Improvement Plan for: CQC Inspection Jan2016 -

Southern Health NHS
NHS Foundation Trust

Version No: Final V1.0
Progress last updated: 26/10/2016 - TM

Date: *27/05/2016*

MONITORED VIA CQC DELIVERY GROUP WEEKLY

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CQC progress dashboard – all actions including sub-actions - position as at 16/11/16

2016	May	June	July	August	September	October	November	December
Red	**0**	**0**	**1**	**4**	**1**	**1**	**0**	0
Amber	**0**	**0**	**0**	**0**	**0**	**0**	**1**	0
Green	**0**	**0**	**0**	**0**	**0**	**0**	**0**	5
Blue Completed	**26**	**36**	**17**	**3**	**5**	**2**	**0**	0
Expected number of completed actions each month	***27***	***36***	***18***	***7***	***6***	***3***	***1***	***5***
Validation Process								
Blue - **unvalidated - documents checked - still to be reviewed in practice**	**0**	**0**	**1**	**2**	**2**	**2**	**1**	
Blue - **reviewed during Exec site visit but further work required**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Blue - **Exec validated during site visit**	**27**	**36**	**16**	**1**	**3**	**0**	**0**	

* Reverted back to Red

Blue - Exec validated
Blue - unvalidated
Green
Amber
Red
not begun

Requirement Notice?	Action/s to be taken	How will completion of the action be evidenced (Evidence and method of review)	Who is responsible for completing the action Name & Job Title	Date action must be completed	Month	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Recovery plan - date action will be back on Track	Progress - to include position statement, risks, obstacles, action taken etc.	*Evidence saved in folder*	*Evidence checked and approved (TRACEY TO DO)*	*Exec assurance received*	How will you evidence that the completion of the actions has led to the intended outcome	Intended Outcome Achieved Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
Enforcement Action	1.1 Central Quality Governance team to be restructured to deliver a Business Partner model (replicated from HR and Finance model) to strengthen the links and accountability lines between the central governance team and divisional quality structures.	New business partner model will be in place and posts will be appointed into (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/08/2016	August	Red	31/01/2017	19/10/16: The appointment of 3 x Quality Governance Business Partners was due by the end of September. Due to recruitment delays it was agreed that the short-term requirement would be met by recruiting interim candidates. Two of the three Quality Governance Business Partner roles have been recruited to; one will start in November and the other in December / January following due HR processes. The third post currently has been filled by an interim candidate whilst substantive recruitment continues; further interim arrangements to be in place by 31/10/16, whilst substantive positions to be filled.	***IN FOLDER:*** *1.1 - Governance team Structure as of 1 August 2016 showing vacancies*			Tracking examples of risks being identified and escalated Review of Board and sub-committee agendas at year end against top organisational risks	
	1.4 Establishment of and appointment to new role - Deputy Director of Nursing and Quality,Mental Health and Learning Disabilities Division - to provide senior professional and governance leadership. Interim appointment to be made whilst the substantive appointment is recruited to	Interim and then substantive appointments made and individuals in post	Mark Morgan Divisional Director Mental Health and Learning Disabilities	Interim appointment 31/05/2016 Substantive appointment 30/11/2016	November	Amber		May: Post agreed at Trust Executive Group. Interim appointment made (Debra Moore) to provide professional leadership pending recruitment of a substantive individual					
	1.6 Risk Management Policy to be reviewed (including Risk Appetite Statement)	Revised Policy will be published (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/08/2016	August	Blue - unvalidated	31/10/2016	19/10/2016: Risk management strategy has been approved. Risk appetite framework was submitted to the Trust Board at the end of September and will be submitted to the AARC in October. 14/11/2016: The Trust Board approved the Risk Appetite Statement, Risk Management Policy and Strategy subject to minor amendments.To be presented at next Trust Board.	*IN FOLDER:* *Risk Management Strategy and Policy (DRAFT out for consultation)* *To receive copy of finalised Trust Board minutes and mark action as complete - validated*	*YES - MA*			
