CQC Improvement Action Plan - Inspection September 2016

Version No	3.6
Date	02/06/2017
Leads	Sara Courtney, Chief Nurse Tracey McKenzie, Head of Compliance and Assurance Mehreen Arshad, Programme Lead (PMO - Quality and Improvement Planning) Briony Cooper. Programme Manager (PMO- Quality and Improvement Planning)

CQC September 2016 Action Plan Dashboard

Completion	**62%**

Action Plan Position Status

RAG status	Dec	Jan	Feb	Mar	Apr	May	June
Overdue	0	2	0	2	2	1	
At risk of Slippage	0	0	0	0	1	0	
On track	17	15	16	9	5	4	
Complete	0	0	0	5	5	23	
Unvalidated	20	20	21	21	24	9	
TOTAL	37	37	37	37	37	37	0

Assurance and Validation Process

	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unvalidated	7	5	3	3	0	1	1
Validated	0	0	0	0	0	0	4

	Apr	May	Jun	Jul	Aug	Sep	Oct
Unvalidated	5						
Validated	2						

Version Control

NHS Southern Health NHS Foundation Trust

Change record

Date	Author	Version	Page	Reason for Change
19.4.17	L Connor	V3.1	All	Set up change record and version number system
27.04.17	B Cooper	v3.1	IP	41.8 bathrooms Parklands - changed to at risk of slippage. 42.6 and 42.7 anti roll guttering Elmleigh at risk of not meeting recovery date 30/05/17.
5.5.17	Lconnor	V3.2	all	Chased for update on over due, at risk and unvalidated actions.
12.05.17	B Cooper	v3.3	IP	guttering completed - changed from overdue to complete-unvalidated; 41.8 Parklands bathrooms should be completed by May 18th and so changed to on track from risk of slippage; 43.3 updated
18.5/17	I Connor	V3.4	All	42.6 building work complete-unvalidated. Added evidence to 41.4, 44.1, 45.2.
02.06.17	B Cooper	v3.5	All	41.8 building works completed - change to complete-unvalidated; 42.3 changed form on track to overdue with recovery date 16/06/17.

UIN	Trust Action	Completion Date	Action Status	Recovery date	Progress Update	Evidence	Executive Validation
RN043 43.1	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan. In addition to include:	30/09/2017	On Track	n/a			
RN043 43.2	INTERNAL REVIEW: Embedment of the new committee structure for quality governance	30/06/2017	On Track	n/a			
RN043 43.3	EXTERNAL REVIEW: Well-led review carried out by NHSI in Q4 2016/17 or Q1 2017/18 (tbc by NHSI)	30/06/2017	On Track	n/a	09/5/17: Discussed at QIPDG, SC stated External well-led review was not carried out by NHSI and it was thought that CQC inspection would be a focused Well Led inspection. However, although CQC inspection in March 17 had some well-led elements, it was not a Well Led focused inspection. Expect it will form part of the comprehensive CQC review in Q4 2017-18.		
RN043 43.4	EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan	31/08/2017	On Track	n/a	07 April 2017: Niche gave initial feedback on phase 2 testing and overall felt good progress being made and could see significant improvements in Board visibility and culture. Had yet to look at all evidence and will ask for additional evidence as original request did not include everything required for assurance.		

actioned 28april

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Regulation Breached	Cause of Regulation Breach	Trust Action	Executive Accountability
RN043 43.1	43	REQUIREMENT NOTICE	WELL-LED	n/a	Trust-wide	Governance processes	The trust must continue to review and embed more effective governance systems to ensure effective monitoring of quality and safety	Regulation 17 HSCA (RA) Regulations 2014 Good governance	Whilst a number of new processes had been introduced and strengthened, the trust had not embedded systems and processes to ensure quality and safety of services.	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan. In addition to include:	Sara Courtney - Interim Chief Nurse
RN043 43.2										INTERNAL REVIEW: Embedment of the new committee structure for quality governance	
RN043 43.3										EXTERNAL REVIEW: Well-led review carried out by NHSI in Q4 2016/17 or Q1 2017/18 (tbc by NHSI)	Paul Streat, Director of Corporate Governance
RN043 43.4										EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan	Sara Courtney - Interim Chief Nurse

