CQC Quality Improvement Plan

Assurance Report January 2016

This report is produced to provide staff, patients, stakeholders, the CQC and the board with an assurance against the Quality Improvement Plan developed and agreed in response the CQC inspection report that was published in July 2015. This is a monthly report (commenced September 2015 onwards), following which the main Quality Improvement Plan will be updated

The report will be submitted to the Trust Executive Management Team (EMT), Quality Committee, the Trust Board, TDA and the CQC and will be shared with local commissioning groups. A summary will be published on the Trust intranet and Trust website.

The first section presents the progress on the Warning notices and Compliance actions, the 'Must do actions'. The second section provides information about the progress on the 'Should do' actions to date.

Levels of Assurance

Ongoing compliance is a key priority for the Trust. First, second and third level assurances are in place and facilitating the continuous improvement cycle by highlighting concerns and inconsistencies so these can be focussed on and corrected. As previously reported, the assurance system highlighted areas where further action was required to attain full compliance specifically MHA/DoLs/Safeguarding and Care Planning. Additional actions and auditing are now being undertaken and deadlines revised before full compliance can be confirmed. The revised deadlines relate to staffing levels but also to MHA/DoLs/Safeguarding and Care Planning levels of assurance are still not being satisfied.

Overview of progress to date

There are now a total of 15 Must do actions outstanding. Three actions relate to capital, two are system wide and 10 are internal actions. Of the 10 internal actions outstanding 6 relate to Older Adult Services.

Action Outstanding by Service Line

	Total Must do	Outstanding		
		Internal	Capital	System wide
Acute	8	2	1	1
CRSL	8	2		1
Forensic	6		2	
Older People	12	6		
	34	10	3	2

Warning action – Littlestone

The Warning notices relating to Littlestone were responded to immediately with actions undertaken to address the issues and ensure governance is now place to prevent the risk of re-occurrence. The CQC inspection team returned to inspect compliance on 21 May 2015. The inspection team noted that improvements had been made and were satisfied that appropriate steps have been taken to allow the warning notices to be withdrawn.
A second CCG review visit took place on the 25th November 2015. Their report concluded that the "visiting team identified the significant progression that has been made in a number of areas. The improvement in this unit is evident in the satisfaction feedback received from service users family/carers. They gave glowing recommendations of all aspects of care being received and also the level of involvement they could input into their family members care and decision making. Overall there were no areas that the visiting team felt posed a risk to patient safety."

Warning Notice – Frank Lloyd Unit

CQC inspectors visited the Frank Lloyd Unit during January and expressed concern over some elements of care on the Unit. They have since issued a Warning Notice which the Trust is responding to urgently.

Must do actions – Acute Service Line

The refurbishment within the 136 Suite in the East of the county has been completed and the facility is now in use.

The Service Line is focussing on ensuring consistency of standards in all wards and reviewing actions in place in light of audited outcomes specifically MHA and Care planning. For example

- The Lead Nurse will complete a detailed case notes audit by end of February
- There will be a formal feedback of audits against mental health act compliance on the wards, these are achieved by way of external scrutiny visits supported by mental health act administrators
- Locality matrons will be asked to included randomised audits of patients rights within the now established 3 tiered assurance framework
- Further training on behavioural care planning to be rolled out by March
- Further director led drive on SafeT training by March to increase compliance figures
- By the end of February the 136 policy will have had a full review against the new code of practice and serious incident learning, and will be out for consultation to all stakeholder agencies
- Audits occurring to look at the use of caged vehicle and the decision making process that will have a trends analysis and action plan by March

Must do actions - CRSL

In 8 out of 9 teams the case loads are below 40. The remaining team, South Kent and Canterbury, is working to plans to achieve this target by the end of March. PODs have been implemented across CRSL which are utilising case load clinics and RAG rating. CMHTS Case loads are a standard item on the agenda for CRSL patient safety meeting.

Work with partners to address capacity has resulted in agreement that KCC Primary care health and well being service will become operational on 01/04/2016 and West Kent CCG are implementing a GAP analysis process on care pathways.

Full assurance has been obtained that all teams have lone working protocols adapted specifically for each individual area.

Lead Nurse and Quality Lead carrying out specific care plan reviews and RiO sample checks to confirm recording of consent in care plans during February. A Consent to Share Information form has been produced and will be ratified by the Information Governance team prior to roll out across the Service Line (SL) by end of Feb to meet the March deadline.

BI reporting in place for capacity to consent. OA Lead Nurse is using this to work with individual wards to target improvements. FSSL leading on additional work around capacity to consent to treatment to ensure consistent best practice across all Service Lines.

