Quality Improvement Plan for: CQC Inspection Recommendations - January 2020

Version: 0.1
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Must/ Should actions	**Core service**	**CQC recommendation** *from the Inspection Report*	**Cause of breach/issue raised by CQC**	**Theme**	**Trust Action** **Process:** *actions to be taken/processes to be put in place to meet the recommendation.* **Outcome:** *expected improvement for patients/carers/staff following implementation of process actions.*	**Evidence to show completion**	**Completion date**
MUST	Wards for older people with mental health problems	The trust MUST ensure that all patients have access to a clinical psychologist and psychological therapies to meet their needs.	Patients on five of the seven wards had limited access to a clinical psychologist and psychological therapies. Two wards had recruited a psychologist for two days per week, but others had no provision and nursing staff told us that they didn't have the skills to deliver any psychological therapies.	Workforce	PROCESS: 1. To agree revised structure chart for clinical psychology/psychological therapies staffing in OPMH across all divisions to include community/inpatient posts. This will include a plan for the remaining 3 organic wards. 2. Meet with Clinical Director of Portsmouth and South East division to discuss establishment of 8b clinical psychologist post. 3. Secure the required funding for these posts and recruit into them. 4. Introduce the Comprehend Cope and Connect (CCC) psychological formulation model to include training for all staff. OUTCOME: 1. Patients on all OPMH wards will have access to psychological therapies. 2. All appropriate patients will have a CCC formulation – will be recorded within RIO accessible to all staff and a copy offered to patient and can be shared with carer with consent.	PROCESS: 1. Structure chart for clinical psychology/psychological therapies 2. Establishment of new 8b post 3. Funding in place 4. Staff trained in CCC model OUTCOME: 1. Recruitment to psychology posts 2. Audit of CCC formulation	PROCESS: August 2020 OUTCOME: December 2020
MUST	Wards for older people with mental health problems	The trust MUST ensure female lounges are not used by male patients and are available for female patients to use throughout day.	Female patients did not always have a female-only designated area as the female-only lounges were accessed by male patients. The female only lounges were often used for other activities and meetings. We saw male patients wander into female lounges. One was a frequent user of the female lounge because he wanted to use exercise equipment in the room.	Privacy and Dignity	PROCESS: Divisions to review their local operating procedures for female only lounges and that staff are clear about maintaining female only lounges and that these are not used as dual purpose areas. OUTCOME: There will be access to gender specific areas across all inpatient sites.	PROCESS: Divisions to confirm action complete plus provide their local operating procedures. OUTCOME: Peer review / ward accreditation visits	PROCESS: May 2020 OUTCOME: July 2020

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MUST	Wards for older people with mental health problems	The trust MUST ensure that staff record their decision-making when carrying out mental capacity assessments and ensure staff have a sound understanding of the Mental Capacity Act 2005.	Staff across the services had limited understanding about the use of Mental Capacity Act. The service did not have a procedure for monitoring the use of the Mental Capacity Act and recording of mental capacity assessments was minimal and variable within the patient records.	Mental Health Legislation	PROCESS: 1. To appoint a Mental Health Legislation Manager for the Trust to lead on implementation of the Mental Capacity Act, including implementation of the Liberty Protection Safeguards scheme. 2. To review the current policy, guidance, training, supervision, and recording arrangements. 3. To roll out the new Mental Capacity Act training across divisions to provide staff with the skills and knowledge about the core responsibilities and provisions of the Mental Capacity Act. 4. Divisions to have procedures in place to ensure training is completed, mental capacity assessments are completed and that the Mental Capacity Act is followed. OUTCOME: Staff are skilled and confident in all areas of mental capacity and are able to appropriately evidence and record their practice	PROCESS: 1. Manager in post 2. Updated policy, guidance, training, supervision and recording arrangements 3. Training programme 4. Numbers of staff trained/divisional procedures OUTCOME: Mental Capacity Act Audit	PROCESS: August 2020 OUTCOME: MCA Audit - tbc (new MH Manager to design and carry out audit)