Enforcement Action	2.3 Develop a strategic 3 year capital programme to ensure appropriate short/medium/long term planning	Longer term strategic plans for Capital planning will be in place	Paul Johnson Head of Estate Services	31/03/2017	Mar-17	Green						Site visits consistently show evidence of staff aware of ligature risks associated with their units and of measures in place to mitigate risk.	
	2.11 Improve the robustness of the Site-specific security management reviews. All new reviews will go back over recommendations from previous years' reports to identify what actions, if any, have not been addressed and what management controls are in place to manage any identified risks	All security risks will be clearly identified, assessed and mitigated	Paul Johnson Head of Estates Services	30/08/2016	August	Blue - unvalidated		July 2016: The organisation has put in place a cyclical process over a 24 month period to audit sites with regards to security and this forms part of the Health Safety and Security Assessment process.	***In folder:*** *2.11.1. HSSA dates 2016 - 2023 xls spreadsheet* *2.11.2. HSSA Guidance document* *2.11.3. Antelope hse - ECT HSSA 2016 document* *2.11.4. Antelope Hse Saxon - HSSA 2016 document* *2.11.5. Saxon Ward Antelope Hse - role risk assessments document* *2.11.6. ECT Antelope Hse role risk assessments document*	*YES - TM*			
Trust wide Must Do	See actions in 2 above												
	3.2 The Quality, Improvement and Development Forum (QID) will receive assurance reports regarding the mitigation of risks associated with the environment. This will allow for exception reporting to the Quality & Safety Committee.	QID papers and minutes (submission of documents)	Deputy Directors of Nursing: Sara Courtney Paula Hull Debra Moore	31/07/2016	July	Blue - unvalidated	30/09/2016	July 2016: New reporting structures have been drafted and first meetings will take place in August to finalise TORs and membership. Environmental risks will be reported to the SAFE group by exception on a monthly basis 09/08/16 - Sara Courtney to develop framework by 16/08/16 23/09/16 - Agreed at CQC delivery meeting that estates would populate frameworks by end of September and will then liaise with clinical teams around addressing gaps identified 30/09/16 - all in place on SharePoint	***In folder:*** *3.21 - Screenshot of risk summaries on SharePoint* *3.22 - Example1 - Antelope* *3.23 - Example2 - Elmleigh*	*YES - TM*		Clearly auditable evidence of identification and mitigation of risk and of appropriate escalation	
	3.3 Existing team dashboards will be further enhanced to align them to the Trust's approach to team-level objective setting via the navigational maps.	All teams will have team performance dashboards in place and Trust Board will have visibility of every teams performance (submission of documents)	Simon Beaumont Head of Information Sara Courtney Deputy Director of Nursing and Quality	31/03/2017	Mar-17	Green		May: Information team presenting team level performance to Trust Executive Group on a weekly basis from April 2016. Programme in place to roll out the planned improvements over the financial year.					
	3.4 A systematic approach to providing 'intensive support' to frontline teams highlighted as having a reduced level/quality of delivery performance will be developed and rolled out across the Trust throughout 2016 . This will include a review of Practice Development roles and capacity	Trust wide team performance will be supported with a systematic approach to 'intensive support' programmes (submission of documents)	Sara Courtney Deputy Director of Nursing and Quality	31/12/2016	December	Green		May: Organisational Development leads presented current programmes of support and a proposed 'intensive support' package to Trust Executive group in April 2016					