Further Rehabilitation specific training in relation to safeguarding and clinical risks assessments are being undertaken by Trust corporate leads. Lead Nurse to conduct a review in RiO taking a sample from across the community teams and rehab to get an accurate picture of where the teams are now.

Must do actions – Older Adult Service Line

As with the Acute Service Line, the Older Adult Service Line is focusing efforts on remaining areas of inconsistency, using the results and outcomes from audits and assurance systems to highlight areas of inconsistency and requirements for further work. Care planning and MHA/DoLs/Safeguarding consistent good practice remain a focus of work across the Service Line and the Trust. As does risk management and the processes and systems in place to ensure risks are recognized and actively managed.

Risk Management - Training programme to ensure that staff who had access to the Risk Module on Datix were confident in following the risk management process, including the application of the Control Calibration Tool.

The Training package was targeted at reinforcing the responsibilities of a 'Risk Manager' under Datix and provided guidance in applying the Control Calibration Tool when assessing risks. Additionally Risk trainers have been undertaking a 1:1 visit with the attendees in their work environment to ensure that they fully understand the process and provide assurance that these processes are being embedded.

The directorate are introducing a system to ensure that all team Risk Assessors are providing confirmation of the monthly review of the team Risk Register at the monthly team meeting and the identification and display of the team top 3 risks.

An in-depth review of risks across the SL with 1-1 refresher meetings arranged for those indicating any concerns. All services to have a copy of their top 3 risks displayed.

Safeguarding Alerts related to 'Falls' has been discussed at DTM with further guidance to all teams on the raising of alerts.

All teams to ensure that the Top Ten Policies are available in paper form in a file on the ward.

Incident Reporting and description of 'level of incidents 'to be displayed in the staff office on all wards.

DoLs Breach Report and Capacity and Consent audit findings to be reported to the Directorate Team Meeting on a monthly basis for review, identification of 'hot spots' and agreement of associated actions including Care Plan and Risk Assessment audits, training and support.

All services have a risk detailed on the local on Datix for monthly review.

Trust Safeguarding Lead to re-visit Frank Lloyd and ensure all OA wards have been visited and that staff are confident in identifying abuse.

All Service managers and Ward Managers are required to attend the new training available now.

There is recognition that there are specific workforce challenges in DGS, Shepway and Thanet. Efforts are being made to recruit additional staff in the OA community teams and CAPA is being rolled out across all teams.

Lead Nurse and Quality Lead carrying out specific care plan reviews and RiO sample checks to confirm recording of consent in care plans during February.

A minimum standard bridging statement to be produced to support the Care Planning Guide.

Team Leaders to sign confirming that all staff have read and understand the Care Plan Guide and supporting 'bridging statements'.

A 2 hour workshop is to take place for services in the East and Medway/West respectively to provide a PCCP (to include capacity/consent) refresher session for Ward Managers/DWM's and Snr Practitioners.

A Consent to Share Information form has been produced and will be ratified by the Information Governance team prior to roll out across the Service Line (SL) by end of Feb to meet the March deadline.

BI reporting in place for capacity to consent. OA Lead Nurse is using this to work with individual wards to target improvements. FSSL leading on additional work around capacity to consent to treatment to ensure consistent best practice across all Service Lines

Patients do have a Crisis Card that has details of who to contact in an emergency. Out of hours crisis support is a recognised gap in service provision and is a risk on Datix. SL Director continues raising this issue with Commissioners.

Safeguarding DoLs breach reports to be requested on a monthly basis from the Trust team for reviewing. The report to be reviewed on a monthly basis with Snr Managers.

A Best Interest Assessor to be identified and invited to attend either a workshop or meeting in February 16 to provide insight.

Trust Safeguarding Lead confirmed that ward managers are submitting data to Safeguarding Team in the form of a DoLs breach report. The Safeguarding team will have reviewed all OA wards by the end of the February.

Must do actions – Forensic and Specialist Services

The Service Line must do actions are now largely complete.

The Service Line continues to work closely with the Capital and Estates team on progressing Business Cases for capital works.

The Service line is assisting other Service Lines and leading on a Trust wide basis initiatives such as capacity to consent where their systems and practices were recognized to be good and effective.

Changes to planned actions and completion dates

The actions relating to staffing are being reviewed for completion dates in view of particular areas of recruitment difficulties. It is likely the deadlines for these actions both Must and Should do's will be revised to July 2016. The completion dates for System wide actions will have to be clarified when contractual agreements are reached. If Commissioners agree to increase capacity in March, the impact of the increased capacity will not be effective until September 2016.