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RN039 39.1	39	REQUIREMENT NOTICE	SAFE	n/a	All inspected	Documentation & Record Keeping	The trust must ensure better consistency in relation to the quality and detail of risk assessments across the wards	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	There was inconsistency in the quality and detail of risk assessments across the wards	All patients, where environmental risks have been identified, will have an environmental safety plan recorded within RiO. This will record the mitigations for the risks identified with their risk assessment.	Mark Morgan - Operational Director	Jan-17	AMH Environmental meeting minutes Acute Care Forum minutes Review of safety plans within RiO	Risk assessments that are up to date and evidence that that are reviewed following incidents.
RN039 39.2					Elmleigh					The use of MDT care plans will be standardised across all AMH units and wards through the work carried out by the task and Finish Group, established via the Acute Care Forum.		Apr-17	Discussion will be evidenced in the minutes of the ACP Forum	
RN039 39.3										Elmleigh Ward Managers will review each individual's risk assessment on RiO to ensure that, where appropriate, the mitigations for environmental risks are clearly recorded within the patient's record.		Jan-17	Environmental risks mitigations are recorded within RiO- evidence provided via AMH CQC minutes	
RN040 40.1	40	REQUIREMENT NOTICE	SAFE	Forensic inpatient / secure	Ravenswood House	Documentation & Record Keeping	The trust must ensure that staff at Ravenswood House review risk assessments regularly and following incidents.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	The risk assessments at Ravenswood House were not reviewed and updated following incidents.	Carry out a review of all HCR20s and rectify any breaches	Mark Morgan - Operational Director	Nov-16	Up to date HCR20s	Risk assessments that are up to date and evidence that that are reviewed following incidents.
RN040 40.2										NHSE to carry out external review of HCR20s		Nov-16	Up to date HCR20s	
RN040 40.3										Conduct audit by reviewing all risk assessments, RiO summaries and progress notes		Sep-16	Audit results showing full compliance	
RN040 40.3										Communicate to all staff the importance of updating risk assessments in light of risk incidents		Sep-16	copy of staff briefing minutes of team meetings	
RN041 41.1	41	REQUIREMENT NOTICE	SAFE	Forensic inpatient / secure	Ravenswood House	Environmental	The trust must complete plans to improve and make safe the range of environments across the mental health and learning disabilities services in line with its estates improvement plan.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	The premises at several locations, identified in this report, were subject to plans to improve and make them safe. This work had not yet been completed	The service to be placed in derogation by the commissioners due to Medium Secure Standards in relation to the perimeter fence not being met.	Mark Morgan - Operational Director	Sep-16	Copy of Derogation Notice from the commissioners	Safe environment
RN041 41.2										The Estates Department to produce options and costings for fencing for the service to consider		Dec-16	Fencing option paperwork	
RN041 41.3										Due to the perimeter fence all leave in the grounds will now be classed as community leave via section 17 and will be approved by the MOJ where required.		Sep-16	Section 17 leave records	
RN041 41.3--->41.4										Review daily perimeter check log back to May 2016 to identify gaps. All relevant staff will be reminded of their requirement to complete the log on a daily basis. Additionally, individual staff who were present on the days of the missed sign off will also be spoken to.		Oct-16	Team meeting minutes Audit data	
RN041 41.3-->41.5				Adult mental health rehab	Forest Lodge					Carry out remedial paintwork on ceilings to address immediate concerns prior to full works being completed		Apr-17	Completed works, signed off by service	
RN041 41.4-->41.6										Full refurbishment of the communal bathrooms to be undertaken as part of wider refurbishment work at Forest Lodge. A 12week refurbishment programme of work is starting on 3 January 2017 and due to be completed in April 2017. The bathroom refurbishment will include the ceiling repair as well as addressing the current mechanical ventilation issues, which are causing condensation.		Apr-17	Completed works, signed off by service	
RN041 41.5-->41.7				Acute mental health inpatients	Parklands					The maintenance issues in the en-suite bathroom to be addressed immediately. This includes replacing the cistern, some pipework and the damaged wall panelling, as well as full deep clean. The bathroom will be reopened by 14th October 2016.		Oct-16	Completed works, signed off by service	
RN041 41.5-->41.8										Bathrooms will be fully refurbished as part of a wider refurbishment programme in Parklands Hospital. The works are due to start in January, and they have been programmed to focus on bathrooms first, with completion anticipated by the end of March, however this may run into April. The rest of the works should be completed by the end of May.		May-17	Completed works, signed off by service	
RN042 42.1	42	REQUIREMENT NOTICE	SAFE	Acute wards for adults of working age and psychiatric intensive care units	Elmleigh	Environmental	The trust must review the risks identified at Elmleigh in relation to lack of action following incidents, poor lines of sight, multiple ligature risks, safe management of mixed gender areas, risks from patients absconding and ineffective staffing arrangements.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	The premises at several locations, identified in this report, were subject to plans to improve and make them safe. This work had not yet been completed	POOR LINES OF SIGHT: Parabolic Mirrors and CCTV to be installed to increase visability Any remaining gaps in visibility will be mitigated via nursing risk assessment or other methods, as appropriate	Mark Morgan - Operational Director	Feb-17	Mirrors and CCTV in place to increase visibility	Safe environment
RN042 42.2										POOR LINES OF SIGHT: The risks are being mitigated by risk assessment of the individual patients. This is reviewed every time there is a change in patient's need/ presentation and reflected within the patient's RiO record. Observation levels may be increased in order for staff to monitor more frequently their mental state and risk to self and others. Additionally, staff may be allocated to the central observation area (at the top of the T) so that they have patient's bedrooms and main ward corridor in their line of sight.		Sep-16	Up to date risk assessments on RiO	
RN042 42.3										LIGATURE RISKS: Replacement programme of Elmleigh Green Bay windows has been identified as phase 1 priority to reduce the ligature points. The windows in the other bedrooms are being replaced in phase 2. The works will be undertaken March to May 2017		May-17	New windows installed	

