Leicestershire Partnership NHS
NHS Trust

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TRUST BOARD PAPER - 31 OCTOBER 2013	
Title	**Leicestershire Partnership Trust's Quality Improvement Programme**

Executive Summary

Introduction

The Trust was issued with two warning notices by the Care Quality Commission in July 2013 and a 30 day plan to address immediate actions related to care planning and discharge planning was enacted, as reported previously to this Board.

Outcome of the Risk Summit

Due to the escalation of concerns about the Trust's adult mental health services a Risk Summit was convened on August 29 where local stakeholders and agencies came together to share their concerns with the Trust. Actions arising from the summit included:

1) The Trust was required to produce a Quality Improvement Programme to provide assurance that the necessary improvements to the safety and care of patients in the Trust's adult mental health services were being undertaken and could be sustained into the future.

2) The Trust was required to design and produce a regular SITREP (operational) report so that the Trust and commissioners could jointly examine staffing, bed occupancy and other operational matters on a daily/weekly basis for additional assurance, particularly with respect to patient safety.

3) That an Oversight and Assurance Group be formed to hold the Trust Board to account collectively

Progress on Risk Summit Actions

The SITREP was immediately designed with commissioners and has now been operating for 2 months.

The Oversight and Assurance Group was also immediately put into place and meets every two weeks convened by the NHS Trust Development Authority (TDA).

It was agreed that the Trust would develop the Quality Improvement Programme (QIP) collaboratively during September and October with a view to approval of the programme plan by the Oversight and Assurance Group and the Trust Board by the end of October.

The aim of this document is to provide a single, consolidated and coordinated plan of action to address the risks and issues raised, showing the timeframes for improvements to be made, how improvements will be measured, who is responsible for the respective elements of the programme and how the Trust will be held accountable for delivery internally and externally of the overall programme.

The Development of the Quality Improvement Programme

Over the last 8 weeks the QIP has been developed in partnership with a wide range of stakeholders including our leadership team, our clinical and operational staff, the NHS Trust Development Authority, local clinical commissioning groups, local authorities and their scrutiny committees, local Healthwatch, local service user groups, their advocates and voluntary sector organisations. A copy of the engagement plan is attached at Appendix A

The Trust is extremely grateful to all parties who have engaged in this intensive piece of work and for the opportunity to discuss the issues we have faced in an honest and transparent way throughout. The overall format of the QIP has been recommended by the Trust Development Authority.

Measuring Achievement

A feature of the QIP is the inclusion of specific metrics so that improvement can be evidenced over time, and where applicable a trajectory for improvement will be developed to show the scale and pace of change we are aiming for.

Some of the metrics already have established baselines and mechanisms for data collection. Others are new areas of focus or represent new ways of working, and therefore require the development of baseline information and additional mechanisms for collecting and analysing data. The programme indicates timescales for this work where appropriate.

In terms of governance arrangements, the delivery of the QIP will be governed internally via a new Quality Improvement Programme Board reporting directly into the Trust Board. Delivery will be assured by the Oversight and Assurance Group which was formed following the Risk Summit and which will hold the Trust Board to account externally for delivery.

The Oversight and Assurance Group is external to the Trust and chaired by the NHS Trust Development Authority (TDA).

The Oversight and Assurance Group is established for the period of time that the Trust's position is escalated to the TDA and will determine at which stage the Trust will be de-escalated with respect to the assurance achieved on the Quality Improvement Programme.

The role of the Oversight and Assurance Group is therefore as follows:

- Approve the Quality Improvement Programme

- Hold the Trust Board to account and assure the delivery of the programme externally
- Determine which specific actions from our programme are the ones that they wish to see achieved in order that we can be de-escalated; following which, the programme will continue to be assured by the Trust Board and its local commissioners, e.g. as business as usual.

Cultural Change

It is important to stress that much of this programme is about cultural change, including some important changes in professional practice and clinical leadership that have a direct impact on the safety, effectiveness and experience of care in the adult mental health unit (and elsewhere in the Trust).

We have also listened carefully to feedback from service users, voluntary sector groups, advocacy groups, councillors, and service users about where further cultural changes are needed from their perspective.

While these changes can and will be the subject of audit against key metrics in terms of quantitative measurement, the Trust is keen to ensure that equal emphasis is given to qualitative and softer measures of improvement.

The overall experience of staff and patients in the planning, delivery and experience of care is where we wish to see the greatest impact of these cultural changes. We expect to see this translated into improved public confidence in the quality of the Trust's services, and that there are tangible improvements in our leadership, accountability and transparency.

Extending the programme across other aspects of the Trust's Business and Services

While the QIP focuses primarily on adult mental health services, we have identified a number of thematic areas of the plan where action will be immediately extended across other clinical divisions.

We have also reflected in depth, as an organisation and as a Board, on the lessons learned from the July CQC report, and the events leading up to this at the Trust, along with various other aspects of the escalation period we have experienced. We are very aware of the impact this has had on our patients, staff, stakeholders and the public in general. Our discussions with local scrutiny committees have focused heavily on these matters.

Our overall approach to quality assurance and risk management is being fundamentally reviewed as a result of reflecting on lessons learned, including for example the introduction of improved early warning systems for our clinical services and a review of our approach to regulatory assurance, being led by our Chief Nurse.

It is the Trust's ambition to use the QIP as an important stepping stone on our quality improvement journey. Through the QIP and work in hand to refresh our

quality strategy we must go well beyond "recovery" and aim again for excellence in line with our organisational vision.

We recognise there are expectations internally and externally about demonstrating a stepped change in the pace of our actions and the impact they are having, but we also need to sustain improvement for the medium and longer term. The timescales we have set out in the QIP therefore intend to strike a balance between these two requirements.

Although the QIP will be the subject of the external Oversight and Assurance Group for the remedial period (e.g. until we are de-escalated by the TDA), the Trust will continue to develop and deliver its quality improvement plan on a rolling programme of work. The Quality Improvement Programme will therefore:

- Become business as usual
- Cut across all clinical services
- Remain top priority
- Be highly visible form ward to board.

We will continue to be open, honest and transparent about our progress and welcome all challenge and feedback on any aspect of our care and services at any time.

Sharing our Learning

Our experience may be valuable to other Trusts who face similar challenges in delivering sustainable high quality mental health care, especially given the escalating pressure this month on the overall capacity and quality of mental health care nationally and the introduction of the new CQC inspection regime.

We will actively share what we have learned for the benefit of other Trusts locally, regionally and nationally.

We are also responding to the new Chief Inspector of Hospital's national engagement about the methodology for assessing community and mental health trusts under the new CQC Inspection regime

Recommendations

The Trust Board is asked to:

- Approve in principle the Quality Improvement Programme and associated metrics subject to the approval of (and any amendments required) by the Oversight and Assurance group
- Approve the LPT governance arrangements, including establishing the Quality Improvement Programme Board with effect from November 2013

Related Trust Objectives	• We will continuously improve quality and safety with services shaped from user and care experience, audit and research. • We will build our reputation as a successful, inclusive organisation, working in partnership to improve health and

	wellbeing.
Risk and Assurance	The delivery of the QIP will provide measurable improvements in quality assurance for the care and treatment of patients in the adult mental health service and other clinical services within the Trust.
Legal implications/ regulatory requirements	The delivery of the QIP will provide improved assurance that CQC standards can be maintained in the medium term. Failure to maintain CQC regulatory standards can lead to fines and/or deregulation of the affected services.
Presenter	Peter Miller, Chief Executive
Author(s)	LPT Executive Team Judy McCarthy, Head of Strategic Programme Office Will Legge, Chief Information Officer

Leicestershire Partnership NHS
NHS Trust

"Quality Improvement Programme"

A programme to achieve sustainable high quality adult mental health services so the Trust and its stakeholders can be confident about the quality of care for local service users

October 2013

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1. Introduction

In response to concerns raised at the Risk Summit on 29 August 2013, the Trust has worked with a wide range of people to develop this Quality Improvement Programme.

The programme contains a comprehensive set of activities to address specific risks identified following an inspection by the Care Quality Commission in July 2013, and a number of other related risks and issues of concern that have been raised by local commissioners, local Healthwatch, NHS England and the Trust Development Authority. All these matters were discussed in depth at the Risk Summit and at the inaugural meeting of the Oversight and Assurance Group held on 11th September 2013.

