Leicestershire Partnership NHS Trust

Report to the LLR Health Scrutiny Committee Meeting
Tuesday 19 March 2019

Care Quality Commission Inspection 2018 – Trust Response

1. Introduction/Background

1.1. The Care Quality Commission (CQC) report published in February 2019 relates to the inspection dated 19th November 2018 to 13 December 2018. The report describes the CQC's judgement of the quality of care provided by Leicestershire Partnership NHS Trust ('the Trust).

1.2. Whilst there were a number of positives included within the report, the Trust was disappointed by the number of issues identified. It is working closely with regulators to translate the messages into action and improvements for its staff, patients and carers.

1.3. An urgent action plan has been developed in response to the nine key improvement areas; actions will be completed by the 27th May 2019. Further action plans are being drawn up to respond to additional areas of concern raised within the report.

1.4. The Trust has put a strong governance framework in place to support the oversight and scrutiny of progress to ensure that the right action is taken in timely way, which meets the needs of our regulators and our own internal commitment to improve.

1.5. This improvement work will tie in to existing work streams which are already progressing to transform some of our services. We also recognise that a number of key initiatives will support all areas of development; this includes our single electronic patient record project, our drive to strengthen quality improvement and our approach to developing a just and learning culture across the whole Trust.

1.6. The CQC inspected the following five core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for older people
- Specialist community mental health services for children and young people
- Long stay / rehabilitation mental health wards for working age adults
- Wards for people with a learning disability or autism.

1.7. Ratings for the whole Trust:-

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good →← Jan 2018	Requires improvement →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018
Mental health	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019
Overall trust	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019

1.8. Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good ↑ Jan 2018	Requires improvement →← Jan 2018	Good ↑ Jan 2018
Community health services for children and young people	Good Nov 2016	Good Nov 2016	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Community health inpatient services	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Community end of life care	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall*	Good →← Jan 2018	Requires improvement →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018

1.9 Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019
Long-stay or rehabilitation mental health wards for working age adults	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019	Requires improvement ↓ Feb 2019	Good ↑ Feb 2019	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019
Forensic inpatient or secure wards	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Child and adolescent mental health wards	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Wards for older people with mental health problems	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Wards for people with a learning disability or autism	Requires improvement →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019
Community-based mental health services for adults of working age	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018	Good ↑ Jan 2018	Requires improvement →← Jan 2018	Good ↑ Jan 2018	Requires improvement →← Jan 2018
Mental health crisis services and health-based places of safety	Requires improvement →← Jan 2018	Good ↑ Jan 2018	Good →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018
Specialist community mental health services for children and young people	Requires improvement →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019
Community-based mental health services for older people	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Community mental health services for people with a learning disability or autism	Good Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016
Overall	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019

1.10. Key Themes

Whilst the CQC found examples of good practice, there were a number of key themes requiring further improvement:-

- Access to treatment for specialist community mental health services for children and young people.
- Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation.

- Environmental issues.
- Fire safety issues.
- Medicines management.
- Seclusion environments and seclusion paper work.
- Risk assessment of patients.
- Physical healthcare.
- Governance and learning from incidents.

1.11. The CQC issued a Warning Notice to the Trust on the 30th January 2019. This was served under section 29A of the Health and Social Care Act 2008. An immediate improvement plan (Appendix A) has been developed in response to the nine key improvement areas; actions will be completed by the 27th May 2019. A further improvement plan (Appendix B) has been drawn up in response to the must do's and should do's raised within the core services inspection report.

2. Discussion

2.1. Immediate Response

In order to protect the safety of our patients, we undertook a number of immediate actions following the CQC's initial verbal feedback; this included:-

- Daily review of seclusion paperwork
- At short breaks, all mixed sex accommodation was ceased. The Trust has moved to male and female weeks in collaboration with CCG colleagues, families and carers.
- Environmental risks have been identified and logged for repair, replacement or removal and work has commenced.
- Patients are given a choice as to where physical health observations are undertaken to maintain privacy and dignity.

2.2. Since the beginning of February 2019:-

- We have approved the appointment of two additional premises officers which are out to advert.
- The children's and young people's service has received funding for increased workforce capacity to support the reduction of the neurodevelopmental waiting list and are currently recruiting to this.
- Additional resource has been identified for our rehabilitation wards, for nursing staff to focus on individualised physical health care plans.
- An external review of our incidents and learning processes Trust wide has been commissioned and commenced on the 18th February 2019.
- Two medicines management assistants have been recruited to support medicines management within the wards at the Bradgate Unit.
- Interim labelling of medication with date specific use put in place with immediate effect, with spot checks ongoing by senior nurses.

2.3. S29A Warning Notice

The Notice details nine areas where systems and processes are not operated effectively across the Trust to ensure that the risk to patients is assessed, monitored, mitigated and the quality of healthcare improved. These relate to:-

- Access to treatment for specialist community mental health services for children and young people.

- Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation.
- Environmental Issues
- Fire safety issues
- Medicines Management
- Seclusion environments and seclusion paperwork
- Risk assessment of patients
- Physical healthcare
- Governance and learning from incidents

2.4. The Trust has responded with an immediate improvement plan (Appendix A) to address each of the areas highlighted within the Notice. This has been compiled in consultation with Regulators and the relevant services.

2.5. All actions must be completed by the 27th May 2019.

2.6. Core Services Must and Should Do's

The core inspection report identified a number of must do's and should do's, these are provided in detail within Appendix B. A short and medium term improvement plan has been developed; this is an iterative process and an excerpt from this plan has been appended. Work continues to develop a robust response to the Well Led component, and for the actions to be developed into a SMART format. The actions will be subject to change following on-going review and refinement.

2.7. There are a number of themes which are common across the services:-

- Medicines Management
- Seclusion
- Sharing and Learning
- Single sex accommodation
- Estates
- Care planning
- Well led
- Staffing / workforce / recruitment
- Physical health (including smoke free)
- Infection Prevention and Control
- Performance and data
- Equality and diversity
- Mental Health Act legislation
- Patient engagement

2.8. We have mapped these themes to our clinical priorities. The Trust held a development day on the 5th March 2019 to undertake a thematic analysis with representation from medical, nursing and enabling managers; this involved a review of where overarching quality improvement actions can be included to strengthen the core service response.

3.0. **Governance**

The CQC found a number of reoccurring issues despite the Trust closing actions following the 2016 and 2017 inspections. Previous governance arrangements have not

been adequate enough to reassure regulators and commissioners that action taken this time will be timely, robust and will result in sustainable improvement. The Trust is commissioning an external review of previous governance arrangements to understand the weaknesses and strengthen these.