MUST	Wards for older people with mental health problems	The trust MUST ensure there is a patient alarm system on all older person's wards which enables patients and visitors to alert staff to their need for urgent support.	Patients on Beaulieu ward were unable to access a nurse call alarm from their bedroom areas so could not call for help from their bedrooms in an emergency. Staff told us these had been removed during refurbishment	Patient Safety	Divisional Director of Nursing confirms that all patient bedroom areas have nurse call alarms and that patients are able to call for help from their bedrooms in an emergency.	PROCESS: N/A OUTCOME: N/A	PROCESS: OUTCOME:
MUST	Wards for older people with mental health problems	The trust MUST ensure consistency in the disposal of clinical waste in line with their policy on handling and disposal of healthcare waste, to prevent a breach of the Hazardous Waste Regulations 2005. The trust must ensure that the carpet on Beechwood ward is suitable and meets infection control standards.	Staff did not protect patients from infection control issues when disposing of clinical waste. Staff did not work in line with the trust policy on handling and disposal of healthcare waste. The management of infectious waste was not consistent across all wards. We saw paper bin liners in the bins that were designed for clinical waste and on some wards, it was not clear how this waste was being managed safely. The use of paper bin liners was not in line with the trust's policy. There was a carpet on Beechwood ward that posed an infection control risk. Staff had escalated this, but this had not been addressed.	Patient Safety	PROCESS: 1. To review and update SH NCP 47 Handling Disposal of Healthcare Waste Policy to reflect current practice. 2. To complete compliance checks that wards comply with updated Waste Policy. 3. To replace carpet on Beechwood ward. OUTCOME: Patients are cared for in environments which meet infection control standards.	PROCESS: 1. updated policy in place 2. compliance checks on wards 3. replacement flooring OUTCOME: Infection control and prevention team visit to wards to confirm wards meet IPC standards	PROCESS: September 2020 OUTCOME: October 2020

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MUST	Mental health crisis services and health based places of safety	The trust MUST ensure that all patients in the crisis service have a holistic, person-centred care and crisis plan within their records. Records must be clear, up-to-date and information recorded consistently in the electronic record.	Across the service records were not always clear, up-to-date and easily available to all staff providing care, with staff recording information inconsistently in different parts of the electronic record. Some paper records for patients in the health-based places of safety contained recording gaps. Staff working for the crisis teams still did not consistently develop and record holistic, recovery-oriented care and crisis plans informed by a comprehensive assessment and in collaboration with families and carers. Staff working for the mental health crisis teams worked with patients and families and carers to gather information but did not always develop individual care plans and update them when needed. Care plan recording was inconsistent, and when plans were produced they were not always personalised and holistic.	Records Management	PROCESS: 1. Identify teams who require additional support to complete holistic personalised up to date care plans and ensure support and additional training is provided to those teams. 2. Review documentation in place currently and revise in collaboration with staff, patients and carers. OUTCOME: Patients are involved in developing care plans which describe their needs and wants.	PROCESS: 1. Divisions to confirm completion of action 2. Audit care plans OUTCOME: Feedback from service users / carers	PROCESS: June 2020 OUTCOME: September 2020
MUST	Mental health crisis services and health based places of safety	The Trust MUST ensure that the physical environment of the health-based places of safety are fit for purpose and meet the requirements of the Mental Health Act Code of Practice.	The physical environment of the health-based places of safety did not fully meet the requirements of the Mental Health Act Code of Practice. For example, two of the three suites did not have a clock (this is important so that people brought into the suites know how long they have been there). There was no toilet door at the Antelope House suite and in the Elmleigh suite the toilet had no walls or door for privacy	Mental Health Legislation	PROCESS: 1. Divisions to complete compliance checks of the health-based places of safety with regard to the Mental Health Act Code of Practice. 2. Divisions to take corrective actions to address any areas of non - compliance. 3. The Trust Section 136 Suite Forum will monitor progress with this action. 4. The Trust Section 136 Suite Forum will report progress updates and escalation of issues to the relevant Trust meeting. OUTCOME: Patients are kept safe and their privacy and dignity are respected while in the places of safety. Trust Places of Safety will be compliant with the Mental Health Act Code of Practice.	PROCESS: 1. Compliance checks per division 2. Actions to address non-compliance 3. Minutes of 136 Suite Forum x 3 4. Reports OUTCOME: Patient feedback Compliance checks	PROCESS: August 2020 OUTCOME: October 2020

