BOARD OF DIRECTORS MEETING (Open)

Date: 14 February 2018 **Item Ref:** 07iii

TITLE OF PAPER	Final Task & Finish Oversight Group: Status Report
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	February January 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	6th February 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: **14 February 2018**

Subject: **Final Task and Finish Oversight Group: Status Report (06/02/18)**

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 receive the Status Report from the Task and Finish Oversight Group on actions from the CQC Well Led Inspection (May 2016) and Comprehensive Inspection (November 2016).

The report was received and discussed and a number of minor amendments were agreed and approved at the Trust Management Group (TMG) held on 11th January 2018.

The up-dated report was received and discussed at the Quality Assurance Committee on 22nd January 2018.

Appendix 3 details the most recent CQC Inspection ratings for Primary Care and Adult Social Care (Wainwright Crescent).

2. Summary

Following the final Task & Finish Oversight Group held in December 2017, this report was received at the QAC on 22nd January 2018.

The report details the progress and status as at 31st January 2018 of Regulatory Breaches, "Must Do's" and "Should" actions, following the CQC Well Led (May 2016) and 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).

Well Led Inspection (May 2016):

Following the Well Led Inspection 14 actions were identified:
- 2 “Must do” actions (11 individual actions) and
- 3 “Should do” actions.

All 14 (100%) actions are complete.

The Comprehensive Inspection (November 2016):

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:

- 17 (19%) are On Track (Amber).
- 12 (13%) are Complete (Green).
- 60 (68%) are Complete & Quality Assured via a CSPI (Blue).

Of the 17 Amber Actions:

Safe Domain (9)

2 x Seclusion: G1 & Forest Lodge
1 x Ligatures: Forest Lodge
1 x Clinic Rooms & Samples: SMU
1 x Risk Assessment: SMU
2 x Physical Health Monitoring: Working Age Adult Community & Rehab Wards
1 x Collaborative Care Planning: Working Age Adult Community
1 x Taking Medications: Forest Lodge

Caring Domain (4)

3 x EMSA: Provider; Dovedale Ward; & Working Age Acute Wards
1 x Taking Medications: Forest Lodge

Well Led Domain (2)

1 x Governance: Provider
1 x Supervision: HBPoS Maple Ward

Responsive Domain (1)

1 x Phones: SMU requires IMST Works

Effective Domain (1)

1 x Blanket Restrictions: Forest Lodge

3. Next Steps

- 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) QAC/Board and the CQC.

- Further CSPI's for all Green & Amber Actions are being undertaken & due for completion by the end of February '18.

- With effect from January 2018, the Director of Operations & Transformation and Clinical Director, in collaboration with Care Standards and the Directors of Estates & IMST will ensure the continued performance management of outstanding actions across the clinical services via the new Senior Clinical Operations Performance & Governance Group.

- A Progress Report from Care Standards, with input from the Director of Operations, will be received at EDG in early March 2018.

- Progress will continue to be shared with the CQC on a quarterly basis via the formal Engagement meetings. The next meeting is scheduled for 21st February 2018.

4. Required Actions

For 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 March 2018.

6. Contact Details

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Final Task and Finish Oversight Group: Status Report

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:

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

Status of the 89 Actions:

- 17 (19%) are On Track (Amber).
- 12 (13%) are Complete (Green) & in/awaiting CSPI process.
- 60 (68%) are Complete & Quality Assured via a CSPI (Blue).

Of the 17 Amber Actions:

9 = Safe Domain (& 4 actions require Estates works: Seclusion x 2, Ligatures & Clinic Rooms).
4 = Caring Domain (& 3 actions require Estates works: EMSA)
2 = Well Led Domain
1 = Responsive Domain (& requires IMST works: Phones)
1 = Effective Domain

2 x Amber Actions: **Provider Report**

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

15 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)
4. G1 Must 2: Seclusion Room (Safe)

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

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

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

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

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

Higher Risk Amber Musts/Shoulds & Actions:

- 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 & are effective. The intention is to implement improved operational governance systems & processes with full effect from April 2018.

