CQC Quality Summit: 6th April 2017
Draft High Level Action Plan

BoD: 12.04.17
Item: **5 iii**

1 Introduction

1.1 Trust Report

In March the Trust received the final reports from the Care Quality Commission (CQC) for the November 2016 comprehensive inspection. The results shown in the table below detail the scores achieved by Core Service and Domain.

CQC REPORT		TEAM	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	Overall
PROVIDER REPORT								
Sheffield Health and Social Care Provider Report		Provider	Requires Improvement	Good	Good	Good	Good	**Good**
CORE SERVICES								
1	Long Stay Rehab mental health wards for working age	Forest Close CERT	Requires improvement	Requires improvement	Good	Good	Requires improvement	**Requires Improvement**
2	Community mental health services for people with a learning disability or autism	Community Intensive Support Service Community Learning Disability Team	Good	Good	Good	Good	Good	**Good**
3	Wards for people with learning disabilities or autism	Firshill Rise Assessment and Treatment Service	Good	Good	Good	Good	Good	**Good**
4	Wards for older people with mental health problems	Dovedale G1	Requires improvement	Good	Good	Good	Good	**Good**
5	Forensic inpatient/secure wards	Forest Lodge Assessment Forest Lodge Rehab	Requires improvement	Good	Good	Good	Good	**Good**
6	Community based mental health services for adults of working age	South East North South West	Requires improvement	Good	Good	Good	Good	**Good**
7	Community based mental health services for older people	Memory Service FICS North CMHT	Requires improvement	Good	Outstanding ☆	Good	Good	**Good**
8	Substance Misuse	Drug (opiate) Service Drug (non-opiate) Service Alcohol Service Burbage Ward	Requires improvement	Good	Good	Outstanding ☆	Good	**Good**
9	Acute wards for adults of working age and psychiatric intensive care units	Burbage Stanage Endcliffe Maple	Requires improvement	Good	Good	Good	Good	**Good**
10	Mental health crisis services and health based places of safety	Place of safety OOH Liaison psychiatry	Requires improvement	Good	Good	Good	Requires improvement	**Requires Improvement**
PRIMARY CARE: CLOVER GROUP								
Jordanthorpe Health Centre		Clover Group	Requires improvement	Good	Good	Requires improvement	Good	**Requires Improvement**

The Safe Domain 'Requires Improvement'. The Effective, Caring, Responsive & Well Led domains are all 'Good' giving the Trust an overall rating of 'Good'. In summary:

- 8 out of 10 core services are rated Good overall.
- Crisis and HBPoS are rated Requires Improvement.
- The Rehabilitation Wards for working age are rated Requires Improvement
- Clover Group Primary Care are rated Requires Improvement

Out of a total of 50 scores (10 core services times 5 Domains) the Trust has scored: 11 Requires Improvement & 37 Good ratings.

The Trust achieved two 'Outstanding' ratings: one for community based mental health services for older people in the Caring Domain; and the other in Substance Misuse in the Responsive Domain.

The two Learning Disability Core Services, Community mental health services for people with a learning disability or autism and wards for people with learning disabilities or autism are the two core services to achieve Good across all 5 Domains.

1.2 Primary Care: The Clover Group Practice

The Clover Group has been given an overall rating of "Requires Improvement". The Safe and Responsive Domains are rated as "Requires Improvement" with "Good" ratings for the remaining three Domains.

2. Key Focus for Improvement & Challenge

The Trust will focus on areas that have scored "Requires Improvement" to improve compliance as well as ensuring continued improvement on those areas rated as "Good" to aim for "Outstanding". Our priority is to focus on the "Safe" Domain and to improve performance and safety.

Following the November 2016 inspection, all core services developed action plans to address issues arising from the comprehensive inspection. Since the inspection, many actions have been completed already. The Trust has also committed to investment and transformation of how services are delivered in order to improve compliance and provide quality assurance to the Board.

Examples of some of the actions completed since the inspection include:

- CLDT:
  - Low number of MCA Capacity/Best Interest Assessments in place: SOP developed to clarify when Capacity/Best Interest Assessments are required at each stage of pathway.

- Acute wards:
  - Separate action plan in place to reduce and mitigate risk of ligation including further investment.
  - EMSA Compliance.