The actions which failed to meet deadlines in December, Canterbury 136 suite and full assurance of Lone working protocols were completed in January.

Continued auditing and assurance checks are indicating that MHA/DoLs/Safeguarding, Care planning including clinical risk assessments deadlines of March 2016 may not be achievable. Senior Nurses and Compliance team members are conducting ward visits during February and will confirm the viability of the March deadlines.

Dashboard as at 29/01/16

Quality Improvement Plan

Dashboard

Must do	34
Should do	49

Progress as at	29 01 16	Complete	On track	At Risk
Must do	34	19	13	2
Should do	49	20	25	4

Completion dates	Date	Complete	On track	At Risk
Must do				
Mar-16	30	19	9	2
3 months or more	4	0	4	0
	34			

Completion dates	Date	Complete	On track	At Risk
Should do				
Mar-16	40	20	16	4
3 months or more	9	0	9	
	49			

Action category		Total	Complete	Ongoing
Internal Actions	Must do	26	16	10
	Should do	36	17	19
Capital Requirements	Must do	6	3	3
	Should do	9	3	6
System wide	Must do	2		2
	Should do	4		4
		0		

Action by Service Line

	Must do	Should do
Acute	8	11
CRSL	8	5
Forensic	6	24
Older People	12	9
	34	49

Domain

	Must do	Should do
Safe	26	24
Effective	4	13
Caring	0	0
Responsive	2	11
Well Led	2	1
	0	0

Theme

	Must do	Should do
Patient Centred Care and Treatment	6	11
Risk/safety/privacy and dignity/PSTS	7	22
Safeguarding	2	0
Medicines Management	4	4
Estates/136/seclusion	8	9
MCA/MHA	5	3
Caseload	1	0
Supervision	1	0

Regulation	No. of Actions	
	Must	Should
Compliance action Regulation 9 - Patient Centered Care and treatment	4	9
Compliance Action Regulation 10 - Risk/Safety	7	22
Compliance Action Regulation 11 - MCA/Safeguarding	3	0
Compliance action Regulation 15 - Risk/safety/privacy and dignity/PSTS	4	3
Compliance Action Regulation 13 - Medicines Management	4	4
Compliance Action Regualtion 17 - Estates/136/seclusion	5	8
Compliance Action Regulation 18 - MCA/MHA	5	3
Compliance action Regulation 22 - Patient safety Caseloads	1	
Compliance Action Regulation 23 - Supervision	1	
	0	0

Status of plan

Rating below relate to the progress of the enforcement/compliance action as a whole based on the date of **overall completion**. The table also provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

	Blue	Fully Assured – Three levels of assurance obtained confirming compliance
	Green	Assured / in progress – First level assurance obtained, second level of assurance in place, third level confirmation of compliance being obtained
	Amber	More assurance required – First level assurance in place, second level in progress, third level assurance still required
	Red	Not assured – Second and third level assurance not yet in place or non compliance reported

Assurance levels

First level assurance is ward manager, second level assurance from Modern Matron or Service Managers, third level assurance is Corporate Team or Trust level specialists such as infection control or resuscitation leads or where applicable third level assurance will be independent of the Trust.

Must do Actions due for completion January 2016 or earlier	Issue	Progress rating	Issues / Comments
Warning Notices RGP1-2006656243 RPG1-2006671545	Littlestone Continuing Care Unit		Action completed and ward has been revisited by CQC. Warning notices have been withdrawn. CCG independent assurance visit took place on 25 November 2015. The Report has been received with positive confirmation.
MI1 - Acute	Emergency Equipment		Equipment reviewed, replaced, updated where required – action progress reverted to Amber as less than 100% compliance on 3rd tier assurance checks
MI9 – Community LD (CRSL)	Lone Working Practice		Final 3rd tier assurance now received that all local protocols in place
MI10 – Rehab (CRSL)	Risk Management and Learning		Significant progress with incident reporting with Datix training introduced, flowcharts updated and weekly monitoring at Business Unit Meetings. Learning shared through CRSL briefings, team and business meetings. Rehab-specific learning is being communicated immediately via e-mail. Risk Management Team assurance received.

