Update on High Level Action Plan to address regulatory "Must Do" issues identified by the Care Quality Commission
23 December 2016

"Must Do" Areas	Regulation	Due date & status	Exec sponsor	Delivery owner/s	Governance reporting	Actions Undertaken and Evidence
CQC HL 1: **Care planning** ***The Trust must ensure that staff consistently and regularly review and update nursing care plans. They must ensure that nursing care plan documentation is personalised and addresses all the needs identified in the assessment (This action was specific to Community Learning Disability Services)***	9	22-12-16	Alison Bussey	Kenny Laing	Trust Management Team; Quality Governance Committee; Operational Board	1. The new Care Planning Policy was introduced in October 2015. It is available on the Trust website but can be found at *"CQC HL 1.1 - Care Planning Policy"* 2. Following receipt of CQC findings in relation to Care Planning in the Learning Disability Directorate, the Clinical Director has led work with all professional leads to support clinical leads in improving care planning. Assurance of this work has been sought via all Learning Disability Directorate Care Plans being audited during October and November 2016. The results of the nursing care plan audit have demonstrated improved performance in relation to personalisation, addressing identified needs and having been reviewed – results of this audit can be seen at *"CQC HL 1.2 - Audit Report - Nursing Care Planning Dec 2016"*. The implementation of Multi-Disciplinary Team Care Planning will take place in 2017. 3. The Learning Disability directorate has developed a new multi-disciplinary LD care plan. This will enable a more personalised approach to care planning by ensuring a more holistic assessment of a person's needs, through incorporating the Health Equalities Framework (HEF) and will enable all professional groups to measure health inequalities before and after interventions (planned care). This new MDT care plan has been designed and is currently being tested ready for implementation in January 2017. Evidence of this can be found at: *"CQC HL 1.3 – My Care Plan – MDT Care plan – Sept 2016" and "CQC HL 1.3 – My Care Plan screen shots Dec 2016".* 4. To ensure sustained compliance with the care planning standards outlined in the audit, the Trust has introduced the management supervision Standard Operating Procedure – this can be found at:

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						http://www.sssft.nhs.uk/working-here/clinical-policies-yellow/198-clinical-and-managerial-supervision-policy-promoting-best-practice-in-health-and-social-care-deliveryg-best-practice-in-health-and-social-care-delivery *http://www.sssft.nhs.uk/images/Policies/Supervision_Policy/Management_Supervision_SOP.pdf* 5. In addition to what the CQC asked, the LD directorate has undertaken training in risk assessment to improve the overall personalised assessment of the needs of people with Learning Disability. We have introduced the FACE risk assessment tool which is sensitive for use with people with a learning disability. Training for clinical staff in the use of Learning Disability FACE risk assessment tool has been delivered from October 2016. Evidence includes attendance register, and training materials. This can be found at: *"CQC HL 1.5 – Agenda 21st Oct 2016 FACE LD", "CQC HL 1.5 – FACE LD – Updated guidance notes – Sept 2016", "CQC HL 1.5 – FACE Risk Profile – LD" and "CQC HL1.5 - Risk Assess & Management Care Pathway – Oct 2016".* Attendance registers can be seen at *"CQC HL 1.5 – Face LD risk training 211016"* and *"CQC HL 1.5 – Face LD risk training 221116"*

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CQC HL 2: Rapid tranquilisation ***The Trust must ensure that their policy on rapid tranquillisation is up-to-date and reflects current prescribing guidance from NICE. The Trust must ensure that clinical staff have a consistent approach to the use of rapid tranquillisation, understand its risks and record its use and the this is appropriately monitored***	12	22-12-16	Abid Khan	Mo Azar	Trust Management Team; Medicines Optimisation Committee; Operational Board	1. The RT policy has been re-written based upon latest NICE guidance (NG10), approved at the Policy and Procedures Committee and ratified by the Board on 29th September 2016. See file: *"CQC HL 2.1 – Rapid Tranquillisation Policy – Ratified Sept 2016"* 2. Clinical pharmacists have delivered ward based RT training sessions to 264 inpatient nursing staff, ward managers and doctors following the approval of the new RT policy. See files: *"CQC HL 2.2 – RT Briefing Session for Doctors Induction 2016 – slides"* and *"CQC HL 2.2 – RT Training for Clinicians– slides"*. Additional RT training sessions are planned for 2017 and the RT training delivered within the trust DMI training course is being updated in line with the new RT policy. A training summary and data on use of rapid tranquillisation is provided at *CQC HL 2.2 - Rapid Tranquillisation Project Summary.* 3. A3 posters of the RT process for nursing staff (appendix 4 of the RT policy) have been professionally printed and issued to each ward for display in the clinic room. 4. RT audit data was collected in October & November for submission to POMH-UK (topic 16a). The national RT audit report is due for publication June 2017. This audit data has also been analysed by the SSSFT audit department in order to give the trust a timely insight into current standards of RT in clinical practice. This baseline audit showed that 50% of RT episodes had some documented evidence that the patients physical health was monitored following administration, 37% had some documented evidence that the patient refused physical health checks following administration and 13% had no documented evidence that the patients physical health was monitored following administration. See slides: *"CQC HL 2.4 – POMH-UK Topic 16a Rapid Tranquillisation – Audit Tool".* *5.* The audit results will be shared with the inpatient wards in January 2017 and presented throughout Jan/Feb 2017 at a variety of trust meetings and committees. See files: *''CQC HL 2.2 Rapid Tranquillisation Project Summary''* 6. Incident forms are completed following any incident of rapid tranquillisation. This information is then analysed by directorate and

