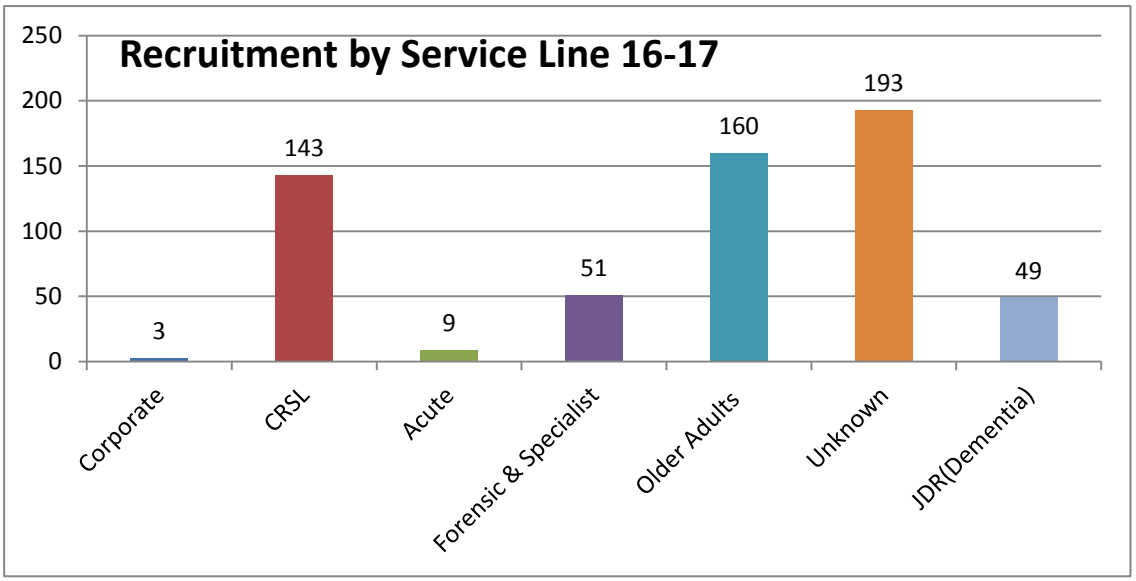
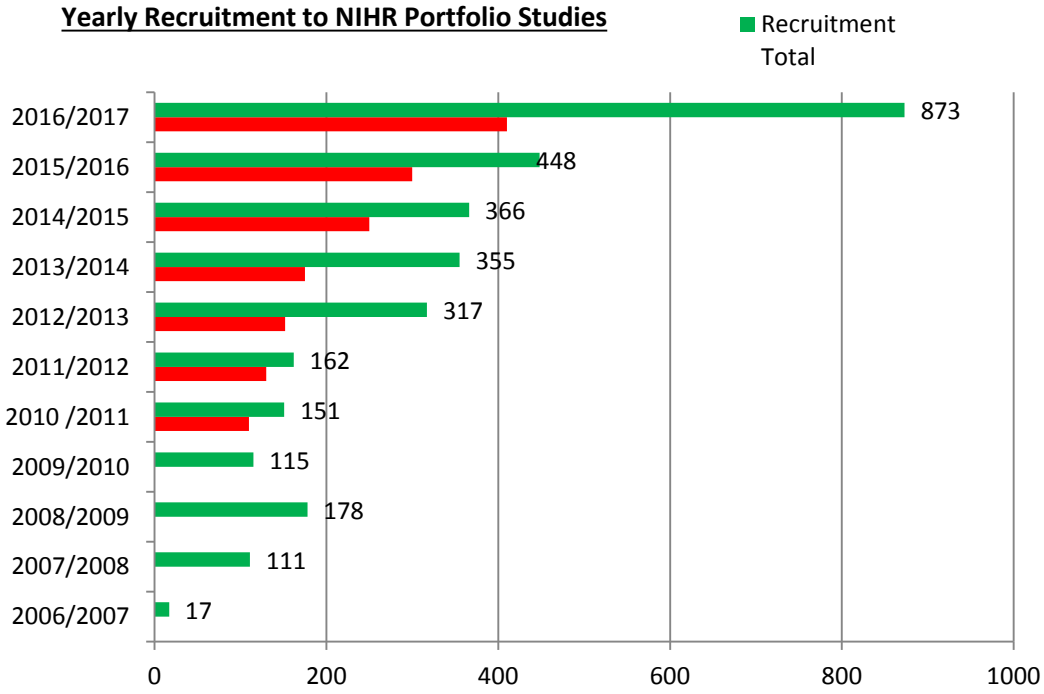


Figure 2: ***NIHR Portfolio Recruitment by Service Line - 1 April 2016 to 31 March 2017***



KMPT's overall year on year increase in recruitment since 2006 is detailed here in Figure 3.

Figure 3: ***Yearly Recruitment to NIHR Portfolio Studies against Target set by CRN:KSS***



Recruitment Headlines

KMPT were the first UK site to recruit to the AFTER Trial (Aggression Following Traumatic Brain Injury (TBI): Effectiveness of Risperidone – a Feasibility RCT) which is open across the Neuropsychiatry services in Kent and Medway. We remain the highest recruiting trust to this study.

KMPT were also the highest UK recruiters to the following studies

- **Evaluating support for carers of people with dementia**

- **Social Factors, Care and CTOs. Service User & Practitioner Perspectives**

- **The Health, Lifestyle and Wellbeing Survey (HWB)**
  Our collaboration with University of York on HWB and SCIMITAR+ has led to 2 publications and 1 new paper being written with KMPT Researchers as Collaborators. KMPT have also been approached to join the HWB steering committee to facilitate the future development of the HWB study, ensure the academic and intellectual integrity of the content, maximise the research opportunities for the HWB cohort and ensure financial viability of the study.

- **European Long-acting Antipsychotics in Schizophrenia Trial (EULAST)**
  (A Clinical Trial of an Investigational Medicinal Product) Our collaboration with the European Group for Research in Schizophrenia (EGRIS) and

performance on their EULAST Study has resulted in KMPT being approached by Alkermes to open a new commercial CTIMP in Schizophrenia.

This large multinational multicentre study sponsored by Alkermes, is a Phase 3, multicentre, randomized, double-blind study to evaluate the effect of ALKS 3831 compared to olanzapine on body weight in young adults with schizophrenia, schizophreniform disorder, or bipolar I disorder who are early in their illness.

This trial should lead to a second Phase 3 Study to Assess the Long Term Safety, Tolerability, and Durability of the treatment.

In addition our working collaborations and high recruitment performance with Exeter University for both IDEAL and GREAT dementia studies last financial year has also resulted in KMPT being approached to support a bid for a future dementia study.

Collaborative working between ourselves and East Kent Hospitals University NHS Foundation Trust (EKHUFT) has also enabled us to open and recruit to our first Phase II non-commercial drug trial "RADAR", which requires a an MRI component for the participants being provided at EKHUFT's William Harvey Hospital

The following are examples of further clinically relevant NIHR Portfolio studies that we are also involved in:

EQUIP – A group based intervention for inpatient learning disabilities developed by Professor Peter Langdon from the Tizard Centre that is currently underway within the Tarentfort Centre, Dartford.

We are also excited to have opened two studies looking at staff wellbeing

"Mindshine 3" - We are looking for 350 members of staff, with at least 1 day per week of client contact to take part in this RCT of the 'Headspace' mindfulness self-help app. Recruitment to finish in June 2017.

"Compassion" *Developing and Validating a New Self-Report Measure of Compassion*
This study recruiting across Kent Surrey and Sussex is helping to develop a questionnaire which measures self-reported compassion in NHS staff In a role that involves at least one day per week (on average) of direct patient contact towards other people and towards the self.

The following are examples of clinical relevant home grown research projects that we are currently involved in:

"**SPEAKS**" – Dr Anna Oldershaw (Clinical Psychologist, Eating Disorders) has been awarded an NIHR Clinical Fellowship Award to develop an RCT into Specialist Psychotherapy with Emotion for Anorexia in Kent and Sussex.

Peer Supported Open Dialogue (POD) – The team won Health Foundation Award funding to evaluate the implementation of this new model in KMPT. Adopted onto the NIHR Portfolio this study is now open and recruiting in KMPT.

In addition Professor Catherine Kinane and Annie Jeffrey (Carer Lead) are co-applicants for the now approved NIHR Programme Grant of £2.1 million, led by Professor Steve Pilling at UCL. This **ODESSI** study is multi-site RCT into Open Dialogue in the NHS.

FIP-MO Fire Setting Study – received an ESRC Outstanding Impact in Society Award. KMPT's first Clinical Research Associate (Dr Nicola Tyler), jointly funded with the University of Kent, has now been in post for 18 months to develop this project further, and has been working on this and various other forensic research projects.

We are also still attracting interest from commercial companies with 1 dementia industry study recently opened

"ALOIS" - Prospective non-interventional study of patients with mild to moderate Alzheimer's disease and their caregivers in four European countries. This is an observational study that is due to close in March 2017.

We are also working on studies that are not part of the NIHR Portfolio but are important to provide evidence to help improve services in KMPT.

Prison Mental Health Needs Assessment – NHS England awarded KMPT approximately £85K (profit = around £40K) to undertake a mental health needs assessment in all the prisons in Kent, Surrey and Sussex. This contract was won by tendering against private and 3rd sector agencies, and is particularly timely as it will provide data to aid in the re-commissioning of prison mental health services in early 2018. It is hoped that KMPT's role in this research will place them in prime position to regain the prison mental health services contract within the region, and plans for post research strategy and service development workshops alongside NHS England and 3rd sector providers are underway. This project is led by Dr Helen Miles and Dr Nicola Tyler.

Avoidable Detention East Kent CQUIN – With Sarah Dickens acting as the Research Lead for this large project she is working with a Research Assistant and two service user researchers, who are all supporting the research element of this CQUIN.

KMPT's academic relationships continue to strengthen (e.g. Kent Health, University of Kent, Canterbury Christchurch University, University College London, Imperial, Kings College London: Institute of Psychiatry), including clinicians acting as co-applicant on research bids.

Our Executive Medical Director, Dr Catherine Kinane, has recently been appointed as a Visiting Professor in the Faculty of Health and Wellbeing at Canterbury Christ Church University further helping to strengthen our education and research profile.

Clinical Research Network (CRN): KMPT continues to be integrated into the CRN:KSS. Sarah Dickens continues to represent KMPT on various forums (e.g.

Strategic Funding Group, Research and Development Managers Forum and the Workforce Development Steering Group).

Phlebotomy Supervised Practice Scheme: To develop and maintain the research teams clinical skills a phlebotomy supervised practice continues to run successfully in conjunction with Maidstone Hospital. They provide training for the Clinical Research Team to phlebotomist standard, which is repaid by each trained individual working as a phlebotomist for one session a month at the hospital.

KMPT Research Centre: The Research Team moved into their new premises at Beech House on the 1 February 2017. This provides an appropriate clinical space in order to undertake research, including complex industry studies and represents a significant step forward in formalising the research department within KMPT.

The KMPT staff awards this year featured a specific "**Achievement in Research Award"**, which was won by Dr Nicola Tyler (Forensic Psychologist in Training / Clinical Research Associate) for her work on the FIP-MO fire setting programme. The KMPT research team was also nominated and shortlisted for the Best Team Improvement Award.

Trust wide research events are now held regularly around the trust focussing on our around core research themes or quality areas. Event have now run for Dementia, Forensic Services, and Psychosis with dates planned for Learning Disabilities, Neuropsychiatry and Specialist Services.

These events are open to all relevant individuals (across service lines) with a research interest in that topic (e.g. clinicians working in this area, academic partners in local universities, industry links, service users or carers, wider health economy partners or other stakeholders / commissioners).

They involve presentations of ongoing or completed research to improve dissemination to relevant individuals and increase impact of research on clinical activities and quality of patient care; service user feedback, provision of networking opportunities to link academics and clinicians with a similar interest to collaborate on future research, profile raising and promotion of research, and offer free research CPD activities. Events are well attended and initial feedback has been very positive.

Increasing nurse involvement in research We are working with local training providers (e.g. Canterbury Christ Church University) to ensure that mental health nursing students will now be taught a specialist research module, with students producing a research proposal as well as a literature search on their chosen area. Also in the trust, qualified nurses, HCA's and student nurses now attend a Nurses Research and Development group (NuRD).

Patient and public involvement and engagement remains a key focus. The trust's Expert by Experience Research Group (EbyE) work directly with the research team to develop research ideas and to consult on our service user facing documents etc. The research team have also continued to offer research training sessions in order to continue to support the EbyE group to develop their skills.

Sarah Dickens, Research and Development Manager also won the Clinical Research Network, Kent, Surrey and Sussex award for "Outstanding Patient and Public Engagement in Research" for her work using Twitter to develop ideas for physical health in mental health research alongside her equivalent at Kent Community Healthcare Foundation Trust (KCHFT).

We now also send thank you letters and Certificates of Participation to all participants of studies, and as of September 2016, all research participants are now given the opportunity to complete a questionnaire on their experiences. 44 have been collected to date, which show:

- 100% strongly agreed / agreed the researcher was friendly and professional.
- 89% felt research should be normal part of healthcare.
- 89% rated their whole research experience out 8 or above out of 10 (none below 5).

Other initiatives underway during 2016-17 include:

Clinical Record Interactive Search (CRIS) System: This system is now moving into the testing and implementation stage, a project led by University of Oxford and involving 15 mental health trusts in the UK. It is funded by the DoH, NIHR and MRC CRIS sits above RiO and can extract data presenting it in an anonymised form for research and audit purposes. It is also hoped that it may have use in quality improvement; audit and development work within the trust, embedding the notion of evidence based practice and service development based on actual local data.

Patient Portal: We are working with the Patient Portal team to incorporate research as a standard feature for patients to interact directly with the research team, and find out what research is suitable for them, removing clinician burden and improving service user choice. We are also working with the team to develop research into the effectiveness of the portal itself.

Social Media: The **@KMPT_Research** Twitter account is continuing to grow, allowing promotion of KMPT research activities and engagement in national research agendas and with the wider public. We have over 1000 followers.