	3.5 Team Quality Improvement plans will be in place for every team across the Organisation by the end 2016 These will encompass all elements of the Navigation Maps, will include core measures as well as tailored measures to the specific team objectives	Every team will have its own team level Improvement plan linked to its team Navigation Map, incorporating all improvement actions (submission of documents)	Sara Courtney Deputy Director of Nursing and Quality	31/12/2016	December	Green		May: Many teams within Learning Disabilities, Mental Health, Childrens and the ISDs have already initiated the creation of a single Improvement plan as a result of their Nav Map exercise. These are not standardised at present			*YES - 21/07/16 - Ridgeway Centre - DM* *21/07/16 - Bluebird - DM*		
Enforcement Action	The Trust will deliver the Mortality and SIRI action plan in full and to time.	Monitored through separate SIRI and Mortality Action Plan										Internal audit of invetigation process to be added to audit schedule for Q4	
	4.7 The Organisational learning strategy will be reviewed and updated	New strategy (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/08/2016	August	Red	31/10/2016	October 2016: The Organisational Learning Strategy has been drafted and is currently out for review and consultation. To be Approved in November 2016	**In folder** *4.7 - copy of draft strategy*				
	4.9 All SIRI investigation reports to include as standard a Terms of Reference which requires the investigator to determine whether any similar incidents have taken place within the team/unit in the preceeding 12 months and what action was taken as a result of these. This will allow for improved identification of themes and lead to improved actions to address the root causes. - 48hr panel chairs to be advised of new requirement - Commissioning manager training will include reference to this requirement	Investigation reports (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/08/2016	August	Blue - unvalidated		June 2016: This work is in progress as part of the on-going improvements to the SI reporting process August 2016: Processes in place but do not have sufficient evidence from each area to validate at present					
	4.10 The Trust will upskill frontline staff in quality improvement methodologies using the existing Team Viral programme to support this	Course content and Attendance logs (submission of documents)	John Monahan Organisational Development	31/03/2017	Mar-17	Green		June 2016: Plan in place to develop training day for Quality Ambassadors who will be appointed to teams as part of the implementation of the Quality Improvement Strategy in Q3 2016/17.					
Trust wide Must Do	5.3 Undertake a review of the Trust's staff engagement strategy	Review report (submission of documents)	Amanda Smith Deputy Director of Workforce Emma McKinney Associate Director of communications	30/09/2016	September	Red	31/10/2016	October 2016: The Staff Engagement Plan was been modified and an update is given regularly at the CQC Delivery Group. The PMO have not received a new revised Staff Engagement Strategy to underpin this plan. New post in place in HR to look at developing strategy - which is planned to be in place by January 2017.	**In folder** *5.3 - copy of staff engagement plan*				
	5.4 A review of staff feedback mechanisms will be undertaken to determine whether there are sufficient processes in place for staff to escalate matters beyond their line manager when these fall below the threshold that would require whistleblowing procedures to be followed. This will include a review of the methods through which feedback is collated and used when this is received at events such as staff briefings, staff survey etc. Promotion of exisiting/new mechanisms to be communicated to staff	Review report and communications (submission of documents)	Amanda Smith Deputy Director of Workforce Emma McKinney Associate Director of communications	31/10/2016	October	Blue - unvalidated			***In folder:*** *5.41. Your Voice -Team brief and poster* *5.42. Comms actions to promote - Your Voice* *5.43. weekly bulletin with example of improvement in estates comms*	*YES - TM*			