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MUST	Mental health crisis services and health based places of safety	The trust MUST ensure it meets its legal obligations in the health-based places of safety.	Leaders did not have assurance that the trust was meeting its legal obligation to ensure people did not stay in the health-based places of safety for longer than 24 hours or have an extension granted by an approved person because staff were not consistently completing the required hourly checks. There were no systems in place to ensure staff entered correct entry times, completed the hourly checks or to ensure staff would escalate appropriately so action could be taken if people had been in the health-based places of safety nearing the 24-hour period.	Mental Health Legislation	PROCESS: 1. Divisions to review local procedures for health-based places of safety and amend where required to ensure there are systems in place to support entry of correct admission times, completion of hourly checks and escalation processes. 2. Front-line staff to advise and design above systems and check these systems work in practice using 'plan, do, study, act (PDSA) cycle. 3. The Trust Section 136 Suite Forum to review the Trust escalation protocol against proposals from the divisions. 4. The Trust Section 136 Suite Forum to develop training materials and deliver training on the legal obligations and protocols to 136 suite staff. OUTCOME: Patients do not stay in health-based places of safety for longer than 24 hours or if required have an approved extension, where breaches do occur, the Trust will ensure its protocols expedite the discharge of the patient from the PoS to an appropriate ward and that the patient will remain cared for in the least restrictive manner.	PROCESS: 1. Divisional standard operating procedures 2. Checks that standard operating procedures are effective 3. Minutes of 136 Suite Forum 4. Training programme/numbers of staff trained OUTCOME: Performance data for 136 Suites Training and Systems will be in place to support staff with complying with the Pan Hampshire Section 136 Policy and Protocol.	PROCESS: October 2020 OUTCOME: December 2020
SHOULD	Wards for older people with mental health problems	The trust SHOULD ensure that patients privacy maintained on Elmwood ward.	On Elmwood ward it could be possible to see into patients' bedrooms from a meeting room used by staff on the first floor of the building. This could compromise the privacy of patients.	Privacy and Dignity	PROCESS: **Trust has contacted CQC to request further information to clarify this recommendation as Trust is unable to replicate.** OUTCOME:	PROCESS: OUTCOME:	PROCESS: OUTCOME:
SHOULD	Wards for older people with mental health problems	The trust SHOULD ensure patients can make phone calls in private.	Patients could not always make a phone call in private, unless they had their own bedroom and a mobile phone. On Beechwood ward staff said patients could make a call from the staff office.	Privacy and Dignity	PROCESS: Divisions to have local procedures in place to enable patients to make phone calls in private and test these procedures are effective. OUTCOME: Patients are able to make phone calls in private.	PROCESS: Local procedures in place. Divisions to test effectiveness of procedures OUTCOME: Feedback from service user audits	PROCESS: June 2020 OUTCOME: August 2020
SHOULD	Wards for older people with mental health problems	The trust SHOULD ensure staff know about plans for the eradication of dormitory accommodation	Some patients had to sleep in dormitories. While the trust had plans to eradicate dormitories in the future staff had little knowledge of what the plans were and when this might happen.	Privacy and Dignity	PROCESS: To develop and implement communication strategy to ensure that staff are kept up to date with the future plans to eradicate dormitory accommodation. OUTCOME: Staff are aware of the plans to eradicate dormitory accommodation.	PROCESS: Communication updates OUTCOME: Minutes of divisional governance meetings	PROCESS: May 2020 OUTCOME: July 2020

