High Level CQC Action Plan

Phase 1: Implementing the actions

Not on track to deliver	0
On track to deliver	28
Delivered	0
Total	**28**

Phase 2: Testing the action

not commenced	
On track to deliver	
Delivered	
Total	

	Intention	CQC Reg	Exec Lead	Overview Committee	Workstream Lead	Monitored by	Site/Location	Action	Completion date	Revised Completion Date	Phase 1 Progress workstream actions	Impact/evidence/progress	Date phase 1 and 2 completed	How we are testing the compliance
1. Incident Management	We want our service users to receive safe care and treatment and where there is an incident the Trust makes improvements. To do this the Trust must ensure that the Serious Incidents are investigated in appropriate timescales, and that appropriate action is taken to remedy the situation and prevent recurrence.	12 & 17	Director of Nursing & Professions	Quality & Safety Committee	Interim Head of Quality Governance	Task & Finish Group reporting to the compliance group	Trust wide	1.1 Review SI processes and take action to improve processes	30.10.19		On track to deliver	* 100% of investigations within the Trust's control are completed within 12 weeks. * There is a 100% visibility of all investigations including those which are outside the Trust's control.	28.2.20	* Weekly review of Quality & Governance Call out boards. * Exceptions highlighted to COO's weekly call out. * A monthly report to compliance group.
							Trust wide	1.2 .Develop and implement a process to share learning with teams and across the organisation	15.10.19		On track to deliver	* all individuals involved in serious incidents have a debrief within 72 hrs * 100% of learning from incidents is shared with the team concerned. *100% learning from incidents is shared across the wider organisation * 85% of staff know how to access learning from incidents and events *100% of learning from incidents within a care group has been considered by care group quality and safety meeting	28.2.20	* Review of 72 hr report template * Serious Incidents panel review of incidents * monthly report by SI team * randomised sample surveys
							End of life care	1.3 Develop and embed training on incidents management in the End of Life care team	31.8.19		Delivered	* 100% of currently employed staff will have completed the incident training by September 2019. * 90% of staff will receive refresher training/or training for new staff as a rolling metric.	31.11.19	* Weekly monitoring of trajectory through daily lean management process. * routine monitoring of workforce metrics

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2. Restrictive Interventions	There are occasions when we may have to use restrictive practices when caring for our patients to ensure the safety of themselves and others. When we do this is important that our patients are treated with dignity and safeguarded from abuse. To do this the Trust must have effective oversight of restrictive practices and ensure they are only used when warranted	17 & 13	Chief Operating Officer	Mental Health Legislation Committee	General Manager for Mental Health	Positive and Proactive Group reporting to the compliance group	In-patients	2.1 Design and implement a clear process for reviewing, reporting and escalation of restrictive interventions, ensuring our in-patient staff are fully appraised of restrictive interventions.	31.8.19	30.9.19	On track to deliver	* 100% of individual restrictive interventions are risk assessed, care planned and reviewed weekly as a minimum and this is recorded in the clinical records. * Teams are regularly discussing use of restrictive interventions at the daily clinical report-out. * 100% of seclusions/long term segregation have a relevant care plan in place. * Positive and Proactive meeting	31.1.20	* Monthly care plan and clinical risk assessment audit * Reviewed at DLM meeting * Clinical audit of care plans and risk assessments * Ward Quality checks * Mental Health Act Quality Checks
							In-patients	2.2 Ensure that where blanket restrictions are in place they are in line with the Mental Health Act Code of Practice and Trust policy	30.9.19		On track to deliver	* 100% of blanket restrictions are in line with Trust policy and based upon a risk assessed approach * Where blanket restrictions are in place there are documented reviews in line with Trust policy	31.1.20	* Monthly care plan and clinical risk assessment audit * Reviewed at DLM meeting * Clinical audit
							In-patients	2.3 Where individual restrictive interventions are in place these are implemented and reviewed in line with Trust policy.	31.8.19	1.11.19	On track to deliver	Where individual restrictive interventions are required documentation is completed in full and this is identified in the patient's care plan in at least 90% of the time.	31.1.20	* Care plan audits