The aim of this document is to provide a single, consolidated and coordinated plan of action to address the risks and issues raised, showing the timeframes for improvements to be made, how improvements will be measured, who is responsible for the respective elements of the programme and how the Trust will be held accountable for delivery internally and externally of the overall programme.

The programme has been developed from a number of concerns identified by stakeholders:-

- Governance
- Workforce and Leadership
- Quality Strategy
- Quality Assurance
- Clinical and Operational Effectiveness;
- Cultural Change
- Transparency
- External Regulation + Reviews

A programme management approach will be undertaken to deliver this programme and report on progress. A programme management approach is already established within the Trust and is currently being used to manage delivery of the other service improvements in our clinical divisions.

Scope

A number of serious concerns were raised about the quality of the Adult Mental Health inpatient service at the Bradgate Unit by the Care Quality Commission in their report following an inspection in July 2013. The Trust immediately initiated urgent work to address the report findings including the implications of two warning notices issued to the Trust which related to discharge planning and care planning.

While the Trust focused initially on these matters in July and August 2013, the Trust has since performed an intensive piece of work in September and October to develop a medium term Quality Improvement Programme. While the focus for this has primarily been for our Adult Mental Health service, the programme also recognises that high quality, safe services must be sustained across all our clinical divisions.

The culture of quality improvement and quality assurance within the organisation clearly needs further development so that lessons learnt from our Adult Mental Health service are fully embedded and readily transferred across other areas of the Trust. The programme therefore includes how we will create a stronger platform for quality through our refreshed quality strategy and put in place a much better system to alert the Trust from “ward to Board” to any future risks to deterioration in quality care across all our services.

The Quality Improvement Programme therefore has a number of aims that apply across all our clinical services as illustrated in the box on page 5 below.

AIMS

- Ensuring the most effective care is provided in a person centred manner
- Service users (and wherever possible those that matter most to service users such as their carers, family members, friends) are actively involved in the decisions regarding their care
- Improving the safety, communication and service user involvement in the discharge process
- Ensuring safe staffing levels and a skill mix that takes into account all the factors that affect the intensity of care and support needed to address individual care plans
- Improving the quality of physical health care on mental health wards
- Improving the ease of developing and using care plans as well as embedding care plans within the care process
- Enhancing the skills of staff in the assessment and effective management of risk
- Providing support and creating opportunities for staff to learn continuously from practice (near misses, serious incident investigation recommendations, service users feedback) and reduce clinical variability
- Improving the patient experience, healing nature and safety of the environment
- Ensuring treatment and recovery focuses on the wider determinants of health and wellbeing (employment, housing, finances, social isolation etc.)
- Care provided is able to accommodate the needs of the individuals with diverse needs and backgrounds

Principles for Improving

This Quality Improvement Programme has been designed to embed the following principles:

1) **Rights** - the programme is underpinned by the statutory requirements placed on all Trusts by the NHS Constitution and Duty of Candour

2) **Planning** – the Trust has a clear, consolidated programme of work that collectively meets the needs of our service users, the Trust and all stakeholders/agencies.

3) **Service User and public participation** – service users, their advocates and public representatives have played an important role in developing this Quality Improvement Programme. Clinicians, directors and staff are working together on the "Quality Improvement Programme Board" with these stakeholders and will continue to do so throughout the delivery of the programme, and as "business as usual" within the Trust. In developing the improvement activities we have listened carefully to the views of service users, their advocates, local voluntary sector organisations, county and city councillors, and our own democratically elected shadow council of governors

4) **Listening to the views of staff** – the Trust is committed to improving staff experience and the levels of staff engagement and staff satisfaction. There are a number of established ways in which the Trust seeks the views of staff including formal consultative forums, the annual NHS staff survey and the Trust's local quarterly pulse surveys, staff support groups and the Trust's various feedback mechanisms which have been further strengthened this year by adopting to the "speak out safely campaign" which actively encourages staff to raise concerns about care quality. Staff views are also obtained through some of the mechanisms established to improve patient experience including the 'Changing your Experience for the Better' programme and Trust Board member visits to clinical areas. The Listening into Action (LiA) programme also brings staff together to share their thoughts and ideas and make improvements together. The Trust has already captured a large range of staff views through large engagement events, and is currently rolling out the programme to the first set of teams within the Trust and putting place the quick wins that have been prioritised.

5) **Openness and transparency** – all possible information and intelligence relating to the quality of the care provided to our patients has been and will continue to be made available to our partners and stakeholders including our Shadow Council of Governors, local Clinical Commissioning Groups, local Healthwatch, Patients' Panel, Staffside representatives, the Care Quality Commission (CQC), the General Medical Council (GMC), Health Education East of England (HEEoE), the NHS Trust Development Authority (NTDA) and NHS England. The Trust continues to be open to expertise from outside of the Trust and welcomes this advice and expertise. The Trust Board recognises its role in promoting this work and being held accountable. The Trust Board continues to challenge itself and take on board feedback from all parties on the type, quantity and quality of information shared in the public domain whether via our public meetings, website, newsletters, media, social media and other routes.

6) **Cooperation between organisations** – this programme has been built around strong cooperation between all of the different organisations that make up the local health and care system, placing the interests of service users first at all times.

7) **Leadership** - this programme recognises the development needs of clinical and managerial leaders within the Trust and has been designed so that improvements can be made in the management culture of the organisation from ward to Board, with the Board promoting a leadership style built on service user centred values.

2. Background

Context

On 30 July 2013 the Trust was served with two Warning Notices, in line with the CQC Enforcement Policy, against the Bradgate Mental Health Unit registered location. In addition the unit was also judged as non-compliant with three Outcomes resulting in three Compliance actions against Outcomes 7, 14 and 16.

Outcome 4	**Care and welfare of people who use services**	**Warning Notice**
Outcome 6	**Cooperating with other providers**	**Warning Notice**
Outcome 7	Safeguarding people who use services from abuse	Compliance Action
Outcome 14	Supporting workers	Compliance Action
Outcome 16	Assessing and monitoring the quality of service provision.	Compliance Action

The inspection report was published on 20 August and is available on the CQC web site. The report and Enforcement notices were shared at the Trust public Board meeting on Thursday 29 August 2013.

An action plan was sent to the CQC on Wednesday 4 September 2013 and on Thursday 5 September 2013 and Friday 6 September 2013 requests were received for the provision of further information.

On Monday 9 September 2013 the CQC returned to the unit to review progress against the two Warning Notices.

The population and communities we serve

The following characteristics summarise the population we serve.

- A catchment population of approximately one million people living within the city of Leicester and the surrounding counties of Leicestershire and Rutland.
- In common with the national pattern, more boys are born than girls; however as women tend to live longer, the ratio of males to females is approximately 50:50.
- Our local catchment area falls within the boundaries of NHS Midlands and East, in which we play an active role in the provision of specialist services on a wider regional basis.
- We relate to three local authorities, seven district and borough councils, and three Clinical Commissioning Groups.
- The City of Leicester and counties of Leicestershire and Rutland bring together a rich mix of urban, suburban and rural districts, diverse in cultural heritage and ethnicity.
- The total Leicester City population as at 2012 is 331,606 which represents an 18% increase since 2001.
- Deprivation is a significant issue for many of our citizens. Almost half of our population is highly disadvantaged. Of the 152 local authority areas in the UK, Leicester has the 20th most deprived population, with almost half of these people living in the fifth most deprived areas in England.
- Rutland residents and the majority of the population in South Leicestershire have above average levels of affluence compared to the rest of England. However, there are pockets of relative deprivation concentrated mainly in urban areas.
- The majority of the population who live in Leicestershire County and Rutland are white British (91% and 97% respectively)[1], whilst Leicester City has a more diverse population than England overall, with approximately 50% from Black and minority ethnic groups (BME). The majority of Leicester's BME population are South Asian, with 37% from Indian background.[1]
- There are also a significant populations from other countries such as Eastern Europe, who also represent diversity, but are not represented in BME statistics.
- In addition, the population figures are not well established for other vulnerable groups such as asylum seekers and those with protected characteristics under the equalities act, such as lesbian, gay, bi sexual and transgender people.
- A large number of students live in Leicester, and therefore there is a youthful population with almost half aged under 29, and that number is increasing. There is a higher proportion of people in the older adult categories in Leicestershire County and Rutland.