3.1. The key changes so far this year are:-

- Our improvement plans have been developed with pace and in collaboration with all relevant stakeholders.
- Our improvement plans are aligned to the Trust's overarching objectives, clinical priorities and quality account; the Trust has identified a number of key work streams which require Trust-wide quality improvement input. For instance, care planning, which was a reoccurring theme across the core services; there is now an executive lead, and a group identified for delivery. A separate action plan which focuses on improvement has been appended (Appendix C) as an illustration of this approach.
- We have strengthened existing governance arrangements to ensure oversight and scrutiny of progress (detailed below).
- Executive leads have been identified to support the continuation of medium term actions.
- Outcome measures continue to be identified and 'closing the loop' is a key part of the process for implementing action and being assured that sustainable improvement has been met.

3.2. Internal Governance

The first draft of the immediate improvement plan was shared with NHSI, CQC and the Trust's Commissioners. Progress against this and the short term plan will be monitored by the Regulators at the scheduled quarterly Provider Review Meetings with NHSI, and Engagement Meetings with the CQC. Ongoing liaison with the Trust's CQC Hospital Inspector will ensure that progress is monitored at frequent intervals.

3.3. The immediate and short term improvement plans will be monitored fortnightly by the Quality and Professional Practice Senior Management Team, with regular fortnightly updates provided to the Executive Team. Monthly updates will be provided to the Quality Assurance Committee and the Board.

3.4. Internally the Trust is implementing an Executive Team Task and Finish Group. The Group will scrutinise the evidence provided by service areas to demonstrate that sufficient, appropriate action has been taken. The services and the Group will also reflect on whether the action taken has been successful in addressing the original weakness identified by the CQC. This process will provide robust confirm and challenge, resulting in either a) a request for further evidence to support the existing action, b) request that further action be recommended, or c) provide a recommendation to the QAC for formal closure of the action. Where action has resulted in improvement, the panel will request on-going evidence to demonstrate that this has had a sustainable impact.

3.5. This improvement work will tie in to existing work streams which are already progressing to transform some of our services. We also recognise that a number of key initiatives will support all areas of development; this includes our single electronic

patient record project, our drive to strengthen quality improvement and our approach to developing a just and learning culture across the whole Trust.

3.6. External governance

A Quality Review Summit is planned for April 2019, to involve the Trust, NHSI, the CQC and Commissioners.

3.7. The Trust and the CCG's have been working collaboratively to ensure that robust mechanisms are in place to secure monitoring, assurance and support over the completion of actions. The existing CAMHS Quality and Performance Review meeting will be extended to enable additional focus on progress and improvement within the CAMHS service. In addition to this, the Clinical Quality Review Group will be extended to review progress against the wider improvement plan.

4. Conclusion

4.1 The Trust has responded to the warning notice and the core inspection report with an immediate improvement plan, and a plan containing short to medium term actions. The immediate plan will be delivered by the 27th May 2019.

4.2. Governance arrangements have been strengthened to support the quality and timeliness of improvements. Liaison with external stakeholders has been confirmed.

5. Appendices

- Appendix A – Warning Notice: Summary of findings and excerpt from the LPT improvement plan (page 5).
- Appendix B - Inspection Report: Summary of must and should do's and excerpt from the LPT Improvement Plan
- Appendix C - LPT collaborative care planning action

Appendix A: Warning Notice: Summary of findings and excerpt from the LPT Improvement Plan

Access to Treatment
The CQC found that since the inspection from 2015 onwards, the Trust had not taken sufficient action to ensure that all patients within the specialist community mental health services for children and young people received the service they needed in a timely way. The Trust must ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.

The following excerpt from the full plan includes the action and progress to date

Area	Objective / improvement	Action	Progress to date
CAMHS OP	Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.	Agree a trajectory and resourcing model to deliver significant improvement by 27th May 2019.	Demand and capacity modelling complete. £315k to end March 2019 Approved and funded additional 18 WTE by 4th March.
		Continue to validate waiting lists	
		Clarify the governance arrangements for the oversight and scrutiny of long waiters	
		Recruit to staffing requirements to achieve agreed trajectory	
Neuro - Developmental	The Trust must meet in the needs of patients with neuro development issues in a timely way	Identify trajectory and resourcing model to deliver significant improvement by 27th May 2019	Seven WTE appointed. Evaluation of the Healios Service
		Recruit and deploy new staff.	
		Implement capacity improvement plan	
		Confirm on-going methodology for the validation of waiting lists	
		Add number of patients with ASD/ADHD seen by crisis onto score card and monitor reduction	
Crisis	The specialist community mental health services for children and young people crisis team to meet their commissioned target to telephone patients within two hours and assess them within 24 hours	Review of existing systems and processes to identify opportunities for improvement.	
		Completion of demand and capacity modelling to deliver required outcomes.	

Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation
The Trust had not ensured that wards for people with a learning disability or autism were compliant with mixed sex accommodation guidelines. We were not assured that the Trust had taken action to ensure that they had complied with the Mental Health Act Code of Practice paragraphs 8.25-6. This issue had been raised following inspections carried out in 2014 and 2016. The Trust must ensure that all wards comply with guidance on the elimination of mixed-sex accommodation. In addition to this the Trust failed to appropriately and accurately report breaches in mixed sex accommodation to the Commission.

Area	Objective / improvement	Action	Progress to date
Short Breaks	Cease mixed sex breaches by maintaining male and female weeks and not accepting emergency patients / accommodating family preferences	Liaison with families and re-booking patients who will breach male and female weeks.	Team Manager has gathered dates of planned breaches in order to scope resolutions.
		Not admitting patients in an emergency that will breach mixed sex guidelines	Staff informed that all emergency admission requests go through the Team Manager and Service Manager
		Revise the SOP for emergency requests for short breaks	SOP revised to eliminate mixed sex breaches in an emergency.
		Communicate the revisions to practice to families, with clear rationale.	Letter signed off for distribution and sent to families
		To notify CCG Commissioning Lead of change in process with immediate effect	Email confirmation received that CCG is supportive of no breaches.
Bradgate Unit	Strengthen the process for agreeing a clinically required breach of mixed sex guidelines	Revise the bed management SOP	Draft completed and going to Executive Team for discussion 11/03/19
		Confirm the internal and external reporting of mixed sex breaches.	Confirmed that there are no additional notification forms required for breaching this guidance. Link below: https://www.cqc.org.uk/guidance-providers/notifications/notifications-nhs-Trusts Agreed with commissioners that we will externally report on all breach types - justified and unjustified. Regarding internal reporting, the IQPR includes reports of ALL breaches – not just sleep breaches.
		Strengthen the content of the e-irf	

Area	Objective / improvement	Action	Progress to date
		forms and ensure there is an accountability process supporting any admission resulting in a breach type.	
		Review and amend the Trust Policy on Same Sex Accommodation.	Policy currently being drafted to take to April PCEG
Cedar and Acacia at the Willows	Walk by mixed sex breaches will not occur as a result of accessing laundry facilities.	To establish clear practice guidance on the use of laundry facilities by males and females at the Willows.	On Cedar and Acacia, male patients now access the laundry facilities using an alternative entrance or they will use the facilities on Sycamore which is male only.