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- Dovedale Ward:
  - Medicines Management: Controlled drugs audits carried out to ensure processes are followed.
  - Viewing panel in access doors not obscured: this was rectified prior to the CQC inspectors leaving the Trust in the inspection week.

- Clover Group:
  - Defibrillator at Darnall Primary Care Centre calibrated immediately after inspection
  - Action plan in use for solutions to access. Monitored through Senior Management Team and Joint Executive Board.
  - Review of repeat prescribing protocol to include info about scripts being collected.

- Assessment & Treatment Service, Firshill Rise:
  - Medicines Management: MDT tracker changed to discuss and monitor weekly to ensure all checks are being carried out and documentation completed correctly. Weekly managers' check also commenced as normal practice.
  - Clinical dispensing areas weekly cleaning schedules completed and checked.

- Memory Services, Edmund Rd:
  - Staff unaware how to operate alarm system and to raise alarm: A revised protocol for how to operate the alarm system and how staff should respond has been produced and disseminated to all staff. Also discussed at governance meetings.

- Forensic: Forest lodge:
  - The intumescent strip (part of the fire safety system) in the door into the toilet in the seclusion room identified as having the potential to be removed and used to harm self or others – Trust Fire Officer inspected this and similar doors on other sites and these strips were removed.
  - Intercom not effective in seclusion room: this has been resolved by Estates.
  - Blanket restrictions are in place in the form of searching all patients on return from leave: Senior clinician from east London Foundation Trust attended Trust on 24th March to provide a teaching session on blanket restrictions. This is also being managed through the Reducing Restrictive Interventions Board.
  - Access to pantry reviewed and the standard operating procedure to support this to ensure patient safety.

- Forest Close:
  - Bungalow 3 cleaning standard: deep cleaning undertaken immediately after the inspection.
  - Availability of allocated nurse to each bungalow: Rotas reviewed to ensure effective distribution across the 24 hour day and to ensure effective use of senior clinical staff.
  - Bungalow 3 alarm system unable to be heard in other bungalows: Personal alarms re-tested and can be heard from elsewhere. Risk assessment undertaken and provided as guidance along with a standard operating procedure for usage of Bungalow 3.

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3. High Level Action Plan

The Trust is committed to improve compliance in all core services and across all Domains. All 11 core services including the Clover Group have been working to local action plans since the week of the inspection in November 2016.

The Trust has inextricable internal links between compliance, regulation, quality assurance and improvement in its corporate management team structure. The Trust's overall aim and focus is to be "Outstanding" in all domains for all eleven core services.

This is a high level action plan in response to the comprehensive CQC inspection and has been shared with the CQC and stakeholders at the Quality Summit on 6th April 2017.

There is a high level focus and investment in Safety and the key priority areas are:

- Community Mental Health Service Reconfiguration
- Rehabilitation Wards
- Health Based Place of Safety (HBPoS).
- The Clover Group
- Governance of and operational delivery on Patient Safety

Table A below is the high level strategic action plan.

Table B is the high level action plan that addresses the key issues from overall summary in the Provider report.

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TABLE A: Draft High Level Strategic Action Plan

Trust wide/ Strategic Actions		Actions Taken to Date	Actions to be Taken	Target Date	Responsible
ACHIEVE "OUTSTANDING" IN THE SAFE DOMAIN					
1	Service User Safety Group	The membership and terms of reference of the Service User Safety Group have been revised and this group is now led by the Executive Medical Director	• Focus of this group is Safety and this group will hold the organisation to account • The Director of Care Standards & Quality Assurance post holder will attend this group • The Executive Medical Director and Executive Director of Nursing will jointly lead the Safe agenda for the Trust	April 2017	Mike Hunter, Medical Director Liz Lightbown, Exec Director
2	Investment in a substantive Senior Director for Quality and Patient Safety	The Trust committed to investment in a substantive Senior Director for Quality and Patient Safety. Currently covered by an Interim Director of Care Standards.	Substantive post to be re-advertised The post holder will provide strategic direction and an operational grip on care standards, quality assurance and clinical governance across all Directorates and Corporate Services. Key focus will be improving quality and patient safety	Part time Interim in place Appointment to full time post Sept 2017	Liz Lightbown, Exec Director Mike Hunter, Medical Director
3	Care Standards Peer Inspections and RCP Accreditation	Care Standards Mock inspections have already been established and action plans are in place. Action plans are monitored through the Care Standards team.	The Mock Inspections being developed into Care Standards Peer Inspections. The Care Standards Peer Inspections will be developed around the Royal College of Psychiatrists Accreditation Standards and the Trust intends to acquire accreditation through this process.	May 2017	Liz Lightbown Exec Director Care Standards Team