Equality and Diversity Developments 2016-17

Introduction - This year 2017, KMPT`s three year Equality and Diversity Objectives formulated on the Refreshed Equality Delivery System (EDS2) comes to its end. This provides an opportunity for the trust to evaluate progress to date. KMPT equality and diversity goals and objectives are organic and are reflected in this update where new NHS England national mandatory initiatives/responsibilities developed during the implementation of the EDS2 has been incorporated into existing program of work. This report therefore provides progress update on the following areas:

- Equality and diversity objectives set within four goals. These are better health outcomes, improved patient access and experience, representative workforce and inclusive leadership

- Generic data analysis enabling identification of health inequalities within services

- NHS England Workforce Race Equality Standard(WRES) with agreed actions to ensure employees from black and minority ethnic(BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace

- NHS England Accessibility Information Standard(AIS) – aims to ensure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively

Equality Act 2010 and Community Engagement Strategy - Different engagement events involving representatives from Mental Health Action Groups and other voluntary organisations and interest groups in discussion around various trust initiatives. The many engagement activities have enabled a better understanding of issues on difference through a first hand account. For example:

- Complaints staff periodically involves relatives in discussions to gain better understanding of specific cultural and diversity issues.

- Equality and Diversity Steering Committee improved and widened representation from BME voluntary organisations to share intelligence on addressing health inequalities and hold trust to account. This is a direct result of the *Lets Talk Conference* of October 2015.

- Intelligence gained through engagement led to the appointment of full time peer support workers from diverse backgrounds to help promote social inclusion and combat stigma and discrimination faced by different mental health service users.

- Intelligence obtained from involvement and engagement has led to the revision and updating of KMPT Community Engagement Strategy.

- Equality and Diversity Manager made presentations on the protected characteristics and provided a rationale for why both public and voluntary sector organisations need to capture data to help inform and shape service delivery and design.

Data and health inequalities within services

- KMPT Quality Committee tackled the incompleteness of data collection on protected characteristics in order to provide a realistic picture of fairness within service provision
- KMPT also sought to use data to identify emerging trends around health inequalities amongst protected groups specified within the Equality Act 2010 and thereby institute appropriate interventions for positive and effective outcome for all service users. The table below details specified areas of investigation
- Data completeness for ethnicity, gender, sexual orientation, religion, age and marital status
- Open referral demographics v's average demographics as per ONS census
- Contact demographics v's average demographics as per ONS census
- Treatment demographics v's average demographics as per ONS census
- Number of contacts by ethnicity and gender groups
- Length of Stay and 28 day readmission reported by ethnicity and gender within service line – the data for this is currently being reviewed and will be made available for the next report
- Serious incidents by ethnicity and gender
- Use of Mental Health Act by ethnicity and gender
- Physical restraint and seclusion by ethnicity and gender

Some key challenges emerging from data interrogation

The introduction of the above data analysis highlighted the following challenges providing the trust the opportunity for remedial actions

- Incomplete data reporting where protected characteristics may not be requested and/or recorded by clinicians, where some data may be recorded in progress notes rather than reportable data fields thereby making the data impossible to extract

- Patients reluctance to provide equality monitoring data to staff coupled with staff lack of confidence to ask because of fear of intrusion into patient right for confidentiality. This may hinder ability to provide person centred care resulting in disproportionate adverse impact against particular protected groups.

- **Addressing the issues** - The introduction of Single Point of Access (SPoA) enabled a process to capture the demographic information on the screening call, with all call handlers being trained to obtain information

- A newly designed mandatory e-learning on equality and diversity was introduced, highlighting KMPT's legal duty to monitor and the importance of identifying trends to enable the organisation to take appropriate action in a timely manner

- Section 136 Street Triage Project implemented by KMPT led to improved user experience of receiving rapid assessment and access to appropriate mental health services and averted and reduced unnecessary use of detention under section 136 of the mental health Act. In particular, for those from mixed White/Afro-Caribbean background. This initiative challenged and addressed cultural misconceptions by some police officers through training and joint working leading to improved police officers knowledge and understanding of

mental illness and culture. This initiative continue to be very popular and is still evolving and attracting external interest and partnerships

- Still significant work to do particularly, in completeness for sexual orientation and religion

- KMPT Quality Committee continue to further steps to improve completeness of equality and diversity data, particularly when recording serious incidents, restraints and seclusions

- Trust to undertake work to explore barriers and enablers to access continued use of services by patients from BME backgrounds and explore initiatives to reduce the number of black service users under section.

Other Initiatives

- **Disability and reasonable adjustment** - medium secure women`s service improved reasonable adjustments awareness and developed full wheelchair access. This was followed by Littlebrook Wards which has improved access for service users with mobility problems and bedrooms now have en-suite shower and toilet

- **KMPT LGBT Network** – Work with Acute Service Bed Manager led to work on changing admissions protocol and guidance to offer appropriate choice to transgender service users needing admission in addition to the development Guidance on supporting transgender service users

- A proposal from LGBT network for intersex term to be used for service users who do not define themselves as either male or female

- Equality and diversity training continues to be very popular. Training highlights the essence of robust data collection key to enable strategic planning of prevention and after care in the community. Training also focuses on culturally sensitive and person centred approach to care

Religion and belief

- A Pastoral, Spiritual and Religious Care policy was written and adopted in 2017
- A Pastoral, Spiritual and Religious Care strategy/policy is currently being developed
- Longer term patients are assisted with faith support from external faith leaders – notably Sikh, Muslim and Christian. These initiatives are impacting positively on patients
- Smaller but significant contribution is made by Chaplains in supporting patients in the community by visits or by phone calls and feedback has been positive and patients state that the support has kept them out of hospital
- Chaplains regularly contribute junior doctor's and trainee GP training programmes.

Race, Ethnicity and Workforce Race Equality Standard (WRES) - NHS providers are mandated to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organization.

- KMPT continues to routinely publish its equality and diversity comparative data analysis covering the six protected characteristics

- In 2016 KMPT published its WRES analysis using UNIFY 2, a system for sharing and reporting NHS and social care performance information returns. The report provides comparative data from 4 of the 9 WRES indicators, reflective of the national staff survey questions while itemizing forward actions to address the invisibility of BME staff in Band 9 and Board, VSM and director level.

    - Forward actions include - Active encouragement Green Button reporting, re-energising and refreshing staff forums/ networks
    - Using representative Peer Support Workers, rigorous pursuit of staff shadowing schemes, professional development, coaching and mentoring initiatives
    - The development, support and an implementation of a generic Diversity and Inclusion group. Group will hold to account the mainstreaming of equality and diversity within HR functions

- The WRES led to the refresh of the Black and Minority Forum (BME) providing greater prominence for the need for cultural change and improving overall staff experience
- Making race an important dimension in recruitment and retention and development opportunities for BME staff so that their skills are fully recognized and utilized
- BME staff to channel personal experiences and skills to help impact positively on health inequalities amongst BME groups within mental health

In 2016 KMPT appointed its first black Executive Director of Nursing and Quality. According to Alison Moore a freelance health writer, “only a handful of directors of nursing are from a BME background. The only one in a mental health trust, and the only one from an African country, is Mary Mumvuri, executive director of nursing and quality” Mary who provided a detailed account to the BME forum inspired BME staff.

Disability and Accessible Information Standard
From 31 July 2016, all organisations that provide NHS care or adult social care were mandated to follow NHS England Accessible Information Standard. The standard aimed to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with health and social care services.

- KMPT developed Accessible information policy, Accessible Standard eLearning posters displayed in all training rooms to raise awareness
- RiO (electronic system) was reconfigured to capture accessibility needs of patients and service users. Commissioning Officer commended trust for the comprehensive work adding *'If I do get any requests for support around policy making, or examples, would you be happy to have yours shared, or are these for your trust's use only?'*

Disability and reasonable adjustment
KMPT has detailed data analysis. These together with issues emerging from staff will be crucial in KMPT`s revision of its Equality and Diversity Strategy for 2018 and beyond.

Implementation of Duty of Candour

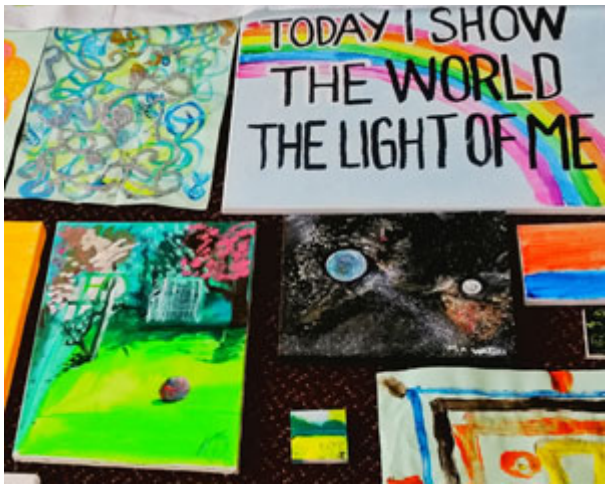
For each serious incident that occurs within the trust a manger from another team or in some cases a manager from another service line is asked to lead the learning review. It has always been good practice to involve patients and carers in learning reviews as they often want and need answers about their care or the care of their relative.

With the advent of Duty of Candour it is not just good practice to involve families in learning reviews it is mandatory and this is reflected in both the Serious Incident Policy and the Duty of Candour Policy.

The investigator is required to write to the patient/relative informing them of a learning review and to ask if they want to participate, at the end of the process the investigator is required to offer to share the findings of the learning review with the family or patient.

Service users get arty

Service users from our Tonbridge Road unit and Rosebud Centre in Maidstone showcased their works of art at the Maidstone Community Centre in Maidstone during July 2016



Pictured: Art work produced by service users

The exhibition recognised the vital work of our Peer Support Workers within the Trust.

A Peer Support Worker is a person who has 'lived experience' of a mental illness. They can offer an understanding through shared experiences, reflecting on their own recovery they attain a mutual respect and build a trusting relationship.

Peer Support Worker Tracy Gibbons works at Tonbridge Road; a mixed gender inpatient adult mental health rehabilitation unit situated in Maidstone. Tracy is just one of many Peer Support Workers who work alongside service users as part of their rehabilitation and recovery. Last week, Tracy helped set up the exhibition with service users from both units.

Tracy said: "Art provides a welcomed distraction for service users; it helps them with their wellbeing and recovery journey. It helps them to relax and talk. They have taken pride in their work and are proud to showcase their achievements".

Goals agreed with commissioners - use of the CQUIN payment framework

A proportion of the trust's income in 2016-17 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The CQUIN payment framework aims to support the cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of discussions between the eight Clinical Commissioning Groups (CCGs) across Kent and Medway, NHS England, the South East Commissioning Support Unit (SECSU) and KMPT.

Local quality improvement priorities and progress in achieving them in 2016-17 were discussed and agreed at board level quarterly and monitored through the Finance and Performance Committee and at monthly internal CQUIN Delivery Group and Service Line Performance Meetings, and at external Contract Quality and Performance Review Meetings between the Trust and CCGs throughout the year. The CQUIN framework made part of KMPT's income dependent on locally agreed quality and innovation goals (2.5% of contract value in 2016-17). The use of the CQUIN framework indicates that KMPT has been actively engaged in quality improvements with commissioners.

The 2016-17 CQUIN scheme is available to providers which have chosen the enhanced alternative – the Enhanced Tariff Option for the full year 2016/17. KMPT elected to take this option. For CQUINs 2016-17 is an evolutionary year: it offers an opportunity to consolidate efforts on national goals from previous year's schemes whilst also shifting the focus on new national goals.

Given the financial challenge facing the NHS in 2016-17, and the need to continue to deliver high quality care for patients, the national goals seek to incentivise quality and efficiency and to reward transformation across care paths that cut across different providers. For mental Health the national priorities are Improving NHS staff health and wellbeing through the introduction of health and wellbeing initiatives, achieving a step change in healthy food for staff, visitors and patients, improving the uptake of flu vaccination for frontline staff, improving the physical health of patients with SMI, effective communications with General Practitioners and enabling care to be provided closer to home for those that need access to urgent and emergency care. The local CQUINs for 2016-17 were implementing dementia pathway between primary an secondary care, improving crisis care for patients, improving outcomes, safely reducing avoidable repeat detention under the Mental Health Act, medication safety, optimising length of stay in specialised mental health services and supporting frequent users detained under section 136.

Please see Appendix C for details of the full CQUIN Payment and achievement for 2016-17.

Peer Support Week – Fun day magic

The Beacon in Ramsgate hosted a wonderful Fun Day to celebrate Peer Support Week on Monday 4 July. Terry Pankhurst (Thanet CMHT OT Technical Assistant) was town crier for the day and opened the event, getting it off to a great start.

With the sun beating down on the Beacon courtyard, handmade bunting flickering in the breeze, the smell of incense sticks, and silk scarfs draped over the trees, staff and service users were able to explore various stalls, enjoy some refreshments and find out more about Peer Support Workers and the contribution.

Natalie Livesey, Peer Support Lead said: “It was heart-warming to see the impact in which the concept of employing people with lived experience has had on our service by talking to several service users.”

She continued: “The day was a real celebration of how far our workforce has come and how we have inspired the way forward for many. There were generous gifts donated along with tasty treats and refreshments, all of which really depicted one of Peer Supports core principles - mutual sharing.”

Registration and regulation

The trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008 and is registered without conditions for its 17 registered locations.

During 2016, the trust continued to implement the actions identified from the 2015 CQC comprehensive inspection by way of its Quality Improvement Plan (QIP). Appendix … illustrates what actions had been taken and successfully implemented by January 2017; this was shared with the CQC.

Also in 2016, the trust received two unannounced focussed inspections from the CQC; one at the Frank Lloyd Continuing Care Unit and one at Little Brook Hospital. The CQC conducted these inspections as concerns were highlighted about aspects of care being provided at these sites during MHA monitoring visits (also conducted by the CQC). Quality improvements plans for both sites were developed which aimed at addressing the areas of concern identified following these inspections. The CQC received regular updates and monitored the progress made at engagement meetings with the trust.

In January 2017, the trust received its second comprehensive inspection undertaken by the CQC and the draft reports were received in March 2017 for factual accuracy checks. The trust was rated as 'good' overall and received an 'outstanding' for the caring domain.

The final reports will be published in April 2017 with a quality summit involving all stakeholders taking place in May 2017. A new QIP will be developed to include the must do's and should do's identified as requiring improvement during the 2017 inspection. This will be monitored by the CQC Oversight Group and shared with the Quality Committee and the CQC at regular intervals.