Environmental issues

The Trust had not ensured that they maintained the safety of patients due to poor ward environments. Similar environmental issues had been raised with the Trust in previous inspections. Fixtures and fittings were often worn, stained and/or in a state of disrepair and not all environmental risks had been identified or mitigated against. The Trust must ensure all environmental risks are identified and mitigated against and that risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks. We found the following issues in the acute wards for adults of working age and psychiatric intensive care units, and long stay or rehabilitation mental health wards for working age adults' services.

Area	Objective / improvement	Action	Progress to date
Repairs maintenance and cleaning Multiple Sites	Establish a co-ordinated and responsive repairs and maintenance process to quickly address and resolve issues promptly.	All outstanding repairs and maintenance issues highlighted within the regulatory notices will be fixed and resolved.	**Stewart House** All doors have now been replaced. The tile in the OT kitchen has been replaced. **BMHU** Ashby windows have all been replaced. Bosworth windows have started to be replaced – finish date 22/02/219. Aston & Thornton have had all of their 'high absconsion risk' windows replaced. The remaining

Area	Objective / improvement	Action	Progress to date
			windows are scheduled to be replaced during the refurbishment of the wards (date to be agreed). Ashby has all new lighting in place. Bosworth's lighting will be replaced in March 2019. Aston/Thornton – All lighting checked and those not working have been reported to estates. Upgrade to lighting planned for 2020/2021 capital programme. Review of timescales required.
		Appoint two new premises managers to replace vacancies.	Posts currently out to advert and interviews planned for mid-March.
		Premises managers to populate central log for each ward on the environmental issues and improvements.	
		Undertake a monthly review of whole unit issues to include progress and slippage going forward	
		To strengthen our internal governance arrangements and clarify the escalation process for unsatisfactory delays.	
		AMH Head of Service to confirm other responsibilities in a specification for Director of Finance.	
Ligature risk assessments Multiple Sites	Ligature risk assessments to be tailored and include actions. To ensure that systems and processes are in place to enable timely and adequate	Head of Health and Safety will co-ordinate the completion of a physical review of all ligature risk assessments across BMHU and Rehab.	Maple Ward: Football table has now been moved to the recreation room which patient's only access under staff supervision as this is a locked area. Stewart House Dining Room: The ligature risk assessment has been reviewed and updated with

Area	Objective / improvement	Action	Progress to date
	response to actions.		appropriate controls for all unlocked patient areas
		Ward sister / charge nurses will ensure there is a ward based clinical mitigation plan in place for each of the risks identified.	The review of all wards commences week 3/03/19 with Health and Safety rep., ward Sister/ charge nurse and Matron to check for further ligature risks and ensure clinical mitigations of any risks is reflected.
		Ward sister / charge nurses will ensure that the ligature risks for each individual patient is assessed through the risk assessment process and where required a person centred ligature care plan is in place.	
		Head of Health and Safety will ensure that all of the ligature risks identified through the risk assessment are collated on a central database.	
		To introduce a RAG rating for each room on the Bradgate to support staff in knowing which rooms have fixed ligature points.	
		Head of Business to develop and submit removal and replacement requests as part of capital programme.	

Fire Safety Issues
Staff did not manage the risk of patients smoking in the ward in line with the Trust smoke free policy. We found the following evidence of when patients, staff and visitors could have been placed in potential high-risk situations. The Trust reported 14 fires caused by lighters or matches brought onto the ward by patients since November 2017, this included a large garden fire in the garden of Bosworth ward.

Area	Objective / improvement	Action	Progress to date
Smoking cessation Multiple areas	To provide clear guidance to staff and patients on alternatives to smoking and maintain safe, cleaner and healthy environment	AMH Head of Service to review the Smoke Free policy to ensure clarity for staff and patients about expectations.	
		Confirm designated ward vaping areas	
		Explore options to improve communication about Smoke Free via website / leaflets / signage	
		AMH Head of Service to contact LCC Smoking Cessation Service to explore vaping and provision of vapes as alternative NRT for new admissions.	Reviewing policy from Nottinghamshire Healthcare regarding the use of e-Burns in inpatient areas and for use on escorted leave.
		Medical Director to set up workshop with Consultants to review and confirm Section 17 arrangements in line with Smoke Free Policy	Workshop with Consultants organised for 15th March.
		AMH Head of Service to liaise with Matron for Crisis to agree an advance clinical directive with CMHT / Crisis Teams for patients to confirm NRT if they were to be admitted.	
		Head of Estates to organise the removal of discarded cigarette ends within the courtyard areas of all inpatient services.	Estates Manager to obtain quote for cleaning courtyard areas.
		Head of Communications to explore options to improve communication about Smoke Free via website / leaflets / signage	
Evacuation Multiple areas	Safe evacuation in the event of a fire. Disabled patients will have	Ward Sister to send AMH PEEP and guidance sheet to all Ward Sister/charge nurses and to be point of contact for any queries.	

Area	Objective / improvement	Action	Progress to date
	a personal emergency escape plan in the event of fire	Fire Safety Management Policy to be revised to include information about General Emergency Evacuation Plan and Personal Emergency Evacuation Plan	Complete
		A flag to be introduced into SystmOne to identify patients require a PEEP.	SystmOne will be in use by 202. Interim measure will include a PEEP risk assessment on RiO.
		To flag those patients with a PEEP on nursing handover	
		All disabled patients who require a greater level of support than the standard horizontal fire evacuation procedures admitted to an acute, rehab or PICU ward will have a PEEP.	
		Suggesting that PEEP is not necessary per patient due to the approach to the Trust Policy. Director for AMH/LD to make contact with Director of Finance and Head of Health and Safety to get them to confirm approach with CQC.	Advice confirmed with CQC that PEEP is good practice and referenced in our own Fire Safety Policy. See e-mail in Ops folder 19/02/2019.

Medicine Management

The Trust had not made sufficient improvements in medicines management since the last inspection in 2017. The Trust must ensure the safe management of medicines, to include storage, labelling and disposal of medications. We found the Trust medicines management practice was unsafe in relation to the storage, disposal and medicines reconciliation for the following reasons:
We were not assured that staff were administering medication that had not expired as they had failed to record when medication was opened which meant that the expiry dates of the medication could not be determined.

Area	Objective / improvement	Action	Progress to date
Multiple areas	Strengthen medicines management systems and processes to	Head of Nursing to meet with Pharmacy to review medication management improvement plans	Further ward pharmacy checks have been implemented since the CQC visit in November 2019.
		Head of Pharmacy to contact a Head of Pharmacy in an outstanding Trust to establish a different	Northampton Pharmacy contacted – awaiting response.