[1] 2011 figures from Office for National Statistics

- The populations of both the City and Counties are forecast to increase by 2015. There will be significant growth in the 0 – 14 age group and those of working age in Leicester City with lower, albeit significant growth, in the over 65s. This pattern is counter to that seen in the Counties where the major growth is in the over 65 age groups.

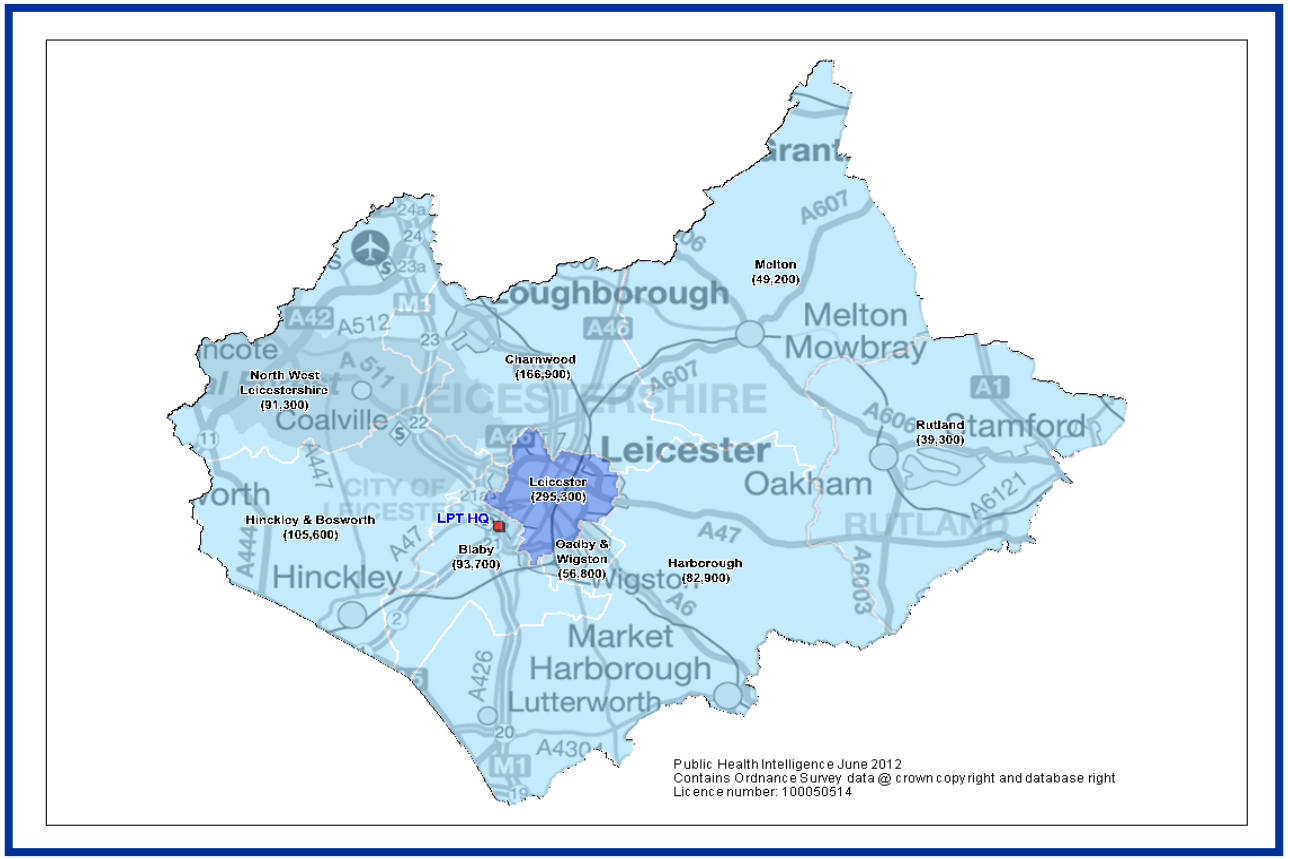
Our commissioners

Our services are commissioned primarily by the three Clinical Commissioning Groups of Leicester, Leicestershire and Rutland, authorised in 2012, these are:

- West Leicestershire
- East Leicestershire and Rutland
- Leicester City
- Some of the Trust's services are also commissioned on a regional/national basis through specialist commissioning

The counties of Leicestershire and Rutland are generally more affluent and less ethnically diverse, with demography older than the national average. There are approximately 680,000 people living mainly in suburban areas and market towns, with pockets of deprivation and approximately 12% of people living in isolated rural villages.

Area Map


Loughborough
Melton
Mowbray
Melton
(49,200)
Charnwood
(166,900)
North West
Leicestershire
(91,300)
Coalville
LEICESTERSHIRE
Leicester
Leicester
(295,300)
Oakham
Rutland
(39,300)
Stamford
LPT HQ
Hinckley & Bosworth
(105,600)
Blaby
(93,700)
Oadby &
Wigston
(56,800)
Harborough
(82,900)
Hinckley
Market
Harborough
Lutterworth
A607
A46
A512
A42
A47
A426
A4304
A6003
A6121
A1
M1
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Health and Care Economy

We operate primarily within the health and social care economies of LLR and work with three corresponding local authorities and seven district councils.

Local Authorities:

- Leicester City Council
- Leicestershire County Council
- Rutland County Council

District Councils:

- Blaby District Council
- Charnwood Borough Council
- Harborough District Council
- Hinckley and Bosworth District Council
- Melton Borough Council
- North West Leicestershire District Council
- Oadby and Wigston Borough Council

The Service User's Perspective

The ability to listen to what matters to people who use and experience our services, and the views of those who matter most to them (e.g. carers, friends, family) and to act on this feedback is the Trust's method of demonstrating its values being turned into action. Demonstrating that we have listened and made changes also underpins our dedication to being an open and transparent organisation.

The Friends and Family Test (FFT) is a national tool based on the commercial Net Promoter Score Test and is a tool used for providing a simple, headline metric, which when combined with a follow up question and triangulated with other forms of feedback, can be used across services to drive a culture of change, recognising and sharing good practice. The overall aim of the process is to identify ways of improving the quality of care and experience of the service users (and those who matter most to them) using NHS services in England

The Trust is participating in a national pilot to roll out the FFT to other services outside of the acute sector, which is the main area of NHS care where the test is currently formally applied and reported. We are feeding back our experience of using this test with our service users in community and mental health services, and have been giving our views of how the test may need adapting in these settings. As part of this we are also working with local commissioners and we have agreed that a further roll-out of the FFT across priority services would provide useful information to the Trust in line with its plans to introduce the 'Changing Your Experience for the Better' programme across all clinical areas. The FFT is used in that context as a baseline and improvement measurement, alongside feedback data from the customer services team (from complaints, concerns and compliments) and through the Trust's Staff Listening into Action Engagement Programme, staff pulse surveys and the annual staff survey.

3. Governance

The Trust has a number of systems and processes in place to provide assurance to the Trust Board and other key stakeholders about the governance of the organisation. These include a committee structure, a risk management system and strategy, a comprehensive risk register and an escalation framework to ensure Trust Board members are aware of all risks to the successful delivery of the organisations key strategic objectives.

In order to place focus on this programme of work a Quality Improvement Programme Board will be established within the Trust. This will be chaired by the Chief Operating Officer, (or Medical Director and Chief Nurse in their absence), and will consist of representatives from each of the divisions. Terms of reference and membership for the Quality Improvement Board are being finalised by early November, and will be published on our website as soon as possible. The first meeting of the Quality Improvement Programme Board will take place in November.

As part of the assurance process, the Quality Improvement Programme Board will develop a risk register to ensure where progress is not being made as quickly as expected, mitigating actions are put in place.

The Quality Improvement Programme Board will be held to account by the Trust Board who will receive the minutes of the Programme Board and the risk register on a monthly basis.

The Quality Improvement Programme Board will provide assurance to the Trust Board, on a monthly basis, regarding the delivery of the programme, including highlighting any risks to delivery and the mitigating actions being taken to ameliorate those risks.