Trust wide Must Do	See action in 5 above											
	6.1 Ensure frontline staff are fully engaged in the Trust's Training Needs Analysis process by reviewing current practice and identifying ways in which this can be improved. Consideration will be given to the hosting of open days by the LEaD department and a communications drive during the months when the TNA process is undertaken.	Staff engagement activities around TNA (submission of documents)	Bobby Moth Associate Director of Leadership, Education and Development	31/10/2016	October	Blue - unvalidated			***In folder:*** *6.11 - LEaD filenote re actions taken* *6.12 - Comms regarding events*			
Requirement Notice	7.2 Task & Finish Group to: - review the functionality of the existing RiO risk assessment tool and determine the improvements required - determine how the new 'My Safety Plan' (collaborative safety care plan) and crisis plans reflect the risk information and are incorporated onto RiO - carry out a gap analysis of the risk assessment and risk care planning training currently available and determine the improvements required - establish trajectory of compliance for My Safety Plans being in place and new risk management training being undertaken	Report from Task and Finish group (Submission of document)	Liz Durrant, Area Manager – Southampton AMH	30/09/2016	September	Blue - unvalidated		June 2016: Task and finish group in place and work has commenced September 2016:	***In folder:*** ***7.2** 1. AMH Divisional Risk Task and Finish Group Minutes 18 May 2016* *7.22. AMH risk task and finish group Minutes 13 July 2016* *7.23 Clinical risk management template* *7.24 Draft My safety plan guidelines* *7.25Physical health assessment screen shot* *7.26 Risk screen proposal document* *7.27 - request for change documents*	*YES - TM*		Increased numbers of patients have a 'My Safety Plan' in place (trajectory to be determined by t&f group and evidenced by RiO report or manual audit) Increased compliance with new training programme (trajectory to be determined by t&f group and evidenced by LEaD reports) Thematic reviews of AMH incidents will be carried out on a 6 monthly basis and will expect to see a reduction in the number of incidents where failings in risk management were a causative or contributory factor.	
	7.3 Make the necessary changes to the risk module on RiO in association with Servelec to reflect the recommendations of the task and finish group	Updated risk assessment module on RiO (Submission of document)	Tony Goodwin, Senior Systems Manager	TBC at end Sept 16 (dependant on extent of changes recommended by T&F group)	TBC	Green		June 2016: Dependant on outcome of above action				
	7.4 Devise a risk management training package and establish a programme to roll this out in 2017 that reflects the recommendations of the task and finish group	New training materials and schedule for roll out (Submission of documents)	Louise Hartland, Governance, Quality and Compliance Manager LEaD	31/12/2016	December	Green		June 2016: Dependant on outcome of above action				
Requirement Notice	8.4 Complete the review of the current Clinical Disengagement Policy and make any necessary improvements to it. The review process will include a Soton Learning network event which will discuss learning from previous incidents associated with clinical disengagement.	Revised (Version 6) SH CP 97 "Clinical Disengagement / Patients who DNA" policy available on Trust website- (Submission of documents)	Area Heads of Nursing: Carol Adcock Nicky Duffin Liz James	30/09/2016	September	Blue - unvalidated		June 2016: Review in progress September 2016: Policy has been reviewed, updated and approved via the AMH governance processes	*8.41 Clinical Disengagement policy (Word & PDF version)* *8.42 Minutes of meeting where policy was approved*	*YES - TM*		Corporate panels will monitor on an ongoing basis whether DNA management continues to be a contributory or causative factor in incidents Biannual audit of DNA management until practice is embedded	
	8.5 Launch revised Clinical Disengagement policy including headlining it at AMH Learning Network event	Communications to staff and agenda of learning network event (Submission of documents)	Area Heads of Nursing: Carol Adcock Nicky Duffin Liz James	31/10/2016	October	Blue - unvalidated		October 2016: Policy has been approved, updated via the governance processes.	*8.51 Email cascade & poster advertising launch event*			
Requirement Notice	9.3 Use results of audit to feed into Trust-wide review of junior medical on-call rota	Trust-wide review report (Submission of documents)	Dr Mayura Deshpande, Clinical Service Director	31/08/2016	August	Red	TBC - recovery plan not yet received	23/08/16 - audit results reviewed and non-compliance identified. Shows wider issue related to junior medical on-call which will not be addressed by end of August. 04/10/16 - interim arrangements in Specialised services still not achieving full compliance. Further work required - recovery plan requested. 18/10/16 - Dr Lesley Stevens asked for review to be undertaken to put in place a long-term measure for the on-call rota. A short-term mitigation is in place to ensure all episodes of seclusion have an initial medical review within the first hour. Consultant cover is arranged where junior medical staff are unable to undertake this. An administrative post is also being recruited currently to ensure that there is a central point for logging all on-call rotas.				Periodic audit of seclusion medical review until practice is embedded	