Area	Objective / improvement	Action	Progress to date
	comply with standards and policy.	approach to medication labelling for start/ end/ do not use after/ medications.	Complete new labelling to be implemented in March 2019.
		Head of Pharmacy to review current process and equipment for medication returns to Pharmacy.	Current process reviewed and alternative medication returns bins have been ordered for each inpatient ward funded from ward medication budget.
		Head of Pharmacy to establish improvement in the safe administration and recording of controlled drugs (CD).	Incidents involving CD's were reviewed. To reduce human error, a computerised CD register and administration support system will be implemented which links with the Trust's current Prescription tracker system. Quote received (£4,515) and awaiting funding approval
		Head of Pharmacy to improve safe storage of medication in ward clinic rooms at the Bradgate Unit. Two Assistant Pharmacy Technicians (Band 3) will be employed to check medication storage, ensure cleanliness and support pharmacy requests and deliveries.	
		Head of Nursing for AMH and Head of Pharmacy, in the interim period of the above actions a safe storage and administration of medication briefing will be issued and Ward Sisters/ Charge Nurses will take responsibility for a weekly check of ward Clinic rooms.	Timescale revised due to Ward Sisters/ Charge Nurse leave. Now complete.
		Matron to identify a Band 6 Registered Nurse at Stewart House and Willows, to take responsibility for medication management procedures with support from Pharmacy.	

Seclusion environments and seclusion paper work

We carried out a review of seclusion practices prior to our main site visit. We reviewed 58 sets of records relating to periods of seclusion that took place between April 2018 and September 2018. We found that records did not always meet the recommendations set out in the Mental Health Act Code of Practice. The Trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Act Code of Practice.

Area	Objective / improvement	Action	Progress to date
All inpatient areas with seclusion areas	Seclusion paperwork / process Ensure compliance with the Seclusion Policy and the Mental Health Act Code of Practice.	Head of Nursing for AMH put in place an initial action plan following the MHA and CQC inspection in November 2018: Confirm the current Seclusion Policy and seclusion documentation is being used in the Willows Rehabilitation Unit	New packs of up to date seclusion paperwork implemented on the 4th December 2018
		Review the current assurance process for seclusion documentation to ensure it is fit for purpose.	Process reviewed with Ward Sister/ Charge Nurses and Team Managers who check seclusion documentation and amendments made to the system to widen final checkers to include Matrons and confirmation of expectations of checks confirmed.
		Head of Nursing for AMH to review Seclusion Policy including the recording process and documentation for incidents of seclusion – test of policy/ documentation prior to sign off.	Meetings have commenced (2 held) with Ward Sisters/ Charge Nurses to review policy and documentation. Meeting with Drs planned 13/02/19 Further session held 28/02/19 and policy/ documents revised

Area	Objective / improvement	Action	Progress to date
			further. To distribute for final comments 8/03/19 and pilot forms from 15/03/19
		Matrons to complete a review of all seclusions and documentation 1 month after the implementation of the new policy and documentation	
Rehab wards	Ensure seclusion policy includes adequate seclusion room checks	Ensure seclusion policy includes adequate seclusion room checks will be included in the action above related to the Seclusion Policy review.	
		Ensure sink fittings identified in Acacia ward seclusion room as a ligature and safety hazard are replaced.	Estates have been asked to liaise regarding appropriate anti- ligature sink fittings, Site visit week commencing 4/03/19.
		Re-sealing of flooring in Maple ward seclusion room by estates.	Flooring re-sealed.

Risk assessment of patients

The Trust did not ensure that staff were assessing the health and safety of patients receiving care or treatment and the Trust did not do all that is reasonably practicable to mitigate any such risks. Staff on Maple ward were not completing or updating patient risk assessments in line with the Trust policy or after incidents had taken place. We reviewed eight patient records and the following six had risk assessments that staff had not updated.

Area	Objective / improvement	Action	Progress to date
Rehabilitation and (all other inpatient areas)	To ensure risk assessments are robust and completed and updated following incidents.	Rehabilitation Matron with support from the Transformation Team to establish a PDSA Group to improve the risk assessment process, including updating risk assessments. A monitoring system will be developed and assurance provided at the monthly Rehab Governance meeting.	All reportable (EIRF) incidents are reviewed by the Ward Sisters and Charge Nurses. When reviewed the patients' electronic records (RIO) will be reviewed to check that the patients risk assessment and care plan has been updated accordingly. This will be documented in the Ward Sisters and Charge Nurses sign off.

Physical health care

The Trust had failed to ensure that all patients' physical health was appropriately assessed on admission and that regular assessments of the physical health needs of patients had been undertaken. Staff had not completed a physical health examination in 14 out of 30 records. We reviewed all records and found that no physical health monitoring had been recorded since the patient had been admitted to the wards.

Area	Objective	Action	Progress to date
Bradgate and PICU	Physical health monitoring	Matrons to confirm the correct checking process is in place for equipment and the Trust calibration schedule includes the equipment.	
Rehabilitation area	All patients admitted to Rehabilitation Wards will have a physical health examination.	Consultant and ward sister / charge nurse to review the current admission process to ensure all patients receive a physical health examination by a doctor on admission to rehabilitation wards and nursing staff complete the cardio-metabolic physical health form. Establish a monitoring process to ensure compliance.	
		Most current physical health examinations are being recorded in the RIO progress notes: Head of Nursing for AMH to resolve the RIO EPR technical glitch which occurs when Doctors try to complete the physical health form within the core MH assessment.	
Willows	Physical health needs will be met in partnership with primary care.	Matron will ensure the Willows recruit 0.2 WTE RGN to work alongside the GP once a week to run clinics and focus on physical health care planning and health promotion.	Stewart House now has an RGN in post who dedicates one day a week to focus on individualised physical health care plans
Ward areas	Ensure patient's privacy and dignity is maintained when receiving physical health observations.	Ward Sisters/ Charge Nurses to establish clear written guidelines for where and how physical health observations are completed on their wards and how any exemptions to the guidelines are recorded: Guidelines to be approved by the Matrons.	All wards have participated in discussion on guidance, finalised approach by 6/03/19

Governance

The Trust did not have robust governance procedures to ensure that they could identify and address issues across the Trust in a timely way. These issues with governance procedures had been reported at the last inspection in 2017. The Trust governance processes had not identified issues around environmental repairs, medicines management, seclusion documentation and sharing lesson learnt from incidents.

Area	Objective	Action	Progress to date
Well Led	Governance Not always focussed on the most important aspects of quality / issues	Director of AMH/LD to invite Executives to review governance arrangements in AMH.LD and FYPC to improve governance systems and processes	New Head of Patient Safety starting 1st March 2019
		Heads of Service to review the systems and processes in place to share information and learning to and from front-line to Directorate level and ensure effective oversight of workforce, finance, performance and quality and safety	
		Recruit a new acting Associate Director focussed on remedial improvement.	
		Recruit a Deputy Nursing Lead for in-patient services	
Well led	Communications. Engage with staff well.	Head of Communications to develop a central communications plan. Planning for communication with staff through forums to occur for the week of the 4th March 2019.	