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RN042 42.4										LIGATURE RISKS: Suspended ceilings at Elmleigh to be reviewed for replacement. Quotes are being obtained at present and the use of Single Tender Waiver is being considered. The programme of work is then to be agreed as part of the capital bid for the unit.		tbc	Ceilings do not pose a risk to the patients	
RN042 42.5										Elmleigh Ward Managers review the each individual's risk assessment on RiO to ensure that, where appropriate, the mitigations for environmental risks are clearly recorded within the patient's record.		Oct-16	Environmental risks mitigations are recorded within RiO	
RN042 42.6										ABSOND RISK: Obtain the quote and fit anti roll guttering to the remaining two courtyards and anti roll guttering on all roof at rear of building which is patient accessible. The programme of work is yet to be confirmed.		Feb-17	Anti roll guttering fitted to the roof	
RN042 42.7										ABSOND RISK: Obtain the quote and fit anti roll guttering to the top of the fence in the blue bay. The programme of work is yet to be confirmed.		Feb-17	Anti roll guttering fitted to the fence	
RN042 42.8										ABSOND RISK: Remove the tree in the courtyard		Nov-16	Tree removed	
RN042 42.9										STAFFING LEVELS: When staffing numbers are low the following actions are completed by the ward to mitigate the risks: 1. Safer staffing is completed every morning which reviews the staffing levels, skills mix, acuity of the patients, availability of the PRISS team, this informs ward of staff deployment requirements, identifies the need to request urgent NHSP shifts etc. 2. Every day the ward reviews the staffing and acuity for next 48 hours and plans accordingly as above. 3. Staff training is cancelled if required to ensure safe staffing levels on the ward 4. Staff are moved from one bay to another to ensure adequate cover through the unit 5. If Registered Nurse staffing levels are low, HCSWS are over recruited to provide additional support to the Registered Nurse 6. Ward managers are supernumerary on the rota, when staffing levels are low, they become ward based and carry out clinical duties for the shift. 7. Band 6s who have management days are requested to complete clinical duties for the shift.		Sep-16	Safer staffing figures unit rota	
RN042 42.10										ACUITY & DEPENDENCY: audit is carried out every 6 months on all of our units to ensure the staffing levels are appropriate for the acuity and dependency of the patient group, in line with the safer staffing requirements.		Sep-16	Acuity and Dependency audit results	
RN043 43.1	**43**	**REQUIREMENT NOTICE**	**WELL-LED**	n/a	Trust-wide	Governance processes	The trust must continue to review and embed more effective governance systems to ensure effective monitoring of quality and safety	Regulation 17 HSCA (RA) Regulations 2014 Good governance	Whilst a number of new processes had been introduced and strengthened, the trust had not embedded systems and processes to ensure quality and safety of services.	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan. In addition to include:	Sara Courtney - Interim Chief Nurse	n/a	Delivery of the outcomes as detailed within the two action plans	Robust governance processes are in place and evidence of embedding is being monitored
RN043 43.2										INTERNAL REVIEW: Embedment of the new committee structure for quality governance		Jun-17	Minutes of Safe, Effective & Caring group meetings Minutes of Quality & Safety Committee Board minutes	
RN043 43.3										EXTERNAL REVIEW: Well-led review carried out by NHSI in Q4 2016/17 or Q1 2017/18 (tbc by NHSI)	Paul Streat, Director of Corporate Governance	Jun-17	NHSI Well-led Review report	
RN043 43.4										EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan	Sara Courtney - Interim Chief Nurse	Aug-17	Phase 2 report	
SD044 44.1	**44**	**Should**	**SAFE**	Child and Adolescent mental Health Wards	Bluebird House	Incident reporting	The trust should ensure the arrangements for agency staff to access the incident reporting system at the Bluebird Unit are embedded	n/a	n/a	Long standing agency workers in post at Bluebird House who have been working on the unit for over 6 months have access to the reporting systems. Additionally, there is a generic agency log-in account set up which enables staff to log on to the system and then they can create their own Ulysses account. Substantive staff should be made aware of this and this should be communicated to agency staff as part of their induction on to the ward	Mark Morgan Operational Director	Oct-16	Increased reporting from agency staff	All incidents are reported in a timely manner
SD045 45.1	**45**	**Should**	**SAFE**	n/a	Bluebird House	Staff engagement	The trust should engage staff to understand the actual extent and impact of staffing levels and mix across the older person`s mental health wards and Bluebird House.	n/a	n/a	Local QIP is in place to manage staffing and the vacancy rate has reduced. There have been new starters in September and another Band 6 started in the first week of October 2016. There are daily reviews of staffing by ward managers and band 6 staff to ensure that staffing is allocated to facilitate leave and escorts .All instances of leave cancellation are reported. There are no reports of observations not being completed as required.	Mark Morgan Operational Director	Oct-16	Daily staffing reviews and QIP minutes	Safe staffing levels