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SHOULD	Wards for older people with mental health problems	The trust SHOULD ensure all care plans are patient centred and that patients are given a copy of their care plan should they want it.	Care records were not always person centred, up to date or regularly reviewed. Of the 22 care records that we reviewed, we found nine that were not person centred.	Records Management	PROCESS: 1. Identify teams who require additional support to complete holistic personalised up to date care plans and ensure support and additional training is provided to those teams. 2. Review documentation in place currently and revise in collaboration with staff, patients and carers. OUTCOME: Patients are involved in developing care plans which describe their needs and wants.	PROCESS: 1. Divisions to confirm completion of action 2. Revised documentation OUTCOME: Audit care plans	PROCESS: June 2020 OUTCOME: September 2020
SHOULD	Mental health crisis services and health based places of safety	The trust SHOULD ensure that staff are confident and able to assess and record capacity assessments and best interest decisions for patients who might have impaired mental capacity.	Staff in the crisis teams did not always record that they had considered a patient's capacity to consent to treatment or did not record whether patients had capacity in the patient electronic records. It was therefore not clear to all looking at the records whether a patient had capacity or not to make a particular decision or when best interest decisions had been made.	Mental Health Legislation	PROCESS: See 1c - same actions OUTCOME: See 1c - same outcomes	PROCESS: OUTCOME:	PROCESS: August 2020 OUTCOME: MCA Audit - tbc (new MH Manager to design and carry out audit)
SHOULD	Mental health crisis services and health based places of safety	The trust SHOULD ensure that patients have access to physical health checks within the crisis service.	Staff were not consistently completing and recording physical health checks for patients in the crisis teams	Patient Safety	PROCESS: 1. Divisions to review and confirm that procedures for physical health checks are in place, with access to necessary equipment and that staff understand and follow 'non contact' physical health observations where appropriate. 2. Divisions to monitor performance that physical health checks are completed appropriately. OUTCOME: Patients have appropriate physical health checks and are safe in our care.	PROCESS: 1. Divisional procedures 2. Performance data OUTCOME: Clinical audit and/or peer review	PROCESS: June 2020 OUTCOME: September 2020
SHOULD	Mental health crisis services and health based places of safety	The trust SHOULD ensure that there is clear senior oversight of the service, particularly the health-based places of safety.	Due to recent changes in the way crisis services and health-based places of safety suites were managed both managers and staff of the services unclear who the senior manager was who held responsibility for the service.	Workforce	PROCESS: 1. The Trust Section 136 Suite Forum and Divisions to review Section 136 Protocols for ambiguities or unclear instructions. 2. Ambiguities or unclear instructions in protocols to be resolved as a single standard document or divisional protocols to implement the new Trust protocol. OUTCOME: The Pan Hampshire Section 136 Escalation Protocol will be clear for each Division in terms of responsibilities and instructions for escalation. Staff will understand the lines of responsibility and oversight for the service including the health-based places of safety.	PROCESS: 1. minutes of meetings 2. Trust 136 Suite protocol/divisional protocols OUTCOME: Peer review/accreditation visits	PROCESS: June 2020 OUTCOME: August 2020

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SHOULD	Acute wards for adults of working age and psychiatric intensive care units	The trust SHOULD ensure that the furniture at Hawthorns 1 and 2 is fit for purpose.	Staff on Hawthorn 1 and 2 told us that the furniture was not fit for purpose as it an infection control risk. Although a capitol bid had been put to the board to replace it this had been unsuccessful as the trust had other immediate priorities that it needed to fund.	Patient Safety	PROCESS: To order new furniture for the ward which is fit for purpose and does not pose an infection control risk. OUTCOME: Patients are kept safe and have a positive experience on the ward.	PROCESS: Furniture in place OUTCOME: Infection Prevention and Control team visit to ward to confirm ward meets IPC standards	PROCESS: February 2020 OUTCOME: May 2020
SHOULD	Acute wards for adults of working age and psychiatric intensive care units	The trust SHOULD ensure that any maintenance work is completed in a timely manner.	Staff said it was it was difficult to get maintenance work done in a timely manner. For example, the washing machine on Saxon ward had been broken for some time and despite reporting this it had not been fixed.	Operational	PROCESS: 1. Estates team to signpost team leads to the new tableau reports on the status of requested maintenance works, enabling them to track and monitor individual works requests. (These include works to be completed by Bellrock/Lift contract.) 2. Estates team to track performance on completion of maintenance works via tableau reports and identify and resolve outstanding works. OUTCOME: 1. Staff are able to track individual requests on tableau and understand estimated completion dates. 2. Increased oversight of maintenance works will drive timely completion.	PROCESS: 1. communication re signposting 2. Tableau reports on maintenance performance /minutes of Estates MOM x 3 OUTCOME: 1. number of staff accessing tableau reports 2. Tableau reports on maintenance performance /minutes of Estates MOM x 3	PROCESS: May 2020 OUTCOME: July 2020