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3. Supervision	As a Trust we seek to support and develop our staff. One of the ways we do this is through regular clinical and management supervision . To do this we must support our staff to access supervision in line with the Trust's policy. To ensure this is happening the Trust must have effective oversight of supervision.	17 & 18	Director of HR and Organisational Development	Quality and Safety Committee	Deputy Director of Nursing	Compliance Group	Trust wide	3.1 Work with ESR to ensure fit for purpose system of monitoring supervision.	30.9.19		On track to deliver	* Information that is reported at all levels is consistent and accurate with what is being reported at DLM.	28.2.20	* Manager *Compliance Group *Quality and Safety *Trust board.
4. Clinical Risk	Ensuring the safety of our service users is of prime importance. To ensure this we must have accurate and timely risk assessments that are based on the need of the patient whilst taking into account their preferences.	9, 12 & 17	Director of Nursing and Professions	Quality & Safety Committee	Head of Nursing - Mental Health	Compliance Group	Mental Health Services	4.1 To review the current clinical risk assessment tools used in mental health services after which. The Trust will ensure staff have the appropriate knowledge and training to undertake risk assessments and implement suitable mitigation plans.	30.9.19		On track to deliver	* 80% of currently employed relevant staff will have received the relevant clinical risk training by September 2019 * 80% of staff will receive refresher or new starter training as a rolling metric	31.12.2019	* Weekly monitoring of trajectory through daily lean management process. * routine monitoring of workforce metrics
							Mental Health Services	4.2 Ensure that clinical risk assessment is carried out in line with Trust policy and national guidance.	30.9.19		On track to deliver	* A reduction in omissions of completion of care plan and risk assessment. * 100% compliance with recording standards for clinical risk including S17 leave, observations and register of movement. * 100% of patients have a care plan and risk assessment which is in line with Trust policy. Where there are omissions, these will be reported and managed via DLM within 24hrs.	31.1.20	* Monthly care plan and clinical risk assessment audit * Reviewed at DLM meeting * Clinical audit * Quality checks * Clinical report out

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							Mental Health Services	4.3 Ensure that the Trust has effective oversight of clinical risk management including all in-patient leave, and observations of patients	30.9.19	30.10.19	On track to deliver		* reduction in the number of incident report forms for omissions relating to clinical risk management including all in-patient leave, and observations of patients	31.1.20	
5. Medicines	In order to ensure we provide the best and safest care for our service users, the Trust must ensure staff follow best practice when managing and dispensing medication to reduce the risk of error and patient harm.	12 &1 7	Medical Director	Quality & Safety Committee	Chief Pharmacist	dicines Management Group reporting to the compliance group	In-patients	5.1 Implement a fit for purpose system to monitor and manage clinic room areas.	30.7.19	30.9.19	On track to deliver		*The Trust will demonstrate 100% compliance with monitoring fridge and ambient temperatures and ensures that actions are taken when temperatures fall outside of requirements. * 100% compliance with clinic audits, including Emergency Equipment and controlled drugs, and that where action is required or exceptions are identified, these are resolved in 24hrs. * 100% of medication charts have the correct authorisation documentation with the medication charts * 100% of liquids and topical medicines are labelled with the date opened * 100% of medications stored in line with guidance	31/12/19	* Reviewed at ward level weekly and reported through DLM meeting * Pharmacy audits * Quality checks
							In-patients	5.2 Ensure that rapid tranquilisation is administered and monitored in line with policy and national guidance.	30.6.19	18.10.19	On track to deliver		* Where there are omissions in records these are followed up in 24 hrs via DLM. 100% of rapid tranquilisation forms will be completed *100% of debriefing for patients within 24hours following the administration of rapid tranquilisation	31.11.19	* DLM * monthly clinical audits *Medicines management group * Chief pharmacist reviews all IRE's relating to medication incidents

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					Me	Trust Wide	5.3 Ensure staff have the appropriate knowledge and training to manage, prescribe and administer medication in line with their role.	31.10.19		On track to deliver	* 100% of currently employed registered staff have received medications management training * 100% of currently available registered in-patient staff have had rapid tranquilisation training * 100% of actively prescribing non medical prescribers are in date with training requirements.	31.11.19	* Weekly monitoring of trajectory through daily lean management process. DLM * routine monitoring of workforce metrics
						Trust wide	5.4 Implement a fit for purpose system to record the prescribing, administration and associated clinical discussions about medication.	30.9.19		On track to deliver	* Where there are omissions these are followed up in 24 hrs via DLM . 100% medication will be signed for. *100% of treatment authorisation charts (T2 & T3) will be with the medications charts. Where there are omissions these are followed up in 24 hrs via DLM	31.1.20	* DLM * monthly clinical audits * Medicines management group * Chief pharmacist reviews all IRE's relating to medication incidents
						Trust wide Trust wide	6.1 Implement a fit for purpose environmental risk management and estates maintenance process, specifically environmental and Fire Risk assessments.	30.7.19	30.11.19	On track to deliver	* 100% of environmental risk assessments are completed on time and comply with Health & Safety regulations. * 90% of actions are in date. Where they have exceeded the date there is an explanation and mitigation. * all issues flagged through environmental risk assessments are responded to in line with Trust policy	31.12.19	* Health & Safety Group. * Ligature and Environmental Risk & Safety Group *Compliance Group *FBIC exception reporting * Internal Audit Annually by Audit Yorkshire