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

Care Standards undertook a spot check of several care records on Insight 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 has been 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 and to be reviewed by Care Standards by 16th February 2018.

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).

- 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). Risk rating to be re-assessed in light of the delay & advised by 16th February. Completion deadline Q3: 2018/2019.

- 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."*

  The SHSC CQUIN Physical Health Audit 2016/17 (for CQUIN) 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 results of the 2017 Early Intervention in Psychosis Audit (part of the CQUIN Physical Health Audit) are expected in February 2018.

  A new part time Lead Nurse for Resuscitation and Physical Health has been appointed, Kate Virgo, who 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 (due end February 2018).

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

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."*

CSPI: Bungalow 1a had multiple gaps in Early Warning Score (EWS) charts (1/12 completed).

Action: Fed back to the Clinical Nurse Manager & Directors, further CSPI to be carried out in February 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: Further CSPI to be carried out by February 2018.

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."*

Action: Further CSPI to be carried out in February 2018.

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.

Action: New Associate Clinical Director, Chris Wood and Deputy Director of Nursing, Tony Bainbridge to lead full review of HBPoS Staffing and Clinical Supervision by February 2018

Communication with the CQC

Progress against all 12 Action Plans, Well Led, Provider and the 10 Core Services 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.

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

Plans have been developed for the single sex wards at MCC with implementation scheduled to commence from 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 is going ahead.

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

Ligatures: Sanitary ware completed. The next phase of the work is replacement of the doors as agreed by the clinical team and a target date for testing the doors is scheduled by 31st January 2018.

Blanket Restrictions: work is on track & includes:

- Prohibited items register leaflet and poster.
- Blanket restrictions register: individual assessment, rationale and documentation related to impact on service users.
- Recalled all SOPs for green room to add in re MHA CoP.
- Put up signage.
- Education & awareness for service users and staff.
- Evidence to be checked.

Target dates: 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: at the next CQC Engagement Meeting, it is planned to cover Mandatory Training, the Sheffield-Gulu International Mental Health Partnership, focus on actions remaining open and a discussion on acceptable progress.

Appendix 1

November 2016 Comprehensive Inspection Amber Actions (on track)

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. The intention is to implement improved operational governance during Jan, Feb & March 2018 to shadow current arrangements with the new governance fully operational with effect from the 1st April 2018.	Director of Operations & Transformation (Michelle Fearon) Clinical Director (Peter Bowie) Director of Corporate Governance (Margaret Saunders) Interim Director of Care Standards (Denise Woods)	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 January 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 to change are under discussion with new Director Team with a planned timetable to EDG & QAC in February '18.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Director of Estates (Helen Payne)	QAC Report Feb '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**	**This is a Higher Risk Action** **CSPI in progress** Spot check on Insight and although plans were in place and up to date, they were not all holistic and collaborative. Anne Cooke also completed an audit following MHA monitoring visits, results supported this conclusion and were reported to EDG. Audit carried out in CMHT's. Outcome for review at Clinical	Quality Improvement Manager (Jon Burleigh) Associate Director (Richard Bulmer) Associate Director Patient Safety (Anita Winter)	CCP Audit Report Jan 2018 Delivery Plan for CCP 31st March 2018	Clinical Effectiveness Group & Senior Clinical Operations Performance and Governance Group