Appendix B: Inspection Report: Summary of must and should do's and excerpt from the LPT Improvement Plan

Acute wards for adults of working age and psychiatric intensive care units

Area	Objective	Action	Progress to date
Bradgate and PICU	The trust should ensure staffing requirements of 136 services do not adversely affect those of acute wards for adults of working age	The rostering team will work with operational managers to review the rosters and staffing requirements.	A proposal of options for staffing the PSAU was taken to the February Directorate business meeting by the business team and it was agreed to request additional funding from commissioners for dedicated PSAU staff.
		To develop a proposal for staffing the PSAU.	
Bradgate and PICU	The trust should ensure the use of bank staff does not impact on the delivery of consistent patient care.	A review of the safer staffing reporting requirements in line with developing workforce safeguards standard guidelines from April 2019 is taking place.	The Trust safer staffing report provides oversight of use of Temporary staff and increased utilisation due to RN vacancies, sickness and increased levels of patient acuity requiring observation support. Regular block booking of bank and agency RNs continues to manage the impact of the increase in RN vacancies across the acute inpatient wards.
		Ensure that bank staff have the skills to provide safe and effective care.	Bank staff attend core induction and are provided with the same mandatory training and competencies expected of substantive staff.
		Improve consistency by use of regular bank staff on individual wards.	Ward Matrons/charge nurses to develop a cohort of regular bank staff if possible and ensure that they are inducted to the individual ward.
Bradgate and PICU	The trust should ensure that staff have access to regular team	Wards to have at least monthly team meetings chaired by the Charge Nurse / Sister or deputy, which will be supplemented by a weekly information sharing email.	The February edition of 'Leadership Matters' which goes out to our leadership and management

Area	Objective	Action	Progress to date
	meetings.	Information from the meeting will be cascaded to all staff and be available for all staff to see.	community was focussed on the importance of team meetings. Service Manager to audit the frequency and minutes of ward team meetings as well as weekly information sharing email.
		Establish a programme of regular team development days across the service.	We have put in place a four month communications plan on importance of team working and support available. This will be rerun every quarter for the rest of the year (embedding message) The importance of teams will be emphasised on leadership development programmes.
Bradgate and PICU	The trust should ensure that the senior executive team are present and visible to staff.	Increase the number of Executive Team Boardwalks.	
		Photos and job titles of the senior executive team and local senior managers are to be made freely available in public and staff areas of the service.	
		To plan a regular programme of Q&A sessions for staff within the unit with the Executive and Service Manager team to increase leadership visibility.	
Bradgate and PICU	The trust must ensure staff involve patients in their care planning and their views are recorded	Unit matrons to drive patient involvement in care plans with clinical staff and ensuring that care plans are co-designed with patients.	The Trust care planning initiative has commenced.

Area	Objective	Action	Progress to date
	appropriately.		
Bradgate and PICU	The trust must ensure all environmental risks are identified and mitigated against. The trust must ensure that ligature risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks.	All environmental risks to be identified and logged for repair, replacement or removal, with mitigation action plans in the interim. Review all ligature risk assessments, replace or remove any identified fixed point ligature risks. A tri-part assessment of current ligature risk assessments for each ward including, Matron, Ward Sister/Charge Nurse and Health and Safety representative Ward Sister/Charge Nurse to develop ward mitigation plans for any ligatures identified through the review and re-assessment and shared with the staff team Ward Sisters/Charge Nurses will ensure that the ligature risks for each individual patient is re-assessed through the risk assessment process and where required a person centred ligature care plan in place.	Health and Safety Team representatives to visit all ward areas week commencing 4th March to update ligature risk assessments and ensure that ward staff are aware of these. Health and Safety Lead to collate all risks centrally.
Bradgate and PICU	The trust must ensure the safe management of medicines, to include storage, labelling and disposal.	Matrons to work with the wards and pharmacy to make sure the storage, labelling and disposal of medication is carried out as per policy. Medication bulletins regarding lessons learned and good practice to be circulated to all ward areas.	Spot checks to be completed by the ward sisters / charge nurses to check compliance. Pharmacy have sourced alternative medication disposal bins and will be rolling out a new labelling system for opened medication. Two ward-based Pharmacy technicians to start work at BMHU at the beginning of April.
Bradgate and PICU	The trust must ensure that medical equipment used by staff is regularly and accurately checked.	Establish that all of the medical equipment is on the Medical Devices database. To ensure all medical equipment is checked annually in accordance with the Medical Devices Policy. To review the process for locally checking equipment in between the annual checks.	All equipment in use has been checked against the trust Medical Devices database. Review of the local checking system has commenced.

Area	Objective	Action	Progress to date
Bradgate and PICU	The trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Act Code of Practice.	Following an episode of seclusion, the paperwork will be reviewed for completeness and quality and reviewed against the patient's care plan.	The unit matrons are scrutinising seclusion paperwork before final sign off.
Bradgate and PICU	The trust must ensure all staff are aware of the Department of Health's guidance on eliminating mixed sex accommodation to ensure appropriate and accurate reporting. The trust must ensure that the privacy and dignity of patients is protected.	All staff to be given information on the Eliminating Mixed Sex Accommodation guidelines. Bed Management Admission Policy to be reviewed to ensure the above guidelines are considered and, in emergencies, i.e. where a temporary mixed sex breach may occur, it is reported correctly and escalated as appropriate.	DoH Guidance circulated to staff. Trust Bed Management Admission Policy and SOP being revised.
Bradgate and PICU	The trust must ensure that environments are regularly maintained and updated to ensure they provide a safe environment for patient care.	Establish a refurbishment programme for the older estate.	The four older wards at BMHU to be refurbished and windows replaced. Ashby and Bosworth ward to be completed in 2019 and followed by a proposal and application for funding for Thornton and Aston wards. Ongoing maintenance plan in place with support from Facilities.
Bradgate and PICU	The trust must ensure patients have personal fire evacuation plans in place where necessary and weekly	Weekly fire checks of the environment to be carried out. All disabled patients who require a greater level of support than the horizontal fire evacuation procedures	Fire checks being completed each week. Spot checks being undertaken by the Team Manager. Reviewed Trust Fire Safety Management Policy to include

Area	Objective	Action	Progress to date
	fire checks of environments are completed.	admitted to an acute, rehab or PICU ward will have a PEEP.	assessing whether a patient can be supported by a General Emergency Evacuation Plan (GEEP) or will require a PEEP. Guidance on developing PEEP care plans has been shared with staff.
Bradgate and PICU	The trust must ensure it reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance.	Dormitory accommodation to be reviewed as part of the work to look at the re-provision of the four older wards.	
Bradgate and PICU	The trust must ensure that sufficient facilities are available to meet the needs of all patients.	A review of the facilities available will be undertaken.	
Bradgate and PICU	The trust must ensure that lessons from incidents and complaints are shared with staff.	Lessons learnt from incidents and complaints to be cascaded from the service business meeting down to ward level meetings and information shared with staff. Wards to have at least monthly team meetings chaired by the Charge Nurse / Sister or deputy.	Currently SI bulletin/newsletter in place and Clinical Governance Team also reviewing the way in which lessons are learnt and good progress can be shared effectively across the Directorate. Service Manager to audit the frequency and minutes of ward team meetings.
Bradgate and PICU	The trust must ensure effective governance systems are in place to monitor the service.	A full review of the Directorate's governance systems will take place.	Clinical Governance Lead working with Service Managers to agree a coherent and consistent governance process across the Directorate.