The must do's included:

Trust:

1. The trust must ensure the governance systems provide sufficient oversight to the board and responsive action around the Mental Health Act.

Community-based mental health services for adults of working age:

2. The trust must address the high caseload numbers allocated to individual staff to ensure that all patients are appropriately monitored.
3. 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.
4. The trust must ensure that staff meet its targets for compliance with mandatory training, in particular personal safety, conflict management and cardiopulmonary resuscitation.

Acute wards for adults of working age and psychiatric intensive care units:

5. The trust must ensure that the service is providing accommodation that adheres to guidance on same sex accommodation.
6. The trust must ensure that all patients have risk assessments that are reviewed regularly and updated in response to changes.
7. The trust must take action to ensure all patients, where appropriate, have access to psychological assessment and interventions.

8. The trust must ensure that all staff have sufficient understanding of the Mental Capacity Act and its guiding principles.
9. The trust must ensure that systems in place to monitor patients using their Section 17 leave are used correctly.
10. The trust must ensure that staff have completed mandatory training in line with their targets.

Forensic inpatient/secure services:

11. 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.
12. The trust must ensure that staff complete all mandatory training.

Care Quality Commission

Last rated
12 April 2017

Kent and Medway NHS and Social Care Partnership Trust

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	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 learning disabilities or autism	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆

Data quality

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

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

- profile, prominence and understanding of data quality at board level
- integration and embedding data quality into organisational practice
- assurance and review programmes
- This Information and Data Quality Strategy has been developed to set out the steps that are necessary for KMPT to take in order to introduce a structured methodology for information and data quality improvement. It will concentrate on addressing the three areas above by:
- Focusing on key data items in the MHSDS (Mental Health Services Data Set) and to support the accurate clustering in preparation for the move to Payment by Results.
- Developing, implementing and embedding a trust wide Data Quality Culture sponsored and monitored at senior management level
- Integrating data quality with the new Performance Management Framework as a key element of the trust's reporting activities

Kent's Dementia Friendly Awards 2016

A special congratulations to east Kent Forget Me Nots group who won this year's Partnership Project Award! Other winners included Chris Norris, KMPT Dementia Service User Envoy who was awarded the Dementia Volunteer Award. Chris is living with frontotemporal dementia.

Pictured left to right: Reinhard Guss, Acting Head of Older People's Psychology – East; Chris Norris, KMPT Dementia Service User Envoy; Rachel Norris (his wife); Stephanie Celina (UKC placement student) and Sammy Bellamy (CCCU student placement).

Melvyn Brooks, a member of the Forget Me Nots Group was also a finalist in the 'Most Inspiring Person Living with Dementia' category.

The Awards ceremony was hosted by the Oasis Academy on the Isle of Sheppey in October. The event is organised by the Kent Dementia Action Alliance and is a chance to celebrate all of the work that communities have been doing across Kent to support those living with dementia, to reduce stigma, increase understanding of dementia and inspire new ideas and collaborative working.

This year, due to the amount of entries nominations were judged in two rounds and carried out by those living with dementia. The first round shortlisted finalists and the second round focused on finding the worthy winners.

Staff from across the trust attended, including the East Kent Forget Me Nots (Dementia Service User Involvement Group), Friends of Mental Health in east Kent, Older People's Psychology Service, and two 'year out' placement students from Canterbury Christ Church University and University of Kent. They were all nominated for the Partnership Working Award.

Pictured left to right: The Forget Me Nots stall with Reinhard Guss, Stephanie Celina and Sammy Bellamy

In addition to the awards ceremony there was a marketplace featuring exhibitors, charities and service providers from around Kent offering help and advice.

NHS Number and General Medical Practice Code Validity

KMPT submitted records within prescribed deadlines for 2016/17 to the Mental Health Services Data Set (MHSDS). Results are published monthly at: http://www.hscic.gov.uk/mhmdsmonthly

The percentage of records in the published data which included the patient's valid NHS Number and GMP Code was:

29,535 of 29,545 = 99.97% for valid NHS number

29,655 of 30,015 = 98.8% for valid GMP Code

KMPT is highly commended at Positive Practice Awards 2016

The trust has been highly commended in two categories at the national Positive Practice in Mental Health Awards 2016. The annual ceremony, held on 13 October, was attended by over 300 people to celebrate all that is positive in mental health around the country.

The Peer Supported Open Dialogue initiative was highly commended in the Crisis Care Pathway (supported by NHS England) category. KMPT is leading the way in the UK piloting this new model of care that both transforms the system in terms of the pathway of care and in which clinicians seek to work jointly with the individual, and their family or social network, the care required from the point of crisis through to recovery. The pilot in the UK also involves peer support workers who have lived experience as important additions to meetings.

Professor Catherine Kinane, Executive Medical Director and Dr James Osborne, Clinical Lead for Open Dialogue attended and accepted the certificate on behalf of the Open Dialogue team. Dr Osborne said: “Being highly commended in in the Crisis Care Category at these national awards was a great opportunity to showcase some of the hard work that is taking place in the trust to improve mental health services. Attending these events also provide a chance to learn about some of the incredible innovations in mental health across the country.”

Our Mother and Infant Mental Health Service (MIMHS) was also awarded highly commended in the Community Perinatal Mental Health Services (supported by NHS England) category. MIMHS is a highly specialist community service for perinatal mental health illness working across primary and secondary care in a consultation, liaison and advisory model.

Pictured: Mother and Infant Mental Health Service (MIMHS) team receiving their certificate

The service was nominated by Tracey Robinson, former trust Programme Manager and shortlisted for the difference the service makes to women. They help women feel empowered around their birth and medication choices, giving them hope of recovery,

ensuring that their role as a mum is taken into account by all involved in their care, and being flexible enough to visit them at home when leaving the house is difficult. The service also considers the needs of partners and other family members by offering support when needed.

For more information please visit: **www.positivepracticemh.com**

Information Governance Toolkit Attainment Levels

The Information Governance Toolkit (IGT) is a performance tool produced by the Department of Health and is now hosted by NHS Digital.
Where partial or non-compliance is revealed, the trust must take appropriate measures (e.g. assign responsibility, put in place policies, procedures, processes and guidance for staff) with the aim of making cultural changes and raising Information Governance Standards through year on year improvements.

The IGT for mental health trusts involves 45 initiatives to be scored (from level 0 to level 3, see key below) and evidenced throughout the year with the final submission (of completeness) in March 2017. The appropriateness of the evidence submitted to NHS Digital is assured by an annual Information Governance audit conducted by TiAA.

Compliance with the IGT audit is part of the programme of assurance with which the trust must comply. The IGT scores are used by the Care Quality Commission when identifying how well the Trust has met the Fundamental Standards of quality and safety. The IGT scores are also used to demonstrate the presence of a secure computing platform in the Trust, which is crucial for the interoperability and information sharing necessary for the Trust's contribution to the Local Digital Roadmaps, STPs and 5 Year Forward View.

All trusts must work to achieve a level 2 in all initiatives.
The trust obtained an overall compliance score of 79%, scoring at least a level 2 in all 45 elements. This means that the trust is classified as `Satisfactory' overall. There are only two classifications available satisfactory or not satisfactory.

Key to Scores

Level	The trust has…
0	Nothing in place to manage the requirement
1	A named person has been identified to take responsibly and they have produced an action plan to achieve compliance
2	Suitable policies and procedures in place or has conducted the necessary training or audit required
3	Robust processes in place to manage the requirement and these processes are regularly reviewed

The total score is calculated by adding together all the scores and dividing by the maximum possible score the whole toolkit.

Prestigious award for firesetting research

Congratulations to Forensic Services who have just won a prestigious Impact through Knowledge Exchange Award as part of the University of Kent's Innovation Awards 2016.

Working with staff from the Centre for Research and Education in Forensic Psychology (CORE-FP) at the University of Kent the team's project is for the development, implementation, and evaluation of the Firesetting Intervention Programme for Mentally Disordered Offenders (FIP-MO). This is a specialist intervention developed for individuals with history of deliberate firesetting who have a mental disorder or personality disorder.

The Impact through Knowledge Exchange award seeks to recognise collaboration between academics and an external organisation on a project which has clearly demonstrated impact in the wider community, for example, multiple services adopting the outcome of the research.

Since its development, over 33 secure services in the UK have been trained on delivering the FIP-MO programme as well as practitioners working in probation and personality disorder units in the prison service.

In securing this award the FIP-MO programme has been recognises for how it has grown to be used across forensic services nationally and how it now plays a role in the care pathway for a significant number of patients.

Forensic and Specialist Services Director, Lona Lockerbie said: "I am delighted that the team has attained this prestigious recognition. The service has been recognised for its national best practice regarding firesetting research for some time now and this award is a very welcome endorsement."

Clinical Coding Audit

The trust was not subject to the Audit Commissions payment by result clinical coding audit during 2016-2017. However the trust did undertake its own audit of patient records and the discharge summaries, when present, were an excellent source of information, thus aiding the coding process.

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

	Total episodes audited	Total correct	% Correct 2016-2017	% Correct 2015-2016
Primary Diagnosis	50	49	98%	100.00%
Secondary Diagnosis	233	187	80.26%	87.76%

Overall the trust continues to make progress in primary diagnosis coding accuracy. Secondary diagnosis coding accuracy is good at 80.26%. The trust has achieved Information Governance Toolkit level 3, information for clinical coding (see page 70 for a key on the toolkit levels).

Primary diagnosis accuracy is excellent at 98%. The trust has exceeded Information Governance Toolkit requirement level 3 for the third year running.

Celebrating nurses at our Nursing Conference

Our Annual Nursing Conference was held on Thursday, 12 May 2016 in conjunction with International Nurses Day; a day dedicated to celebrating all the fabulous work that nurses do around the world. The theme for this year was ‘A force for change, improving health systems’ resilience’.

Mary Mumvuri has only been with the trust for a matter of days as our new Executive Director of Nursing and Governance. As a mental health nurse she wanted to take the time to join the conference and speak about the upcoming launch of the new Leading Change, Adding Value: a framework for nursing, midwifery and care staff by Jane Cummings, Chief Nursing Officer for England. One of the aims of the strategy is improved quality of care, health and wellbeing and patient experience. This was a topic that was discussed throughout the conference; “Keeping the Body in Mind” – Valuing Mental Health equality with Physical Health.

Over 115 qualified nurses, senior management and a CCG Quality Lead attended the event held at The Hilton Hotel in Maidstone.

The day consisted of local and national speakers sharing ideas, discussing issues, best practice and workshops.

Carley Tomlin, Staff Nurse based at the Trevor Gibbens Unit in Maidstone spoke about how morning stretch groups help patients with a mental illness to get physically active. The group aims to improve motivation and increase levels of activity through basic exercises, with even staff taking part. With this in mind, Carley asked those at the conference to get up on their feet to take part in stretches and even a torso twist!

Pictured: Staff taking part in exercises at nursing conference

Key note speaker, Seamus Watson, Mental Health Lead from Public Health England, tackled national issues and interventions for those with a mental health problem, such as premature death, smoking and the need for mental health nurses and physical health practitioners to work closer together.

Dr Femi Odesanya, Specialist Registrar, General Psychiatry spoke about unexpected inpatient deaths who had chronic physical health problems when admitted onto a psychiatric ward. He discussed the positive changes that have taken place and the need to care for physical health problems alongside mental health.

Clare Taylor and Charlotte Bailie from the Early Intervention Service took to the stage to speak about how regular physical health checks and healthy lifestyle education is

offered to all service users. The service supports them to make positive changes to their lifestyle through smoking cessation, drug and alcohol advice or referral, diet and weight management, exercise and medication management.

The Charlton Athletic Community Trust project is a programme which provides opportunities for service users to take part in physical activities like archery, tennis, bowling and climbing to improve fitness, physical wellbeing, increase confidence and raise self-esteem.

Various speakers highlighted ongoing good practice within the Trust; these included smoking cessation with inpatients, improvements in physical health screening in the community and a very powerful story from a service user from the Early Intervention Service who gave an inspiring account of how KMPT has helped her physical health needs through the Charlton Athletic Community Trust project.

Alison Welfare and Sarah Dickens from the Research Team reiterated the need for good quality research and why it is important for continuous improvements of standards of care.

Dr George Umoh, Consultant Psychiatrist presented three cardio metabolic case studies of patients.

In the afternoon, a series of workshops were held by different speakers from across the trust on physical health topics including; smoking cessation, physical health risk board game, relaunch of the Modified Early Warning Score (MEWS) chart and motivational interviewing techniques.

The feedback from the conference has been positive with a great deal of learning reported which can now be imbedded into practice.

Guy Powell, Acting Deputy Director of Nursing and CPA Compliance and Development Manager said: “I was amazed by the large amount of positivity at the conference on the recognition and need for physical health needs of service users to be addressed which are core values of all nurses.”

Our 2017-18 Priorities

For 2017-18 the trust has set nine priorities for improvement; divided into the three areas that constitute quality, these are **patient experience, patient safety** and **clinical effectiveness**.

The nine priorities are:

Patient safety

- To improve the recording of risk management within care plans
- Reduction of violence inpatient care settings.
- To improve the quality and frequency of handovers within the Acute service line and across service lines.

Patient experience

- Completion of the Triangle of Care self-assessment documentation by CMHT – Year 2
- To improve patient experience of care co-ordination
- Develop a standardised patient experience feedback system

Clinical effectiveness

- Implementation of NICE guidance: Gap Analysis
- Quality Improvement System – Rapid Process Improvement Workshops
- To improve the quality of care plans Year 2

Who has been involved in setting our 2017-18 priorities?

During 2016-17 KMPT has continued to involve a range of staff, people who use services and our partners in the non-statutory sector to help set our priorities for the coming year.

The sustained monitoring of our Community Engagement Strategy has provided valuable assistance in producing an in-depth report regarding elements of mental health provision and in commenting on the format of this Quality Account as well as undertaking their formal review of the document.

Our Patient Consultative Committees and Community Engagement Strategy Monitoring and Implementation Group (CESMIG) have identified issues through their involvement with the organisation which they wished the Board to include in the Account.