Requirement Notice	See Action 2 (warning notice tab) for Trust-wide actions which will include AMH services											Staff understanding of ligature management process evident on peer reviews/site visits and
Requirement Notice	See action 2 (warning notice tab) in relation to Trust-wide improvements in ligature/estates management and action 2.12 specifically in relation to the Melbury roof											
Requirement Notice	13.3 External contractor to carry out building works of new seclusion room	Building works completed on new seclusion room (site visit)	Paul Johnson, Head of Estate Services	31/10/2016	October	Red		November 3rd: Works are largely complete; awaiting completion of snag list. Due for completion Nov 4th.	*IN FOLDER:* *13.31 - project meeting notes*			n/a - evidence of individual actions will provide the necessary assurance
Requirement Notice	See action 2 (warning notice tab) regarding Trust-wide improvements in ligature/estates management which will apply to Evenlode											
Requirement Notice	See action 2 (warning notice tab) in relation to Trust-wide improvements in ligature/estates management which will apply to The Ridgeway Centre											Peer reviews and site visits Regular review of incidents linked to the
Requirement Notice	See action 3 (warning notice tab) re plans for team-based improvement plans that will apply across the organisation and action 4 (warning notice tab) re sharing learning across the Trust.											
Requirement Notice	See action 5 (warning notice tab) for Trust-wide actions in relation to the supervision process.											
SHOULD	See action 6 (warning notice tab) re Trust-wide plans relating to the supervision process											
SHOULD	26.3 Additional staff to be trained in graphic facilitation so as to roll it out to all CPA meetings to help improve patients' understanding and involvement in treatment planning	Training records for graphic facilitation and CPA minutes (submission of documents)	Dr Mayura Deshpande, Clinical Service Director, Bluebird House Karen Dixon, Modern	31/12/2016	December	Green		October 2016: Graphic Facilitation training is provided as part of the Bluebird House induction programme. Key elements of the induction programme will be co-ordinated on the LEaD system to ensure accurate records of attendance are maintained. This will be in place for the October 2016 planned induction.				Consistent evidence at site visits, peer review and through patient feedback of involvement in care planning.
SHOULD	28.2 Review the restrictive interventions policy, in line with the position statement and address any identified gaps	Revised restrictive interventions policy (submission of documents)	Dr Mayura Deshpande, Clinical Service Director, Bluebird House & Chair of Safer Forum Debra Moore, Deputy Director of Nursing - MH/LD	31/07/2016	July	Red	31/10/2016	19/08/16 Consultation on draft restrictive practice policy complete - comments being incorporated into document. Restrictive intervention suite of underpinning procedures reviewed 11/10/16 - further comments received on updated policy are being incorporated into the final version. 18/10/16 - This action will remain Red until the policy has been approved and communicated to staff. Additional actions related to training provision will be added to the action plan to align with actions on the Trust Risk Register.	*awaiting copy of completed policy*			Monitoring of restraint by Safer Forum will show restraint techniques being used in accordance with Trust position statement and policy. Duration of restraint will be closely monitored with outlying trends investigated
	28.3 Review the training programme, in line with the new restrictive interventions policy, and produce a paper with recommendations for future training	Recommendations paper presented to TEG Minutes of TEG discussion (submission of documents)			July	Blue - unvalidated		July 2016: Review completed and paper being presented to TEG on 17th August	*awaiting copy of paper*		*YES - TEG Sept16*	
	28.4 Implement the changes to the training programme and roll-out to relevant staff groups	Revised training materials and roll-out schedule (submission of documents)	Simon Johnson, Head of Essential Training Delivery	TBC following outcome of recommendations paper	TBC	Green						
SHOULD	30.3 Carry out a scoping exercise to look at the possibility of moving seclusion paperwork to RiO	Feasibility paper (submission of documents)	Dr Mayura Deshpande, Clinical Service Director	31/12/2016	December	Green						Seclusion paperwork consistently found to be compliant with MHA Code of practice on audit or
SHOULD	See action 28 above.											