MI11 – Forensic	Safekeeping of Medicines on Penshurst ward		Action complete and fully assured
MI12 – Forensic	Infection Control – Clozaril Clinic		Trust Infection Control lead has visited clinic
MI16 – Older Adult Wards	Physical Health, Mobility and Pain Management		Littlestone independent report received
MI8 – Older Adult Wards	Risk Management and Learning		Littlestone independent report received
MC63 – Acute	136 Suites		Canterbury work now complete
MC65 - Rehab	Mixed sex arrangements		Zoning plans in place
MI7 - Rehab	Self medication management		Service Line Actions complete, assurance system in place –specific Ethelbert Road assurance received from Pharmacy Team
MI13 – LD Wards	Raising safeguarding alerts		KCC third tier assurance visit on 10/12/15, positive report
MI17 – Older Adult Wards	Littlestone – risk management pain and physical heath		Littlestone independent report received
MI19 – Older Adult Wards	Risk Management Processes		Service Line Actions complete, Risk Management Team sample check (Cranmer Ward) positive, all wards were not checked by end of January
MI21 – Community Older Adults	Supervision at Swale		Service Line Actions complete, assurance system in place, final assurance check results by 8/01/16
MI3 - Acute	Medicines Management		Assurance given that there are no further specific concerns in the highlighted areas(Cherrywood) being raised by the pharmacy teams monitoring these sites
MI5- Acute	Risk Management		Service Line Actions complete, Risk Management Team Action plan complete
MI15 – Older Adult	Medicines Management		Pharmacy Team assurance required for all Older Adult Wards
MI25 - Rehab	Risk Management		Risk Management Team assurance received
MC68 – Older Adult Wards	Privacy and Dignity – Hearts Delight		Deputy Director of Nursing assurance

Must do's due for completion in January 2016	1 Action due for completion and full assurance		Completion dates for Staffing actions being reviewed
Must do's due for completion by March	10 Actions due for completion and full assurance		System wide actions to be agreed as part of Contract round for 2016/17 Care Planning and MHA/MCA full assurance
Must do's with target completion dates beyond March 2016	3 Actions due for completion		Capital work on Seclusion rooms – dates for capital works now scheduled Seclusion rooms at Allington and Penshurst are scheduled for completion by July and September 2016 respectively but this is still dependant on capital funding availablity

Should do actions

The following provides an update on 'should do' actions that are due by end of January.

REF	Service or Directorate	Issue Identified	Action/s	Date to be completed	Progress Summary	RAG rated completion forecast Red = Deadline likely to be missed Amber = Potential delay Green = Completion forecast on time
SI41	Forensic	The availability of emergency and resuscitation equipment in the HDU at the Allington Centre.	Review the availability of emergency and resuscitation equipment in the HDU at the Allington Centre.	31/10/15	Lead Resuscitation officer has reviewed and made recommendations. A second set of equipment is being purchased for HDU in line with recommendation. Equipment has been re-ordered but not yet delivered.	**Completion date extended** **Equipment received awaiting ward confirmation all are in date**
SI49	Forensic	Pay phones on TGU and Allington	Review the payphone facilities across all wards to ensure all patients have access to make private phone calls and that a consistent approach is agreed across the service line in regards to equality of provision and cost.	31/10/15	Payphone usage is monitored to ensure privacy. Service Line checking: a. all wards have a phone hood or screen b. Posters are by the ward pay phone area to state that private calls to solicitors/IMHA etc. can be made in a separate area where required. c. phone charges are clearly stated	**Action extended to include provision of hoods on phones.**
SI52	LD Wards	The trust should review the provision and access for patients for their finances.	This relates to the times the patients bank is open. Finance Director to review access to the patients' bank in ERC.	31/10/15	Money handling policy has been reviewed and updated Service Manager is reviewing patient monies procedure from the TIAA report, including access to the limited opening hours of the patient. Corporate action point: discussions with the patient bank and the finance director	**Action extended to include all Internal Audit recommendations on money handling** **SL actions complete now Trust Action**
SI28	Acute	The provider should ensure that all patients have a risk assessment which is reviewed	New training has been developed and has been published across the acute service line for all staff to do	30/11/15	Ongoing work to improve training compliance across all areas, which is being picked up through both the training team, and by contact at Director	**Action included in Care Planning assurance actions**

