BOARD OF DIRECTORS MEETING (Open)

Date: 14th March 2018 **Item Ref:** **5 iii**

TITLE OF PAPER	**Progress Report: Regulatory Care Requirements (28/02/18)**
TO BE PRESENTED BY	Liz Lightbown, Executive Director of Nursing, Professions and Care Standards
ACTION REQUIRED	To receive the report for information and assurance

OUTCOME	Members are informed of the continued performance management of outstanding actions.
TIMETABLE FOR DECISION	March 2018
LINKS TO OTHER KEY REPORTS/ DECISIONS	CQC Inspection Reports CQC Engagement Meetings
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	Strategic Aim: Quality & Safety Strategic Objective: A1 01: Effective quality assurance and improvement will underpin all we do. BAF Risk No: A1 01i: Inability to provide high quality care due to failure to meet regulatory standards (registration and compliance).
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Health and Social Care Act 2008 (Regulated Activities) Care Quality Commission's Fundamental Standards Care Quality Commission's Enforcement Policy Mental Health Act 1983
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Failure to comply with CQC Regulatory Standards could affect the Trust's registration, negatively affect care delivery and require additional funding to address.
CONSIDERATION OF LEGAL ISSUES	Non-compliance with regulatory care requirements could result in conditions to the Trust's registration with the CQC and NHS Improvement (segmentation rating).

Authors of Report	Liz Lightbown and Denise Woods
Designation	Interim Director of Care Standards
Date of Report	5th March 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: **14th March 2018**

Subject: **Progress Report: Regulatory Care Requirements (28/02/18)**

Presented by: **Liz Lightbown, Executive Director of Nursing, Professions and Care Standards**

Authors: **Liz Lightbown and Denise Woods, Interim Director of Care Standards**

1. Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
		✓		✓	

To note that the Trust has received the PIR (Pre Inspection Request) from the CQC for the new style Well Led inspection.

To receive the Progress Report: Regulatory Care Requirements (28/02/18) on actions from the CQC Comprehensive Inspection (November 2016).

2. Summary

This is a progress report to outline the work completed in the 2 week operational period since the last report to Board.

The report attached details the progress and status as at 28th February 2018 of Regulatory Breaches, "Must Do's" and "Should" actions, following the CQC Comprehensive Inspection (November 2016). It provides information and assurance about actions that are 'On Track' (Amber), those that are 'Complete' & in the Care Standards Peer Inspection (CSPI) process (Green) and those that are 'Closed' (Blue).

There were **89 actions** in total contained in the Provider and 10 Core Service Reports:

- 39 'Must do' actions
- 50 'Should do' actions

Current status of the 89 Actions:

- 16 (18%) are On Track (Amber).
- 12 (13%) are Complete (Green).
- 61 (69%) are Complete & Quality Assured via a CSPI (Blue).

Work completed in February

The following table identifies the work that the Care Standards Team was required to do. It also contains 5 Must Do and 3 Should Do Amber actions that the operational areas had a deadline for the end of February. (For the full Amber Action list and status please see Appendix 1).

Subject/ MUST Do/ Should Actions	What we said would be done	What has been done Outcome/Progress
Care Standards Team		
Care Standards Peer Inspection (CSPI) by the Care Standards Team on all Green actions.	A CSPI was done for all 12 Green actions.	Despite progress being made on the Green actions, there was a lack of evidence to support completion of any of the Green actions. Services are still working on these.
Extra work completed by the Care Standards Team.	On-site supportive progress visits were done for all 16 Amber actions.	One Amber action was turned Blue: **Must 2: G1 Seclusion Room** *"The trust must ensure that the seclusion room on G1 Ward complies with the Mental Health Act code of Practice with regard to seclusion room facilities."* This room is now compliant and is in use.
Operational Services: Progress on Amber Actions that contain an action with an end of February Deadline		
MUST Do Actions		
Provider: **Must 3 EMSA** (Long term plan)	Report due to Quality Assurance Committee (QAC) in February.	Report to EDG and QAC. More information on gender ratios for Burbage and Stanage wards requested. Report to be resubmitted in March.
Acute Wards and PICU: **Must 3 EMSA**	See above	See above
START: Substance Misuse: **Must 2 Risk Assessments**	All clients who have been in treatment for 12 weeks or more to have a recognised DRAM in place. Care Standards Team together with Deputy Director of Nursing carried out a spot check audit.	Last month the backlog was 60 out of 1,674 (3.5%). In February this has reduced to 34 out of 1,674 (2%). Results of the audit were that information recorded was found to be basic but not sufficient in quality (although better than in the CMHTs). Delivery Plan for CCP improvement being developed by Deputy Director of Nursing.
Long Stay Rehab and CERT: **Must 11 Physical Health**	Head of Care Standards & Quality to support service and complete CSPI. Physical Health monitoring Is being done with some gaps. Inconsistent frequency of monitoring between bungalows.	Pharmacist checking medicines safety regularly. Lead for Physical Health working with service to improve. Checked 4 records and there were some gaps. There have not been any incidences of Rapid tranquilisation since the inspection but improvements have been made.
Forensic: Must 3 Seclusion Suite	SHSC meeting required to review clinical and financial risks and options between Operations, Estates and Finance prior to meeting with HSE.	Meeting with HSE cancelled by HSE to be re-arranged.
SHOULD Do Actions		
CMHT: **Should 3 Collaborative Care Plans (CCP)** **(Higher Risk)**	Collaborative Care Plans audit report to be produced January 2018.	Results presented at Clinical Effectiveness Group in February. 192 care plans were audited over 31 teams covering the period September to December 2017. Of those records audited, results demonstrate: • 62.5% were individualised and personalised • 80.7% had a clear plan in place • 66% had evidence of joint development. Delivery Plan to be ready by 31st March.

Subject/ MUST Do/ Should Actions	What we said would be done	What has been done Outcome/Progress
CMHT: Should 4 Physical health Monitoring **(Higher Risk)**	The results of the Early Intervention Audit should be available in February. Physical health Strategy and Deliver Plan revised and updated.	Results received. The EIP national audit data collected suggests we have made a small improvement but the official results of the national audit will not be available until the report is published. Draft Physical Health Strategy completed but requires agreement through consultation by the end of March.
START: Substance Misuse: Should 1 Phone Calls **(Higher Risk)**	To be discussed at Operational Governance Group, a review of risk rating for consideration to be added to the corporate risk register	Discussed at Operational Governance Group. Risk scored at 16. Not escalated to EDG for consideration for corporate risk register. This will be done in March.