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Trust wide/ Strategic Actions		Actions Taken to Date	Actions to be Taken	Target Date	Responsible
4	Priority focus and Learning from other Trusts	Buddying and coaching relationships with other Trusts are being formed e.g. Bradford District Care Trust (who have scored Good on Safe Domain) and East London Foundation Trust. Other Trusts have also been identified.	The intention is to forge links from "front line" to "front line" and share learning.	May 2017	Liz Lightbown, Exec Director Mike Hunter, Medical Director Care Standards Team
5	Sharing Outstanding Practice	Sharing good practice within the Trust to ensure organisational learning	Event to be planned for 2017/18	Jan 2018	Liz Lightbown, Exec Director/ Care Standards Team
MENTAL HEALTH ACT, MENTAL CAPACITY ACT and DoLS					
6	Investment in Head of Mental Health Legislation	Appointment of Head of Mental Health Legislation A revised governance structure approved covering activities covering MHA, MCA and DoLS legislation and the key committees' terms of references.	Improvement in reporting quality and processes There is a plan in place being led by the Head of Mental Health Legislation	In place Dec 2017	Liz Lightbown, Exec Director
STAFFING, MANAGEMENT & LEADERSHIP					
7	Clinical Directorate Management Restructure: Reinvesting in management and leadership	The Directorate Management Restructure was approved by Trust Board in March 2017	Agreed new management structure to be implemented	Sept 2017	Richard Bulmer, Service Director/ Michelle Fearon, Service Director/ Anita Winter, Service Director

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	Trust wide/ Strategic Actions	Actions Taken to Date	Actions to be Taken	Target Date	Responsible
8	Governance and Performance within Directorates: specifically AMH CMHTs; Substance Misuse; Old Age CMHTs; HBPoS and Crisis Teams; LD Assessment & Treatment Ward at Firshill Rise	A review of governance was commissioned with Internal Audit. The first phase has been completed covering the Board sub-committee governance arrangements. The Trust Board approved the Care Pathways Reconfiguration Plan As part of the Directorate reconfiguration plan the Board approved the development of an operational Patient Safety Lead and dedicated patient safety roles working across frontline core services.	An action plan is being developed to address issues arising. Phase two will cover an audit of governance processes at Directorate level. The Care Pathways Reconfiguration Plan to be approved by Clinical Commissioning Group Appointment of dedicated frontline patient safety staff.	April 2017	Exec Director Liz Lightbown Mike Hunter, Medical Director Clive Clarke Executive Director of Operations

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Sheffield City Council

NHS Sheffield Health and Social Care NHS Foundation Trust

Table B: Draft High Level Action Plan from the CQC Comprehensive Inspection Provider Report:

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Provider Report Summary Findings		Key Actions Taken to Date	Actions to be Taken	Target Date	Responsible
LIGATURE RISKS AND SECLUSION					
1	Ligature Risk reduction in Bedrooms Ligature risks and blind spots in all areas to be addressed	9 Ligature risk reduction bedrooms have been established on the Acute wards: Burbage, Stanage and Maple.		Complete	Lisa Johnson, Deputy Director/ Lorena Cain, Assistant Clinical Director/ Anthony Bainbridge, Assistant Clinical Director/ Maxine Statham, Assistant Clinical Director
2	Seclusion rooms CCTV	Three Acute wards now have CCTV installed	New build planned for 2020	2020	Lorena Cain, Assistant Clinical Director/ Lisa Johnson, Deputy Director
3	Maple Ward Seclusion room to meet the requirements of the MHA CoP	The business plan for the seclusion room on Maple Ward has been approved.	New seclusion room under construction	May 2017	Lorena Cain, Assistant Clinical Director Lisa Johnson, Deputy Director
EMSA					
4	Same Sex Accommodation Options Appraisal	A full Options Appraisal is being completed. Options reviewed in Inpatient Directorate SMT on 14.03.17	Longley Centre capital programme Phase 2 to be delivered	To Executive Directors Group on 13/04/17	Kim Parker, Senior Nurse/ Lisa Johnson, Deputy Director