The Quality Improvement Programme Board activities will also be considered by the Trust's existing Quality Assurance Committee (http://www.leicspart.nhs.uk/Library/QAC_TOR.pdf

The Oversight and Assurance Group is external to the Trust and chaired by the NHS Trust Development Authority. The Oversight and Assurance Group is set up for the period of time that the Trust's position is escalated to the NHS Trust Development Authority and will determine at which stage the Trust will be de-escalated with respect to the assurance achieved on the quality improvement programme. The role of the Oversight and Assurance Group is therefore as follows:

- Approve the programme of work assure the delivery externally
- Determine (during November 2013) which specific actions from our programme are the ones that they wish to see achieved in order that we can be de-escalated - following which the programme will continue to be assured by the Trust Board and its local commissioners, e.g. as business as usual.

The programme will be signed off and closed when all actions have been delivered and the Trust Board, in conjunction with key stakeholders, have received adequate assurance that the programme has been completely delivered and the improvements are sustainable.

However the Trust Board will adopt the Quality Improvement Programme approach and roll it out to other areas of the Trust. When this happens, our progress will be very clear and transparent both in terms of the completion of the programme of work shown in this document and the addition/roll out to other areas of our business, with regular reports via our public Trust Board meetings.

Also our engagement and communication about our Quality Improvement Programme will continue throughout the delivery of this programme of work and into any extension into other areas of the Trust's work. Therefore local scrutiny committees, local VCS organisations, health and wellbeing boards, service user groups, our council of governors, and many others will continue to be closely engaged in our progress and will continue to shape our future aspirations.

Governance Structure

4.Programme Baselines

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
1	Crisis Support (CRHT)	Delivery of CRHT against operational framework (by audit)	100%	Action plan in place to establish baselines	01/02/2014	Chief Operating Officer
2	Crisis Support (CRHT)	Adherence to the new CRHT shift handover protocol being implemented by January 2014	100%	New initiative; baseline to be established	01/02/2014	Chief Operating Officer
3	Crisis Support (CRHT)	SitRep for CRHT implemented and achieving tolerance levels across staffing metrics	80%	New initiative; SitRep to be designed and implemented with Commissioners	01/05/2014	Chief Operating Officer
4	Pre-Admission	Transmission of complete care information with out of area placement providers upon placement within 24 hours	100%	New initiative; based on checklist implementation	01/02/2014	Chief Operating Officer
5	Pre-Admission	Bed Occupancy level	85%	91.8% @ Sept 2013	31/03/2014	Chief Operating Officer
6	Pre-Admission	Delayed Transfer of Care	≤ 7.5%	5.7% @ Sept 2013	01/11/2014	Chief Operating Officer
7	Pre-Admission	Average Length of Stay	30 days	34.6 days @ Sept 2013	03/06/2014	Chief Operating Officer
8	Pre-Admission	Number of out of area placements	≤ 20	26 @ 17.10.13	30/03/2014	Chief Operating Officer
9	Admission	Number of MDT assessment templates completed on admission (by audit)	100%	New initiative; baseline to be established	01/05/2014	Medical Director
10	Admission	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit)	100%	71% @ Sept 2013	01/02/2014	Chief Nurse
11	Admission	Number of admissions seen by a senior doctor within 48 hours (by audit)	100%	New initiative; baseline to be established	01/03/2104	Medical Director

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
12	On-going care on the In-patient Unit	Adherence to service user leave protocols (by audit)	100%	Action plan in place to establish baselines	01/05/2014	Chief Nurse
13	On-going care on the In-patient Unit	Number of service users offered advocacy where clinically appropriate (by audit)	80%	New initiative; baseline to be established	31/12/2013	Chief Nurse
14	On-going care on the In-patient Unit	Number of staff with current valid therapeutic observation of patients training	85%	90.1% @ Aug 2013	01/12/2013	Director of HR & OD
15	On-going care on the In-patient Unit	Number of scheduled weekly ward rounds attended by nurse and doctor versus plan	100%	100% @ 21/10/13	01/02/2014	Medical Director
16	On-going care on the In-patient Unit	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit)	100%	71% @ Sept 2013	01/02/2014	Chief Nurse
17	Discharge	Number of care plans reflecting discharge planning (by audit)	90%	59% @ Sept 2013	01/02/2014	Chief Nurse
18	Discharge	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their discharge planning (by survey)	80% (*Set at 80% in recognition of those people who decline to be involved)*	67% @ Dec 2012	01/11/2014	Chief Nurse
19	Discharge	Continuity of care from the same consultant/community worker	80%	New initiative; baseline to be established	01/04/2014	Chief Operating Officer
20	Staffing	60:40 skill mix qualified / unqualified ratio achieved on the Bradgate Unit	100%	New initiative; recruitment trajectory in place	01/05/2014	Chief Operating Officer
21	Staffing	5 / 5 / 3 staffing levels achieved on the Bradgate Unit	100%	100% @ 17/10/13	01/11/2013	Chief Operating Officer
22	Physical Healthcare	Number of care plans reflecting physical healthcare needs where identified (by audit)	100%	90% @ Sept 2013	01/05/2014	Chief Nurse
23	Physical Healthcare	Number of physical healthcare assessments undertaken versus admissions (by audit)	100%	92% @ Sept 2013	01/05/2014	Chief Nurse

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
24	People with Personality Disorder	Number of Bradgate Unit staff with current valid personality disorder training, against plan	80%	Training commences Nov 2013; baseline data captured from 1st cohort Nov 2013	01/11/2014	Medical Director
25	Risk Assessment	Complete risk assessment documentation present in care record for current episode of care	100%	92% @ Sept 2013	01/03/2014	Chief Nurse
26	Risk Assessment	Number of staff with current valid risk assessment training	80%	92.1% @ Sept 2013	01/05/2014	Chief Nurse
27	Handover	Adherence to In-patient handover protocol (by audit)	100%	New initiative; baseline to be established	01/01/2014	Chief Nurse
28	Continuous learning & staff support	Number of debriefing sessions versus number of violent incidents and Serious Incidents reported	100%	New initiative; baseline to be established	01/01/2014	Chief Nurse
29	Continuous learning & staff support	Attendance rate of MDT learning forums against Terms of Reference	80%	New initiative; baseline to be established	01/01/2014	Medical Director
30	Continuous learning & staff support	Number of MDT learning forums held versus plan	100%	New initiative; baseline to be established	01/01/2014	Medical Director
31	Improvement of the environment	Adherence of staff to seclusion process and policy (by audit)	100%	Action plan in place to establish baselines	01/05/2014	Medical Director
32	Improvement of the environment	Adherence of all seclusion environments to national standard	100%	Baseline will be set by environmental audit	Dependent upon scale of work	Chief Operating Officer
33	Improvement of the environment	Number of ligature assessments undertaken in the Bradgate Unit	100%	All In-patient wards completed	01/12/2013 Non In-patient areas	Chief Operating Officer
34	Improvement of the environment	Improvement in PLACE survey results	90%	PLACE baselines (Sept 2013): • Cleanliness: 87.37% • Condition, appearance and maintenance: 75.12% • Privacy, dignity and wellbeing: 81.96% • Food and hydration: 84.79%	Dependent upon scale of work and 2014 PLACE assessments	Chief Operating Officer

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
35	Equality	Documented consideration of Equality & Diversity patient needs in care plan	100%	87%@ Sept 2013	01/05/2014	Chief Nurse
36	Equality	Number of staff trained in Equality & Diversity Training	80%	96.1%@ Sept 2013	01/11/2014	Director of HR & OD

Governance					
Improving the acute care pathway					
Crisis Support (CRHT) Aim – enhanced level of crisis support					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the response, efficiency and quality of assessment and support provided to patients with acute mental health problems	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Thematic analysis of Serious Incidents within CRHT.** a. Implement the recommendations from the thematic review of serious incidents		Chief Nurse	31/03/2014
	SI 133782 actions 2 and 3 commission internal review of handover between shifts in AMH SPA and review delegation of tasks between SPA and Acute Assessment and Home Treatment **Keogh area of improvement:** - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Office based co-ordinator on each shift to ensure safe allocation of work and hand over between shifts** a. Documented protocol for CRHT handover b. Initial role description for the co-ordinator	Assess the quality of the allocation of cases by co-ordinators	Chief Operating Officer	01/02/2014
			Develop a trajectory to improve the allocation of cases by co-ordinators to the appropriate level of staff/skill mix (qualified or unqualified)	Chief Operating Officer	01/02/2014
			Develop a trajectory for measuring improvements in handover effectiveness	Chief Operating Officer	01/02/2014