Out of the 12 green actions tested as part of the CSPI process, 5 were due to supply sufficient evidence of compliance to the Care Standards Team by the end of February. None were ready to be turned Blue. These actions have been discussed with the Service Managers and Directors and are being escalated to the Director of Operations and Clinical Director. See the following table:

Subject/ MUST Do/ Should Actions	What we said would be done	What has been done Outcome/Progress
Operational Services: Status on Green Actions where CSPI completed that had an end February Deadline **All these actions are Should Do's**		
START: Substance Misuse: Should 3 Care Plans **(Higher Risk)**	Comprehensive CCPs for all clients to be in place.	Compliance at 96%. SOP to be produced with sign off by Governance Group. **This action expected to be completed by 31st March.**
START: Substance Misuse: Should 4 Risk Management Plans	DNA SOPs to be in place with Governance Group sign off.	Opiates and Alcohol DNA SOPs in place. Draft Non-opiates DNA SOP awaiting sign-off. Audit to be completed to demonstrate full compliance. **This action is expected to be completed by 31st March.**
START: Substance Misuse: Should 5 Audits of Care Records	Care records audit results available and feedback to staff.	Care Standards team completed spot check audit with Deputy Director of Nursing and gaps found. Service to commence regular quarterly audits. Support being given to the Service and CCP training to be accessed by staff.
LD Wards: Should 2 Medications administration	The new clinic room to be completed including installation of double drug cupboard.	The clinic room will be operational in early March. **Once clinic room is open this action will be completed.**
LD Wards: Should 3 Mandatory Training	Staff compliance to be >75% in the following subjects: • MCA Level 1 = 94% • MCA Level 2 = 88% • DoLS Level 1 = 83% • **DoLS Level 2 = 71%** • ASD = 88% • Dementia = 77%	**DoLS Level 2 compliance expected to be met by 31st March.**

The 7 remaining Green actions should have been signed off as complete; however the evidence to date does not support full compliance. See table below:

Subject/ MUST Do/ Should Actions	Position Statement	What has been done Outcome/Progress	Anticipated Completion Date
MUST Do Actions			
LS Rehab & CERT: Must 7 Supervision	Local systems are in place but not all supervisions recorded. Staff in LS Rehab are receiving supervision in line with the policy and are **rated as Blue**. However this is a joint action with CERT and compliance in CERT is very low. The new electronic supervision process is in the process of being rolled out to all areas.	LS Rehab = Blue CERT compliance escalated to Director of Operations and Clinical Director.	July 2018
LS Rehab & CERT: Must 1 Blanket Restrictions	Report to EDG 1st March and current policy extended for a month to allow detailed options appraisal on smoking. This affects the completion date of work on blanket restrictions.	Work done includes Register of restricted items, purpose of green room clarification, signage, leaflet and poster awaiting printing.	31st March
SHOULD Do Actions			
CMHT Working Age: Should 2 Lone Working	Further evidence of Lone Working processes in reconfigured CMHTs requested and to be tested by Care Standards Team.	Further CSPI in March with a view to turn Blue.	31st March
CMHT Working Age: Should 5 Team performances, accuracy of information	Quality measures and roll out plan for completion by 31st March.	CSPI to be done when evidence ready.	April 2018
CMHT Working Age: Should 7 Monitoring risk on waiting lists	New team SPA, new SOP produced.	Further CSPI to be done to test SOP.	March 2018
CMHT Working Age: Should 8 MCA embedded	Audits being undertaken. Associate Director of Patient Safety leading.	Audits will provide assurance of compliance.	April 2018
Acute & PICU: Should 1 Supervision	Local processes and trackers in place but compliance on every ward is very low. Rollout of electronic system in progress.	Compliance escalated to Director of Operations and Clinical Director.	July 2018

In addition, the two Clover Group actions will be turned Blue in March once evidence requested is supplied to the Care Standards Team.

3. Next Steps

- The operational team and the Care Standards Team will focus on all Must Do actions to ensure these are prioritised for closure.
- The Care Standards Team will continue to undertake Care Standard Peer Inspections (CSPIs) and ensure oversight of and production of progress reports to EDG (monthly), the Board of Directors and the CQC.

- Well Led Inspection 2018

  We expect the Well Led inspection to take place within 6 months of the PIR (28/02/18), so by the end of August. In that period we can expect unannounced/short timescale warning of inspections to any of our core services.

  We will receive notice of the Well Led part of the inspection. This inspection focuses on the well-led key question at trust level, and draws on the CQC's wider knowledge of quality in the trust at all levels. An assessment of trust-wide leadership, governance, management and culture will be the starting point for the trust-level rating for well-led. The CQC will also consider improvements and changes since the last inspection.

  The Trust has received the PIR (Pre Inspection Request) from the CQC for the new style Well Led inspection. The first (48hr) deadline was met to supply information on sites, services and locations including category of services.

  The second deadline for the PIR is 21st March to complete two very extensive Excel workbooks with statistical information as well as free narrative descriptors.

  A weekly quality assurance process is in place between The Care Standards Team, the Director of Operations and Clinical Director.

  There will be a final quality assurance/sign-off by the Deputy Chief Executive, Medical Director, Executive Director of Nursing, Professions & Care Standards.

4. Required Actions

Members to receive the report for information and assurance.

5. Monitoring Arrangements

Monitoring will be via:

- The Care Standards Team.
- The new Senior Clinical Operations Performance & Governance Group
- The Individuals and Groups identified in the appendices of the report.
- A progress report to the EDG in April 2018.

6. Contact Details

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Progress Report: Regulatory Care Requirements (28/02/18)

BACKGROUND

The CQC carried out an unannounced Well Led Inspection in May 2016 and a Comprehensive Inspection in November 2016.

Action plans were created following receipt of the well led inspection report in August 2016 and the comprehensive inspection report in March 2017.

An Executive led Task & Finish Oversight Group was established in June 2017, running for 7 months to oversee progress against agreed actions, to identify and help resolve any problems to progress and to keep improvements on track. This Group had its final meeting on 11th December 2017.

Once actions are completed, Care Standard Peer Inspections (CSPIs) are undertaken by the Care Standards Team to determine if actions have been completed and can be evidenced and demonstrated in practice.

Once the Care Standards team is satisfied the action has been completed and there is evidence to demonstrate improvement the action is designated complete and recorded as blue, with sign off by the Task & Finish Oversight Group. This process of CSPIs will continue as updated action plans will still be received monthly by the Care Standards team.

PROGRESS & STATUS

Comprehensive Trust-wide Inspection November 2016 (March Report)

There were **89 actions** in total contained in the Provider and 10 Core Service Reports consisting of 39 'Must do' actions and 50 'Should do' actions.

Status of the 89 Actions:

16 (18%) are On Track (Amber) receiving support from Care Standards team.
12 (13%) are Complete (Green) in CSPI process.
61 (69%) are Complete & Quality Assured via a CSPI (Blue).