Date	Visit ref.	Service	Site	Domain	Issue	THEME	CoP Ref:	Action we will take	How we will know it is achieved	Date when action will be completed	Name of responsible manager	Internal Comments from PAS	Progress update	Evidence of Completion	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
25/02/2015	33803	Specialised	Oak Ward, Southfield	2: Purpose, Respect, Participation, Least Restriction	Patient feedback about the quality of the IMHA service was not entirely positive. There was no evidence that the quality of IMHA provision was monitored or patient feedback gathered in this regard. The IMHA service was reactive rather than proactive on the ward, in that advocates came by appointment only.		20.12	• Clinical ward manager and modern matron to liaise with the service user rep and gather any feedback on the IMHA service and feedback directly to the IMHA service if any concerns have been raised. • IMHA posters to be displayed on ward areas • Primary nurses to discuss the IMHA service in 1 to 1's • MDT to discuss in progress reviews and CPA's • Staff meetings to discuss IMHA service and capture issues relating to the quality of the service for feedback to the IMHA service • Clinical ward manager to identify any training needs for staff re: IMHA services • Clinical ward manager and modern matron to speak directly with IMHA service to enquire if a committed day could be given to Southfield. • The Division to work with HCC to ascertain how quality review and standards for the service can be measured	• Clinical ward manager and modern matron to have spoken to service user rep and gathered feedback about IMHA services • Posters will be displayed on ward areas • RIO will confirm IMHA has been discussed in 1 to 1;s with primary nurses • RIO will confirm IMHA has been discussed in CPA's and progress reviews • Clinical ward manager to have training sessions booked covering IMHA topic • Clinical manager and modern matron will have spoken to IMHA services and provide written feedback to the Division • The Division will have notes of a meeting with the IMHA service and HCC to discuss quality standards	30/06/2015	Nicky Bennett	none			
14/01/2016	35471	Specialised	Beech Ward, Southfield	2: Admission to the ward	There was no AMHP report, either full or outline, on file for patient B.		14.93	1. Supervision will be provided to the MHA Administration team to address the importance of obtaining AMHP outline reports as per the Code of Practice. 2. A named person at the relevant local authority will be identified to support a joint process between the Trust and the authority to ensure that such reports are obtained. 3. An MHA audit will take place in three months' time to monitor whether the reports are being provided.	1. Supervision will be held with relevant MHA administration team. 2. The local authority will be contacted and a process set up to for obtaining missing AMHP reports. 3. An MHA audit of AMHP reports will be completed.	1. 12/02/2016 2. 29/02/2016 3. 31/05/2016	Siven Rungien, MHA Manager	none	Partially complete	Supervision provided to team, email discussion with Southampton AMHP lead. Audit to be undertaken. 09/08/16 - audit report received	COMPLETED
09/02/2016	35472	Specialised	Cedar Ward, Southfield	2: Leave of absence	That it was not clear whether or not patients had been given a copy of their section 17 leave form. Some patients told us they were sometimes given a copy.		MHAS: 17 CoP: Chapter 27	1) The MHA Manager will meet with the ward manager to discuss the requirements of the section 17 leave policy and forms.	1) Meeting between MHA Manager and Cedar ward manager; 2) Audit in three months' time to verify compliance with policy as outlined below.	1. 08/04/2016 2. 31/07/2016	Siven Rungien, MHA Manager	Our Section 17 policy requires that copies of the forms are given to patients. To support this, the forms are produced in triplicate: the yellow copies are specifically for patients. Staff are required to tick on the master form that a patients has been given a copy.	Partially Complete	Discussion with ward manager has taken place. Audit to be undertaken 09/08/16 - audit report received	COMPLETED