	Keogh area of improvement: - *Safety* - *Clinical and operational effectiveness* - *Workforce*	**3. Provide routine assurance information against current service model/staffing.**	Implement a SitRep report for CRHT	Chief Operating Officer	01/05/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**4. Co-produce a longer term service model, based on a more detailed diagnostic with the CCG's**	An agreed new service model with commissioners Implement new service model	Chief Operating Officer	31/03/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**5. Refresh/agree between AMH and commissioners the definitions of risk levels and thresholds for CHRT assessment within the agreed timeframes within the triage process. (2hrs, 4 hrs, 72hrs – may need to revisit these time spans especially the 4-72hrs)**		Medical Director	01/05/2014

CRHT Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
1	Crisis Support (CRHT)	Delivery of CRHT against operational framework (by audit)	100%	Action plan in place to establish baselines	01/02/2014	Chief Operating Officer
2	Crisis Support (CRHT)	Adherence to the new CRHT shift handover protocol being implemented by January 2014	100%	New initiative; baseline to be established	01/02/2014	Chief Operating Officer
3	Crisis Support (CRHT)	SitRep for CRHT implemented and achieving tolerance levels across staffing metrics	80%	New initiative; SitRep to be designed and implemented with Commissioners	01/05/2014	Chief Operating Officer

Pre-admission To ensure a speedy and well-co-ordinated process for admission					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the quality of care and patient safety throughout the process of the admission	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**1. Address the bed capacity position for AMH patients** a. Review bed capacity/configuration and ward configuration to achieve sustainable occupancy levels b. Implement solutions by agreement with commissioners	Set a baseline and trajectory for sustainable occupancy levels underpinned by benchmarking data	Chief Operating Officer	31/12/2013
			Set baseline and trajectory for ALOS	Chief Operating Officer	31/12/2013
			Set baseline and trajectory for DTOC	Chief Operating Officer	31/12/2013
			Set baseline and trajectory for reducing out of area placements	Chief Operating Officer	31/12/2013
			DN: Additional metrics will be developed in line with the actions that come out of the review such as the availability and uptake of alternatives to admissions such as step up and step down beds/access to suitable housing solutions/crisis house etc.		
	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Streamline admission and gate keeping to avoid duplication** a. Adhere to the assessment protocol b. Set a standard for the time between agreement to admit and admission taking place c. Checklist of core information to be provided between admitting team and inpatient team including 'out of area' placements	Measure adherence to the admit time standard	Chief Operating Officer	01/02/2014
			Measure the reduction in the duplication of assessments between different parts of the AMH team	Chief Operating Officer	01/02/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Ensure robust process in place for sharing of information/contact with out of county providers**	Set trajectory for the percentage completeness of transmission of the information within 24 hours (with agreed valid exceptions) for admitting service users within LLR and 'out of area'	Chief Operating Officer	01/02/2014

Pre-admission Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
4	Pre-Admission	Transmission of complete care information with out of area placement providers upon placement within 24 hours	100%	New initiative; based on checklist implementation	01/02/2014	Chief Operating Officer
5	Pre-Admission	Bed Occupancy level	85%	91.8% @ Sept 2013	31/03/2014	Chief Operating Officer
6	Pre-Admission	Delayed Transfer of Care	≤ 7.5%	5.7% @ Sept 2013	01/11/2014	Chief Operating Officer
7	Pre-Admission	Average Length of Stay	30 days	34.6 days @ Sept 2013	03/06/2014	Chief Operating Officer
8	Pre-Admission	Number of out of area placements	≤ 20	26 @ 17.10.13	30/03/2014	Chief Operating Officer

Admission To ensure a thorough assessment and development of a good quality care plan					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the quality and effective-ness of clinical care in the first 72 hours of Inpatient stay	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Develop a multi-disciplinary assessment template and process**		Medical Director	01/02/2014
	The results of the AMH Inpatient Survey is being presented on 28 October –action plan will follow **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**2. Those most important to the individual (e.g. carer, family or friends) involvement** a. Pilot introduction of entry and exit questionnaires for service users (and wherever possible those that matter most to service users such as their carers, family members, friends) to test experience of care levels of engagement (e.g. exit questionnaires to assess – *were your needs met?)* b. Admission checklist to capture specific actions and data wherever possible for those that matter most to service users such as their carers, family members, friends) engagement c. Contact GP to advise patient admitted and LPT to extract relevant patient information from the GP within 24 hours (service user summary/discussion where possible)	Measure adherence to admissions checklist in relation to wherever possible those that matter most to service users such as their carers, family members, friends), engagement and GP contact The wards will complete a *Triangle of Care* self-assessment in order to establish a baseline and understand the potential gaps for the involvement and communication with those most important to the individual (e.g. carers, family or friends). Following the self- assessment, actions will be identified and support will be provided in order to address any areas of weakness by the Trust's Patient Experience team.	Medical Director	01/05/2014

	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**3. Seen by senior doctor within the first 48 hours**	Set baseline and trajectory to achieve 100% of admissions being seen by a senior doctor within 48 hours	Medical Director	01/03/2014
	Appleby action plan action 9.1 – Access and Community Services Interface Meeting to review information sharing **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**4. Sharing information between community and Inpatient team** a. Develop an operating protocol for sharing information with community services (inpatient and named nurse and CPN regular contact)		Medical Director	01/05/2014

Admission baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
9	Admission	Number of MDT assessment templates completed on admission (by audit)	100%	New initiative; baseline to be established	01/05/2014	Medical Director
10	Admission	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit)	100%	71% @ Sept 2013	01/02/2014	Chief Nurse
11	Admission	Number of admissions seen by a senior doctor within 48 hours (by audit)	100%	New initiative; baseline to be established	01/03/2104	Medical Director

On-going care on the Inpatient Unit To improve the quality of inpatient care					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Ensuring the most effective care is provided in a person centred manner. *Patient, and wherever possible, carers / family are actively involved in the decisions regarding their care*	**CQC Action Plan – Outcome 4, no. 2** **Review of patient involvement in care plans** **Keogh area of improvement:** - *Patient experience* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Service user led care** a. Demonstrate improvements in service user(and wherever possible those that matter most to service users such as their carers, family members, friends) involvement in care planning	Measure service user, (and wherever possible those that matter most to service users such as their carers, family members, friends) satisfaction and experience through;	Chief Nurse	01/02/2014
			• the entry and exit questionnaires	Chief Nurse	01/02/2014
			• impact of VCS ward forums	Chief Nurse	01/02/2014
			• regular audit of care plans/discharge plans	Chief Nurse	01/02/2014
	Quality Schedule LR 2 **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Redefine and monitor the daily ward reviews** a. Review the process and template used		Medical Director	01/02/2014

	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**3. One to one sessions for service users** a. Ensure service users are • Seen weekly by a senior doctor • Receive a 1:1 session with a junior doctor b. Ensure service users • Receive two 1:1 sessions per week with their named nurse		Medical Director	01/02/2014
	Appleby action plan action 7.2 – Review of clinical psychology provision to wards **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**4. Review the provision of psychological therapy on the wards** a. Define and agree the model of psychological therapy we are aiming for across the inpatient areas and benchmark b. Consider models from elsewhere c. Agree how much improvement can be generated by improved nurse skill mix on the wards and what represents additional investment	Measure achievement of agreed levels of support against a trajectory	Chief Operating Officer	31/03/2014
	Appleby action plan action 6.1 – development of prompt cards for observation **Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness*	**5. Training and education for nursing staff and health care workers in undertaking therapeutic observation of service users** a. Review the therapeutic observation policy b. Ensure comprehensive training plans in place	Measure effectiveness through clinical supervision	Medical Director	01/11/2014

	CQC (MHA) Ashby Ward action plan, action 4 Review of recording section 132 including access to IMHA **Keogh area of improvement:** - *Patient experience* - *Clinical and operational effectiveness*	**6. Improving access to Advocacy** a. Implement standard service user information boards in every ward, and supplement with scrolling digital display	Measure how often we reiterate the information via MHA processes for those detained and for informal patients via Therapeutic Liaison Workers	Chief Nurse	01/11/2014
	CQC (MHA) Ashby Ward action plan, action 5 pilot revised section 17 form **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**7. Service user leave** a. Establish a clearer protocol for escorting and home leave	Measure leave cancellation rates and the reason for cancellation	Chief Nurse	01/11/2014