The following amber action has turned Blue since the last report:

Amber Action	CQC Domain	Current Position	Responsible Director(s)/Lead	Date	Report to
Must 2: G1 Seclusion Room *"The trust must ensure that the seclusion room on G1 Ward complies with the Mental Health Act code of Practice with regard to seclusion room facilities."*	**Safe**	On-going discussions regarding tender costs in progress All work on the seclusion room is now complete and we are now fully compliant and confirmed by Head of MH Legislation.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Director of Estates (Helen Payne)	31st March 2018 **COMP-LETE on 02/03/18**	Senior Clinical Operations Performance and Governance Group

Amber Actions (See Appendix 1 for detail)

There are currently 16 Amber Actions in total, 14 in operational areas (core services) and 2 from the Provider report.

2 x Amber Actions: Provider Report

Must 2: Governance (Well Led)
Must 3: Eliminating Mixed Sex Accommodation (EMSA) (Caring)

14 x Amber Actions: Core Service Reports

Community Based Mental Health Services for Adults of Working Age
1. Should 3: Collaborative Care Plans (Safe)
2. Should 4: Physical Health Monitoring (Safe)

Wards for Older People with Mental Health Problems (Dovedale and G1 Wards)
3. Dovedale Ward Must 1: EMSA (Caring)

Sheffield Treatment and Recovery Team (START: Substance Misuse)
4. Must 1: Clinic Rooms & Samples (Safe)
5. Must 2: Risk Assessments (Safe)
6. Should 1: Phone Calls (Responsive)

Health Based Place of Safety; Liaison Psychiatry Service; Out of Hours/Crisis Team
7. Section 136 and Liaison Psychiatry Must 8: Supervision (Well Led)

Acute Wards for Adults of Working Age
8. Must 3: EMSA (Caring)

Long Stay Rehabilitation and Community Enhancing Recovery Team (CERT)
9. Must 11: Physical Health (Safe)

Forensic Inpatient Low Secure Ward
10. Must 2: Blanket Restrictions (Effective)
11. Must 3: Seclusion (Safe)
12. Must 4: Ligatures Business Case (Safe)
13. Should 1: Privacy & Dignity (taking medications) (Safe & Caring)
14. Should 4: Staffing (Well Led)

Higher Risk Amber Musts/Shoulds & Actions:

Four Amber actions are considered as higher risk and these were highlighted in the last report. This is the latest update:

1. Governance (Provider) (Well Led): *"The trust must ensure that effective governance systems are in place across all services."*

   Governance systems continue to operate across clinical / operational services however their effectiveness has been affected by the directorates' reconfiguration. Improvement work has commenced to ensure these meet required standards and are effective. The intention is to implement improved operational governance systems & processes with full effect from April 2018. The Director of Operations is leading on this work.

2. Collaborative Care Plans (Community Mental Health Working Age Adults) (Safe): *"…all patients have a collaborative care plan, which is personalised, holistic and recovery focussed…"*

   A number of audits have taken place to gather evidence of compliance:

   - Care Standards undertook a spot check of several care records on Insight in January and although care plans were in place and up to date, they were not all holistic and lacked evidence of collaboration. The Head of Mental Health Legislation, Anne Cooke completed an audit following a number of Inpatient MHA Monitoring Visits in 2017, which indicated the same.

   - A collaborative care plan audit was carried out in the Community Mental Health Service (reviewing care records from April – December 2017) led by Quality Improvement Manager Jonathan Burleigh, the outcome/results were presented at the Clinical Effectiveness Group on 16th January 2018.

   - The Care Standards team and Tony Bainbridge completed an audit on collaborative care plans in February. One CCP was audited for each team. Results were not positive with definite room for improvement. Issues included reviews, completion and timeliness.

   Outcomes of all these audits to inform a delivery plan to be in place by the end of March.

   CCP training dates for 2018 have been released.

   In 2018 the new Associate Director for Patient Safety, Anita Winter, working with the new Deputy Director of Nursing (Operations) Tony Bainbridge, will lead on improving collaborative care planning across all services. From a nursing perspective this will form part of a wider area of improvement work on Nursing Assessment, Clinical Formulation, Care Planning, Monitoring, Review and Evaluation (of care) and the effective utilisation of Insight (Electronic Patient Record).

3. Telephony System (SMU START) (Responsive): *"….dealing efficiently with the volume of daily telephone calls…"*

   A specification has been developed by the Information Management & Systems Technology (IMST) team with SMU colleagues to inform / support a business case in line with the Trust Telephony Strategy. The delay in fully addressing this has been added to the Substance Misuse risk register. Currently a part time member of staff in the administration team is managing calls (the number of calls received has dropped).

   This has been discussed at Operational Governance Group and will be escalated to EDG for consideration to be added to the corporate risk register as the risk score is 16. Completion deadline Q3: 2018/2019.

4. Physical Health Monitoring (Community Mental Health Working Age Adults & LS Rehab & CERT) (Safe): *"The trust should continue to improve processes to monitor a patient's physical health needs including adequate monitoring for patients prescribed antipsychotic medications."*

   A number of audits and activity has taken place to establish evidence of compliance:

   - The SHSC CQUIN Physical Health Audit 2016/17 showed that it was hard to find evidence of routine physical health screening and associated interventions. The recent

results from the 2017 National Clinical Audit of Psychosis (NCAP) indicated improvements have been made for in-patients and community patients. However, the NCAP audit covered a time period that crossed the 16/17 CQUIN Physical Health Audit and looked at a slightly different sample of service users, meaning the audits are not directly comparable.

- Discussions with commissioners are taking place as to whether a further physical health audit during Quarter 4 should be undertaken. It is likely that only one audit covering both current audits will be undertaken in future.

- The EIP national audit data collection suggests we have made a small improvement, but this is a national audit and final results will not be available until the report is published. The CCG agreed that the NCAP audit would be used for the physical health part of the CQUIN and a further audit was not required.

Kate Virgo, part time Lead Nurse for Resuscitation and Physical Health is working with medical colleagues, Dr Jonathan Mitchell and Dr Nick Long and others to revise and update the Trust's Physical Health Strategy & Implementation Plan. Kate met with Fiona Goudie, Consultant Clinical Psychologist/Strategic Lead for Psychology and Steve Thomas in Primary Care. The Strategy is not yet completed however Kate is arranging a Final Task & Finish Oversight Group meeting to agree a Status Report and will be meeting with CCG colleagues. Physical Health Strategy to be in place by 31 March 2018.

CERT - believe they are meeting the target but they are not effective in recording in records, therefore there is a lack of evidence to support this.

12 Green Actions: Core Service Reports (See Appendix 2 for detail)

The 12 Green actions are as follows:

Wards for People with Learning Disabilities or Autism
1. Should 2: Medications (Safe)
2. Should 3: Training (Safe)

Community Based Mental Health Services for Adults of Working Age
3. Should 2: Lone working (Safe)
4. Should 5: Team Performance / Governance (Well Led)
5. Should 7: Monitoring Risks on Waiting Lists (Safe)
6. Should 8: Mental Capacity Act (MCA) (Effective)

Sheffield Treatment and Recovery Team (START: Substance Misuse)
7. Should 3: Care Plans (Safe)
8. Should 4: Risk Management Plans (Safe)
9. Should 5: Audits of Care Records (Effective)

Acute Wards for Adults of Working Age and Psychiatric Intensive Care Unit
10. Should 1: Supervision (Well Led)

Long Stay Rehabilitation and Community Enhancing Recovery Team (CERT)
11. Must 7: Supervision (Well Led)
12. Must 1: Blanket Restrictions (Effective)

CURRENT STATUS SERVICES RATED AS REQUIRES IMPROVEMENT (R.I.)