		Effectiveness Committee in January 2018. Anita Winter, Assoc. Dir. for Patient Safety & Tony Bainbridge Dep. Dir. of Nursing to lead on CCP work. Tony to take the nursing lead on Care Planning (re Nursing Assessment, Clinical Formulation, Care Planning, Monitoring, Review & Evaluation work, including Electronic Patient Recording & Clinical Effectiveness issue). Colleagues in QI to support (Jon Burleigh – Clinical Audit).	Deputy Director of Nursing Operations (Tony Bainbridge)		
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 audit took place in November. The 2016/17 physical health audit showed that it was hard to find evidence of routine physical health screening and associated interventions. The 2017 NCAP audit shows that improvements have been made. However, this latest audit has looked at a time period that crosses over the 16/17 audit and looks at a different sample. This means the audits are not directly comparable. It also means it is impossible to show whole scale improvements when you are looking at (partially) the same period. Discussing with the commissioners whether to undertake a further physical health audit during quarter 4 (Jan-Mar '18) to compare with the 16/17 audit. The results of the early intervention audit (which should be available in February) will also help us see if improvements have been made. Physical Health Strategy & Delivery Plan being revised & updated.	Interim Head of Care Standards Julie Walton Lead Nurse Physical Health (Kate Virgo) Associate Director (Richard Bulmer) Associate Clinical Director (Chris Wood) Cons Psych (Jonathan Mitchell)	28th Feb 2018	Senior Clinical Operations Performance and Governance Group & Clinical Effectiveness Group

Wards for Older People with Mental Health Problems (Dovedale and G1 Wards)					
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	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Director of Estates (Helen Payne)	31st March 2018	Senior Clinical Operations Performance and Governance Group
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: • Out to tender Friday 22nd December 2017. • Tender return Friday 26th January 2018 • (5 Weeks taking in the Christmas period.) • Two weeks tender analysis and mobilisation. • Start on site Monday 12th February 2018 • 9 Weeks Contract period.	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**	Discussed in BPG and 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). Proposal to BPG on 13th Dec 2017. January / February '18 Contract negotiations are taking place to review requirements and agree a possible alternative way to address.	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**	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 60. This currently accounts for 1.8% of clients = 60 - 70 people who do not have a completed DRAM. Target date early February	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave)	16th Feb 2018	Senior Clinical Operations Performance and Governance Group

		To CSPI February 2018.			
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>** A specification has been developed by IMST to inform a business case in line with the Trust telephony strategy. This has been added to the Substance Misuse risk register. Currently have a part time member of staff in the admin team answering calls although the number of calls received has dropped. To be discussed at Operational Governance Group with a review of risk rating for consideration to add to corporate risk register. Chris Wood to provide risk assessment details by mid February '18.	Director of IMST (Nicola Haywood-Alexander) Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave)	16th Feb (Risk rating) 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**	Maple ward compliance is currently low, due to sickness absence and vacancy rates. Requested second Supervision report for January 2018. CSPI to be done in February 2018	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Deputy Director of Nursing Operations (Tony Bainbridge)	28th Feb 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. Plans to change wards are under discussion with the new Director Team with a planned timetable to EDG & QAC in February '18	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Director of Estates (Helen Payne)	Report to EDG & QAC Feb 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*	**Safe**	**<u>This is a Higher Risk</u>** January CSPI **:** 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	Interim Head of Care Standards, Julie Walton Associate Director (Richard Bulmer) Deputy Director of Nursing Operations	Feb 2018	Senior Clinical Operations Performance and Governance Group

health monitoring and observations are carried out by staff and recorded." **(See also CMHT Should 4**)		lack of recording of PH Monitoring. New Interim Head of Care Standards visited Rehab Wards 26th January. Action: Julie Walton to support service on improvement actions & complete a further CSPI in February.	(Tony Bainbridge) Lead Nurse Physical Health (Kate Virgo)		
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**	Action required: • Recalled all SOPs for green room to add in re MHCoP. • Put up signage • Talk to SUs and staff to explain • Evidence to be checked Blanket restriction work is on track to include: • Prohibited items register leaflet and poster • Blanket restrictions register individual rationale assessment and documentation related to impact on service users.	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
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	Associate Director (Richard Bulmer) Director of Estates (Helen Payne) Deputy Director of Nursing Operations (Tony Bainbridge) Deputy Director of Finance (James Sabin)	28th Feb 2018	Senior Clinical Operations Performance and Governance Group

		works. <u>Current Position as of 6/2/18</u>: NHSE Jan 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.			
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. This work commences February 7th	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 have been received in January '18.	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 & a further review of how well this is now working / staffing levels to take place in February / March 18.	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