SHOULD	Acute wards for adults of working age and psychiatric intensive care units	The trust SHOULD ensure that the staff are able to observe and communicate with patients in all areas of Hawthorns 2 seclusion room appropriately whilst maintaining the dignity of patients.	It was difficult for staff to observe or communicate with a patient in the seclusion room at Hawthorns 2 when they were using the toilet facilities. Staff had raised this as a potential risk issue, but this had not been addressed by the trust. Staff made every effort to manage patients safely and there had not been any incidents.	Patient Safety	PROCESS: To install an intercom system enabling staff to communicate with patient in seclusion room in Hawthorns 2 at all times. OUTCOME: Patients are kept safe and potential risks are minimised in the seclusion room in Hawthorns 2..	PROCESS: Intercom system in place OUTCOME: Staff feedback that potential risk eliminated	PROCESS: May 2020 OUTCOME: July 2020
SHOULD	Acute wards for adults of working age and psychiatric intensive care units	The trust SHOULD ensure it continues work to ensure female patients requiring psychiatric intensive care beds are accommodated as close to home as possible.	There were no female PICU beds within the trust, so staff needed to refer out of area if a bed was needed. There had been a small number of occasions when patients admitted to Elmleigh ward had needed to be secluded in the health based place of safety suite while they waited for a PICU bed.	Patient Safety	PROCESS: To address issue of no female PICU beds within Trust. OUTCOME: Female patients are cared for as close to home as possible.	PROCESS: Plan in place OUTCOME: Data on PICU beds/out of area beds	PROCESS: July 2020 OUTCOME: September 2020

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SHOULD	Child and adolescent mental health wards	The trust SHOULD ensure there are enough activities for young people throughout the week.	Young people and staff told us young people did not have enough to do when they were not at school Young people and staff at Bluebird House told us there were not enough activities, especially at weekends on Stewart ward.	Patient Experience	PROCESS: 1. Map what activities are available and collate feedback from young people as to why they perceive there is not much activity available out of school hours to understand the scope of the issues. 2. We will map the process for identifying needs and interests related to activities and how we support patients to choose activities. This will include using the Model of Creative Ability (MOCA). Information will then be detailed in every young person's assessment and we will understand and document their needs and wishes clearly. 3. We will develop a profile page on activities for all young people and a personal activity plan for each individual which covers all of their waking hours. 4. The Ward Managers across CAMHS will develop a consistent OpenRiO template for recording shifts which will include activities offered and undertaken by each patient. The Ward Managers will also devise the MDT template so that the nursing report to MDT includes a breakdown of activity by each young person for review at the MDT meeting. The use will be reviewed after one month of implementation. OUTCOME: Young people across CAMHS will be given every opportunity to access activities outside of school hours which are appropriate, meet their needs and that they enjoy. We will be able to evidence the activities offered and undertaken as well as the support offered to help a young person increase their activity levels.	PROCESS: 1. Map of activities and feedback from young people. 2. Process map developed as to how we identify needs and interests with results detailed in every young person's assessment. 3. Evaluate that profile pages and personal activity plans in place. 4. OpenRiO template for general progress notes are in place. MDT template in place. Both templates evaluated for effectiveness. OUTCOME: Activities clearly documented as to what is available and records of activities offered and undertaken for each individual patient.	PROCESS: June 2020 OUTCOME: August 2020