REF	Service or Directorate	Issue Identified	Action/s	Date to be completed	Progress Summary	RAG rated completion forecast Red = Deadline likely to be missed Amber = Potential delay Green = Completion forecast on time
		regularly and updated in response to changes.	in groups as part of team meetings		level, to raise concerns where there are specific issues. Forensic Service Line secondment in place to support education, training and actions	
SI47	LD Wards	The trust should review their systems for recording and monitoring of outcome measures to evidence whether people improved following treatment and care	Medical Lead/Psychology HOS to review the outcome monitoring systems in order to highlight improvements	30/11/15	Staff member is reviewing all current assessment/outcome tools currently used in order to highlight those that are being used well as outcome measures and those that have the potential to be used as outcome measures. All clinicians have been asked to contribute. Meeting booked for 07.12.15 to decide next steps – draft report now available	
SI48	LD Wards	The trust should review and appropriately implement the use of advanced plans of care	Quality Assistant and Psychology lead to audit advance decisions re RIO/quality in line with CQC comments	30/11/15	Local Business Meeting group agreed to establish that all patients have a WRAP, (Wellness Recovery Action Plan) which is a very full advance decision, formatted for people with a learning disability. The WRAP needs to clearly state that the WRAP is also the advance decision. 1 outstanding from 3 wards	
SI 50	Forensic	At the Allington Centre, review how patients access their money as the current arrangements are restrictive	Service Manager to review patient monies procedure from the TIAA report, including access to the limited opening hours of the patient bank and the fact that the cashpoint also has limited operating hours.	30/11/15	Service manager has completed the report and forwarded to Executive for decision. Recommendation is that the cashpoint machine is accessible 24/7 and that the opening hours are extended to 5 days a week. Plan to standardise the role of the PMO to bring it into line with Maidstone, under the legal team	**Action combined with TIAA audit actions – SL actions complete now Trust Action**

REF	Service or Directorate	Issue Identified	Action/s	Date to be completed	Progress Summary	RAG rated completion forecast Red = Deadline likely to be missed Amber = Potential delay Green = Completion forecast on time
SI55	Forensic	Develop a service model for the intensive care unit (ICU) on Penshurst Ward as well as associated protocols which should include the use of the time out practice in the seclusion room on the ward	The CNM is visiting a service providing similar services, including a seclusion room. Following this visit the ward philosophy and model document will be drafted	30/11/15	Development of philosophy and model is continuing – draft ready for approval - being discussed at SL Clinical Governance meeting on 07.01.16	
SI32	Acute	The provider should ensure there are robust processes in place for assessing and managing environmental risks, and that these are followed.	Risk register for the service line is reviewed monthly, and has been tied into the CQC quality improvement plan. Local Risk registers reviewed by Service Managers Lessons learned bulletin providing monthly update	31/01/16	Discussions are underway to better assure that the Trust is robust in management of risks being led by the health and safety team	
SI35	Acute	The provider should ensure there are adequate numbers of appropriately qualified and experienced staff.	There is a total review of staffing underway, the therapeutic staffing plans are moving forward to recruitment, staff have been in a consultation period leading up to this, which will improve the availability of therapeutic activity and the safety of the wards. Recruitment focus is also within the CRHTs to allow the teams to function more within the realm of home	31/01/16	There are continued efforts to recruit to the newly formulated therapeutic staffing model, however in the light of national staffing shortages and difficulties in recruitment there are remaining vacancies within this model. Efforts are continuing	**Staffing deadline review**

REF	Service or Directorate	Issue Identified	Action/s	Date to be completed	Progress Summary	RAG rated completion forecast Red = Deadline likely to be missed Amber = Potential delay Green = Completion forecast on time
			treatment thus improving the quality of service offered by them			
SI61	Older Adult Community	Ensure that teams are adequately staffed to manage any foreseeable risks to continued service provision such as adverse weather or staff holiday and sickness.	Each service with staffing capacity issues has a workforce action plan in place that is regularly reviewed. Anticipated low staffing levels are discussed and options considered/ agreed at weekly team meetings. Performance is regularly 'tracked' via reports. CAPA has been introduced and is being rolled out across the Service Line. The performance team will monitor time to treat, waiting times and the assessment process and report on any breaches.	31/01/16	Quality and Governance compliance reports include workforce issues and associated locality action plans. Workforce dashboard reviewed in the Workforce and Patient Experience Directorate Management Team meetings every month Staffing risks alerted through Datix risk management system SL on target to achieve compliance implementing CAPA across the Service Line	**Staffing deadline review**
SI62	Older Adult Wards	The trust should ensure that it continues to actively recruit to vacant posts.	Implement Therapeutic Staffing Implement Recruitment and Retention action plan	31/01/16	Recruitment is underway for Therapeutic staffing - Therapeutic staffing Interviews arranged commencing 3.12.15 and will continue for 2 weeks Vacancy dashboard showing an overall vacancy rate of 14%	**Staffing deadline review**