Long Stay Rehab and CERT (18 Actions)

Action	Action off track: Executive escalation	Action On Track: Will progress to timescale	Action Complete: Evidence Available	Action Complete & Evidenced (CSPI)	Total
Must do	0	1	2	9	12
Should do	0	0	0	6	6

Amber: Must 11: Physical Health (Safe): *"The Trust must ensure that medicines are managed safely and where required physical health monitoring and observations are carried out by staff and recorded."*

See item 4 under Higher Risk Ambers section. CERT believe they are meeting the target but they are not effective in recording, therefore there is a lack of evidence to support this.

Action: Fed back to the Clinical Nurse Manager and Directors. Physical Health Strategy to be in place by 31 March 2018.

Green Must 1: Blanket restrictions (Effective): *"The trust must review blanket restrictions in the intensive rehabilitation service to ensure that care is provided in a way that demonstrates that risks had been assessed on an individual basis."*

Action:
A report went to EDG on 1st March 2018 and the current policy has been extended for a month to allow for a more detailed options appraisal regarding tobacco possession, storage and access to be prepared and taken back to EDG within the month. It is recognised that this interfaces with other work and wards require absolute clarity and consistency. This delays the work on launch of prohibited items and conclusion of the blanket restrictions work.

Green: Must 7: Supervision (Well Led): *"The trust must ensure that the intensive rehabilitation service and the community enhancing recovery team comply with the trust supervision policy."*

Staff were receiving supervision in line with Trust policy and meeting the Trust target.

Action:
Continued focus on ensuring that therapy staff (2) continue to receive regular supervision and support as per policy.

Intensive Rehab action now rated as Blue. However this is linked to the CERT service where compliance is at Amber as there are 46 of the 73 staff below the 8 times per year target.

Mental Health Crisis Services inc. Health Based Place of Safety (HBPoS)

Action	Action Off Track: Executive escalation	Action On track: Will progress to timescale	Action Complete: Evidence Available	Action Complete & Evidenced (CSPI)	Total
Must do	0	1	0	7	8
Should do	0	0	0	4	4

Amber: Must 8 Supervision: HBPoS (Maple Ward) & Liaison Psychiatry (Well Led): *"Staff must have regular supervisions to help identify and address any support needs."*

Supervision rates for Maple Ward compliance are lower than required due to sickness absence and vacancy rates. The Trust has: improved access to supervision; has provided access to & training for supervisors; developed a Trust-wide tracker system; produced a standardised electronic form for recording the delivery of supervision; and has commenced monitoring of supervision rates/uptake. This new electronic system is in the early stages of being rolled out across all services.

Action: New Associate Clinical Director, Chris Wood and Deputy Director of Nursing, Tony Bainbridge to lead full review of Clinical Supervision with a plan in place by the end of March 2018.

Communication with the CQC

Progress against all action plans is shared with the CQC every quarter at the formal Trust CQC "Engagement Meeting". In between the Engagement Meetings, the Care Standards Team and CQC meet monthly to discuss pre agreed areas for improvement and to showcase good practice. Appropriate senior clinicians and managers are invited to join the monthly 'informal' SHSC / CQC meetings.

Meetings held and planned with the CQC are as follows:

19th July 2017: EMSA (Provider Must 3; Acute & PICU Must 3; Dovedale Ward Must 1): Feb 2018 Update

There is a delay on this work in March 2018. A report went to EDG on 1st March 2018 and the current policy has been extended for a month to allow for a more detailed options appraisal regarding tobacco possession, storage and access to be prepared and taken back to EDG within the month. It is recognised that this interfaces with other work and wards require absolute clarity and consistency. This delays the work on launch of prohibited items and conclusion of the blanket restrictions work.

Plans have been developed for the single sex wards at MCC and work began in January 2018. Stanage will become a male ward, Burbage a female ward and Maple Ward (Longley Site) remaining mixed sex. Estates work for Dovedale Ward at the Michael Carlisle Centre started on Monday 5th March and is scheduled to complete within 9 weeks. A detailed review of bed use is taking place with a full report going to QAC in March.

20th September 2017: Ligature Risks and Blanket Restrictions (Acute Must 1; LS Rehab Must 1; Forensic Must 2 and Must 4): Feb 2018 Update

Ligatures: Sanitary ware completed. The next phase of the work is replacement of the doors and was due to start early February. However, work still on-going and due to delays in accessing the doors will complete at the end of March.

Blanket Restrictions: There is a delay to this work:
A report went to EDG on 1st March 2018 and the current policy has been extended for a month to allow for a more detailed options appraisal regarding tobacco possession, storage and access to be prepared and taken back to EDG within the month. It is recognised that this interfaces with other work and wards require absolute clarity and consistency. This delays the work on launch of prohibited items and conclusion of the blanket restrictions work.

Work completed so far:

- Prohibited items register leaflet and poster designed and completed
- Blanket restrictions register: individual assessment, rationale and documentation related to impact on service users.
- SOPs for green room updated to include MHA CoP
- Cutlery issues resolved at Forest Close
- Signage is in situ.
- Education & awareness for service users and staff has been provided
- At Forensic (Forest Lodge) Individual risk assessments completed for groups of client types in accordance with the dynamics of the people living there. This is a live on-going risk assessment process.

Target dates: All remaining actions are on track for 31st March 2018 full implementation.

25th October 2017: Reporting and Learning from Deaths
Discussion on how the reporting and learning from deaths process works within the Trust took place.

21st February 2018: Quarterly Formal Engagement Meeting
Focus was on actions remaining open and discussion around progress and short controls and long term plans. Discussions also centred on transformational change and the reconfiguration of services, teams and Directorates.

5th March 2018: Informal monthly meeting with CQC
We showcased the work of the Gulu International Mental Health Partnership.

April 2018 (Date TBC by CQC): Informal monthly meeting with the CQC
This meeting will focus on the excellent progress made around compliance with Mandatory Training.