	Trust wide/ Strategic Actions	Actions Taken to Date	Actions to be Taken	Target Date	Responsible
INFECTION PREVENTION AND CONTROL					
5	Substance Misuse Service: Consideration of IPC procedures when activating drug screening tests	Substance Misuse Service has ceased to use clinic rooms to activate drug screening tests. Outline business case approved for Substance Misuse Drug Screening Dirty Utility and clinic facilities.	Work to be completed	Aug 2017	Adele Rowett, Service Manager/ Katie Grayson, Senior Nurse IPC
6	Forest Close Bungalow 3 used for activities was dirty	Bungalow 3 has been deep cleaned and cleaning schedules improved. IPC audit taken place on 24 Nov 2016 with recommendations made. On-going monitoring in place of cleaning schedules.	Recommendation for business case to bring the bungalow up to acceptable standards.	July 2017	Julie Smalley, Clinical Nurse Manager/ Katie Grayson, Senior Nurse IPC
EFFECTIVE PRACTICES					
7	Long Stay Rehab: Forest Close: Most activities were social activities	Full review undertaken and prospectus in place describing aims of all groups and individual work. Recovery college in place.	Practice audit to be completed. Service User Outcomes to be used to measure. To be included in Care Standards Peer Inspections which will include Infection Prevention and Control team	June 2017	Vyvyan Hopkinson, Occupational Therapist/ Julie Smalley, Clinical Nurse Manager/ Noelle Riggott, Occupational Therapist Lead

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Trust wide/ Strategic Actions		Actions Taken to Date	Actions to be Taken	Target Date	Responsible
MANDATORY TRAINING					
8	Compliance at inspection across many subjects was around 60% and this was set against a target of 75%. Mental Capacity Act Training level 1 was 31% and level 2 was 41% compliance	The Trust is working to a 3 year trajectory to deliver improvement as agreed with Commissioners. This plan was approved by the Executive Directors Group in March 2017. Current compliance with most subjects is >80% with the exception of (at the end of February 2017): • MCA Level 1 compliance at 64%, this is an increase of 5.68%. • MCA level 2 compliance at 63%, this is an increase of 10.42%. • DoLS training is at 74%. • Adult basic life support at 78% • Immediate life support at 78% • Dementia awareness 58% • Autism awareness 53% • Mental health act 72% • Medicines management 73% • Respect level 1 41% • Safeguarding children level 2 69% • Safeguarding adults level 2 78% • Domestic abuse 70%	The Trust continues to work to achieve or exceed the trajectory. This is being closely monitored on a monthly basis by the Executive Directors Group to ensure a sustained delivery. The Trust is submitting a revised proposal to CCG. All subjects to be 80% by end of July		Guy Hollingsworth, Corporate Transform-action Lead/ All Directors

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Trust wide/ Strategic Actions		Actions Taken to Date	Actions to be Taken	Target Date	Responsible
MEDICINES MANAGEMENT					
9	Physical Observations in HBPoS Rapid Tranquilisations and staff not following policy in Rehab at Forest Close	• Practice of monitoring of Physical observations and Rapid Tranquilisation is being scrutinised to ensure compliance with NICE guidance. • Staff have been briefed on required practice and policy. • Audit completed but as there have been no reported incidents of rapid tranquilisation to date then no requirement needed for physical observations in relation to this.	Will continue to monitor through monthly reporting and review of data and compliance at Senior Management meeting within the Directorate.	Complete	HBPoS: Shirley Lawson, Senior Nurse/ Kim Wakefield, Ward Manager/ Dr Jonathan Mitchell, Clinical Lead Rehab: Julie Smalley, Clinical Nurse Manager/ Dr. Katie Kendall, Cons Psych.
10	Risk assessments and management processes regarding alarms were not always robust in Rehab in Bungalow 3	Personal alarms retested and can be heard from elsewhere. Risk assessment undertaken and provided as guidance along with a Standard operating procedure for usage of Bungalow 3 B3 now has an integrated alarm system in place		Complete	Julie Smalley, Clinical Nurse Manager
11	Medicines administered from main ward office rather than Clinic Room at Assessment and Treatment Service, Firshill Rise (LD)	Business case re environment issues at Firshill has been presented to Business Planning Group and approved. Work is scheduled to begin in June 2017.	Building works to incorporate current clinic room into the ward starting June 2017	October 2017	Maxine Statham, Assistant Clinical Director