The trust Board has continued to receive presentations from service users and carers throughout 2016-17. As a result, the experience of service users and carers has helped the Board to establish its quality priorities by providing a real insight into the experience of people using the services.

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

2017-18 Patient Safety Priority 1

To improve recording of risk management within care plans

Rationale:
Information obtained from Serious Incident investigations and complaints indicates variations in the recording of how identified clinical risks from clinical risk assessments are managed and recorded in care plans. This has been identified as an area of practice that requires improvement in order to ensure that all clinical risks are managed effectively.

Current status
An audit on clinical risk assessment and management practice carried out within only two community mental health teams during July 2016 revealed that although 90% of service users had a completed clinical risk assessment, only 50% or less of patients had the management of risks identified recorded in their care plan.

At the current time, there is no information system that provides assurance that risks identified and documented during the risk assessment process have been reflected and actioned within the care plan for the same patient.

Plans
In order to obtain assurance that the trust Clinical Risk Assessment and Management Policy is being followed regarding identified risks being recorded and managed in care plans it is planned that a trust wide Clinical Risk Assessment and Management Clinical Audit project is conducted.

The Clinical Risk Assessment and Management Group will lead on the planning and design of a trust wide clinical audit of clinical risk assessment and management practice, with the following time scale:

- By end of Quarter One (30 June 2017) Planning and Design, Approval, Data Collection
- By end of Quarter three (30 September 2017) Data analysis, Results, Root Cause Analysis, Action Planning and Interim report writing.
- The date for 2 data collection (re-audit) will depend on the time required to implement actions from the1st data collection.

Measures
Quality Improvement (Clinical Audit and Service Evaluation) Interim Report to be produced highlighting best practice, lessons learnt and actions to be taken

Monitoring
Monitored through the Clinical Risk Assessment and Management Group, Prevention of Suicide and Homicide Group, Trust wide Patient Safety Group, Quality Committee and up to Board.

2017-18 Patient Safety Priority 2

Reduction of violence within inpatient care settings.

Rationale:
A reduction in violence and aggression will enhance patient experience, patient recovery and engagement with services.
The aimed reduction would be 30% over the course of 2 years, with a 10% achieved in the first year.
It is projected that a reduction in violence and aggression may result in decreased staff sickness rates, staff satisfaction and reduce cost of care within the services.

Current status
Violence and aggression is prevalent in inpatient settings in mental health. In KMPT in 2015 violence and aggression account for 27% at 2131 of all incidents reported. In 2016 this figure rose to 32% at 2972 of all incidents. Research and practise has shown that these incidents are under reported, when this is accounted for it is likely that the rates are higher than what is currently reported.

Plans
To have a Quality Improvement Initiative at one inpatient site: Littlebrook Acute Mental Health, which will involve:

April–June 2017: Formulate an MDT group to lead on the project at Littlebrook and to formulate a project plan

- Collect baseline Data

July-September 2017 implement plan which would include:

- Optimise use of Therapeutic staffing
- Enhance patient activities and reduce boredom on the wards
- Increase the rates of staff to be trained in MAPA
- Enhanced patient involvement/representation in the project
- Reduce use of agency and short term staff cover
- Enhance Debrief and sharing learning from incidents
- Ensure that all staff have access to data and are able to utilise the data to formulate strategies and initiatives.
- Liaise and agreed way of working on this priority with other agencies such as local police force.
- Shared learning from other wards, service lines and other trusts

October to December 2017 review and re-implement project plan

January to March 2018 - evaluate and disseminate further

- When a systematic violence reduction has been established, learning will be shared and spread initiated across to other service lines and sites

Measures
Datix incident reporting of violence and aggression
Admission and Discharge rates
My Kinda Magic service user satisfaction survey
Patients Friends and Family Test scores
Audit Care plans and risk assessments
Staff sickness rates from incidents of violence aggression

Monitoring
Monitored in the Positive and Proactive Practice Group, Trust Wide Patient Safety Group, Quality Committee and Board.

2017-18 Patient Safety Priority 3

To improve the quality and frequency of shift handovers within the Acute service line.

Rationale:
To prevent harm and injury to service users by ensuring that shift handovers are of a high quality, identify any change in risk factors and have the necessary information to ensure that clear treatment plans are handed over between staff shifts

Current status

We currently have shift handovers on the wards

Plans

- To improve the quality of handovers to include issues around risk.
- To identifying changes in risk where there are changes from more chronic in nature to acute
- To improve communication within the service line and ensure that important information is passed on to the staff who have come onto the shift
- To support task allocation so that service users' needs are met by those in the multidisciplinary team with the appropriate skills

Measures

- Measured through auditing handovers sheets and care plans
- Handover conversations and change in patients care plans to be recorded on RIO.

Monitoring
Monitored through the Acute Service Line Governance Group, Trust Wide Patient Safety and Mortality Group, Quality Committee and Board.

2017–18 Patient Experience Priority 1

Completion of the Triangle of Care (ToC) self-assessment documentation by CMHT – Year 2

Rationale:
To ensure that KMPT is working to the principles of carer involvement as described in the ToC.

Current status
KMPT has been involved with the ToC initiative for several years and during 2016-17 the Acute Service has completed the self-assessment documentation for accreditation.

The CRSL has been mapping the current status of CMHT against the accreditation standards and taking action were required

Plans

- To improve the experience of carers whose loved ones are in receipt of services from KMPT
- The ToC self-assessment documentation will be completed by the CRSL with the aim of gaining accreditation in 2018-19

Measures
The CRSL will have completed the self-assessment documentation on the behalf of the CMHT by the end of the fourth quarter (31 March 2018).

Monitoring
The progress on the completion of the self-assessment will be monitored via: the service line patient experience groups, the Trust wide Patient and Carer Experience Group, Quality Committee and Board.

2017–18 Patient Experience Priority 2

To improve patient experience of care co-ordination

Rational
The National Patient Survey 2016 results evidenced a lack of positive experience regarding care co-ordination when compared with other mental health trusts. During 2017-18 a number of complaints in relation to care co-ordination have been received by the trust

Current Status
- The score for care co-ordination in the 2016 National Patient Survey was 7.3
- The trust received 79 complaints relating to care co-ordination from 1 April 2016 to the 31 March 2017.

Plans
The importance of care co-ordination is emphasised during Care Programme Approach training. To develop a deeper understanding of the root causes of patient experience relating to care co-ordination so that meaningful improvements can be actioned, it is planned to conduct a co-produced appreciative inquiry, which will involve service users, carers and staff in a workshop to explore phenomena associated with care co-ordination.

The principles of Appreciative Inquiry include:
- What we believe to be true determines what we do
- How we talk influences how we and others act
- Storytelling is a key part of everyday life
- What we do today is guided by our image of the future
- Change is fostered through having positive relationships

The mile stones for the Inquiry are as follows
- By end of Quarter One (30 June): Recruitment and training of workshop members
- By end of Quarter Two (30 September): Facilitate workshop, produce report and action plan

Measures
- To increase the care co-ordination score in the 2018 National Patient Survey
- To see a reduction in the number of complaints relating to care co-ordination

Monitoring
The progress with this priority will be monitored by the Co-production Network, the Trust wide Patient and Carer Experience Group, Quality Committee and Board.

2017–18 Patient Experience Priority 3

Develop a standardised patient experience feedback system

Rationale:
A standardised patient experience feedback system is required to ensure all feedback is captured comprehensively and all learning and improvements can be obtained.

Current status
Patient feedback is currently captured in a variety of ways and reported through several routes. It is therefore difficult to obtain a clear consistent picture of patient experience across all areas of the trust's activities

Plans
The plan is to review systems available and benchmark against other trusts who perform well in this area to inform decision making before a case for investment is made.

A patient feedback system that uses standardised questions and reporting processes will be developed during 2017-18.

Measures

- By the end of quarter one (30 June 2017) a standardised patient experience questionnaire will be agreed
- By the end of quarter three (31 December 2017) the agreed patient experience questionnaire will be loaded onto a data capture platform
- By the end of quarter four (31 March 2018) reports using a standardised format will be produced.

Monitoring
Reporting will be through the service line patient experience groups, Trust wide Patient and Carer Experience Group, Quality Committee and Board.

2017-18 Clinical Effectiveness Priority 1

Implementation of NICE guidance: Gap Analysis

Rationale:
NICE guidance is based on evidence of clinical and cost effectiveness therefore implementing NICE recommendations can improve the quality of care KMPT provides.

Current status
The NICE implementation policy is being updated to improve the timeliness of appraisal of new relevant NICE guidance.

Plans
The updated NICE implementation policy will require gap analyses by service lines to be completed within 6 months of publication of new relevant NICE guidance, unless there is a documented reason why this is not possible.

Measures
Reported number of relevant NICE guidelines that have completed gap analyses within 6 months of publication.

Monitoring
Service line completion of gap analyses will be reported every two months to the NICE Governance Group. The NICE Governance Group will report summarised completion of gap analyses to the Clinical Effectiveness and Outcomes Group 6 monthly and annual report to the Quality Committee and Board.

2017 -18 Clinical Effectiveness Priority 2

Quality Improvement System – Rapid Process Improvement Workshops

Rationale:
KMPT has set out in its Quality Strategy its intention to embed a culture of continuous improvement across the Trust.

To support this objective, a quality improvement system will be used to enable the reduction of waste, whilst continuing to deliver high quality, effective services that meet the needs of our patients.

Rapid Process Improvement Workshops (RPIWs) will be used as a tool to deliver quality improvements. An RPIW is where a multi-disciplinary team come together for a week to focus on an identified process, generate ideas for improvement, test the ideas and then implement the changes.

Current status

No RPIWs have been run to date. Five members of staff in the trust have been trained in the quality improvement approach and will run five RPIWs in 2017/18.

Plans

- The RPIWs should be aligned to key strategic priorities for the organisation to ensure high impact. A smaller number of the events will also be used to focus on 'quick wins'.
- The first RPIW is scheduled to take place in June and will focus on the CPA Review Process.
- A short list of further subject ideas, generated by senior managerial and clinical staff at the Leadership event in February, has been shared with EMT, who will agree the additional four RPIW topics.
- Once the topics are agree, each RPIW will be assigned a workshop lead and team lead from the trained staff, who will be assessed whilst researching and running the workshop.
- The identified objectives, outputs and outcomes from the RPIWs will be monitored using visual control boards and report outs at 3, 6 and 12 month intervals.
- Further staff will be identified to complete the training in 2017/18 so that RPIWs will become embedded within KMPT quality practice.

Measures

1. Five RPIWs completed in 2017/18
2. At least eight additional staff trained in the approach

Monitoring
To mirror the World Class Management approach described in the quality improvement system methodology, the impact and outcomes of the RPIWs will be monitored using visual control boards situated at the Trust Headquarters, outside the Executive Medical Directors office. Process leads will be held to account for delivering the RPIW objectives at 3, 6 and 12 month report outs. The progress with this priority is to be monitored by the Clinical Effectiveness and Outcomes Group, Quality Committee and Board.

2017-18 Clinical Effectiveness Priority 3

To improve the quality of care plans Year 2

Rationale:
In April 2016 a new electronic care plan proforma was introduced. This has had a positive impact on the quality of care planning across the trust. All service lines have embraced the recovery approach and person centred thinking in the formulation and use of care plans by developing service specific frameworks to apply the common principles of person centred care planning.

The introduction of the new Care Plan format required each service line to review and update their approaches taken in obtaining assurance of the quality of person centred care planning. This work was carried out during 2016-17 and is expected to be fully implemented across all service lines during 2017-18.

In order to promote continued improvement in care planning it is important that the work being undertaken to improve the quality of care plans, as measured through each service line's Care Plan Audit, that this topic remains a clinical effectiveness priority for 2017-18.

Current status
During the last year in order to improve the quality of care plans each service line has developed a Care Plan Audit, which takes place each month. Each audit has been developed to measure the principles of patient centred recovery focused care planning together with taking into account differences in service users and carers needs between each of the four services lines, Acute service line (adult inpatient and CRHT), CRSL (CMHT), Forensic and Specialist Services and Older People Service (older adult inpatient and community services).

The current compliance scores average (percentage of questions answered yes) for each service line during 2016-17 are:

- Acute Service Line = 78% Wards, 67% CRHT Teams (Person Centred Care Planning Audit, Inpatients)
- Forensic and Specialist Services = 87% (My Shared Care Planning Audit)
- Community Recovery Service Line = 61% (Community Recovery Care Plan Audit
- Older People Service Line = 73% (Community) 83% (In-patients) (Combined Inpatient and Community Person Centred Care Planning Audit)

Plans
Each service line to continue with their Care Plan Audits and to report their monthly compliance scores and action taken to improve the quality of care plans as part of their regular reports to the Clinical Effectiveness and Outcomes Group

Measures
Each service line Care Plan Audit to demonstrate an average increase of at least 5 per cent in their average compliance scores (percentage of questions answered yes) with audit standards between April 2017 and March 2018.

Monitoring
To be monitored by service line Governance Groups, Clinical Effectiveness and Outcomes Group, Quality Committee and Board.

Appendices

A: Comments on our 2016-17 performance

B: CQC Quality Improvement Plan

C. CQUIN framework 2016-17

D: Quality Performance Indicators

E. Sign Up to Safety Pledges

F. Sign Up to Safety Improvement Plan

G: Glossary and Abbreviations

H: Auditor's Report

Appendix A :
Comments on our 2016-17 performance

Comments received from Kent County Council Health Overview and Scrutiny Committee:

Dear Lou

Thank you for the draft copy of Kent and Medway NHS & Social Care Partnership Trust 2016/17. The Kent HOSC will not be providing a statement this year as the Committee has not been reconstituted following the election on 4 May; it will be reconstituted on 25 May which is after the deadline for comments.

The Committee looks forward to receiving future copies of the Quality Account.

Best wishes

Lizzy

Lizzy Adam
Scrutiny Research Officer
Strategic & Corporate Services (Governance & Law)

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Comments received from Medway Borough Council Health and Adult Social Care Overview and Scrutiny Committee:

Response to Kent and Medway NHS and Social Care Partnership Trust (KMPT) Quality Account on behalf of Medway Council's Health and Adult Social Care Overview and Scrutiny Committee

Senior representatives of KMPT have continued to regularly attend meetings of Medway Council's Health and Adult Social Care Overview and Scrutiny Committee during 2016-7. The dialogue between the Committee and KMPT has been ongoing and constructive.