On-going care on the in-patient unit Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
12	On-going care on the In-patient Unit	Adherence to service user leave protocols (by audit)	100%	Action plan in place to establish baselines	01/05/2014	Chief Nurse
13	On-going care on the In-patient Unit	Number of service users offered advocacy where clinically appropriate (by audit)	80%	New initiative; baseline to be established	31/12/2013	Chief Nurse
14	On-going care on the In-patient Unit	Number of staff with current valid therapeutic observation of patients training	85%	90.1% @ Aug 2013	01/12/2013	Director of HR & OD
15	On-going care on the In-patient Unit	Number of scheduled weekly ward rounds attended by nurse and doctor versus plan	100%	100% @ 21/10/13	01/02/2014	Medical Director
16	On-going care on the In-patient Unit	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit)	100%	71% @ Sept 2013	01/02/2014	Chief Nurse

Discharge To improve the safety, communication and patient involvement in the discharge process					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the safety, communication and patient involvement in the discharge process	**CQC Action Plan – Outcome 6, no. 2 (b) and (d) Discharge care plan and discharge planning meetings** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Improved discharge care plan** a. Further improve the discharge care plan documentation b. Implement discharge care plan documentation c. Set date for a pre-discharge meeting at the 1st MDT and inform/invite service user (and wherever possible those that matter most to service users such as their carers, family members, friends) community team and relevant stakeholders. Discharge care plan to be finalised in this meeting d. Establish a discharge communication protocol e. Establish a revised discharge summary by agreement with GPs and implement the new process	Monitor the implementation and the professional effectiveness via an updated discharge tool and service user satisfaction exit questionnaires and GP satisfaction via GP feedback/survey	Chief Nurse	01/02/2014
	CQC Action Plan – Outcome 6, no. 2 (d), (e), (g) Planning meetings, liaison with social care managers and social workers **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Achieve much more detailed earlier engagement with social workers on care planning, risk assessment and discharge planning with social care needs identified as early as possible.** a. Design new protocol for county and city hospital social workers covering the Bradgate Unit	Evidence of social work involvement in MDT meetings	Chief Nurse	01/02/2014
			Evidence in care plans and discharge plans of social work involvement and impact of actions taken	Chief Nurse	01/02/2014

Discharge Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
17	Discharge	Number of care plans reflecting discharge planning (by audit)	90%	59% @ Sept 2013	01/02/2014	Chief Nurse
18	Discharge	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their discharge planning (by survey)	80% (*Set at 80% in recognition of those people who decline to be involved)*	67% @ Dec 2012	01/11/2014	Chief Nurse
19	Discharge	Continuity of care from the same consultant/community worker	80%	New initiative; baseline to be established	01/04/2014	Chief Operating Officer

Additional Specific Actions					
Staffing					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Ensuring safe staffing level that takes account of all acuity factors	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Develop a phased approach and implement a SitRep for AMH in conjunction with commissioners with agreed thresholds and triggers which incorporate acuity, staffing/skill mix and bed occupancy metrics** a. SitRep commenced in the Bradgate Unit August 2013; i. Agreement to regularity of reporting ii. Agreement to metrics iii. Agree the escalation actions that will be taken by the Trust to address any operational issues arising from the SIT REP b. Roll out SitRep to other parts of AMH (e.g. CRHT) c. Move to a new skill mix of staff (60/40 ratio)	Recruitment plan	Chief Operating Officer	01/05/2014

	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Roll-out SitRep to other inpatient areas in other divisions**	Early warning dashboard development for other divisions	Chief Operating Officer	01/05/2014

Staffing Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
20	Staffing	60:40 skill mix qualified / unqualified ratio achieved on the Bradgate Unit	100%	New initiative; recruitment trajectory in place	01/05/2014	Chief Operating Officer
21	Staffing	5 / 5 / 3 staffing levels achieved on the Bradgate Unit	100%	100% @ 17/10/13	01/11/2013	Chief Operating Officer

Physical Health Care					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the quality of physical health care on mental health wards	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Review the admission assessment protocol/proforma including the input of senior medical staff in assessing and meeting physical health needs** a. Review the proforma b. Prepare a mandatory checklist for essential investigations	Check compliance and quality of information through auditing the admission documents	Medical Director	01/05/2014
	Wellbeing Strategy audit action 2 Medical and Nursing directors to consider requirement for LPT wellbeing co-ordinator role **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Use existing MDT proforma to discuss physical health need and management during weekly ward rounds**	Check compliance through auditing undertaken by Senior Matrons	Medical Director	01/05/2014

	Appleby action plan action 5.1 – recruitment of RGN Action 5.2 – introduction of Track and Trigger **CQC Action Plan – Outcome 4, no. 3 As above** **SI 132244 action plan action 1 and 6 as above.** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Implement a training programme for mental health nursing staff to include specific physical health assessment needs, skills and care delivery** a. Recruit to the post of Physical Health Nurse b. Develop training package on physical health assessment and management; facilitated by Physical Health Nurse	Monitoring of training attendance	Chief Nurse	01/05/2014

Physical health care Baselines

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
22	Physical Healthcare	Number of care plans reflecting physical healthcare needs where identified (by audit)	100%	90% @ Sept 2013	01/05/2014	Chief Nurse
23	Physical Healthcare	Number of physical healthcare assessments undertaken versus admissions (by audit)	100%	92% @ Sept 2013	01/05/2014	Chief Nurse

People with Personality Disorder					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the skills of staff in managing people with personality disorder	**Appleby action plan action 7.1 – progress with personality disorder care pathway** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Implement rolling programme of training**	Personality Disorder audits of care plans for evidence of improvements to quality of the care plan for people with Personality Disorder; measure also via exit survey with service users	Medical Director	01/11/2014
	Keogh area of improvement: - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Strengthen the existing reflective practice groups to have a greater focus on case studies and lessons learned**	Staff satisfaction with the sessions every 6 months and monitor levels of attendance	Medical Director	01/11/2014

	Keogh area of improvement: - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Strengthen the complex case reviews to focus on lessons learned and changes to practice**	Staff satisfaction with the sessions every 6 months and monitor levels of attendance	Medical Director	01/11/2014

People with Personality Disorder Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
24	People with Personality Disorder	Number of Bradgate Unit staff with current valid personality disorder training, against plan	80%	Training commences Nov 2013; baseline data captured from 1st cohort Nov 2013	01/11/2014	Medical Director

Care Plans					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the ease of developing and using care plans as well as embedding care plans within the care process	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Review the care plan format to improve documentation and streamline for ease of use**	Test the effectiveness of the new format via staff feedback and patient feedback	Chief Nurse	01/02/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Provide bespoke training and development via supervision to individuals to improve the quality of care planning**		Chief Nurse	01/02/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. On-going monitoring of care plans using the existing audit and cycle identified for all Bradgate unit care plans**		Chief Nurse	01/02/2014

Risk Assessment					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Enhancing the skills of staff in the assessment and effective management of risk	**Appleby action plan action 10.1 – Integritas training** **CQC Action Plan – Outcome 14, no. 3 (e) and Outcome 16, no. 1 (c)** **As above** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Deliver an enhanced MDT interactive risk management training programme (this complements the existing mandatory rolling programme ref the Morgan risk tool)**	Regularity of sessions and attendance levels	Chief Nurse	01/05/2014
			The implementation of the agreed risk management approaches into supervision	Chief Nurse	01/05/2014
			Measure effectiveness also via sampling supervision notes	Chief Nurse	01/05/2014
			Measure also via evidence from MDT reviews and use of risk assessment	Chief Nurse	01/05/2014
			Measure via the routine risk assessment audits via care plans	Chief Nurse	01/05/2014

	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Enhance clinical leadership to risk management training through named individuals**	Measure the effectiveness of the agreed risk management approach via supervision	Medical Director	01/05/2014
			Names individuals identified and evidence through their job plans to be able to conduct the role	Medical Director	01/05/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Review and strengthen the peer review approach for consultant's practice; ensure there is a systematic approach across AMH with clear standards including risk management** a. Identify, agree and implement appropriate audit tool		Medical Director	01/05/2014