Area	Objective	Action	Progress to date
Bradgate and PICU	The trust should ensure patients have access to psychological therapy and this is delivered and recorded in line with best practice guidance.	The psychological therapies provision will be reviewed.	
Bradgate and PICU	The trust should ensure a review of the management and implementation of its smoke free policy at the Bradgate Unit.	Medical Director (lead for smoke free) to commission a review of the management and implementation of the smoke free policy at the Bradgate Unit.	Ongoing work to look at NRT alternatives for patients and identify vaping areas on wards.
Bradgate and PICU	The trust should ensure bed management arrangements are more robust in order that patients have access to an acute bed within their area.	To review the bed management processes, patient flow and availability of beds in conjunction with Commissioners.	Work around Red to Green, Housing, EDP and other initiatives are ongoing as part of the Quality Improvement work to reduce the Length of Stay chaired by the Head of Service. Service Managers and the business team are linking in with regional Out of Area Placement concordats and links with commissioners are in place for support to be able to accommodate all LLR patients locally. The transformation work is also focusing on the aim to get OaPs to zero.
Bradgate and PICU	The trust should ensure best practice and innovation within the service is shared.	Review the current processes for sharing best practice and innovation and implement changes.	Standing agenda items on the service business meeting and matrons meeting to share good practice and innovation.

Long stay or rehabilitation mental health wards for adults of working age.

Area	Objective	Action	Progress to date
Long stay or rehabilitation mental health wards for working age	The Trust should ensure all staff are supported to raise concerns about bullying.	The Trust has an anti-bullying support system and helpline in place. HR team will to review with operational managers to ensure staff are supported and aware of support systems in place. Staff side and freedom to speak up guardian to be connected also.	
	The Trust must ensure care plans are personalised and holistic. Regulation 9 (1)(a)(b)(c).	Participate in the Trust wide improvement programme for collaborative care planning	Email sent to all staff requesting care plans to be personalised.
	The Trust must ensure staff involve patients in their care planning and their views are recorded appropriately. Regulation 9 (1)(c) 3(b).		Record Keeping audit to be completed by ward matron 01.04.19
	The Trust must ensure that the privacy and dignity of patients is protected. Regulation 10 (1)	To repair the locks on the two identified toilets so that they can be locked for privacy and dignity.	Looks repaired action complete
	The Trust must ensure that all wards comply with guidance on the elimination of mixed sex accommodation. Regulation 12 (1).	A Trust wide review of the Same Sex Accommodation policy and facilities across the Trust, to include review of move to single sex accommodation where possible	
		Male patients to use the laundry room facilities on Sycamore.	
	The Trust must ensure all environmental risks are identified and mitigated	A Trust wide review of the current Ligature Risk Assessment Tool to take place	

Area	Objective	Action	Progress to date
	against. The Trust must ensure that ligature risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks. Regulation 12 (1) (2)(a)(b).	A tri-part assessment of current risk assessments for each ward including, Matron, Ward Sister/Charge Nurse and Health and Safety representative	
		Ward Sister/Charge Nurse to develop ward mitigation plans for any ligatures identified through the review and re-assessment and shared with the staff team	
		Ward Sisters/Charge Nurses will ensure that the ligature risks for each individual patient is re-assessed through the risk assessment process and where required a person centred ligature care plan in place.	
		The football table on Maple Ward to be moved to the recreation room so it is only accessed by patients under staff supervision.	Action complete
		The Ward Sister and Team Manager to ensure that all staff are up-to-date with risk assessment training	
		To introduce discussions regarding risk and ligatures within Team meetings.	
	The Trust must ensure that environments are regularly maintained and updated to ensure they provide a safe environment for patient care. Regulation 12 (1) (2)(a)(b)(d).	All outstanding repairs and maintenance issues and escalated.	Stewart House doors replaced Tile in the OT kitchen replaced
	The Trust must ensure that staff consistently apply and record appropriate elements of the seclusion	Review of seclusion documentation on a daily basis for any seclusion that has occurred.	

Area	Objective	Action	Progress to date
	policy in line with the Mental Health Act Code of Practice. Regulation 12 (1).		
	The Trust must ensure seclusion rooms comply with the Mental Health Act Code of Practice. Regulation 12 (1) (2)(d).	Seclusion room checks will be completed after patient seclusion is terminated	
		Ensure sink fittings identified in Acacia ward seclusion room as a ligature and safety hazard are replaced.	Estates have been asked to liaise regarding appropriate anti- ligature sink fittings, Site visit week commencing 4/03/19.
		Re-sealing of flooring in Maple ward seclusion room by estates.	Flooring re-sealed.
	The Trust must ensure staff assess and care plan patient's physical health needs. Regulation 12 (1) (2)(a).	Consultant and ward sister / charge nurse to review the current admission process to ensure all patients receive a physical health examination by a doctor on admission to rehabilitation wards and nursing staff complete the cardio-metabolic physical health form.	
		To establish a monitoring process.	
Willows	The Trust must ensure staff assess and care plan patient's physical health needs. Regulation 12 (1) (2)(a).	To recruit 0.2 WTE RGN to work alongside the GP once a week to run clinics and focus on physical health care assessment and planning and health promotion.	Stewart House now has an RGN in post who dedicates one day a week to focus on individualised physical health care plans
Long stay or rehabilitation mental health wards for working age	The Trust must ensure staff update risk assessments following incidents. Regulation 12 (1) (2) (a).	The Ward Sister/Charge Nurse to check the patient electronic record (RIO)at the time of the reportable incidents reviewed to ensure that the patients risk assessment and care plan has been updated accordingly. This will be documented in the Ward Sisters and Charge Nurses sign off.	
		To develop a monitoring system to be reviewed at the monthly governance meeting.	
	The Trust must ensure the	A Band 6 Registered Nurse at Stewart House and the Willows to	

Area	Objective	Action	Progress to date
	safe management of medication, to include storage, labelling and disposal. Regulation 12(1)(2)(g).	take responsibility for medication management procedures with support from Pharmacy.	
Long stay or rehabilitation mental health wards for working age	The Trust should ensure staff support patients to make advanced decisions.	Establish guidance for staff on supporting patients to make advanced decisions about their care and treatment.	
	The Trust should ensure there is clear criteria for admittance to the service	Clinical Director, Head of Nursing and Head of Service to review the admission criteria to the service.	
	The Trust should ensure there is a clear model for the service	Clinical Director and Head of Nursing to review the clinical service model in line with the All Age Transformation programme and clinical pathway review	
	The Trust should ensure patients are provided with food of their choice.	To ensure patient feedback on menu choice is fed into the menu service reviews with the dieticians and local food group.	
	The Trust should ensure all staff are supported to raise concerns about bullying.	Freedom to Speak up Guardian to deliver a number of staff sessions	