KMPT has provided updates to the Committee on four occasions during the year. In addition, the Committee was presented an update on the development of a Medway Mental Health Strategy, which is joint work between Medway Council and KMPT.

The newly appointed Chief Executive of KMPT was welcomed to the Committee for the first time in June 2016. A concern raised by the Committee was that people with mental health issues were being held in cells and that beds should be found for them instead. Concerns remained with regard to the £4.4 million cost incurred during the previous year of providing beds outside Medway. The Chief Executive of KMPT stated that the Trust wished to see patients treated in beds in Medway and looked after by the Trust's staff rather than being placed in private beds. Addressing this would, however, take time and required joined up working with other agencies.

The Committee has previously raised concern about the level of reliance on out of area acute beds, which it had considered to be at an unacceptable level. At the August 2016 meeting, the Committee was advised that the number of mental health patients needing to be placed in beds outside Kent and Medway had fallen from 76 in March 2016 to 49 in June. It was anticipated that this figure would reduce to 15 by November 2016. The Chief Executive of KMPT acknowledged that recruitment and filling of vacancies was proving to be a challenge.

At its November 2016 meeting, the Chief Executive of KMPT informed the Committee that a Whole System Mental Health Workshop had taken place on 12 October 2016. Following this, a report had been presented to the Medway Health and Wellbeing Board on 3 November about the development of a Medway Mental Health Strategy. This work involves close collaboration between Medway Council and KMPT.

The Trust had hit its target to reduce the use of private inpatient acute mental health beds to a maximum of 15 by the end of October 2016. This figure has subsequently been reduced to zero. A plan was in place to ensure that this reduction was sustained and medical professionals were involved in the work. A detailed plan was being developed to address the recruitment issues highlighted at the August meeting.

The Committee raised concerns in relation to the availability of Street Triage. Following discussion, the Committee agreed to request that the Medway Council Cabinet emphasised to the Kent Police and Crime Commissioner the importance of Street Triage. This request was considered by the Council's Cabinet in January 2017. The Committee was pleased to be subsequently informed that funding had

been made available for Street Triage provision in Medway, although the Committee wished to note the importance of this provision receiving adequate, ongoing funding.

At its January 2017 meeting, the Committee was advised that the Care Quality Commission had recently undertaken an inspection of KMPT. The Committee was also informed that KMPT now had a mental health nurse based in the South East Coast Ambulance Service control room at peak times.

Members raised concerns with regards to the time taken for mental health patients to be seen and recruitment challenges facing the Trust. These concerns were acknowledged by the Chief Executive of KMPT who advised that there were now a range of professionals working on mental health wards to help alleviate the pressure and that a bid was being made for funding to provide additional night time staff.

Committee Members reiterated previously expressed concerns about the lack of adequate provision for people with a personality disorder, following the closure of the specialist service. The Chief Executive of KMPT agreed that current provision was not good enough.

In March 2017, the Committee was updated on the development of the Medway Mental Health Strategy. It was anticipated that the Strategy would help to address a number of challenges including ensuring access to effective services in the local areas, helping people to support themselves, making effective use of the voluntary sector, raising awareness amongst clinicians and having a local workforce able to effectively meet the mental health needs of the population. Enabling people to leave acute care provision as quickly as was safe was also important given accepted medical opinion that providing care in the patients' own home was preferable. The provision of effective Child and Adolescent Mental Health Services was acknowledged to be a problem locally. It is anticipated that the draft Mental Health Strategy will be presented to the Committee in August 2017.

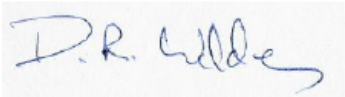
General Comments

- The Committee recognises the significant improvements made by the Trust which has led to the Care Quality Commission rating the Trust as 'Good' following the inspection undertaken in January 2017. However, the Committee recognises that there are still a number of areas that require improvement, as highlighted above and by the CQC findings. In relation to the inspection findings, the Committee notes that a number of areas in relation to acute wards for adults of working age and also in relation to community based mental health services for adults of working age, are rated as requiring improvement.
- The Committee notes that KMPT has been selected as one of twenty health care projects in the country to be part of the Innovating for Improvement Programme and hopes that this will lead to further improvements in services provided by the Trust.
- While recognising that there are ongoing challenges in relation to recruitment, the Committee is pleased to see improved recruitment figures and that KMPT now ranks 17th of 53 mental health trusts in terms of recruitment.
- The Committee has continued to provide challenge and to seek assurance that the measures being put in place by the Trust, commissioners and other partners

would lead to the impact required to achieve an improved CQC rating and is pleased that this had been achieved. The Committee looks forward to working with KMPT over the coming year with a view to supporting the sustainment of improvements made so far and the delivery of further improvement.

- The Committee relies on Healthwatch Medway, which is a non-voting committee member, to feed back patient views and experiences.

Councillor David Wildey, Chairman of Medway Health and Adult Social Care Overview and Scrutiny Committee, 2016-17



This response to the Quality Account has been submitted by officers, in consultation with the Committee Chairman, Vice-Chairman and Opposition Spokesperson, under delegation from the Medway Health and Social Care Overview and Scrutiny Committee.

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Comments received from Healthwatch Kent

Kent and Medway NHS & Social Care Partnership Trust Quality Account Response

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.
For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).
As Healthwatch Kent has experienced cuts in resources along with everyone else, this year we have not been able to look at the report in detail. However, we would like to support the Trust with a comment which reflects some of the work we have undertaken together in the past year.
We have seen that Kent & Medway Partnership Trust values and understands our statutory role as a "critical friend". Some of our involvement with the Trust this year has included:

- Carrying out a number of Enter & View visits to inpatient wards
- Supporting the planning of ward moves to Maidstone
- Monitoring the progress of the Carers Charter
- Meeting regularly with the Chief Nurse to keep up to date with Trust activity
- Input into strategic documents such as Patient Transport policy and Quality Strategy.
- Planning a project to explore Community Mental Health services
- Discussing the implementation of the Triangle of Care Assessment Tool
- Producing a report on out of county beds. The Trust has significantly improved the number of patients who are placed out of county.
- Involvement in meetings to monitor the Care Quality Commission action plan.

We would like to congratulate the Trust on their positive CQC report and look forward to being involved in continuing improvements over the next year.

Healthwatch Kent
May 2017

Comments received from North Kent Clinical Commissioning Groups

North Kent Clinical Commissioning Groups Statement
(inc NHS Dartford, Gravesham & Swanley CCG, Swale CCG and Medway CCG)

The Trust's draft Quality Accounts document was sent to Clinical Commissioning Groups (CCGs) for consultation and comment. The CCGs have a responsibility to review the Quality Accounts of the Trust each year, using the Department of Health's Quality Accounts checklist tool to ascertain whether all of the required elements are included within the document.

The report is well structured and written in a format that is clear and concise, however further explanation of certain terminology may improve the communication further, such as indicating what Rio or CQUINs are.

There are many references to the trust achievement's throughout 2016/17 with positive recognition to individual staff and teams acknowledgements and achievements. In particular a positive achievement is the overall 'Good' rating that the trust was awarded by the CQC following its routine inspection in January 2017, this achievement is not to be underestimated and staff have evidently worked hard to collectively contribute to the award rating. It is recognised within the report that the trust are proud of its areas of achievement, in particular the number of areas rated 'outstanding', but are fully aware of the areas requiring further attention and focus.

The CCG confirms that all required areas have been included within this document in relation to the NHS Services provided or sub contracted and is an accurate reflection of achievement. However, whilst statements are reflected there are omissions for the numbers of patient records which includes NHS number and General Medical Practice Code for patient's GP practice and number of errors introduced into a patient's notes.

It is noted that extensive work has been carried out against the priorities identified for 2016/17 with most priority targets being achieved and in some cases exceeding the expectation. However, it is noted that 3 priority targets were not fully achieved during 2016/17, the quality account could have been enhanced further by expanding on how the trust anticipate continued focus and strive to achieve these areas previously identified as priorities.

The Trust has identified nine priorities for 2017/18, which include projects within the themes of Patient Safety, Patient Experience and Clinical Effectiveness. It has outlined clearly the rationale, current status and how each priority will be monitored and measured. The CCG are in agreement with the priority areas outlined by the trust but aware that further areas of priority continue to remain a focus outside of the Quality Account priorities. The CCG would welcome the opportunity to work with the trust to ensure targets remain on track throughout the year.

The CCG are in agreement of the areas selected by the Trust and recognise that the priorities identified are person and carer centred, appropriate and striving to be effective in improving quality, safety and patient care.

In conclusion, the report is well structured and the trust has made significant improvements across a range of services, this highlights that the quality of patient care and carer support remains a clear focus for the Trust and at the forefront of its service provision.

Gail Locock
Chief Nurse,
NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG

Comments received from East Kent Clinical Commissioning Groups

NHS
South Kent Coast
Clinical Commissioning Group

NHS
Thanet Clinical Commissioning Group

Dover District Council offices
White Cliffs Business Park
Honeywood Parkway
Dover
CT16 3PJ

30 May 2017

BY EMAIL

Helen Greatorex
Chief Executive
Kent and Medway NHS and Social Care Partnership Trust
Farm Villa
Hermitage Lane
Maidstone ME16 9PH

Dear Helen

KMPT Quality Account Response from east Kent CCGs

The east Kent CCGs have reviewed the draft publication of the Quality Account for 2016-2017. As far as the CCGs are able to comment, the Quality Account does describe a broad and representative range of services, and is accurate.

The CCGS welcome the recent CQC inspection report with the overall rating of 'Good' and congratulate the staff for the rating of 'Outstanding' for the caring domain. The priorities set for 2017-2018 will continue to build on improvements made in 2016-17 and demonstrate the strong Quality improvement ethos of the Trust and staff.

The CCGs also welcome the Trust's success in reducing the number of patients who have been placed out of area.

The CCG request data to be produced at a local level for CCG assurance of service outcomes. We value the contribution of staff to improve the quality and safety of services provided to patients, and we welcome the ongoing commitment of the Trust to collaborate with commissioners to achieve assurance. The CCGs would welcome any early invitation from the Trust to engage with the Quality Account and setting priorities throughout the coming year.

Yours sincerely

Hazel Carpenter
Accountable Officer
NHS South Kent Coast CCG
NHS Thanet CCG

Appendix B

KMPT QUALITY IMPROVEMENT PLAN (QIP) FINAL – 28.04.17

This quality improvement plan has been developed in order to address the regulatory compliance standards identified during KMPT's comprehensive inspection 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
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) Patients will have access to psychological therapy as part of their treatment plan where this is identified as a need	1. Review and recruit to psychology posts to cover all acute sites 2. Monitor progress of recruitment at Performance Management Team 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	ASL Service Line Director	1. End Q1 2. End Q2 3. End Q1 4. End Q1	1. Review of staffing 2. ASL staffing report 3. Draft KMPT Personality Disorder Strategy and clinical model 4. Standard operating procedure for referrals
2. SAFE CARE AND TREATMENT – Regulation 12 HSCA					

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
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
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 in place for the management and allocation of new patients.	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 Q1 2. Q1 onwards	1. CMHT performance dashboard
	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
	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	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 Q1 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 improvements are being

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
	17 leave.	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		addressed 3. Training attendance and /course content
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 Accommodation standards	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. 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.	Executive Director of Nursing and Quality ASL Service Line Director	Actions 1-4 completed in January 2017 5. End Q1 6. Q1 onwards	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
	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 4. Repeat the annual Ligature risk assessment across all inpatient as part of Trust audit plan	Executive Director of Nursing and Quality Director of Estates and Capital Planning	1. Completed January 2017 2. Completed 3. End Q2 4. End Q4	1. New beds in place 2. Audit report and associated action plan
4. GOOD GOVERNANCE – Regulation 17 HSCA					
	4.1 The trust must ensure the	1. Review and further strengthen the current	Executive Director	1. Completed January	1. New governance

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
	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.	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.	of Nursing and Quality	2017 2. End Q1 3. Completed January 2017 4. End Q4	structure chart 2. Terms of reference 3. Minutes of MHA Sub-Committee 4. Board reports
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. 95% compliance target completed for all mandatory training courses
	5.2 The trust must ensure that all staff have sufficient understanding of the Mental Capacity Act and its guiding principles (Acute wards)	1. Set trajectory and monitor training figures to ensure they meet the target 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	ASL Service Line Director Head of Safeguarding	1. End Q4 2. End Q4	1. Training data 2. Quality visits reports 3. Audit results
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
7. Workforce					
SW-SD	7.1 The trust should ensure there are	1. Review appraisal system and seek approval	Director for	1. Ongoing monitoring	1. Revised appraisal system

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
	sufficient systems to monitor the training, 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)	from Executive Assurance 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	Workforce & OD ASL Service Line Director	2. End Q1 3. End Q1 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
	7.2 The trust should look at ways to reduce the service's reliance on bank and agency staff (Acute wards)	1. Accelerate and continue 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	ASL Service Line Director	1. End Q3 2. End Q2	1. Agency programme Board work plan and outputs 2. Six months establishment review report
	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. End Q1 3 & 4. Ongoing	1. Team level status reports/dashboards 2. Performance dashboard 3. Reduction in vacancies
	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 meetings and resolve	CRSL Service Line Director	1. Completed 2. End Q1 3. Ongoing - quarterly	1. Team level status reports/dashboards 2. Performance dashboard 3. Improvement in frequency of supervision

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
	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 Q1 3. Ongoing - monthly	1. Team level status reports/dashboards 2. Performance dashboard 3. Improvement in number of appraisals
	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 Q1 2. End Q2	1. Agreed skill mix in place
	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
	7.8 The trust should ensure that band four staff receive appropriate training to allow them to be competent in their role (Forensic/secure wards)	1. Identify and assess individual staff competencies against the set criteria 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	FSSL Service Line Director	1. End Q1 2. End Q1 3. End Q2 4. End Q1	1. Band 4 defines competencies 2. % of completed competency assessments 3. Training data/course registers 4. Training needs analysis
	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	OASL Service Line Director	1. Completed 2. End Q2 3. Completed - ongoing	Staffing establishment levels and shift plans
	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	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

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
		3. Seek assurance from agencies on the level of training provided for each role type before they are sent on assignment			assignments
	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
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
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 patients are given correct information about their rights and to ensure medication is administered lawfully under the Act (Acute wards)	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
	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

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
	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
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
	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
	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
	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
	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
	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	OASL Service Line Director	1. End Q1 2. Ongoing 3. Ongoing	1. Clear garden access .