Appendix 1

November 2016 Comprehensive Inspection Amber Actions (on track): February 2018 Update

Amber Actions	CQC Domain	Current Position	Responsible Director(s)/Lead	Date	Reports To
Provider Report					
Must 2 Governance *"The trust must ensure that effective governance systems are in place across all services."*	**Well Led**	Governance systems continue to operate throughout the organisation. There has been a delay in implementing improved systems owing to directorate reconfiguration. Operational Clinical Governance systems Co-production events have produced a draft governance structure, meeting arrangements, Terms of Reference and standard agenda. Paper reviewed at Senior Team away day on 13th February and formally recommended to EDG in March. Clinical Operations governance arrangements to model in shadow form from February 2018.	Director of Operations & Transformation (Michelle Fearon) Clinical Director (Peter Bowie) Director of Corporate Governance (Margaret Saunders)	1st April 2018	Senior Clinical Operations Performance and Governance Group & Executive Directors Group
Must 3 EMSA *"The trust must ensure that it complies with guidance on mixed sex accommodation in all of its inpatient services."*	**Caring**	Reconfiguration and occupancy work affect the deadline. Plans are being developed for the single sex wards at MCC, starting implementation in March 2018 with Dovedale & expected completion by May /June 2018. Stanage will be a male ward and Burbage a female ward. Maple ward remains mixed sex. Plans have been agreed but implementation date to be set. Update to QAC on 26th February. More research is being done into male/female admissions and lengths of stay. A further report to go to EDG and QAC in March.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Director of Estates (Helen Payne)	QAC Report March 18 May/ June '18 (Dove dale Ward)	Senior Clinical Operations Performance and Governance Group & Executive Directors Group

Community Based Mental Health Services for Adults of Working Age					
Should 3: Collaborative Care Plans *"The trust should ensure all patients have a collaborative care plan, which is personalised, holistic and recovery focussed."*	**Safe**	**<u>This is a Higher Risk Action</u>** **Care Standards Team supporting** Care standards team did a CSPI spot check on Insight in January and although plans were in place and up to date, they were not all holistic and collaborative. The Head of MH Legislation also completed an audit following MHA monitoring visits reports, results supported this conclusion and were reported to EDG. Audit carried out in CMHT's. Outcome of review went to Clinical Effectiveness Committee in February 2018. 192 care plans were audited over 31 teams covering the period September to December 2017. Of those records audited, results demonstrate: • 62.5% were individualised and personalised • 80.7% had a clear plan in place • 66% had evidence of joint development. Care Plan, Risk Assessment and Record Keeping audits will be shared with CEG via a single report every 6 months <u>Internal Audit (360 Assurance) carried out an audit and the findings included:</u> Care plans across the Community, Acute and Inpatient, Specialist and Learning Disability Directorates were developed in collaboration with service users (34 out of 36 care plans 94%) had evidence of service user involvement in the development of the plans. Each Directorate had some mechanism in place to monitor the quality of care plans. However, these 'audits' were	Quality Improvement Manager (Jon Burleigh) Associate Director (Richard Bulmer) <u>CCP Leads:</u> Associate Director Patient Safety (Anita Winter) and Deputy Director of Nursing Operations (Tony Bainbridge)	Delivery Plan for CCP in place by 31st March 2018	Clinical Effectiveness Group & Senior Clinical Operations Performance and Governance Group

		inconsistent in terms of frequency, sampling and content. Care Standards team and Tony Bainbridge completed an audit on collaborative care plans in February. One CCP was audited for each team. Results were not positive with definite room for improvement. Outcomes of all these audits to inform a delivery plan to be in place by end March. CCP training dates for 2018 released.			
Should 4: PH monitoring *"The trust should continue to improve processes to monitor a patient's physical health needs including adequate monitoring for patients prescribed antipsychotic medications."*	**Safe**	**<u>This is a Higher Risk</u>** Physical Health 2016/17 audit took place in November. The audit showed that it was hard to find evidence of routine physical health screening and associated interventions. The NCAP data (National Clinical Audit on Psychosis) was submitted to Royal College. Indications are results have improved for in-patient and community elements but the NCAP report not officially released until 25 June 2018. Findings from the audit to go to Quality Improvement Forum in March. The EIP national audit data collection suggests we have made a small improvement, but this is a national audit and final results will not be available until the report is published. The CCG agreed that the NCAP audit would be used for the physical health part of the CQUIN and a further audit was not required. Draft Physical Health Strategy being revised, including stakeholder input (CCG etc.) This will be presented to EDG by 31st March.	Associate Director (Richard Bulmer) Associate Clinical Director (Chris Wood) Cons Psych (Jonathan Mitchell) Lead Nurse Physical Health (Kate Virgo) working with Interim Head of Care Standards Julie Walton	Physical Health Strategy in place by 31 March 2018	Senior Clinical Operations Performance and Governance Group & Clinical Effectiveness Group

		Lead Nurse Physical Health (Kate Virgo) has an action plan in place to improve PH recording compliance.			
Wards for Older People with Mental Health Problems (Dovedale and G1 Wards)					
Must 1: EMSA Dovedale Ward *"The trust must ensure that Dovedale ward complies with mixed sex guidance."*	**Caring**	Paper for Dovedale approved, works going ahead: • Works on site were delayed until 5th March 2018. • 9 Weeks Contract period. • SOP in place A detailed review of bed use is taking place with a full report going to QAC in March.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Director of Estates (Helen Payne)	May/ June 2018	Senior Clinical Operations Performance and Governance Group
Sheffield Treatment and Recovery Team (START: Substance Misuse)					
Must 1: Clinic rooms & Samples *"The trust must ensure that staff use clinical rooms appropriately and adhere to infection control procedures."*	**Safe**	Proposal to BPG on 13th Dec 2017. Investment turned down due to high level of 2 year capital depreciation costs. Alternative steps being considered to use room provided for "Pick & Mix" needle exchange level 3 as this is to be stepped down in office (with a mobile van to provide "Pick & Mix" level 3). Contract negotiations taking place to review requirements and agree possible alternative less costly way to address. A business case is being prepared for short term. Chris Wood to take back to BPG.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave) Director of Estates (Helen Payne)	March '18	Senior Clinical Operations Performance and Governance Group
Must 2: Risk Assessments *"The trust must ensure that staff document and update client risk assessments and risk management plans using the correct tools in the electronic records."*	**Safe**	**Care Standards Team supporting** The service continues to focus on reducing the number of clients who have been in treatment for 12 weeks or more and do not have a recognised DRAM. The backlog has been reduced from 1,674 to 34 individuals. B7 Manager leading on process. Care Standards team completed audit in January 2018 and records selected fell short of full completion. Care Standards team and Tony Bainbridge undertook a further	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave) Nursing Operations (Tony Bainbridge)	Delivery Plan in place by 31 March	Senior Clinical Operations Performance and Governance Group