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6. Environment & Equipment	It is important that we maintain the health and safety of those accessing our services and our staff. To do this we must ensure our premises are safe, fit for purpose, that our equipment is safe and we routinely assess, monitor and mitigate against risks.	12 & 15	Director of Finance and Estates	Quality & Safety Committee	Facilities Business and Governance Manager	H&S Group reporting to the compliance group	In-patients	6.2 Implement a fit for purpose ligature risk assessment and management process across all inpatient areas.	30.7.19	31.10.19	On track to deliver	* Ligature risk assessments are accessible on all wards with ward plans highlighting key anchor point risks. * 100% of risk assessments are completed on time and quality assurance / sign off completed per policy and procedure. * inpatient ligature risk assessments reflect best practice and any national guidance. * the outputs of ligature risk assessments are accessible to staff in all areas * 100% of areas have clear and approved ligature action plans with clearly assigned estates and operational actions. * 90% of relevant staff have received (clinical risk assessment) training in the identification and management of ligature anchor points	31.1.20	* Reviewed at DLM meeting * Quality checks * Clinical report out * routine monitoring of workforce metrics
							In-patient areas	6.3 Source and implement a fit for purpose call alarm system for patients to seek assistance in an emergency	30.09.19		Delivered	* All inpatients wards will have a nurse call alarm system * The trust will trial the use of wrist band nurse call alarms for more vulnerable individuals	31.12.19	* Capital Planning & Invetsment Group roll out oversight and final sign off * Environmental check and operational sign-off * Operational service audits of clinic areas
re & Care Planning	The care and treatment our service users receive must be appropriate to their needs and reflect their preferences. All service users must be treated with dignity	9	ing Officer	y Committee	and Adult/Childrens Community	e Group	Trust-wide	7.1 Ensure that all care plans are developed in line with local policy and national guidance and reflect any reasonable adjustments	30.9.19	30.11.19	On track to deliver	* the Trust has a fit for purpose care plan audit process in place that is relevant to all services. * 100% of patients have a care plan which is in line with Trust policy. Where there are omissions identified through audit, these are discussed with relevant individuals and teams. * 90% of people in in-patient setting who require reasonable adjustments to be made will have this indicated on a care plan	31.1.20	* Monthly care plan audit * Reviewed at DLM meeting * Quality checks * Clinical report out
							Trust wide					* the Trust has a fit for purpose care plan audit process in place that is relevant to all		

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7. Person Centred ca	treated with dignity and respect. To do this care plans must be developed collaboratively with the service user where possible and updated as their circumstances change.	17,	Chief Operat	Quality & Safety	Heads of Nursing - Mental Health :	Complianc	Trust-wide	7.2 Ensure that care plans are reviewed and updated in line with local policy and national guidance.	30.9.19	30.11.19	On track to deliver	services. * 100% of patients have a care plan which is in line with Trust policy. Where there are omissions identified through audit, these are discussed with relevant individuals and teams. * 90% of people in in-patient setting who require reasonable adjustments to be made will have this indicated on a care plan	31.1.20	* Monthly care plan audit * Reviewed at DLM meeting * Quality checks * Clinical report out
								7.3 Ensure that all service user clinical records are developed and maintained in line with the local records management policy.	31.8.19	30.11.19	On track to deliver	* 100% of clinical records are maintained in line with Trust policy. Where there are omissions identified through audit, these are discussed with relevant individuals and teams.	31.1.20	* Monthly care plan and clinical risk assessment audit * Reviewed at DLM meetings * quality checks * Clinical report-out
8. Mental Health Legislation	We have a responsibility to our service users to offer the best professional standard of care. To do this we must ensure we are always delivering services that are compliant with relevant mental health legislation.	17, 10 & 12	Chief Operating Officer	Mental Health Legislation Committee	Mental Health Legislation Lead		Trust	8.1 Ensure that all Trust policies are kept updated to reflect the Mental Health Act Code of Practice	30.9.19		On track to deliver	100% of policies and procedures relating to mental health legislation will reflect the most recent legislation	31.12.19	* Internal mental health quality checks * clinical report-outs
							Trust	8.2 Ensure that all staff have the appropriate level of knowledge, skills and access to information to enable them to implement mental health act legislation.	30.11.19		On track to deliver	* 90% of staff have received MCA & MHA training * 100% of required clinical documentation will be accessible to relevant staff including AHMP reports, section 17 leave, Consent and section papers	31.1.20	* Weekly monitoring of trajectory through daily lean management process. * routine monitoring of workforce metrics * MHA audit
							Trust	8.3 To ensure that effective governance systems relating to Mental Health Legislation and its implementation across the Trust are in place to assess, monitor and improve the quality and safety of services.	31.8.19	30.11.19	On track to deliver	* 100% of DoLS are discussed at clinical report out and are proactively managed with escalation as required. * 100% of appropriate service users are referred to an IMHA * Where Mental Health Legislation audit identified issues, 100% will have actions identified to improve these * 90% service users will have had their rights read in line with the code of practice	31.12.19	*MHA Audit *MCA Audit * Clinical report out *MHLC