Risk assessment Baselines

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
25	Risk Assessment	Complete risk assessment documentation present in care record for current episode of care	100%	92% @ Sept 2013	01/03/2014	Chief Nurse
26	Risk Assessment	Number of staff with current valid risk assessment training	80%	92.1% @ Sept 2013	01/05/2014	Chief Nurse

Hand Over					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Checking and searching procedure to be clear and consistent. Guided with intelligence on risk posed by the patient	**Appleby action plan action 2.2 – review of handover policy** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Harmonise, review and improve the protocol which includes all aspects of handover (e.g. ward to ward handovers; shift to shift, internal/external; daily review) with clear diagrams/flow charts to assist staff to follow systematic processes** a. Implement training programme		Chief Nurse	01/01/2014

Hand Over Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
27	Handover	Adherence to In-patient handover protocol (by audit)	100%	New initiative; baseline to be established	01/01/2014	Chief Nurse

Embedding a system for continuous learning & Staff support					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Providing support and create opportunities for staff to learn continuously from practice (near misses, SI investigation recommendations, patient feedback) and reduce clinical variability	**Keogh area of improvement:** - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Review and strengthen the policy for staff support, including for violence, aggression and Serious Incidents**		Chief Nurse	01/01/2014
	Keogh area of improvement: - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Identify and provide additional training for specific staff who can lead debriefing sessions**	Include database of key people and their training, the number of sessions they have led, along with feedback from staff who have attended those sessions	Chief Nurse	01/01/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Develop a MDT forum for reviewing lessons learned ref. professional practice**	Measure resulting changes in practice and other actions taken	Medical Director	01/01/2014

	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**4. Utilise all available data such as staff feedback, service user experience, professional practice and Serious Incident thematic review to implement new mechanisms for disseminating lessons learned** a. Develop and implement ward level scorecards b. Develop and implement early warning data sets		Medical Director	01/05/2014

Continuous learning & staff support Baselines

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
28	Continuous learning & staff support	Number of debriefing sessions versus number of violent incidents and Serious Incidents reported	100%	New initiative; baseline to be established	01/01/2014	Chief Nurse
29	Continuous learning & staff support	Attendance rate of MDT learning forums against Terms of Reference	80%	New initiative; baseline to be established	01/01/2014	Medical Director
30	Continuous learning & staff support	Number of MDT learning forums held versus plan	100%	New initiative; baseline to be established	01/01/2014	Medical Director

Improvement of the Environment					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the patient experience, healing nature and safety of environment		**1. Ward environment** a. PLACE results are available for each inpatient area – recommendations to be actioned b. Cleaning schedule to be reviewed with manager of Domestic Services to ensure that cleaning requirements are met	FM metrics in the Interserve contract PLACE action plan implementation	Chief Operating Officer	01/05/2014
	Appleby action plan action 8.1 – review of ligature risk assessments **CQC Action Plan – Outcome 16, no. 3 (f) (g)** **CQC (MHA) Ashby Ward action plan, action 7**	**2. Ward environment – patient safety** a. Review Ligature assessment policy b. Ligature risk assessment – review to be completed for each ward using new tool from Ligature Risk Policy (approved March 2013) *NB: the ligature risk assessment review referred to here will be completed across Bradgate by end of October with report to QAC.* c. Refurbishment of bathrooms to the 4 old wards to remove already identified ligature risks (already in 13/14 Capital programme and awaiting commencement date of work) d. Structural solutions to minimise patients with high risk absconding – SALTO system, additional CCTV, intercoms and additional security doors to be installed throughout the Bradgate site including Glenvale area	Staff satisfaction with environment	Chief Operating Officer	01/05/2014
				Chief Operating Officer	30/11/2013
				Chief Operating Officer	30/11/2013

		– Capital works approved and work has commenced e. Review of current fencing – business case to be developed following recommendations		Chief Operating Officer	31/12/2013
	CQC Action Plan – Outcome 7, no. 1 (d) (e) **Review of seclusion rooms and resulting building work** **1 (g)** **Review of Seclusion Good Practice Group** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Seclusion** a. Review of all seclusion rooms to ensure fit for purpose b. Costs to be obtained for air conditioning to seclusion rooms c. Seclusion Group – this group is to be chaired by a clinician and purpose of the group will be to ensure that seclusion practice is monitored and that best practice is being adhered to as per the seclusion policy – this group is already in place and a lead clinician has been identified as Chair – the Chair of the Seclusion Group will write the annual seclusion report which is submitted to the SCQG	Feedback on the seclusion room changes from staff and service users	Chief Operating Officer	01/05/2014
			Evidence of improvements to privacy and dignity including those relating to single sex accommodation arrangements	Chief Operating Officer	01/05/2014

Improvement of the environment Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
31	Improvement of the environment	Adherence of staff to seclusion process and policy (by audit)	100%	Action plan in place to establish baselines	01/05/2014	Medical Director
32	Improvement of the environment	Adherence of all seclusion environments to national standard	100%	Baseline will be set by environmental audit	Dependent upon scale of work	Chief Operating Officer
33	Improvement of the environment	Number of ligature assessments undertaken in the Bradgate Unit	100%	All In-patient wards completed	01/12/2013 Non In-patient areas	Chief Operating Officer
34	Improvement of the environment	Improvement in PLACE survey results	90%	PLACE baselines (Sept 2013): • Cleanliness: 87.37% • Condition, appearance and maintenance: 75.12% • Privacy, dignity and wellbeing: 81.96% • Food and hydration: 84.79%	Dependent upon scale of work and 2014 PLACE assessments	Chief Operating Officer

Equality Meeting the needs of individuals with Diverse needs					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Care provided is able to accommodate the needs of the individuals with diverse needs and backgrounds	**CQC Action Plan – Outcome 14, no. 1 (b) (d)** **Keogh area of improvement:** - *Patient experience* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. To improve overall staff awareness of the needs of service users by revising the equality and diversity training so that this has a focus on the assessment of the protected characteristics and how care is planned and delivered with these in mind**		Director of HR & OD	01/11/2014
	CQC Action Plan – Outcome 14, no. 1 (a) **CQC (MHA) Thornton Ward action 6 staff to ensure use of interpreters** **Keogh area of improvement:** - *Patient experience* - *Workforce* - *Clinical and operational effectiveness*	**2. Ensure appropriate provision and access to language and communication support to enable service user communication, including translation services**		Chief Nurse	01/05/2014

Equality Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
35	Equality	Documented consideration of Equality & Diversity patient needs in care plan	100%	87%@ Sept 2013	01/05/2014	Chief Nurse
36	Equality	Number of staff trained in Equality & Diversity Training	80%	96.1%@ Sept 2013	01/11/2014	Director of HR & OD

Effective governance Supporting effective governance of the Trust					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Ensuring the adequacy of Ward to Board mechanisms to support effective governance of the Trust	**Keogh area of improvement:** - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Establish a Board Assurance and Escalation Framework that describes the effective ward to board reporting mechanisms to ensure effective governance of the Trust**		Chief Nurse	31/12/2013
	Keogh area of improvement: - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Review the organisational risk management strategy to ensure there is effective ward to board reporting and management of risks across the Trust**		Chief Nurse	31/12/2013
	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Implement the priority areas from the Trust's analysis of the Francis Report**	Board Analysis of Francis Report Thematic actions agreed in Q2 Progress report in Q3 (October Board Report) Annual Review Q4	Chief Executive Officer	February 2013 June 2013 October 2013 February 2014

Leicestershire Partnership NHS
NHS Trust

QUALITY IMPROVEMENT PROGRAMME (QIP)
CORPORATE ENGAGEMENT PLAN

Appendix A

Key for RAG Rating	
	Action not commenced
	Action On-going and to time
	Action Completed
	Action has missed deadline

Communications & Reputation Management **Director with lead responsibility:** **Director of Business Development**			
Patient, Carers & Service Users	**Who**	**By When**	**Progress/Assurance**
Contact patient and carer groups with information and reassurance	Chief Nurse	Complete	An initial meeting was organised with service users at Network for Change on 13/09/13 in response to group concern.
"*Changing your experience for the better*" – review recent comprehensive results from service user focus groups within AMH	Chief Nurse	Complete	A meeting was organised for 17/09/13 inviting voluntary and community sector organisations to provide them with information regarding the CQC findings, Trust actions and to hear from them about any concerns they may have. Patient experience team and AMH Divisional Director have undertaken a thematic review of these findings to support development of Quality Improvement programme.