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SD045 45.2					OPMH wards					Recruitment plan has been drawn up with input from Head of Nursing & AHP, HR & Recruitment. New models of working have been worked up and costed. Letter from HoN sent to all OPMH staff September 2016 explaining what senior staff were doing about vacancies. Further comms sent to GWM staff December 2016 to futher improve engagement. There have been qualified new starters. An agreed plan to over recrut to HCSW in each OPMH ward has had some success in the organic wards. Further recruitment initiatives planned for hard to recruit to areas. Daily review of staffing with ward managers escalating challenges to Matrons & HoN where required. Recriutment/vacancies will be on QUIP plans where appropriate. Visits planned in Jan & Feb 2017 of Matrons & HoN to ward team meetings to engage staff further. Skill mix review taken place in GWM - engagement improved with staff.All incidents concerning staffing levels reported via Ulysses - escaltion will also have ocurred to mitigate risk. Qualified nursing vacancies on risk register.	Gethin Hughes Operational Director	Dec-16	Daily staffing reviews and QIP minutes. Team meeting minutes. Comms sent to staff. Risk register. Recruitment plan.	
SD046 46.1	**46**	**Should**	**WELL-LED**	n/a	Trust-wide	Staff engagement	The trust should continue to actively engage and meet with staff during this time of uncertainty change of leadership	n/a	n/a	Fully deliver and embed all the actions from the January 2016 CQC inspection relating to staff engagement. In addition:	Paul Streat, Director of Corporate Governance	n/a	Staff survey results Your Voice Feedback external visits by stakeholders	A workforce who feel valued, listened to and safe to raise concerns as well as empowered and able to generate new ideas and make decisions to implement positive changes
SD046 46.2										Recruit staff engagement expert to carry out review and gap analysis		Dec-16	Expert in post	
SD046 46.3										Launch staff engagement programme		Dec-16	Presentation of staff engagement phased approach	
SD047 47.1	**47**	**Should**	**SAFE**	n/a	AMH rehab	Patient acuity & dependency	The trust should ensure it monitors the changing requirements of patients that may be admitted to the rehabilitation and older person`s wards, to ensure that patient and staff safety is maintained within the environment.	n/a	n/a	An admission protocol will be written for service users who are temporarily transferred from the Acute Mental Health wards to AMH Rehabilitation units	Mark Morgan - Operational Director	Feb-17	Admission protocol will be in place	Safe environment for both patients and staff
SD047 47.2					OPMH					The Admission, Transfer & Discharge Protocol to be followed. Escalation Protocol to be written for patients who require transferring to other mental health units and for patients whose discharge required expediting.	Gethin Hughes - Operational Director	Feb-17	Escalation Protocol will be written, shared & available.	