		audit in February 2018, the information recorded was found to be basic but is not sufficient in quality. Tony Bainbridge to include in Delivery Plan for CCP improvement.			
Should 1: Phone calls *"The trust should ensure the service deals efficiently with the volume of daily telephone calls received. Clients and other professionals should be able to contact the service with the minimum of delays."*	**Responsive**	**<u>This is a Higher Risk</u>** In the longer term, a specification has been developed by IMST to inform a business case in line with the Trust telephony strategy programmed for Autumn 2018. This has been added to the Substance Misuse risk register. Business case went to IT Strategy Group 26/02/18 and then to BPG on 17th April 2018. In the meantime, funding for 2 x wte B2s was signed off by SMT and recruitment in progress. There are plans in place to get a calls management dashboard that will provide live data of calls coming in, length of time waiting etc. This has been discussed at Operational Governance Group and will be escalated to EDG for consideration to be added to the corporate risk register as the risk score is 16.	Director of IMST (Nicola Haywood-Alexander) Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave)	Escalat-ion to corpor-ate risk register March 2018 IMST 2018/ 2019 QTR. 3	Senior Clinical Operations Performance and Governance Group
Health Based Place of Safety; Liaison Psychiatry Service; Out of Hours/Crisis Team					
<u>136 and Liaison Psychiatry Must 8: Supervisions –</u> *"Staff must have regular supervisions to help identify and address any support needs."*	**Well Led**	**Care Standards Team supporting** Maple ward compliance is currently low, due to sickness absence and vacancy rates. New Associate Clinical Director, Chris Wood and Deputy Director of Nursing, Tony Bainbridge to lead full review of Clinical Supervision with a plan in place by the end of March 2018. The supervision tracker and the supervision results are far below the required level for the Trust. Will remain on amber.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Deputy Director of Nursing Operations (Tony Bainbridge)	July 2018	Senior Clinical Operations Performance and Governance Group

Acute Wards for Adults of Working Age and Psychiatric Intensive Care Unit					
Must 3: EMSA *"The trust must ensure ward accommodation complies with all aspects of same-sex guidance."*	**Caring**	Reconfiguration and occupancy work affect the deadline. Plans are being developed for the single sex wards at MCC, Stanage will be a male ward and Burbage a female ward. Maple ward remains mixed sex. A detailed review of bed use is taking place with a full report going to QAC in March.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Director of Estates (Helen Payne)	Report to EDG & QAC March 2018	Senior Clinical Operations Performance and Governance Group
Long Stay Rehabilitation and Community Enhanced Recovery Team (CERT)					
Must 11: Physical health *"The Trust must ensure that medicines are managed safely and where required physical health monitoring and observations are carried out by staff and recorded."* **(See also CMHT Should 4**)	**Safe**	**<u>This is a Higher Risk</u>** Team members Kate Virgo, Brenda Ong and Laura Ambridge (pharmacy) Initial findings: Bungalow 1a had multiple gaps in Early Warning Score (EWS) charts (1/12 completed fully) showing lack of recording of PH Monitoring. Head of Care Standards, Julie Walton visited Rehab Wards 26th January to carry out further CSPI. Patient records seen and staff interviewed. Pharmacist checking medicines safety regularly. Lead for Physical Health working with service to improve. Checked 4 records and there were some gaps. There have not been any incidences of rapid tranquilisation since the inspection but improvements have been made.	Interim Head of Care Standards, Julie Walton Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge) Lead Nurse Physical Health (Kate Virgo)	Physical Health Strategy in place by 31 March 2018	Senior Clinical Operations Performance and Governance Group
Forensic Inpatient Low Secure Ward					
Must 2: Blanket restrictions *"The trust must ensure that restrictive practice is based on individual patient risk of patients and not applied to all patients routinely as a blanket restriction."*	**Effective**	<u>There is a delay in March on this work:</u> A report went to EDG on 1st March 2018 and the current policy has been extended for a month to allow for a more detailed options appraisal regarding tobacco possession, storage and access to be prepared and taken back to EDG within the month. It is recognised that this interfaces with other work and wards require absolute clarity and	Associate Director (Richard Bulmer) Deputy Director of Nursing (Tony Bainbridge) Head of Mental Health Legislation (Anne Cook)	31st March 2018	Senior Clinical Operations Performance and Governance Group & Restrictive Practices Group

		consistency. This delays the work on launch of prohibited items and conclusion of the blanket restrictions work. Care Standards Team support started in February 2018. • Guidance in the search policy for the Trust. • Searching is discussed in Governance meetings. • Searching will be risk assessed until this can be lifted. • Staff awareness and embedding. Doing this by supervision, away days, monthly reviews, and review sessions weekly. • Blanket restrictions is being addressed Trust wide.			
Must 3: Seclusion *"The trust must ensure that the seclusion suite is compliant with the requirements of the Mental Health Act Code of Practice."*	**Safe**	Discussed at TOG in November (further work required on the options). Paper presented at Directorate SMT further amendments agreed to be completed by the end of December. Discussed as part of the Capital Prioritisation meeting attended by estates and finance. It was confirmed that any capital work for Forest Lodge Seclusion Room (estimate £300,000+) should be developed into a Business Case for presentation to NHS England (Commissioners). Referred back to Estates for cheaper options. Re NHSE, in their contracting NHSE would not ordinarily fund any capital charges associated with the works. NHSE January contracting meeting cancelled by NHSE, next meeting scheduled for late February. SHSC Pre-meet required for review of clinical & financial risks & options required b/w Operations, Estates & Finance.	Associate Director (Richard Bulmer) Director of Estates (Helen Payne) Deputy Director of Nursing Operations (Tony Bainbridge) Deputy Director of Finance (James Sabin)	March 2018	Senior Clinical Operations Performance and Governance Group

		Business case being finalised to go to BPG. Doors end date is 28th March. Works in progress. There is a weekly restrictive dashboard to oversee seclusions. **CSPI will include check on Risk Register**			
Must 4: Ligatures business case *"The trust must ensure that work is completed according to the business case submitted to the trust to reduce and remove the ligature risks identified."*	**Safe**	Sanitary ware is completed. The next phase of the work is replacement of the doors and was due to start early February. Work still on-going and due to delays in accessing the doors will complete at the end of March. Remains amber.	Associate Director (Richard Bulmer)/ Deputy Director of Nursing Operations (Tony Bainbridge) Director of Estates (Helen Payne)	April '18	Senior Clinical Operations Performance and Governance Group & Service User Safety Group
Should 1: privacy & dignity re meds *"The trust should ensure that patients' privacy and dignity is upheld when taking medication."*	**Safe and Caring**	Business Case for the Clinic room was received and approved by Business Planning Group (BPG) in November '17. Two quotes for the work received in January '18. Estates measured up in February and waiting work to start including a completion date. In the meantime, measures are in place to offer patients to go elsewhere if they wish.	Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge) Director of Estates (Helen Payne)	Q2 18/19	Senior Clinical Operations Performance and Governance Group
Should 4: staffing *"The trust should ensure that there are enough staff on shift to meet the minimum staffing requirements of the wards."*	**Well Led**	Rota reviewed & required changes made. Budget movement of bank and agency nurses into the substantive registered nurse line complete. Appointment of additional band 5 & 6 nurses with full recruitment now achieved. CSPI and further review of how well this is working/staffing levels took place in February: • Now fully staffed with band 5 nurses. • One Band 6 is retiring and one on secondment. • Acting band 5 and recruiting authorised. • Band 3 one vacancy.	Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge) Deputy Chief Nurse (Giz Sangha)	March 18	Senior Clinical Operations Performance and Governance Group