External Stakeholders	Who	By When	Progress/Assurance
Forwarding draft CQC report (July inspection) to lead commissioner	Chief Operating Officer	Complete	Completed 08/08/13
Share response with the CCGs electronically before 15/8/13	Chief Nurse	Complete	Completed 15/08/13
Meeting with Local Health Watch	Chief Nurse		LPT Chairman met with Local Health Watch representatives on 17/09/13 Letter from Local Health Watch to Acting CEO in August reference CQC update. Letter from Local Health Watch to CEO in October and meeting on 30/10/13
Commissioner awareness, involvement and support for the immediate and medium term actions: set up an extraordinary exec team meeting with commissioners	Director of Finance	Complete	Commissioner meeting held 15/8/13.
MP Briefings	Acting CEO	Complete	Regular appointments in place. All MPs offered a telephone call updating them on the position ref July inspection. All MPs receive monthly LPT stakeholder briefings
Immediate initial meeting with TDA to brief on CQC and FT.	Acting CEO and Exec team	Complete	Constructive meeting held with TDA on 13/8/13 Actions incorporated into Immediate Action Plan and Quality Improvement Programme where applicable. Further meeting with TDA on 2/9/13.
Meetings with CCGs to further develop QIP Plan and metrics	Chief Nurse	Complete	Meetings held 24/9/13 and 03/10/13 to confirm and challenge content of the latest version of the QIP and discuss proposed metrics. On-going TDA input via Oversight & Assurance Group and monthly IDM meetings

Local Authorities, Scrutiny Committees and Health and Wellbeing Boards	Who	By When	Progress/Assurance
Briefing sessions offered to overview and scrutiny committees x3	Director of Business Development	2/8/13	All scrutiny officers contacted, this led to:- • Leicestershire County Council; Medical Director and Chief Operating Officer attended to present report on 12/9/13 • Follow up meeting at Leicestershire County Council on 27/11/13 (CEO, Chief Nurse and Medical Director) to present update report. • Leicester City; Acting CEO and Director of Business Development attended to present report on 3/9/13 and Chairman, Medical Director and Director of Business Development attended to present update report on 15/10/13 • Rutland County Council; Director of Business Development and Chief Nurse attended and presented report on 26/9/13 The Chair of the Leicestershire County and Rutland Adult Safeguarding Board was invited to the Leicestershire County Council scrutiny meeting on September 12; we suggested the same approach for Leicester City.
Generic Report produced for Scrutiny Committees that can be adapted over time/to address specific council queries.	Director of Business Development	21/8/13	Report completed and submitted initially for Leicester City deadline for papers (21/8)
Briefing sessions to be offered to safeguarding adults boards locally x 2	Director of Business Development	Complete	Incorporated into scrutiny plans above
Briefing sessions offered to the chairs of the three local health and wellbeing boards	Director of Business Development	10/08/13	Acting CEO office contacted all three Chairs to offer individual briefings as needed. Acting CEO briefing meeting held with Councillor Ernie White on 21/8/13. Chairman meeting Councillor Rory Palmer on 30/10/13

Internal Communications	Who	By When	Progress/Assurance
Statement on the receipt of the full CQC report Statement on increasing independence of SI investigations	Director of Business Development	Complete	Complete – combined and issued via staff briefing and stakeholder briefing on 7/8/13
Statement to clarify suicide numbers – for Chair and CEO	Chief Nurse	Complete	Issued to CEO and Chair on 6/8/13. Further detail and refinements made to data analysis by Chief Nurse by 20/8
Communications forward planner showing reputational issues and mitigation plans	Director of Business Development and Head of Communications	Complete	Complete - shared at Senior Management Team on 5/8/13 Updated for Executive Team meeting on 12/8/13 and then updated bi-weekly and presented at Executive Team meetings and Senior Management Team meetings.
Communications forward events planner and channel of good news stories	Director of Business Development and Head of Communications	Complete	Forward planner in place and managed proactively via divisional communications leads.
Cascade of CQC report (July inspection) through AMH	Chief Operating Officer and Divisional Director	Complete	Cascaded. Medical Director confirmed all appropriate clinical staff have received it personally.
On-going staff communication to reinforce Trust Board's support and report our progress	Acting CEO & Chair through communications	Complete	Special editions of team brief on CQC Report (July inspection) through July and August
Acting Chief Executive initial meeting with AMH Consultants at Bradgate Unit	Acting Chief Executive	Complete	Acting Chief Executive held constructive meeting with AMH Consultants on 9/8/13. Medical Director to lead on taking forward the key issues raised which focused on what is preventing good quality care from their perspective.

Issue CQC report to other Divisional Directors and discussion/action on: • thematic review of CQC report by other divisions • additional divisional communications/leadership on patient safety and record keeping • identification of other areas of CQC risk (Oakham House/Agnes Unit) where record keeping/case note improvements and other interventions are needed	Director of Business Development/Chief Operating Officer	Complete	Discussed with Divisional Directors who are progressing actions accordingly. COO follow up via fortnightly Ops team and monthly Executive Performance Reviews with Divisions Initial Thematic review complete and reported to Senior Management Team on 19/8/13
Briefing arrangements for lead governor/governor communications	Board Secretary	Complete	Acting CEO met with staff governors 29/8/13. Chairman/Lead Governor considered extra-ordinary Council of Governors meeting. Lead Governor receiving all stakeholder briefings and regular updates from the Chairman. Council of Governors briefed at their July and October meetings
Trust Board and CQC Report/Response	Acting Chief Executive	Complete	Complete: Response shared with Trust Board at 29/8/13 meeting/development session. Paper presented to Trust Board in public session 29/8/13 including immediate action plan, warning notices and full CQC report.
Weekly briefing for Board to be shared with Matrons across all divisions	Chief Nurse	On-going	
Other Communications actions	**Who**	**By When**	**Progress/Assurance**
Small suite of initial public facing products on the Trust, patient safety and other activities/profile. Review of ward information packet at the Bradgate Unit	Medical Director, Chief Operating Officer and Head of Communications	On-going	Initial topics agreed w/c 12/8/13. Initial products by 30/8/13, then rolling programme. Refreshed service user ward information packet draft being reviewed by communications and VCS during October
Annual General Meeting on 7/09/13	Acting Chief Executive	Complete	Meeting to finalise arrangements 15/8/13. Communications plan for CQC July inspection report publication finalised 22/8/13 including AGM aspects

Co-ordination ref publication of CQC Report and associated communications including handling for Trust Board and Risk Summit on 29/8/13.	Chief Nurse and Director of Business Development	Complete	LPT Communications plan developed and enacted 27-30 August in relation to the publication of the CQC report Communications handling plan developed and enacted for the Trust Board meeting. Coverage by BBC East Midlands Today, Leicester Mercury and BBC Radio Leicester. Co-ordination of communications following the Risk Summit being led by Area Team. LPT fully engaged in this process and issued a further staff and stakeholder briefing w/c 2/9/13.
Weekly stakeholder update to core communications stakeholder list	Director of Business Development and Head of Communications	Complete	To review regularly at 3 and 6 weeks. First bulletin 31/7/13; second bulletin 08/8/13; third bulletin 12/8/13 & 13/8/13 (Now monthly as before)
Continuing engagement – October 2013 onwards	**Who**	**By When**	**Progress/Assurance**
Engagement with Senior Leadership Group (approx. 150 people) on the Quality Improvement Programme	CEO		Meeting arranged for 27/11/13
New Ward Forums at Bradgate Unit, inclusive of patients, VCS and Ward Staff	Chief Operating Officer, Chief Nurse and Medical Director		Ward Forums are in the process of being arranged/re-established
Communications plan for the publication of the September CQC inspection Report	Director of Business Development		Communications plan in place
On-going VCS engagement	Director of Business Development and Head of Patients Experience	On-going	Post the September briefing, a further VCS engagement follow up session was held on 22/10/13 to gather feedback on the draft Quality Improvement Programme with the next session planned for 12/11/13
Trust Board engagement	CEO	On-going	Board development sessions 25/7/13 in relation to the July inspection CQC report. Board development sessions held 29/8/13, 26/09/13 and 31/10/13 with continual focus on quality assurance and transparency