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
		3. Continue monitoring of related incidents and update 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 Q1	Convex mirrors installed
	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
	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 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	FSSL Service Line Director	Completed	1. Building works protocol 2. Record of consultation
	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. End Q1 2. End Q2 3. End Q1	1. Learning flyer 2. Training data 3. Datix reports
	11.5 The provider should address	1. Continue to review Team/Ward risk registers	OASL Service Line	1. Ongoing	1. Patient safety service line

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
	outstanding risk register items that may pose a risk to staff and people using the service (CMHSOP)	at monthly meetings 2. Maintain and regularly review risks and mitigations at service line meetings .	Director	2. Q1 onwards	meeting minutes
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
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 Q1	1. Agreed decision noted at (TWHSM)
	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. End Q1 2. End Q2	1. Preferred devices in use across relevant teams. 2. Identified alarm system for Jasmine
	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. End Q3	1. Locks in place
14. Service line specific					
	14.1 The trust should put systems in place to ensure 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)	1. Review and provide guidance of the care 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	ASL Service Line Director,/PSTS Lead	1. End Q2 2. Ongoing	1. Quality Account quarterly report on this safety objective
	14.2 The trust should ensure that all patients have care plans that are individualised, incorporate their	1. Continue with monthly person centred care planning audits 2. Review specifically the role of non-	ASL Service Line Director	1. Ongoing 2. End Q2 3. End Q3	1. Audit results 2. Training data 3. Service user feedback

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
	views and are recovery focused (Acute wards)	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			
	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 Q1 2. End Q1 3. End Q2	1. Dashboard used in teams 2. Workforce report 3. Demand and capacity report
	14.4 The trust should implement the new 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)	1. Relaunch standard operating model following consultation in the service line	CRSL Service Line Director	1. End Q2	1. CMHT standard operating procedure in use
	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. End Q1 2. Ongoing - monthly	1. Filing guidance 2. Audits
	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. End Q1 and ongoing 2. End Q2	1. Commissioners performance and quality meeting minutes 2. Demand and capacity report
	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 the compliance % is under target. The	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

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED
	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
	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. End Q1 2. Ongoing	1. Learning bulletins 2. Audit results

Appendix C: CQUIN framework 2016-17

Indicator name	Description of indicator	Overall Value	RAG	Status Achievement
		£ 3,697,485		
National CQUIN NHS Staff health and wellbeing The introduction of health and wellbeing initiatives	Option B- To plan and implement physical activity, mental health initiatives and improve access to physiotherapy for people with musco-skeletal issues.	£ 324,170		Full delivery of CQUIN milestones achieved as set out in the national guidance.
National CQUIN NHS Staff health and wellbeing Healthy food for NHS Staff, visitors and patients	To achieve a step change in health of the food offered on the trust premises in 2016/17	£ 324,170		Full delivery of CQUIN milestones achieved as set out in the national guidance including data to UNIFY achieved.
NHS Staff health and wellbeing Improving the uptake of flu vaccination from frontline clinical staff	To achieve an uptake of flu vaccination by frontline clinical staff of 75% by December 2016	£ 324,170		The Trust did not achieve the CQUIN target of 75% but made an improvement to previous year's compliance and achieved 58.4%
National CQUIN: Cardio Metabolic Assessment and Treatment for Patients with Psychoses	To demonstrate full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in inpatients with psychoses and EIPS and community patients.(Set target-90% inpatient and EIPS and 65% community	£ 259,335		Full delivery of CQUIN milestones and achievement of target within inpatients-96% and Community services- 83%. Partial achievementt of target within EIS-50%

Indicator name	Description of indicator	Overall Value	RAG	Status Achievement
National CQUIN: Communications with GPs	90% of patients to have either an updated CPA ie a care programme approach care plan or a comprehensive discharge summary shared with the GP. A local audit of communications to be completed.	£ 64,835		Full delivery of CQUIN milestones and achievement of target as set out in the national guidance
LOCAL CQUINs				
Outcomes CQUIN (East Kent CCGs)				
Outcomes CQUIN (East Kent CCGs) Clinician Reported Outcome Measure (CROM)	Use of HoNOS 4 factor with intention to see improvement in score from 15/16 baseline	£177,053		Full achievement of CQUIN milestones . Discussions continue with commissioners.
Outcome CQUIN Patient Reported Outcome Measure (PROM)	Demonstrate that patients recovery focused outcome have been identified, monitored and achieved – target % included	£147,544		Full achievement of CQUIN milestones . Discussions continue with commissioners.
Outcomes CQUIN Patient Reported Experience Measure (PREM)	Introduction of patient experience questionnaire in services	£88,526		Partial achievement expected. Discussions continue with commissioners

Crisis Care(East Kent CCGs)				
Indicator name	**Description of indicator**	**Overall Value**	**RAG**	**Status Achievement**
Crisis Care CQUIN 1A (East Kent CCGs)Review of Pyschiatric Intennsive Care Outreach with the aim of reducing admissiions and length of stay	To reduce level of admissions to PICU• To reduce mean and median length of stay in PICU(MAY 2016)• To improve effectiveness of PICU outreach and home treatment team• To improve support for the management of patients who challenge on acute in patients ward preventing admissions to PICU• Improve appropriate use of PICU beds and how they are managed.• Improve joint working between crisis , acute and home treatment team , community and PICU and outreach teams	£177,053		Full achievement of CQUIN milestones agreed with commissioners.
Crisis Care CQUIN 1B (East Kent CCGs)Mental Health Act Detention	Safely Reducing Avoidable Repeat Detentions under the Mental Health Act	£88,526		Full achievement of CQUIN milestones. Discussions continue with commissioners.

Indicator name	Description of indicator	Overall Value	RAG	Status Achievement
Crisis Care CQUIN 1C (East KENT CCGs): Ensuring NICE compliance and improving quality	To ensure Crisis Care Plans adhere to NICE guidance.	£118,035		Partial achievement of CQUIN milestones expected. Discussions continue with commissioners.
Dementia CQUIN- Improving dementia diagnosis (West Kent CCG)	To Improve the process from referral to a diagnosis for those patients with Dementia with the aspirational target of reaching a diagnosis in no more than 12 weeks .	£185,659		Full achievement of CQUIN milestone agreed with West Kent CCG.
Dementia CQUIN (East Kent CCG)	Implementation of the dementia pathway between primary and secondary care developed during 2015/16 to improve diagnosis and post diagnostic support.	£88,526		Full achievement of CQUIN milestone agreed with East Kent CCGs.
Medicine Safety(North Kent CCG)	To ensure that 95% of patients in acute admission and older peoples admission wards receive medicines reconciliation with 24 hours of admission or next working day, in line with NICE recommendation 1.3.1 (NICE NG5) and the National Patient Safety Agency (NPSA) 2. That all in-patient charts should have a completed drug allergy box on all charts in use. 3. To have a reduction in the number blank boxes on medication charts to 5%. 4. To pilot the Medicines Safety Thermometer	£198,536		Full achievement of milestones and targets agreed with North Kent CCGs

Indicator name	Description of indicator	Overall Value	RAG	Status Achievement
Crisis Intervention (North Kent)	To develop and enhance outcomes for patients who require Crisis Intervention • To improve effectiveness of PICU outreach and home treatment team • To improve support for the management of patients who challenge on acute in patients ward preventing admissions to PICU • Improve appropriate use of PICU beds and how they are managed. • Improve joint working between crisis , acute and home treatment team , community and PICU and outreach teams	£397,071		Full achievement of milestones expected. Discussions continue with commissioners.
Physical Health-Implementation of ECG monitoring (West Kent CCG)	To ensure all patient's with a new prescription for specified medications have an ECG carried out before the medication is dispensed.	£92,830		Partial achievement of CQUIN milestones .
Crisis Care (West Kent CCG)	To improve the crisis care pathway in West Kent through;-aiming to reduce the number of section 136's that are not converted to another section of the Mental Health Act (MHA) through improved understanding of those that enter the system in this way.	£185,659		Full achievement of milestones and targets agreed with West Kent CCGs

NHS England CQUINs (Forensics and Specialist Service Line)				
Indicator name	**Description of indicator**	**Overall Value**	**RAG**	**Status Achievement**
Reducing the Length of Stay in Specialised Mental Health services Reducing the Length of Stay in Specialised Mental Health services	The overall aim of this CQUIN is the development of strategies for optimising the care pathway. This will be done by decreasing the length of time service users within specialised services progress through the pathway achieving the outcomes expected as agreed and described in the initial care plan prior to and at admission. There will be an expectation that on admission that an 'expected discharge date' will be set and all plans and pathway progression should be aligned to achieving this outcome in line with an x% target reduction to the average LOS set for the service	£455,787		Full achievement of milestones and targets agreed with NHSE

Appendix D: Quality Performance Indicators

NHS Outcomes Framework domain	QPI ref	QPI	Freq of Report	15/16 FINAL	16/17 YTD	Q1	Q2	Q3	Q4
Domain 1	**Preventing people from dying prematurely**								
	1	Never Events - inpatient suicide using non-collapsible rails	Mth	0	0	0	0	0	0
	2	Death or severe harm as a result of a patient falling from an unrestricted window	Mth	0	0	0	0	0	0
	3	Number of suicides (suspected) while in KMPT care - inpatient or community	Mth	42	48	16	12	12	8
	4	Number of patient safety incident related deaths reported to NPSA	Mth	72	54	18	14	13	9
Domain 2	**Enhancing Quality of Life for people with long term conditions**								
	5	Number and % of service users in PbR clusters 4, 8 & 10 who have a designated care co-ordinator	Qtr	4258 75.3%	4222 76.4%	4562 78.6%	4404 74.8%	4358 76.2%	4222 76.4%
	6	Number and % of service users in PbR clusters 4, 8 & 10 receiving a comprehensive assessment . Definition agreed was those who had a Care plan, HoNOS (under 12 months old) and Risk assessment (under 12 months old)	Qtr	4385 77.6%	4497 81.3%	4889 84.2%	4796 81.4%	4592 80.2%	4497 81.3%
Domain 3	**Helping people to recover from episodes of ill-health**								
	8	All inpatients who have Risk assessment within 72 hours All inpatients who have Risk assessment in total	Mth	83% 95%	89% 97%	85% 96%	88% 97%	88% 97%	91% 96%
	9	CPA clients in all clusters who have advance care plans in place	Qtr	200	231	197	195	209	231
	10	Number and percentage of service users using a Recovery Star: Open pathways on cluster 6, 10, 13, 16 & 17 for a minimum of 8 weeks who have a recovery star	Qtr	8%	186 8.5%	210 9%	190 8%	192 9%	186 8.5%
Domain 4	**Ensuring people have a positive experience of care**								
	11	All inpatients who have nutritional assessment within 72 hours All inpatients who have nutritional assessment in total	Mth	64% 80%	65% 73%	77% 87%	57% 61%	59% 65%	63.2 70%

NHS Outcomes Framework domain	QPI ref	QPI	Freq of Report	15/16 FINAL	16/17 YTD	Q1	Q2	Q3	Q4
	12	Complaints - number - report trends & actual (not including MP enquiries)	**Qtr**	405	360	87	95	92	86
	13	Complaints - ratio to contacts - report actual	**Qtr**	0.10%	0.09%	0.08%	0.10%	0.10%	0.09%
	14	Complaints - number - report trends & actual - COMMUNICATION & ATTITUDE OF STAFF	**Qtr**	108	117	29	30	30	28
	15	Complaints - % of all formal complaints relating to COMMUNICATION & ATTITUDE OF STAFF	**Qtr**	27%	33%	33%	32%	33%	33%
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**								
	16	Incidents of serious self harm by **inpatients** (only SIs) inlcudes **mod and severe**	**Mth**	2	2	1	0	1	0
	17	Incidents of serious self harm by **inpatients** (only SIs) **severe** only	**Mth**	0	0	0	0	0	0
	18	Total of Acute inpatients (all age) experiencing one or more incidents of control and restraining (MH02) - Quarterly reported (excluding hold1 for personal care)	**Qtr**	1338	3273 (1614)	919 (329)	640 (407)	894 (475)	820 (403)
	19	Total of Acute inpatients (all age) experiencing one or more incidents of seclusion (MH03) - excludes forensics	**Qtr**	154	251	56	39	73	83
	20	Number of all patients who had recorded incidents: physical assault on the patient (MH10) (all levels)	**Qtr**	448	391	133	125	69	64
	21	The proportion of detained acute/ALL inpatients who have absconded in **last three months** (inl AWOL on MHA) (MH14) (Sis)	**Qtr**	10	3	0	2	1	0
	22	Number of Serious incidents - reported on STEIS, trends, ethnicity & actual only those recorded on STEIS)	**Mth**	188	182	49	39	43	51
	22b	Number of ALL serious incidents ((level 4/5)including awaiting decisions from Mortality panel	**Mth**	195	188	49	39	43	57

NHS Outcomes Framework domain	QPI ref	QPI	Freq of Report	15/16 FINAL	16/17 YTD	Q1	Q2	Q3	Q4
	24	Number and % of Grade 2 SIS that are breached over 60 working days on STEIS	**Mth**	0	29	0	0	5	24
	25	Number of medication errors (all levels)	**Qtr**	351	397	84	114	92	107
	26	Falls - **OPMH inpatients over 65 -falls** Assessments of risk within 24 hours of admission to acute inpatients (NPSA definition)	**Mth**	99%	99%	97%	100%	100%	99%
	28	% eligible staff receiving child safeguarding training at level 1	**Mth**	98%	98%	99%	99%	99%	95%
	29	% eligible staff received adult safeguarding training at level 2 = KMPT level 1	**Mth**	89%	91%	90%	94%	89%	92%
	30	% eligible staff who have received an enhanced CRB check	**Mth**	100%	100%	100%	100%	100%	100%
	31	Hand Hygiene training - (2 yearly)	**Mth**	83%	89%	88%	89%	91%	90%
	32	Hand Hygiene audit	**Mth**	96%	92%	96%	85%	96%	95%
	33	Violence against MH Staff **(community)** assaults (MH11) - actual (all levels)	**Qtr**	33	116	23	41	40	12
	34	Violence against MH Staff **(inpatient)** assaults (MH11) - actual (all levels)	**Qtr**	868	1042	310	278	285	169
	35.a	The number of all falls in **older adult inpatient wards** which result in **harm** to the patient (incl suspected) (all levels)	**Qtr**	259	222	76	55	41	50
Quality Account	35.b	Number of falls **in older adult inpatient wards** which result in harm to the patient (incl suspected) **moderate/severe harm** (only Sis STEIS)	**Mth**	19	9	3	3	0	3