		• Band 2 recruited another 5. **Will remain amber until recruitments are in place**			

Appendix 2

November 2016 Comprehensive Inspection Green Actions (in CSPI Process): February 2018 Update

Action Plans: Greens only for CSPI	CQC Domain	Position Statement	Responsible Director(s)/Lead	Date	Reports to
CMHT Working Age					
Should 2: Lone working *"The trust should ensure there are robust processes in place to protect staff who are working alone in the community."*	**Safe**	**CSPI completed** Lone working policy on intranet was revised. The CMHT SOP requires updating following reconfiguration. New North/West team Lone Working process not working in practice. Buddy System for the South team working but to be tested by Care Standards team. Sarah Roberts-Morris provided copy of the electronic buddy system as part of the evidence needed for this action. Further evidence requested.	Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge)	31st March 2018	Senior Clinical Operations Performance and Governance Group
Should 5: Team performances *"The trust should ensure that managers have an accurate overview of their team's performance."* ***Links to Provider Governance Must Do.***	**Safe and Well Led**	**CSPI completed** Two out of four dashboards from the governance officers in the CMHTS show different metrics being measured & weak directorate oversight. Patient feedback i.e. F&F, CQC survey not included. Presently there are in place trust dash board information, including Qlickview. Mobilisation leads working with Care Standards on metrics as requested by Liz Lightbown & as discussed/agreed at EDG. Quality measures and rollout plan is being worked on for completion by 31st March 2018. To include going forward: • Collaborative care planning/risk assessment • Patient experience feedback (including quality & dignity) – FFT/CMHT Survey results. • Physical health	Michelle Fearon Director of Operations Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge)	April 2018	Senior Clinical Operations Performance and Governance Group
Should 7: Monitoring risks on waiting lists *"The trust should*	**Safe**	**CSPI completed** By summer 2018 the waiting time should be 3 weeks with assessment of risks still at 2	Associate Director (Richard Bulmer) Deputy Director of	March 2018	Senior Clinical Operations Performance and

ensure that staff monitor patients on waiting lists to detect any increases in their level of risk."		weeks. • SPA operational from 18.12.17 • SOP in place –2 weeks for contact • Waiting list established under new process • Web page updating and clarity Further CSPI in March to look for evidence of contacts at 2 weeks to assess any change in risks. • SPA team has the evidence ensure they continued with the SOP. • Care Standards to test the SOP. • SOP provided by Nicola Whatley (SPA)	Nursing Operations (Tony Bainbridge)		Governance Group To
Should 8: MCA *"The trust should ensure that staff are confident in adhering to the Mental Capacity Act to embed consent and capacity considerations into their everyday practice."*	**Effective**	**CSPI completed** This refers to staff understanding of patients' decision-making capacity. The new Insight forms (MCA & CAT1-5) are being rolled out and training has been delivered, so the way these are used or not might reflect staff understanding. However, the first principle of the MCA is that capacity must be assumed to exist unless it is proven that it does not, so the absence of a record would not necessarily reflect a lack of understanding of the legislation. A further training session on the forms is planned by the Head of MH Legislation in March as the reconfiguration has brought to light that not everyone attended the first round of training Community overall training compliance: MCA level 1 – 92% MCA level 2 – 79% In the new structure, both recovery teams and SPA are over 80% for MCA Level 2 (Trust target) MCA (and DoLS) are currently the subject of internal audit activity (360 Assurance). An audit of each is due for completion by the end of Q4,	Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge) Head of Mental Health Legislation (Anne Cook)	April 2018	Senior Clinical Operations Performance and Governance Group & Mental Capacity Act Steering Group

		Anita Winter is leading and the audits are being undertaken by Grace Brennan, a psychology trainee. This is a performance monitoring audit and is important from an assurance point of view, but is not clinical audit and so does not go on the clinical audit plan. This has been discussed and agreed at both CEG and QAC. **These audits will provide assurance of compliance and will be available in April 2018.**			
Substance Misuse					
Should 3: Care plans *"The trust should ensure all clients have up to date, person-centred care plans that are personalised, holistic and focus on recovery from substance misuse and treatment."*	**Safe**	**<u>This is a Higher Risk</u>** This links with the Trust wide work around CCPs. All practical steps continue to be taken to support clinical staff. CCPs with service users are being undertaken. 96 +% achieved **CSPI completed** Care Standards team supporting the service with quality assurance and improvement and to do an audit early March. The audit tool will be used by the service to do quarterly audits going forward to ensure compliance maintained. An SOP is to be produced and will be taken to Governance group on the 26.2.18 for sign off. Evidence to be seen. **This action should turn Blue in March**	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave)	March 2018	Senior Clinical Operations Performance and Governance Group & Substance Misuse Governance Group
Should 4: Risk management plans *"The trust should ensure risk management plans include actions staff should take if a person missed an appointment."*	**Safe**	Opiates and alcohol DNA SOP is complete. Draft Non-opiates SOP awaiting sign off through governance meeting on 26/02/18. **CSPI completed** This links to the CSPI work for Should 3 • Audit to be completed by Care Standards team early March and audit tool will be used by the service to do quarterly audits going forward to ensure compliance maintained. • A DNA SOP has been produced and approved in the	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave)	March 2018	Senior Clinical Operations Performance and Governance Group & Substance Misuse Governance Group

		Directorate Governance Sub Group. **This action should turn Blue in March**			
Should 5: Audits of care records *"The trust should ensure that routine quality audits of care records are undertaken."*	**Effective**	Care records audit results received back from Trust. Feedback to staff to be agreed. **CSPI completed** Care Standards team supporting the service with quality assurance and improvement and to carry out audit early March and audit tool will be used by the service to do quarterly audits going forward to ensure compliance maintained. Compliance will come once a regular audit is in place. This will link with Trust wide Records audit.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave)	March 2018	Senior Clinical Operations Performance and Governance Group & Substance Misuse Governance Group
LS Rehab					
Must 7: Supervision *"The trust must ensure that the intensive rehabilitation service and the community enhancing recovery team comply with the trust supervision policy."*	**Effective and Well Led**	**CSPI completed** **(Includes Trust wide action for Supervision)** The Trust continues to roll out improved access to supervision including: • training for supervisors, • development of consistent tracker systems, • contribution to a standardised electronic recording form for the delivery of supervision, • access to regular staff support/ reflective practice and team level promotion. • Full roll out of the electronic reporting by Q2 18/19. Report Received at WODC 30th Jan 2018. <u>Evidence of compliance with the regulation:</u> Staff were receiving supervision in line with Trust policy and meeting the Trust target. However, continued focus on ensuring that therapy staff (2) continue to receive regular supervision and support as per policy. **Intensive Rehab action now rated as Blue.** However this is linked to	Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge)	July 2018	Senior Clinical Operations Performance and Governance Group