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9. Service Accessibility	In order to support the best possible outcomes for our service users, we must do everything we can to provide the right care in the right setting. To do this we must maximise the appropriate use of our in-patient and community services.	9 & 12	Chief Operating Officer	Quality and Safety Committee	Heads of Nursing - Mental Health and Adult/Childrens Cor	Compliance Group	Trust-wide	9.1 Review referral processes including admission and access to services, waiting times and, where required develop a quality improvement plans.	30.11.19		On track to deliver	* board level and care group visibility of waiting times for all services * where access KPI's are in place, services are meeting these * where services currently have waiting times, waiting times will reduce	31.1.20	* weekly COO report out. * SLG
							Trust-wide	9.2 Review discharge processes	31.10.19		On track to deliver	*100% of patients will have a discharge plan in line with Trust policy.	31.1.20	* care plan audit * Clinical report out * caseload management * caseload management audit
10. Supporting Staff to do their job	In order to deliver safe and high quality services, the Trust must have sufficient numbers of suitably qualified, competent, skilled and experienced staff. To do this, we need to focus on becoming an employer of first choice and our staff must be suitably inducted and receive regular training and supervision to ensure they have the knowledge and skills required.	17 & 18	Director of HR and Organisational Development	Quality & Safety Committee	Deputy Director of HR & Organisational Development	Compliance Group	Trust wide	10.1 Review compliance with mandatory and role specific training and adopt improvement plans where required.	30.8.19	1.11.19	On track to deliver	Training will be maintained consistently at the Trust agreed standards for 3 months	31.12.19	* SLG *DLM
							0-19	10. 2 Develop and implement a new staffing model in line with the 0-19 service revised specifications.	1.8.19	31.10.19	On track to deliver	* staffing model to deliver new service specification will be in place * new caseload standards established * compliance with caseload standards	31.12.19	* 0-19 strategic mobilisation meeting *SLG
							Trust Wide	10.3 Ensure temporary staff have timely access to induction, training and information required to be able to deliver their roles safely.	30.9.19	31.10.19	On track to deliver	* 100% of temporary staff have had an appropriate inductions in line with Trust policy * 80% of temporary staff have received mandatory and role specific training * risk and safety information is readily available to all staff, including temporary staff	31.12.19	* SLG * DLM Quality checks * Monitor compliance on ESR

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11 Information technology	In order to ensure that our patients receive safe care and treatment, our staff must be able to provide contemporaneous documentation.	12 & 17	Director of Informatics	FBIC	Head of Informatics	Informatics Board	Trust-wide	11.1 The Trust will roll out improvements to the IT network to improve connectivity	15.9.19		Delivered	* fewer incidents reported via the IT service desk on connectivity	28.2.19	* informatics board *Capacity & Demand reported to SLG
12. Dignity and respect	We must treat our service users and carers with dignity and respect at all times. To do this we must treat them in a caring and compassionate way.	10	Director of Nursing and Professio	Quality & Safety Committee	Quality, Health and Innovation Lea	Patient Safety Group	Trust-wide	12.1 To reinforce communications about dignity and respect	31.8.19		Delivered	* complaints/FFT feedback about poor attitude of staff in in-patients will reduce by 15%	31.1.20	* Compliance group
13. Governance & Quality Improvement	The Trust is continuously seeking to improve the quality of service it delivers. To do this we must have effective systems and processes enabling us to assess, monitor and improve our services	17	Brent Kilmurray	Q&S Committee	Phil Hubbard	Compliance Group	Trust-wide	13.1 Review approach to clinical audits to ensure they are used as a tool for monitoring and improvement.	31.8.18		Delivered	* 100% of clinical audits are shared with the relevant team. *100% of action plans are completed. * 90% of staff are aware of audits in their area and any improvements required as a result of them	31.12.19	*Patient Safety Group
								13.2 Design and implement a standardised approach to governance across the Trust using an Integrated Governance Framework.	30.10.19		On track to deliver	* a clear and consistent approach to quality governance across the Trust	28.2.20	* Quality & Safety Committee *Audit * Trust board

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								13.3 Train 10 leaders in the Care Trust Way improvement methodology and put in place a programme of improvement activity.	31.12.19		On track to deliver		* appropriate number of certified leaders to support roll out of QI methodology * the Trust has in place a proactive programme of improvement activity that is regularly reviewed and refreshed	28.2.20	* monitoring of development and implementation at Trust board level