NHS Outcomes Framework domain	QPI ref	QPI	Freq of Report	15/16 FINAL	16/17 YTD	Q1	Q2	Q3	Q4
	36	1. Reduction in the number of patients who take their own life during an **inpatient** admission (including AWOL/ABSCOND/and on LEAVE) 2. Reduction in the number of patients who seriously self harm (SSH) themselves during an **inpatient** admission. **(severe)**	**Mth**	2 0	0 0	0 0	0 0	0 0	0 0
	37 a.	The percentage of inpatient service users who have had physical health checks within 72 hours This looks at: Nutrition, Weight, Height, Smoking, Blood Pressure, Pulse and Respiration.	**Mth**	90%	93%	95%	94.0%	91.0%	91.0%
	37 b.	The percentage of inpatient service users who have had physical health checks within a week of admission	**Mth**		96%	96%	96.0%	95.0%	95.0%
	37 c.	The percentage of inpatient service users who have had physical health checks completed during entire inpatient stay.	**Mth**		98%	99%	98.0%	97.0%	97.0%
	38	The percentage of community service users who have been in the team for 6 weeks or more, who have received a physical health assessment by either the community team or via their GP.	**Qtr**		36.0%	31.8%	30.7%	36.0%	36.0%
	39	Clostridium difficile actuals	**Mth**	2	0	0	0	0	0
	40	MRSA Bacteraemia - actuals	**Mth**	0	0	0	0	0	0
	41	Infectious diseases (TB, Norovirus)	**Mth**	0	1	0	0	1	0
	42	Number of incidents of patients experiencing mixed sex accommodation	**Mth**	0	2	2	0	0	0
	43	Number of incidents reported of patients using wrong gender bathroom	**Mth**	0	0	0	0	0	0

Appendix E: Sign Up to Safety Pledges

Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally. We will:

• Publish our annual patient safety priorities in the Trust's Annual Quality Account

• Implement safer staffing reports to the Board in order to ensure that nurse staffing levels are adequate to meet the "acuity and dependency" of their patient population

• Produce and publish our patient safety improvement and implementation plan

• Contribute to National Mental Health data on Cardiometabolic Monitoring of our in-patients with a psychosis illness, which will be published on the NHS England web site

• Promote best practice in reducing restrictive interventions

Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are. We will:

• Share learning from incidents, complaints, investigations and quality improvement/assurance projects from both external and internal sources through the Trust Learning from Experience Group, Patient Safety Group, Video linked Learning events and Annual Quality Conference

• Join the South East Coast Patient Safety Collaborative

• Participate in a portfolio National Clinical Audit and Patient Outcomes Programme projects that we are eligible to take part in

• Develop further checks and measures, including trends and analysis of incidents

• Publish a monthly Learning, Listening and Improving Bulletin

Honesty. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. We will:

• Embed openness as our Trust value across the organisation with honesty, kindness and compassion

• Continue with the roll out of the face to face Customer Care Training and to implement a Customer Care e-learning package

• Maintain the annual Customer Care Week to ensure that Trust visions and values are embedded throughout the organisation

• Publish lessons from serious incidents

• Promote patient and carer engagement in research and service development

Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. We will:

•Participate in South East Coast Patient Safety Collaborative

• Continue to participate in South of England Improving Safety in Mental Health Collaboration

• Identify a patient safety champion within each service line to regularly disseminate safety information across their service line

• Promote a Patient Safety Award as part of the Trust annual staff awards programme

• Continue sharing information on learning and best practice with GPs, local authorities and other partners in order to embed shared learning

Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress. We will:

• Encourage the sharing and discussion of improvement experiences associated with patient safety learning and best practice at patient engagement groups and team meetings

• Publish examples of reflective practice in order to embed its use

• Continue to promote the `Support Line Services' and `The Big White Wall' online support service to staff, together with the implementation of the Staff Egagement and Wellbeing Action Plan 2013/2014

• Ensure that staff receive supportive supervision and have Performance Development Plans

• `Inspiring Innovation' scheme that awards funding to clinical teams to support and pump prime local patient safety and quality improvement initiatives within clinical areas

Appendix F Sign up to Safety Improvement Plan

Safety Improvement Plan 1st April 2015 to 31st March 2018 (reviewed bi-monthly)

Clinical Risk Reduction: Suicides and serious self-harm

AIM	Actions	Measures	2015 - 2016	2016 -2017
To reduce suicides and serious self-harm during in-patient admission, or while in contact with a CRHT or while in treatment with a working age adult community team	To implement the KMPT Suicide Prevention Strategy	Number of suspected suicides and Severe/Moderate harm incidents for In-patient admissions, Crisis Resolution and Home Treatment (CRHT)Teams and Community Mental Health Teams.	In-patient admissions = 0 suspected suicides and 2 incidents of Severe/moderate Self harm CRHT = 5 suspected suicides and 1 incident of Severe/moderate self-harm Community Mental Health Teams had 37 incidents of suicides and 13 incidents of severe/moderate self-harm recorded.	In-patient admissions = 0 suspected suicides and 2 incidents of Severe/moderate Self harm CRHT = 8 suspected suicides and 4 incident of Severe/moderate self-harm Community Mental Health Teams had 32 incidents of suicides and 14 incidents of severe/moderate self-harm recorded.

Clinical Risk Reduction: Management of Violence

AIM	Actions	Measures	2015 - 2016	2016 -2017
Reduce number of violent incidents on Trust premises and if they occur to reduce the harm caused from such incidents	Participate in Safe Wards initiative http://www.safewards.net/ Use to Orchard Tool Kit on Older People In-patient wards Further actions to be provided by the Management of Violence and Aggression Group See 2017-18 Patient Safety Priority 2 *Reduction of violence within inpatient care settings* on page 80	Number of violent serious incidents (physical abuse , assault or violence) as defined by the Quality Digest	Number of patients who had recorded incidents: physical assaults on the patient 448 Violence against MH Staff (Community) assaults = 33 Violence against MH Staff (in-patients) assaults = 868	Number of patients who had recorded incidents: physical assaults on the patient 391 (decrease of 13% on 2015-16) Violence against MH Staff (Community) assaults = 116 (increase of 352%) Violence against MH Staff (in-patients) assaults = 1042 (increase of 120%)

Safer Discharges minimising patient safety events (Priority discontinued December 2016)

AIM	Actions	Measures	2015 - 2016	Current Status 2016 -2017
To reduce reliance on external acute bed providers	To identify patients who frequently present out of hours in crisis and to develop an MDT led crisis management plan of care. To appoint patient flow coordinators for each inpatient facility who would work on developing close working relationships with community services, social care as well as other agencies such as housing which would help in moving patients through their care pathway and enable proactive discharge planning early on in the patient's care pathway. Patient flow coordinators to produce a weekly report for their wards and highlight discharge ready patients and any difficulties preventing these patients from progressing through their care pathway. Patient pathway board has identified that discharges are delayed when in patient consultants are on leave. Senior management to review cross cover and formal hand over arrangements and consider nurse led discharges which are already a norm in CRHT.	Number and % of service users in PbR clusters 4, 8 & 10 who have a designated care co-ordinator	75.3%	76.4% (Increase of 1%)

AIM	Actions	Measures	2015 - 2016	Current Status 2016 -2017
	Staff engagement and training in risk assessment and management. Use of video conferencing If required, earlier referral to Forensic and Specialist Services			

Medication

AIM	**Actions**	**Measures**	**2015 - 2016**	**Current Status 2016 -2017**
To reduce harm from medication incidents	Monthly Blank Boxes Audit by Ward Managers Medicine safety thermometer Medication incidents recorded on Datix Where appropriate staff will be encouraged to use Plan, Do, Study, Act (PDSA) cycles and other Quality Improvement Methods to reduce medication omissions and increase allergy recording See 2016-17 Patient Safety Priority 3 To reduce harm from medication incidents on page 16	To reduce the percentage of Blank Boxes on prescription cards To increase the percentage of medicines reconciled within 24 hours To increase the reporting of medication related incidents	The number of reported Blank Boxes on prescription cards per month from November 2015 to March 2016 was 9% The monthly a percentage of medicines reconciled within 24 hours was 79% The number of medication incidents reported was 279, average of 28 per month	The number of reported Blank Boxes on prescription cards per month from April 2016 to March 2017 was 3% (a reduction of 67% on the 2015-16 monthly average) The monthly a percentage of medicines reconciled within 24 hours was 95% (an increase of 16% on the 2015-16 monthly average The average number of medication incidents reported was 33 per month (an increase of 15% on the 2015-16 average)

Patient Safety Culture and Clinical Risk Assessment Transformation

AIM	Actions	Measures	Baseline 2015 - 2016	Current Status 2016 -2017
To reduce harm by promoting an effective patient safety culture within the Trust	Pilot and evaluate the use of a Patient Safety Culture Tool within one team Further actions dependant on outcome of Pilot workshop	Number of teams completing two workshop cycles	A Pilot Patient Safety Workshop was conducted on the 17th March 2016 involving staff from the Trevor Gibbons Unit, Forensic and Specialist Services Service Line. Further workshops will be planned after the evaluation of the pilot has been reviewed.	No patient safety workshops conducted during 2016 – 2017 although presentations on patient safety workshops (based on the evaluation of the pilot workshop carried out in 2016) were made to the Patient Safety Group and offered to Service Line Governance Groups.
To transform the current clinical risk assessment process into a recovery focused risk assessment process.	a) New Risk Assessment and Safety Plan to replace Risk Summary Form on Rio b) Patient and carers to be involved in safety planning c) High quality safety planning training (involving patients and carers) to be designed and implemented d) Staff Supervision to promote reflective practice and effective practice to be enhanced through improvements in training and the provision of supervision	The number of Patient Safety Plans produced	a) The current Rio Risk Summary will be replaced with a new Risk Assessment and Safety Plan. The new document will guide the clinician into using the 3 Tiered approach at every risk assessment. The Prevention of Suicide and Homicide Group are working on this and I need to confirm when the new document will be ready. It will also be dependent on the Rio Team adding it to Rio and it will of course have to go through governance etc. b) We should be able to use a similar approach to patient and carer inclusion as practiced in the Forensic Service Line. This can then be evidenced within the new safety plans. I will check with Forensic as to how they have implemented this and how they measure this. c) New Safety Planning training will be designed together with the implementation of a training strategy. We will need to make contacts with Patient and Carer groups and develop' involvement' plans. Again experience from forensic	The developments as described in the 2015-2016 baseline has continued during 2016-2017 --- After completing testing by clinicians, the new electronic patient record risk summary (complete with prompts and information screens) is soon to be rolled-out Trust-wide. The new summary includes guidance on risk management and safety planning and links in with care plans and crisis/ relapse/contingency plans. --- The Tiered Approach (SAFE-T) to assessing clinical risk has been incorporated into the new risk summary for guiding best practice for assessment and management /safety planning The Tiered Approach has been embedded within the revised Clinical Risk Assessment and Management Policy 2016-2019 and is set as a mandatory training and is monitored for compliance by each Service Line. The Clinical Risk /Safety Planning transformation is to be supported by

AIM	Actions	Measures	Baseline 2015 - 2016	Current Status 2016 -2017
			service line may help us here as well as other user/carer groups d) Review current supervision provisions across the Trust ensuring adequate reflective practice is evidenced and make improvements as necessary. Clinical supervision training will be developed together with training matrix and strategy for the delivery of the training. Safety planning to be written into supervision policy and reinforced through supervision training and evidenced in supervision notes	clinical supervision and training, as part of the promotion of a "patient safety culture" within KMPT. Training for Managing Risk in Supervision has already been developed and preliminary discussions are underway with Psychology re supervisory leads. Staff Supervision is also being reviewed, please see 2016-17 Clinical Effectiveness Priority `To improve the provision and quality of clinical supervision' page 26 and see 2017-18 Patient Safety priority `To improve recording of risk management within care plans, on page 79 ` Service user and carer guidance for safety planning is ongoing and will be incorporated within a training strategy for safety planning (currently under development).