Wards for people with a learning disability or autism

Area	Objective	Action	Progress to date
LD Inpatient – Agnes Unit	Ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the	All staff will be advised of the appropriate recording of the seclusion policy Through the following actions a. Discussion of seclusion policy and areas for improvement in the registered nurses meeting b. Overseeing the cascading the information by deputy sister	

Area	Objective	Action	Progress to date
	Mental Health Code of Practice	at each of the three PODs to healthcare support workers c. Discussion of seclusion policy within the medical team by the consultant All seclusion paper work will be scrutinised on a day to day basis by ward sister / deputy sister. On a weekly basis the Team Manager and Matron will oversee the sign off process.	
LD Short breaks	Ensure that all wards comply with guidance on the elimination of mixed-sex accommodation	All bookings for the 2019 calendar year will be reviewed for mixed sex breaches All service user and family's bookings where breaches will occur will be contacted and advised of the changes, alternatives stays where possible will be offered to accommodate the patient and carer needs or alternative provision considered. Emergency bookings will not be accepted where a breach will occur. Standard Operating procedure and emergency booking procedure to be updated.	All bookings have been reviewed and family's contacted regarding changes to dates or cancelled stays. Emergency booking standard operating policy has been updated.
LD Short breaks	Ensure that staff adhere to infection control principles and that items such as hairbrushes are not used for different patients.	Check all staff are up to date with Infection Control training. Review the homes guidelines on use of service users personal toiletries and grooming items.	Any unlabelled grooming items have been removed from the short break homes.
LD Inpatient Wards	Ensure effective governance systems are in place to monitor the service	The LD Service leads will work with the divisional governance lead to review and develop the service governance structures.	
LD Short breaks	Ensure that medication errors, where electronic prescribing has not been introduced, are reported as incidents	Confirm the process for medication incident reporting with all staff at the homes team meetings. Review all medication error incidents that are reported for learning and share with staff in team meetings.	All incidents are considered under the Trust Medication Error Policy and these are reviewed monthly by the Matron for shared learning.
LD Inpatient Wards	Ensure that learning from incidents and complaints is discussed with all staff,	Develop a framework of shared learning from incidents and complaints as part of the Directorate governance review.	Until this is developed incident and complaint learning is being shared

Area	Objective	Action	Progress to date
	including health care assistants.		from service governance meetings with ward staff teams in their team meetings.
LD Inpatient Wards	Ensure there are clear systems to gather feedback from patients and carers and use it to make improvements to the service.	Review the current systems for gathering patient and carer feedback – Ward/ home patient meetings, complaints, service user forums, friends and family tests, patient stories and feed into service reviews and service quality improvement plans.	

Specialist community mental health service for children and young people.

Area	Objective	Action	Progress to date
	The Trust must review their recruitment processes and ensure there is adequate staff available to reduce the patient waiting lists for assessment and treatment in the children and young people's service. Regulation 18 (1).	To recruit additional resources to support using funding available.	
Neuro-developmental	The Trust must review their service provision for patients with attention deficit hyperactivity and autism spectrum disorders and reduce service waiting times in the children and young people's service. Regulation 9 (1)(a)(b)(c).	Include cohort in trajectory for reduction of waiting time	
		Agree service model and progress towards it	Diagnostic model agreed – treatment model needs more work.

Area	Objective	Action	Progress to date
Infection Control	The Trust must ensure children and young people's service staff follow the Trust's infection control procedures and processes. Regulation 12 (1) (2)(a)(b)(h).	Ensure cleaning rota's completed as part of team leader / site manager role	
		Replace beanbags with wipe clean ones	Bean bags have been disposed of. Any future purchases to be in consultation with the IPC Team.
		Review handwashing facilities in clinic rooms and develop a plan to ensure facilities are adequate	
		Link with infection control team to pick up review process for alternative sites and standards	
CAMHS Leadership	The Trust must ensure there is effective leadership of the children and young people's service across the Trust. Regulation 17 (1) (2)(a)(b)(e)(f).	Implement the new CAMHS leadership structure	
		Develop new and existing local leaders by identifying key staff to engage in the proposed development days for Team Leaders /Ward Managers	In-patient ward development day identified for 20th March.
CAMHS Governance	The Trust must ensure effective governance systems are in place to monitor the service. Regulation 17 (1).	CAMHS Operational Governance Groups to have a standard agenda which demonstrates review and learning from SI's incident and Complaints	
		Develop assurance checklist / scorecard	
		Ensure assurance processes embedded within FYPC	
		Develop and embed assurance meetings across inpatient and community settings	
Data systems	The Trust must ensure they have accessible and comprehensive data/systems for the children and young people's service to	Improve data quality by implementing comprehensive data quality plan and processes	

Area	Objective	Action	Progress to date
	measure their performance and risks. Regulation 17 (1).		
Physical health needs assessment	The Trust should review how they assess and monitor patient's physical health needs in the children and young people's service.	Ensure that the requirements for undertaking physical health checks on Children and Young People in mental health services are met	Medication reviews for ADHD. Others – interaction with other stakeholders GP Pathway leads – NICE recommendations for Physical Health Checks
Service user and carer engagement	The Trust should review and improve their systems for engaging patients and carers in development of the children and young people's service.	Implement a regular user group	
Incident reporting	The Trust should review their safeguarding children and incident reporting policies to reflect staff practice.	Confirmation of policy review and timeline for completion of updated policy	
Meeting diverse needs	The Trust should review their processes for meeting patient's diverse needs	Implement a quality improvement project for the collation and utilisation of protected characteristics information including EIA's for services	Early intervention service Service user group to link to develop a plan to meet the diversity of our community
		Ensure care planning represents the diverse needs of our patient group	
		Include in records audit programme	
Estates and Premises	The Trust should ensure that premises are suitable for purpose in the children and young people's service, such as at Westcotes House.	Agree refurbishment plan for Westcotes House with Trust Board	

Community based mental health service for older people

Area	Objective	Action	Progress to date
MHSOP CMHT	To ensure effective disposal of needles.	To ensure the effective disposal of out of date needles. The checking of date to stock needles in the CMHT bases has been added the CMHT fortnightly medicines checklist. This will reviewed three monthly for a spot check. Spot check June 2019	All out of date stock removed.
MHSOP CMHT	To ensure all environments are alarmed and environmental risk assessments completed.	All bases have access to either the integral alarm system or a hand held alarm for personal safety and to raise the alarm in an emergency. All MHSOP outpatient facilities environmental risk assessments are reviewed to ensure compliance with compliance with staff PPE. To audit compliance against the health and safety checklists monthly.	All clinical areas have been checked and staff have access to personal alarm systems.
MHSOP CMHT	To ensure all patients have access to their care plans	This links to LPT collaborative care planning action (Appendix C)	
MHSOP CMHT	To ensure the senior exec team are visible to staff	Trust wide action	
MHSOP CMHT	The Trust should ensure that the staff knowledge and training is improved around CTO	To cross reference the CTO training register to ensure all clinical community staff to identify staff who have yet to receive additional CTO training.	
MHSOP CMHT	Trust should ensure staffing levels meet the needs of the eservice.	Weekly staffing hot spot review	This is in place
MHSOP CMHT	The Trust should ensure that staffing levels meet the needs of the service.	Review staffing levels and recruitment support.	