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						presented as part of routine quarterly incident reporting at the Quality Governance Committee. 7. Further local audit will begin in 2017 via a SSSFT audit tool. Regular feedback will be given to inpatient wards by the Clinical Pharmacist team in order to generate ward based reflection on clinical practice in relation to RT. This will continue until the new RT policy is fully embedded into clinical practice and it can be evidenced that improvements to clinical standards and patient safety are sustained. *"CQC HL 2.7 – FINAL Rapid Tranquillisation Audit 2016 data collection tool".*

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CQC HL 3: Seclusion & Segregation ***The Trust must comply with the Mental Health Act Code of Practice requirements for documenting observations and decision making in any episodes of seclusion and long-term segregation***	17	22-12-16	Alison Bussey	Kenny Laing	Trust Management Team; Quality Governance Committee; Operational Board	*1.* All the ward managers have been sent the suite of seclusion and segregation Standard Operating Procedures (SOP's), these can be found at *"CQC HL 3.1 – Restrictive Practices Policy", "CQC HL 3.1 – Seclusion in a Seclusion Room-Suite SOP", "CQC HL 3.1 Seclusion Other than in a Seclusion Room SOP", "CQC HL 3.1 – Use of Long Term Segregation SOP".* Additionally, the Trust Clinical Skills Educator has attended ward meetings to present and discuss the practice requirements in relation to these SOP's and the MHA Code of Practice. An example of this can be seen at: *"CQC HL 3.1 – Ward Managers Meeting Agenda 7 11 16"* 2. Assurance that improved reporting of incident of seclusion, in keeping with the MHA Code of Practice, is in place can be seen via increased reporting of seclusion (both in seclusion rooms and in rooms other than seclusion rooms). The reporting of seclusion in rooms other than seclusion rooms has increased since the introduction of the SOPs (in March 2016). This can be evidenced by the chart found at *"CQC HL 3.2 - Seclusion Incidents Graph Feb 15 - Nov 16".* 3. Additional training for Seclusion and Segregation has been provided for all clinical ward staff attending the Trust's De-escalation Management and Intervention (DMI) training courses. The compliance with DMI training as at November 2016 was 89%. Please see attendance register *"CQC HL 3.3 – DMI Training Attendance Figures April-Dec 16"* and the slides from training package at *"CQC HL 3.3 – Seclusion and Segregation Training Slides".*

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CQC HL 4: Waiting times (community young people) ***The Trust must review the waiting times from assessment to treatment for patients and put systems in place to reduce the length of wait***	18	30-11-16	Alison Bussey	Carolyn Gavin	Trust Management Team; Quality Governance Committee; Operational Board	1. The Trust has reviewed how waiting lists were being managed on RiO and identified improvements to how the reports were generated. The way data was pulling previously included CYP that had a manual clock stop or did not get onto the waiting list. This caused patients to appear to be waiting for 1223 days, which was inaccurate. We have now rebuilt the report structure and updated RiO so that data is pulled accurately. Please see example at *"CQC HL 4.1 – Waiting Lists"*- this includes screen shots of current waiting lists for CAMHS Early Years and CAMHS Incredible Years. CAMHS Incredible Years is the waiting list for parenting groups (please note that this programme is in addition to core treatment). The CAMHS Teams can now access RiO on a daily basis to check on waiting times for their area. 2. The Trust has now employed an extra member of staff to the CAMHS Team to run parenting groups. Therefore increasing the capacity to deliver more parenting groups as part of the CAMHS Incredible Years programme. Parenting groups are 12 weeks long and are delivered across the geography of the patch. Parenting groups are part of on-going therapeutic interventions and are run in conjunction with other therapies. 3. Following these changes, we asked parenting groups to complete a one-off survey for feedback around their waiting times to ensure any issues could be dealt with quickly. The results of 19 responses can be found at *"CQC HL 4.3 – Questionnaire Responses – Parenting Groups"*. This includes comments received from parents and shows that whilst the wait was problematic before, this was no longer an issue. This one-off survey was completed during September/October and November 2016.

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CQC HL 5: Clinic room deep clean ***The Trust must ensure that the cleaning standards of the clinic room at Telford & Wrekin Crisis Resolution and Home Treatment team are maintained. The clinic room was not clean and had ants, spiders and cobwebs. Cleaning records were not maintained***	12	31-08-16	Alison Bussey	Robert Graves	Trust Management Team; Infection Control Committee	1. The room was deep cleaned on 4th August 2016 and this was noted in the attached minutes of the Infection Control Committee meeting *“CQC HL 5.1 – Minutes of ICCM 8.9.16”.* The room was actually incorrectly signed as it was not being used as a clinical room. This has now been re-signed as a store room so that it is clear as evidenced at the attached photograph *“CQC HL 5.1 – Renamed Clinical Storage Room Photographs”* along with a photograph to show it is being used as a clinical store room at *“CQC HL 5.1 – Clinical Storage Room Photograph”.* 2. The Assistant Facilities Manager, held a meeting with the House Keeping staff at Telford & Wrekin Crisis Resolution and Home Treatment to reaffirm the importance of using the schedule to maintain the cleanliness of the team working space. A training programme for one of our members of staff can be found at *“CQC HL 5.2 – TP Training Programme”.* The schedule now in use instructing domestic staff on cleaning requirements can be found at: *“CQC HL 5.2 – Castle Lodge Domestic Work Schedule”.* 3. The cleaning supervisor undertakes monthly verification of cleaning/ cleaning schedules. Please note that the Telford & Wrekin Crisis Resolution and Home Treatment Team are due to move to new more purpose built premises from April 2017.

KEY: **Completed**