Physical Health

AIM	Actions	Measures	2015 - 2016	Current Status 2016 -2017
To reduce harm to patients from poor physical health and injury (Falls, VTE and Smoking Cessation)	Falls The falls risk assessment tool has been reformulated and will be piloted on Sevenscore Ward. The physical health group will monitor the results The physical health in the older adult training now includes a session on falls to support increasing the training for ward	-To reduce the number of moderate/severe falls -To reduce the number of VTE incidents during 2016 -To increase the number people admitted and people under the care of community mental health teams who smoke who are offered a smoking cessation intervention	Falls: 19 VTE: 5 patients involved in a VTE related incident (up to and including November 2015) Smoking Cessation of people admitted to an in-patient unit who were declared smokers were offered a smoking cessation intervention Q1 63.4%, Q2 54.7%, Q3 64.0%,	Falls: 9 (a decrease of 111% when compared to the same number of falls in 2015-16) VTE: 3 patients involved in a VTE related incident (up to December 2016) Smoking Cessation of people admitted to an in-patient unit who were declared smokers were offered a smoking cessation intervention Q1 60.2%, Q2 88.3%, Q3, 100% Q4, 100%

AIM	Actions	Measures	2015 - 2016	Current Status 2016 -2017
	staff The Trust wide Physical Health Group will look at a greater analysis of the figures to draw out themes. Where appropriate staff will be encouraged to use Plan, Do, Study, Act (PDSA) cycles and other Quality Improvement Methods to innovate fall reduction. VTE Future plans for reducing VTE incidents include taking in consideration the following actions: Mandatory E learning for VTE for all clinicians (this is available) Datix report for all incidences to capture VTE in real time Reporting via Staffzone – similar to infection control Review the RIO 2 risk assessment form to improve awareness of the risk factors even if deemed mobile Consider minimum VTE risk assessment especially for long term inpatients. i.e. forensic Raise staff and public		Q4 70% Of service users under the care of our community teams who smoke were offered a smoking cessation intervention Q1 32.3% Q2 37.4% Q3 39.9% Q4 34.3%	Of service users under the care of our community teams who smoke were offered a smoking cessation intervention Q1 41.2%, Q2 75.1%, Q3 100% Q4 100%

AIM	Actions	Measures	2015 - 2016	Current Status 2016 -2017
	awareness about VTE Publishing a patient information leaflet on VTE Publishing and distributing posters re risks/awareness of VTE Where appropriate staff will be encouraged to use Plan, Do, Study, Act (PDSA) cycles and other Quality Improvement Methods to innovate VTE reduction Smoking cessation The Trust has a smoke free policy across all hospital grounds and buildings. This includes ensuring there are no designated smoking areas, and no staff-supervised or staff-facilitated smoking breaks for people using our inpatient services Service users who smoke and are admitted to our inpatient units will be supported to remain smoke free during their stay. The key interventions will be: -Providing information on the hospital policy and the benefits of stopping smoking to all service users including on, or			

AIM	Actions	Measures	2015 - 2016	Current Status 2016 -2017
	prior to, admission -Providing support to smokers or those on Nicotine Replacement Therapy (NRT) on admission Provision of a personal stop smoking plan for all those who smoke or have recently stopped smoking or use NRT -Providing a range of NRT pharmacotherapies -Ensure service users who require NRT have access to stop smoking pharmacotherapies at all times -Ensure service users have access to intensive behavioural support if they require it.			

Appendix G: Glossary and Abbreviations

A & E	Accident and Emergency
AfC	Agenda for Change
AGM	Annual General Meeting
AIMS	Accreditation for Acute Inpatient Mental Health Services
ALE	Auditors Local Evaluation
ALOS	Average Length Of Stay
AWOL	Absent Without Leave
BME	Black Minority Ethnic
BPPC	Better Payment Practice Code
CAB	Citizen's Advice Bureau
CAF	Common Assessment Framework
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CIPs	Cost Improvement Programmes
CMHTs	Community Mental Health Teams
CNST	Clinical Negligence Scheme for Trusts
CoG	Council of Governors
COPD	Chronic Obstructive Pulmonary Disease
CQUIN	Commissioning for Quality and Innovation
CQC	Care Quality Commission
CRES	Cash Releasing Efficiency Savings
CRHT	Crisis Resolution Home Treatment Team
CROM	Clinician Rated Outcome Measure
CSFF	Community Services Feedback Form
CSIP	Care Services Improvement Partnership
CRS	Care Records Service
DGH	District General hospital
DOH	Department of Health
DOLs	Deprivation of Liberty Safeguards
DRE	Delivering Race Equality
DToC	Delayed Transfer of Care
EBITDA	Earnings Before Tax Depreciation Amortization
EFL	External Financing Limit
EMT	Executive Management Team
EPEX	Effective Project Executive Programme
ESR	Electronic Staff Record
EWTD	European Working Time Directives
FT	Foundation Trust
FTE	Full Time Equivalent
GIS	Geographical Information System
GP	General Practitioner
GRiST	Galatean Risk Screening Tool
HCC	Health Care Commission
HIS	Health Informatics Service
HoNOS	Health of the Nation Outcome Scale
HR	Human Resources
IAPT	Improving access to Psychological Therapies
IBP	Integrated Business Plan
ICT	Information and Communication Technology
I&E	Income & Expenditure

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

SIC	Statement on Internal Control
SLA	Service Line Agreement
SLM	Service Line Management
SLR	Service Line Reporting
SMF	Senior Management Forum
SMT	Senior Management Team
SSAS	Specialist Supported Accommodation Services
STR	Support Time Recovery
SUIs	SeRiOus Untoward Incidents
SWOT	Strengths, Weaknesses, Opportunities, Threats
TFT	Thought Field Therapy
ToC	Triangle of Care
VTE	Venous Thrombus Embolism
VfM	Value For Money
WC	Working Capital
WF	Workforce

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

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

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

Advocate
An advocate is a person who can support a service user or carer through their contact with health services. Advocates will attend meetings with service users and help service users or carers to express concerns or wishes to health care professionals. Although many people can act as an advocate (friend, relative, member of staff), there are advocacy services available that can be accessed through the Trust. These advocates are trained and independent.

Aftercare
This is the support or care that a person can expect to receive once discharged from inpatient care. Typically a discharge plan will be developed by the multidisciplinary team with the service user which will make clear what care and support will be provided. (See Care Plan, CPA).

Agenda for change
Is the current National Health Service (NHS) grading and pay system for all NHS staff, with the exception of doctors, dentists and some senior managers.

Appropriateness of care
When in a clinical situation, the expected benefits (e.g. improved symptoms) of care outweigh the expected negative effects (e.g. drug side effects) to such an extent that the treatment is worth carrying out.

Approved Social Worker (ASW)
Approved Social Workers (ASW) have specialist training and experience in identifying disorders of mental health and are familiar with the problems experienced by users of mental health services and their families. They are employed by Local Authority Social Services and work in hospitals and in the community as part of the community mental health teams. They will organise social care support for people in contact with mental health services, such as helping with housing and getting welfare benefits. They work closely with health professionals and, under the current Mental Health Act, they work with two doctors to assess a person who may need admitting to hospital. Social workers can also act as care coordinators for people on care programmes.

Assertive Outreach
Assertive outreach services aim to support people in the community who find it difficult keeping in contact with mental health services.

Assessment
Assessment happens when a person first comes into contact with health services. Information is collected in order to identify the person's needs and plan treatment.

Caldicott Guardian
A senior healthcare professional in each NHS organisation is responsible for safeguarding the confidentiality of patient information. The name comes from the Caldicott Report, which identified 16 recommendations for the use and storage of patient identifiable information.

Care Co-ordinator
A care co-ordinator is the person responsible for making sure that a patient gets the care that they need. Service users and carers should be able to contact their care co-ordinator (or on-call service) at any reasonable time. Once a patient has been assessed as needing care under the Care Programme Approach they will be told who their care co-ordinator is. The care co-ordinator is likely to be a community mental health nurse, social worker or occupational therapist.

Care plan
A care plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy (see Care Programme Approach).

Care Programme Approach (CPA)
The Care Programme Approach is a standardised way of planning a person's care. It is a multidisciplinary (see definition) approach that includes the service user, and, where appropriate, their carer, to develop an appropriate package of care that is acceptable to health professionals, social services and the service user. The care plan and care co-ordinator are important parts of this. (See Care Plan and Care Co-ordinator).

Carer
A carer is someone who looks after their relatives or friends on an unpaid, voluntary basis often in place of paid care workers.

Client (see also service user)
An alternative term for patient which emphasises the professional nature of the relationship between a clinician or therapist and the patient.

Cognitive Behaviour Therapy (CBT)
Cognitive Behaviour Therapy (CBT) is a talking treatment designed to alter unwanted patterns of thought and behaviour; it addresses personal beliefs which may result in negative emotional responses, concentrating on understanding behaviour rather than the actual cause of a problem.

Commissioning for Quality and Innovation (CQUIN)
CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of a NHS Trust's income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

Community Mental Health Team (CMHT)
A multidisciplinary team offering specialist assessment, treatment and care to people in their own homes and the community.

Gatekeeping
A process used to manage fair and equitable access to services.

Consent to treatment
If you are an informal patient, you have the right to refuse any treatment you do not wish. You have a right to receive full information about the treatment, its purpose and possible side effects. If consent is not obtained the treatment cannot normally be given.

Discharge
The point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan (see Care plan).

Episode of care
The period when a service user enters the care of the Trust to when they are discharged from all services provided by the Trust. This care could be, for example a combination of care provided by inpatient stays, outpatient attendances, a CPN, or use of services from an OT and a day hospital.

Home treatment team
A team usually consisting of a psychiatrist, nurse and social worker. The team provides a mobile service offering availability 24 hours, seven days a week and an immediate response. The team provides a gate keeping function to hospital admission and enables earlier discharge from hospital.

Integrated Care Pathway
Integrated Care Pathways are a multi-disciplinary and multi-agency approach to mapping service users' care from admission through to discharge and ongoing care. The aim is to pull together all the information into one file that will make it easier for the clinicians involved to give the best care for the patient.

Mental Health Act (1983) (MHA)
The Mental Health Act (1983) is a law that allows the compulsory detention of people in hospital for assessment and/or treatment for mental disorder. People who are detained under the Mental Health Act must show signs of mental disorder and need assessment and/or treatment because they are a risk to themselves or at risk to others. People who are detained have rights to appeal against their detention.

National Institute for Clinical Excellence (NICE)
It provides clinical staff and the public in England and Wales with guidance on current treatments. It coordinates the National Collaborating Centres from whom it commissions the development of clinical practice guidelines.

Patient Advice and Liaison Service (PALS)
All NHS Trusts are required to have a Patient Advice and Liaison Service. The service offers service users information, advice, quick solution of problems or access to the complaints procedure.

Person Centred Care Planning
Personalised care planning is a fundamental part of the personalisation agenda that places service users at the centre of the care planning process, and recognises that they are best placed to understand their own needs and how to meet them.

Primary Care
Primary care is the care that you will receive when you first come into contact with health services about a problem. These include family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

Recovery Star
Is a tool for optimising individual recovery and gaining the information to create a recovery-focused Care Plan.

RiO
RiO is the Trust's Clinical Patient Information System, which is a secure electronic system used by clinicians to record the care provided to service users.

Secondary care
Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional. Mental Health Services are included in secondary care (see also tertiary care).

Section
This is used to refer to one of the sections of any Act of Parliament. A person who is detained in hospital under the Mental Health Act (1983) is commonly referred to as ‘sectioned’.

Service user
This is someone who uses health services. Other common terms are patient, service survivor and client. Different people prefer different terms.

Single Assessment Process (SAP)
The Single Assessment Process (SAP) for older people was introduced in the National Service Framework for Older People. The purpose of the single assessment process is to ensure that older people receive appropriate, effective and timely responses to their health and social care needs, and that professional resources are used effectively.

Talking treatments
These are psychological treatments in which improvement in a person’s symptoms or wellbeing is achieved by talking with a therapist or counsellor rather than, or as well as, taking medication.

Therapeutic relationship
The therapeutic relationship (also called the helping alliance, the therapeutic alliance, and the working alliance) refers to the relationship between a mental health professional and a service user. It is the means by which the professional hopes to engage with, and effect change in, a service user.

User involvement
User involvement refers to a variety of ways in which people who use health services can be involved in the development, maintenance and improvement of services. This includes patient satisfaction questionnaires, focus groups, representation on committees, involvement in training and user-led presentations and projects.

Appendix H: Independent Auditor's Limited Assurance Report to the Directors of Kent and Medway NHS and Social Care Partnership Trust on the Annual Quality Account

Independent Auditor's Limited Assurance Report to the Directors of Kent and Medway NHS and Social Care Partnership Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of Kent and Medway NHS and Social Care Partnership Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Percentage of patients on Care Programme Approach (CPA) followed up within seven days of discharge;
- Percentage of patient safety incidents resulting in severe harm or death.

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

Respective responsibilities of directors and auditors

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

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

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

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account. Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2016 to 22 June 2017;
- papers relating to quality reported to the Board over the period April 2016 to 22 June 2017;
- feedback from Commissioners dated 30 May 2017;
- feedback from Local Healthwatch organisations dated May 2017;
- feedback from Overview and Scrutiny Committee dated 9 and 12 May 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England)Regulations 2009, dated 12 July 2016;
- the latest national patient survey dated 15 November 2017;
- the latest national staff survey dated January 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 12 May 2017;
- the annual governance statement dated 25 May 2017;
- the Care Quality Commission inspection report dated 12 April 2017.

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

This report, including the conclusion, is made solely to the Board of Directors of Kent and Medway NHS and Social Care Partnership Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Kent and Medway NHS and Social Care Partnership Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

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

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

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

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

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

26 June 2017

Your Views

We want to know what you think. Therefore, if you have any comments to make about this Quality Account, or you would like further copies, please contact:

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This report can be downloaded as a PDF from www.kmpt.nhs.uk

If you or someone you know cannot read this document, please advise us of your/their specific needs and we will do our best to provide you with the information in a suitable format or language. Contact: 01622 724100.

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

Bengali

ট্রাষ্ট, এর সার্ভিসসমূহ, বা আপনার কেয়ারের (যত্নের) ব্যাপারে আপনি কোন তথ্য চাইলে, অনুগ্রহ করে আপনার পছন্দসই ভাষায় কিছু তথ্য সরবরাহের আয়োজন করার জন্য আমাদের কর্মীদের বলুন।

Chinese

如果你需要什麼訊息有關這個基金信託會、它為你提供的服務或你得到的照料，請向我們的工作職員要求將一些相關訊息翻譯成你能閱讀的語言。

Polish

Jeśli potrzebujesz informacji na temat Trustu, zakresu naszych usług lub otrzymywanej opieki, poproś kogoś z personelu o udostępnienie informacji w Twoim języku.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਟ੍ਰਸੱਟ ਬਾਰੇ, ਇਸ ਦੀਆਂ ਸੇਵਾਵਾਂ ਬਾਰੇ ਜਾਂ ਤੁਹਾਡੀ ਕੀਤੀ ਜਾਂਦੀ ਦੇਖ-ਭਾਲ ਬਾਰੇ ਕਿਸੇ ਵੀ ਪ੍ਰਕਾਰ ਦੀ ਜਾਣਕਾਰੀ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਤੁਹਾਡੀ ਪਸੰਦ ਦੀ ਬੋਲੀ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਦਾ ਪ੍ਰਬੰਧ ਕਰਨ ਲਈ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਕਰਮਚਾਰੀਆਂ ਨੂੰ ਪੁੱਛੋ।

Turkish

Trust (Vakıf), sunduğu hizmetler veya size verilen bakım hakkında bilgi edinmek istiyorsanız, lütfen personelimizden size tercih ettiğiniz dilde bilgi sağlanması için istekte bulunun.