Area	Objective	Action	Progress to date
MHSOP CMHT	The Trust should ensure that the senior executive team are present and visible to staff.	Boardwalks in place and a programme of visits occur.	
		We are launching the culture and leadership programme which is an NHSI programme and will support strengthening this area.	

Appendix C LPT collaborative care planning action

Regulatory Warning	Area	Objective	Action	Timeline	Lead	Status	Progress - DATE
Change Aim - Using a two cycle of PDSA methodology transfer the learning from MHSOP to improve the quality of recovery orientated Collaborative Care Planning conversations and practice co productively with staff, patients and carer's on all of the AMH and Rehabilitation Wards that will meet current CQC regulatory warning.							
How will we know that a change is an improvement? **Outcome Measure(s)** • Percent of patients with a collaboratively agreed care plan • Percent of staff who have demonstrated having collaboratively written and completed care plans (appointments completed & Patient Rated Outcome Measure) **Process Measure(s)** • Percent of patients with a completed care plan **Balancing Measure(s)** • Percent and description of care plans not completed collaboratively as evidenced by the PROM							

PDSA Cycle 1		
PLAN – Phase 1		
To plan to undertake phase 1 PDSA focused into improving care planning practice to improve the experience of meaningful collaborative care planning between practitioners and patients collaboratively.	**PLAN – Phase 1** 1. **Clinical Oversight** - senior clinical oversight and implementation of the care planning work programme 2. **Checklist for writing collaborative care plans and quality review (DO)** - Develop the check list from CQC report to structure care planning focus, conversations and care planning agreements to cover 4 key areas : a) Mental Health	**Phase 1** PDSA - March 18th 2019 – 31st May 2019

PDSA Cycle 1		
PLAN – Phase 1		
	b) Physical Health c) Social d) Spiritual/Cultural And will require collaborative care plans to have been written with and contain evidence of: - **Patients Voice and agreements on collaborative care:** The patients voice contained within the care as either 'I' or by their first name within the plan with their hopes and aspirations and self-management plans for recovery - **Smoking cessation support:-** Care plan contains agreements with patients are made as to the choice of use of substitute treatments for those patients experiencing physical symptoms of stopping smoking because they are dependent nicotine. That the agreed plan with the patient is in place to manage this psychologically from an emotional dependency perspective. - **Risk and Positive Risk Taking:** Risks are transferred from the risk assessment and ways of managing this to support recovery and self-management are agreed with the patient into the care plan where they can be evidenced. - **Physical healthcare** - checks are completed and identified from assessment are to be agreed with the patient to support monitoring, self-management and recovery which are evidenced as contained within the care plan - **Mental Health Act –** That the care plan contains the role of staff in advocating and providing patients' rights information on a regular basis (to be agreed with the patient) and Mental Health Advocacy is offered. - **Capacity to consent –** Evidence contained within the care plan that capacity has been assessed and consent given to share a care planning process with carer's or where capacity is not established that carer's are involved in the care planning process. - **Receipt of care plan on completion:** That it is care planned	

PDSA Cycle 1		
PLAN – Phase 1		
	that the patient will receive a copy of the completed care plan and is recorded on RIO.	
Improve the quality of nurses & AHP collaborative Care Planning conversations and practice with patients ensuring that patients have a meaningful and positive experience and receive a printed copy of their agreed care plans.	**PLAN – Phase 1** **Evidence Based Electronic Information Pack** - All practitioners on the wards who are involved in care planning will receive electronic guidance pack containing: - **Exemplars of care plans** as to what 'What good looks like' (Lloyd, 2012) to improve the writing of collaborative Care Plans including EQUIP study Guidance (2018) - **CQC brief guide** on Recovery orientated practice (March 2018) - **100 ways to support** recovery edition 2 - **CHIME** (2014) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis - **Recovery Orientated Language Guide** (NSW, 2013) - **Ten Top Tips for Recovery Orientated Practice** (Sainsbury's Centre for Mental Health, 2008) - '**The EQUIP Programme** main findings in mental health care planning research' https://www.youtube.com/watch?v=PEjI3zq5FcQ	
	PLAN – Phase 1 - Establish Peer Review Teams - Establish process for review and timeline for returning practice comments - Establish with ward teams Collaborative Care Planning Time allocation and review dates	

PDSA Cycle 1		
PLAN – Phase 1		
	- **Recovery & Collaborative Care Planning Café (Community of practice)** Option of attendance for staff, patients and carer's at the Recovery and Collaborative Care Planning Café as the established community of practice for learning and sharing.	
	PLAN – Phase 1 **Experts by Experience** - Engage and establish patient interview group with Experts by Experience and Patient Experience Team to undertake 6 item EQUIP PROM to measure impact and receipt of care plans	
The completion of the programme in that all patients will have engaged in a care Planning conversation resulting in a collaboratively agreed care plan Completion of peer review of all care plans for quality check and to develop and improve care planning practice	**DO – Phase 1** **Undertake** the collaborative care planning conversations and writing process alongside all patients in AMH and Rehab Wards. **Undertake Peer review** of all care plans for each patient residing on each AMH and Rehabilitation ward care planning practitioners in collaboration with each individual patient residing in LPT to improve practices.	March 18th 2019 – April 30th
PROM Implement Patient Rated Outcome Measure (EQUIP) for patient receipt of care plans and experience of collaborative care planning pr0cess	**DO – Phase 1** All patients on each AMH ward to participate in completing the PROM to measure experience of collaboratively involved in care planning	March 18th 2019 – April 30th
Improve sharing of learning to drive quality improvements across the mental health wards	**Study** - Establish feedback into teams and to the patients the outcomes of the PROM's and ensure the learning is integrated into PDSA cycle 2	30th April – 31st May
Maximise the learning to informs and incorporate into the establishment of the PDSA cycle 2	**ACT - Phase 2 PDSA establishment** – Incorporate the learning from phase 1 improvements in action and put in measures to sustain the gains made in practice and learning	31st May – 30th September

PDSA Cycle 1		
PLAN – Phase 1		
Develop and establish new audit process for continuously improving collaborative care planning process		