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	Trust wide/ Strategic Actions	Actions Taken to Date	Actions to be Taken	Target Date	Responsible
STAFFING, MANAGEMENT & LEADERSHIP					
12	Qualified Staffing cover inconsistent at Forest Close Rehab:	• Work to the National Quality Board Safer Staffing recommendations: “Right staff; Right Place; Right Time” • Effective management rota in place and overseen by Deputy Director of Nursing. • Communication of red rules within rota and requirement to ensure adequate distribution across the 24 hour service to ensure 1 RMN per bungalow per shift as a minimum. • Recruitment underway to cover 4 RMNs vacancies and 2 staff blocked booked from agency	The plan is being monitored monthly at Ward and Directorate level.	Complete.	Julie Smalley, Clinical Nurse Manager/ Giz Sangha, Deputy Chief Nurse and Action Clinical Director

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Trust wide/ Strategic Actions		Actions Taken to Date	Actions to be Taken	Target Date	Responsible
BLANKET RESTICTIONS					
13	Blanket Restrictions at Forest Close and Forest Lodge and access to bedrooms on G1 at Grenoside	1. The Restrictive Practices Group is chaired by the Medical Director and the terms of reference are being reviewed 2. The Policy is currently being updated to ensure this is in line with practice and meets national guidance 3. Sharing Best Practice and learning from others: Dr Paul Gilluley from East London gave a clinical teaching session.	1. To ensure lawful and safe practice, the Head of Mental Health Legislation will work with ward managers and senior clinicians to ensure effective assessment of every patient. 2. Policy to be ratified. Implementation Plan required for the Policy & SOP to ensure clinicians are aware & understand updated Policy & SOP 3. Action plan in place following teaching session.	Complete and meeting regularly Sept 2017	Nicola Sorsby, Senior Nurse supported by: Debbie Breese, Assistant Clinical Director/ Dr Jonathan Mitchell, Clinical Lead/ Anne Cook, Head of Mental Health Legislation Restrictive Practices Group
RISK MANAGEMENT					
14	AMH CMHTs waiting lists of up to 9 weeks	Task and Finish groups for service redesign are now completed. Mobilisation leads appointed. Service improvement meeting on 30/03/17 discussed issue of managing risk for those waiting for services.	New service model to be in place by August 2017. The appointed leads for the access function to prioritise a review of practice and standardisation of practice all teams.	August 2017	Paul Nicholson, Deputy Director

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	Trust wide/ Strategic Actions	Actions Taken to Date	Actions to be Taken	Target Date	Responsible
15	Management of Lone Working in CMHTs for Adults of working age not consistent	Inconsistencies in how lone working arrangements are implemented have been reviewed. New policy produced.	Awaiting ratification of policy	May 2017	CMHT Team Managers
16	Substance Misuse transferred patients (one third of total client base)	Although all transferred clients had been risk assessed this was not on the Trust DRAM template. At the time of the inspection 55% of transferred clients had a DRAM in place and now 75% have a DRAM in place. The current position for the whole service is 81% and increasing on a weekly basis.	The team are working through the remaining clients who transferred	June 2017	Olawale Lagundoye, Clinical Director/ Adele Rowett, Service Manager
TEAM PERFORMANCE					
17	CMHT Governance: Managers had limited oversight relating to team performance	• Internal audit to be carried out on governance • Teams have greater access to local governance data (team key performance dashboards) and the ability to benchmark against other teams. • Quarterly cycle of team governance reviews being done by Deputy Service Director and a Clinical/Service Director.	• Internal audit on governance at team level • Directorate management restructure • Service reconfiguration	Sept 2017	Michelle Fearon/ Richard Bulmer/ Service Directors/ Clinical Directors

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