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SHOULD	Child and adolescent mental health wards	The trust SHOULD ensure that all staff receive regular supervision.	Some staff on Stewart ward did not always receive regular supervision and supervision was sometimes cancelled	Workforce	PROCESS: 1. The Practice Educators and the Clinical Improvement Lead at Bluebird House will implement a session on supervision within the Band 6 development programme. 2. The Practice Educators will roll out the dates for supervision training for the next 12 months and ensure that they are on LEaD for staff to book on to the sessions. This will include the "Having Difficult Conversations" elements of the training. 3. We will have booked all staff onto this training over the next 12 months. 4. We will implement the system used at Leigh House across all CAMHS services so that it is consistent for all services - Reflective practice - Ward Supervision - Management supervision - Peer support supervision - Safeguarding supervision - Individual Clinical supervision - Same formats for recording 5. All Appraisals will be regarded as the 12th Management Supervision and will set the objective for clinical supervision being a mandatory requirement to work within the service. It will be mandated into everyone's appraisal that they will attend a minimum of 8 clinical supervision sessions per year as well as their management supervision. 6. We will monitor supervision for all staff of all disciplines through the CAMHS Operational Meetings on a monthly basis. OUTCOME: Staff will access all appropriate forms of supervision on a regular basis and it will be integral to role and work undertaken. Supervision compliance will be at a minimum of 95% by 30.11.20.	PROCESS: 1. Band 6 development programme will include supervision 2. Dates for supervision training on LEaD 3. Staff booked onto supervision training 4. Leigh House system in place in all CAHMS sites 5. Appraisal data 6. minutes of CAHMS Operational meetings x 3 OUTCOME: Supervision data	PROCESS: August 2020 OUTCOME: November 2020
SHOULD	Child and adolescent mental health wards	The trust SHOULD review its procedures for booking carers and families visits to young people on Hill ward to ensure they run smoothly.	Two carers of young people on Hill ward said their visits were shortened or cancelled and one arrived for a visit and was told it was not booked. In forensic service visits need to be booked due to security issues.	Patient Experience	PROCESS: 1. Review the policy/ procedures for booking visits / facilitating visits on secure CAMHS wards. 2. Develop a process for centralised booking and pilot it with involvement from Reception and Administration staff – then roll out for secure CAMHS. OUTCOME: Visits to secure services will have an appropriate and monitored booking system that reduces the risk of visits being arranged inappropriately, cancelled or delayed as much as possible. Cancelled visits will be the exception with clear evidence as to why it was appropriate to cancel or change a visit.	PROCESS: 1. Updated policy/procedure 2. Process for centralised booking system across CAMHS OUTCOME: Visits are appropriately planned with the number of cancelled visits and appropriate rationale for cancellations documented	PROCESS: June 2020 OUTCOME: August 2020

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SHOULD	Child and adolescent mental health wards	The trust SHOULD continue to address the staff morale issues at Bluebird House and should provide support regarding forthcoming changes.	Staff morale was varied at Bluebird House and some staff said they were stressed about forthcoming moves	Workforce	PROCESS: 1. Clinical Improvement Lead will become the project manager for the Quality Improvement (QI) project with supervision from Head of Nursing & AHPs. Head of Nursing & AHPs will review cultural survey and the staff survey results and bring this into the QI project plan. 2. The division will make sure that the actions and the plan from the QI project is fully supported and the Head of Nursing & AHPs will take overall responsibility. 3. Develop a communication strategy in each service/ unit – this should include a newsletter, update meeting, staff meetings. 4. Communication box in nursing office and staff rooms. 5. Quarterly listening groups set up for all staff facilitated by a matron from another area. 6. A “You Said/ We Did” communication on a quarterly basis (minimum) devised at the CAMHS Operational Meeting and delivered by the Head of Nursing & AHPs. OUTCOME: Staff will have various means of communicating information on a two way basis which will be managed through the CAMHS Operational Meeting which will look to evaluate the morale of staff on an ongoing basis.	PROCESS: 1. QI project plan 2. QI project plan progress updates 3. Communication strategies in place 4. Communication boxes in place 5. Listening groups 6. 'You said, we did' quarterly communication OUTCOME: Minutes of CAMHS Operational meeting x 3	PROCESS: May 2020 OUTCOME: July 2020