		the CERT service, CSPI in progress but compliance is at Amber.			
Must 1: Blanket restrictions *"The trust must review blanket restrictions in the intensive rehabilitation service to ensure that care is provided in a way that demonstrates that risks had been assessed on an individual basis."*	**Effective**	**CSPI completed** <u>Delay in progress in March:</u> A report went to EDG on 1st March 2018 and the current policy has been extended for a month to allow for a more detailed options appraisal regarding tobacco possession, storage and access to be prepared and taken back to EDG within the month. It is recognised that this interfaces with other work and wards require absolute clarity and consistency. This delays the work on launch of prohibited items and conclusion of the blanket restrictions work. Trust wide and local blanket restriction work completed: • Prohibited items register completed and leaflet and poster awaiting delivery • Blanket restrictions register individual rationale assessment and documentation related to impact on service users. • Service has revised the blanket restrictions and prohibited practices. • The purpose of the green room has been clarified • Signage improved to inform service users.	Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge) Head of Mental Health Legislation (Anne Cook)	31st March 2018	Senior Clinical Operations Performance and Governance Group Restrictive Practices Group
Acute & PICU					
Should 1: Supervision *"The trust should continue to roll out the improved access to supervision."*	**Effective and Well Led**	**CSPI completed along with Trust wide action for Supervision:** The Trust continues to roll out improved access to supervision including: • training for supervisors, • development of consistent tracker systems, • contribution to a standardised electronic recording form for the delivery of supervision, • access to regular staff support/reflective practice and team level promotion. Full roll out of the electronic reporting by Q2 18/19	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood)	July 2018	Senior Clinical Operations Performance and Governance Group

		Update Report Received at WODC 30th January 2018. • All trackers for the wards reviewed and all below target. • Burbage and Stanage reviewed. Serious shortfalls in the supervision sessions - Stanage mainly red and staffing levels impacting on this. • Maple & Endcliffe also not compliant. Escalated to Director of Operations and Clinical Director.			
LD Wards					
Should 2: Meds *"The trust should ensure that medication is administered in such a way that does not compromise safety."*	**Safe**	**CSPI completed** The new clinic room is nearing completion, awaiting double drug cupboard delivery. Remainder of building work is fully complete. The clinic room will be operational in early March. **This action will be blue once we have seen the room open (expected early March)**	Associate Director (Debbie Horne) Associate	March 2018	Senior Clinical Operations Performance and Governance Group
Should 3: Training *"The trust should ensure that staff complete mandatory training for autism awareness, dementia awareness and Deprivation of Liberty Safeguards."*	**Safe**	**CSPI completed** Currently the figures are: MCA Level 1 =94% & Level 2 =88% DoLs 1 =83%, **DoLs 2 =71% (compliance expected March 2018)** ASD = 88% Dementia =77%. **This action is expected to go Blue in March once DoLS level 2 >75%**	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Head of Mental Health Legislation (Anne Cook)	March 2018	Senior Clinical Operations Performance and Governance Group

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Appendix 3

Position with Primary Care and Adult Social Care CQC Inspections

Primary Care

The Clover Group was re-inspected by the CQC on 25 September 2017. The final report was published 25th October 2017 which recognised improvement, both Safe and Responsive domains were rated as good (previously RI) as well as all six population groups, the overall rating for the Clover Group is 'Good'.

The Care Standards team continues to work with the Clover Group to assess compliance against the two outstanding 'Shoulds':

Should 1: *"Review the task policy to include clear guidelines for all staff at each stage of the process."*

Status Green: Task Policy in place, Rolling monthly audits being undertaken by Support Managers and reported through Operations Group (fortnightly meetings). Exception report only to SMT. Checks Sheet received. Issues are flagged on the report. Non-compliant tasks are being escalated and policy discussed with staff members

Care Standards requested evidence then can turn **Blue (expected early March):**

- Task Policy
- Agenda for the last Ops Meeting.
- Last Audit results including a copy of the Checks Sheets
- Exception report to SMT

Should 2: "*Continue to monitor the access and capacity plan and patient feedback with regard to improving timely access to appointments."*

Status Amber:

- Phone system purchased and network lines installed 16/02/18.
- Software is there to monitor but system is not yet live and discussed at Operations Group. (The old system still provides information). Once the new system is fully installed can install more lines and receive the analytics to change staff and manage process. No need for extra resources.
- Complaints are at 20% of levels 2 years ago with no complaints at Darnall for 12 months around access.
- Patient feedback and Patient Groups continue.
- The Access Plan is up to date
- The plan is to reduce nurses and increase GPs with fewer appointments with greater number of resolutions.
- Access meetings held at Darnall
- Review of skill mixes taken place.
- Reduction in access ECP (Emergency Care Practitioners). One full time employed and to be trained as GP Paramedic.
- Physios employed to do assessment and signposting.
- Third of consultations, third of time so one sixth of cost.
- New Pharmacist employed under a National Scheme. The Lead Pharmacist will work at Darnall

- Now occasional appointments left over for the day and some spare appointments at 11am (Improvement).
- Backlog of clinical care of medically unexplained symptoms - the team work on lowering patient expectations and management of care.
- Appointments and availability has improved.

Care Standards requested evidence then can turn **Blue (expected early March):**

- Latest Darnall action plan
- Access Meeting minutes.
- Performance report monthly

The Clover City Practice inspection took place on 20th November and in December the Practice was rated Good in all Domains and all population groups. There are no actions required from this inspection.

Adult Social Care: Wainwright Crescent

The CQC undertook an unannounced Inspection at Wainwright Crescent on 12th September 2017 and the inspection report was published on 23rd November 2017. The overall rating is "Requires Improvement" (RI) the same overall rating as last time although the Responsive domain has improved from RI to good.

In addressing the Action Plan from the previous inspection, the CQC found sufficient improvements had been made to: protect people against the risks associated with the safe management of medicines; & improve the systems in place to monitor and improve the quality and the safety of the service provided and embedded in practice, however two new concerns (regulatory breaches) were found regarding:

- Risk Assessments: gaps in (Safe Domain)
- Care Planning Documentation: effective audit of (Well Led Domain)

The Action Plan was sent to the CQC on 21st December 2017. All actions were completed by 31st January 2018.

A CSPI was completed in February 2018 and support from the Care Standards continues through the Interim Head of Care Standards working with the Team Manager on the purpose and function of Wainwright Crescent to ensure consistent & effective systems are in place to achieve good governance.

It is recognised that the staff at Wainwright Crescent undertook a lot of research and extensive consultation to ensure that changes made to the forms/process were right for service users, stakeholders and outcomes. They have made a great deal of progress but there have only been a couple of new service users since the introduction of the new forms. The service is also moving from paper to electronic and access to training. The recommendation is the actions remain green.