Appendix 2

November 2016 Comprehensive Inspection Green Actions (in CSPI Process)

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 in progress** Revisited Lone working policy on intranet. The new SOP written but not implemented (will be changed after reconfiguration). Staff are at increased risk in the interim as the buddy system and sign in and out is not consistently in use.	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 in progress** 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. Mobilisation leads to work 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.	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 ensure that staff monitor patients on waiting lists to detect any increases in their level of risk."*	**Safe**	**CSPI to do February 2018** By summer 2018 the waiting time should be 3 weeks with assessment of risks still at 2 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 CSPI to look for evidence of contacts at 2 weeks to assess any change in risks.	Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge)	March 2018	Senior Clinical Operations Performance and Governance Group
Should 8: MCA *"The trust should ensure that staff are confident in adhering to the Mental Capacity Act to embed consent and capacity*	**Effective**	**CSPI to do February 2018** Training for roll out of INSIGHT form continues through to end of December 2017. MCA and DoLS audits to be added to Trust clinical audit schedule.	Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge) Head of Mental Health Legislation	March 2017	Senior Clinical Operations Performance and Governance Group & Mental

considerations into their everyday practice."			(Anne Cook)		Capacity Act Steering Group
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>** **CSPI to do February** All practical steps continue to be taken to support clinical staff. CCPs with service users are being undertaken. 96 +% achieved	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave)	Feb 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**	**CSPI to do in February** START alcohol DNA SOP is complete and awaiting sign off through governance and then will go to the Directorate Governance Sub Group.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave)	Feb 2018	Senior Clinical Operations Performance and Governance Group & Substance Misuse Governance Group
Should 5: Audits of care records *"The trust should ensure that routine quality audits of care records are undertaken."*	**Effective**	**CSPI to do in February** Care records audit results received back from Trust. Feedback to staff to be agreed.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Nurse Manager SMU Services (Mike McCrave)	Feb 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 to be done in February 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. Report Received at WODC 30th Jan 2018.	Associate Director (Richard Bulmer) Deputy Director of Nursing Operations (Tony Bainbridge)	July 2018	Senior Clinical Operations Performance and Governance Group

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 in Progress** Actions underway: • Recalled all SOPs for green room to add in re MHCoP. • Put up signage • Talk to SUs and staff to explain • Need evidence to be checked Blanket restriction work is on track: • Prohibited items register completed and leaflet and poster to be done • Blanket restrictions register individual rationale assessment and documentation related to impact on 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 to be done in February 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 Update Report Received at WODC 30th January 2018.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood)	July 2018	Senior Clinical Operations Performance and Governance Group
LD Wards					
Should 2: Meds *"The trust should ensure that medication is administered in such a way that does not compromise safety."*	**Safe**	**CSPI to do in February** The new clinic room is nearing completion, awaiting double drug cupboard delivery.	Associate Director (Debbie Horne) Associate	Feb 2017	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 to do in February** Currently the figures are: MCA Level 1 =94% & Level 2 =88% DoLs 1 =83%, DoLs 2 =71%, ASD = 88% Dementia =77%.	Associate Director (Debbie Horne) Associate Clinical Director (Chris Wood) Head of Mental Health Legislation (Anne Cook)	Feb 2017	Senior Clinical Operations Performance and Governance Group

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, Audits being undertaken and reported, non-compliant tasks are being escalated and policy discussed with staff members

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 has been purchased, awaiting installation. Reason for delay is awaiting the fibre connection to the building. Estimated duration date <2 months. On-line booking of appointments is available.

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 will take place in February 2018. The Interim Head of Care Standards is working with Team Manager on the purpose and function of Wainwright Crescent to ensure consistent & effective systems are in place to achieve good governance.