Summary Milestones Plan for CQC Improvement Action Plan

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Southern Health NHS
NHS Foundation Trust

UIN	WARNING NOTICE ACTIONS	Target date	Status	July	August	September	October	November	December	January	February	March
WN001 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.	31/08/2016	Not on Track									
WN001 1.2	Review of Ward to Board reporting on quality performance (Board and its sub-committees)	30/06/2016	Unvalidated									
WN001 1.3	Executive Quality Portfolios to be revised and strengthened with the three Clinical Executives forming a 'Quality Team'	30/06/2016	Complete									
WN001 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	31/05/2016	On Track									
		30/11/2016	On Track									
WN001 1.5	New Divisional Quality Performance Reporting framework to be launched and embedded across the organisation to ensure Ward to Board quality performance reporting and escalation of concerns, including 'hotspot' reporting	31/07/2016	Complete									
WN001 1.6	Risk Management Policy to be reviewed (including Risk Appetite Statement)	31/08/2016	Not on Track									
WN002 2.1	The Trust will review and redesign the Trust Infrastructure Group (TIG) decision making framework to ensure Quality Impact Assessment and Risk mitigation is a core element of prioritisation of capital bids.	30/06/2016	Complete									
WN002 2.2	New process to be designed and fully implemented to ensure delays to any estates work linked to patient safety are escalated to both TIG and Trust Executive Group. This will include a monthly 'capital status report' to the Trust Executive group	31/05/2016	Complete									
WN002 2.3	Develop a strategic 3 year capital programme to ensure appropriate short/medium/long term planning	31/03/2017	On Track									
WN002 2.4	Each MH/LD/OPMH inpatient unit will have its own site-specific environmental and estate work plan.	30/06/2016	Complete									
WN002 2.5	Estates team to produce and install standardised displays of capital plans for each site	31/07/2016	Complete									
WN002 2.6	The previous Task and Finish ligature group terms of reference and purpose will be reviewed and a new Trust Ligature Management Group will be formed. Membership will be reviewed and strengthened with increased clinical membership, including the appointment of a senior clinical co-chair with estates.	28/02/2016	Complete									
WN002 2.7	The Trust ligature risk assessment tool will be redesigned away from using 'the Manchester Tool', to using industry agreed risk assessment methodology (5x5)	30/04/2016	Complete									
WN002 2.8	An annual ligature risk assessment programme will be rolled out	30/06/2016	Complete									
WN002 2.9	The Ligature Management Policy will be updated to ensure the new risk assessment process is clearly documented	30/06/2016	Complete									
WN002 2.10	Appoint a dedicated full time Trust clinical ligature project manager	01/03/2016	Complete									
WN002 2.11	Improve the robustness of the Site-specific security management reviews.	31/08/2016	Unvalidated									
WN002 2.12	Install anti-climb guttering at Melbury Lodge to reduce the risk of service users accessing the roof and garden fencing. During the undertaking of the works, security will be enhanced in the garden area, staffing levels will be increased, risk assessments and admission criteria will be reviewed.	11/05/2016	Complete									

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WN 3.1	3.1 The Trust approach to thematic review will be more systematic and robust.	30/06/2016	Complete									
WN 3.2	The Quality, Improvement and Development Forum (QID) will receive assurance reports regarding the mitigation of risks associated with the environment.	31/07/2016	Unvalidated									
WN 3.3	3.3 Existing team dashboards will be further enhanced to align them to the Trut's approach to team-level objective setting via the navigational maps.	31/03/2017	On Track									
WN 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	31/12/2016	On Track									
WN 3.5	Team Quality Improvement plans will be in place for every team across the Organisation by the end 2016	31/12/2016	On Track									
WN 4	The Trust will deliver the Mortality and SIRI action plan in full and to time											
WN 4.1	Amend Mortality reporting process to ensure all Learning Disability and Adult Mental Health inpatient deaths are reported as SIRIs and undergo full Root Cause Analysis	30/06/2016	Complete									
WN 4.2	All Root Cause Analysis Investigations that are not SIRIs (excluding pressure ulcers) will go through the same processes as SIRIs	30/06/2016	Complete									
WN 4.3	IMA audit tool will be amended to ensure it includes adequate checks against RiO	31/05/2016	Complete									
WN 4.4	The Trust will commission an external review of the experiences of family members in the investigation process to provide recommendations on how this can be improved.	30/09/2016	Not on Track									
WN 4.5	The Trust will appoint a Trust Patient Experience Lead	30/06/2016	Complete									
WN 4.6	CAS system to be used to disseminate learning from SIRIs where corporate panel has grade these as level 4 or 5	30/05/2016	Complete									
WN 4.7	The Organisational learning strategy will be reviewed and updated	31/08/2016	Not on Track									
WN 4.8	Where corporate panels grade incidents as 4 or 5, a follow-up panel structure will be put in place to gain assurance re competion of action plans.	31/08/2016	Complete									
WN 4.9	All SIRI investigation reports to include as standard a TOR 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.	31/08/2016	Unvalidated									
WN 4.10	The Trust will upskill frontline staff in quality improvement methodologies using the existing Team Viral programme to support this	31/03/2017	On Track									
WN 5.1	Medical Director will review Associate Medical Director appointments and Roles and clarify the role of the Clinical Director with Divisional Directors to ensure consistency	31/07/2016	Complete									
WN 5.2	A structured leadership visibility programme will be introduced to inlcude executive safety walkabouts, 'Back to the Floor' programme etc.	31/07/2016	Complete									
WN 5.3	Undertake a review of the Trust's staff engagement strategy	30/09/2016	Not on Track									
WN 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	31/10/2016	On Track									

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	See action in 5 above											
WN 6.1	Ensure frontline staff are fully engaged in the Trust's Training Needs Analysis process	31/10/2016	On Track									
WN 6.2	Conduct a staff survey to include a question that evaluates whether staff feel that their appraisal and/or revalidation process has adequately addressed their training needs	30/09/2016	Not on Track									
WN 6.3	A review of the current supervision policy and procedures to be undertaken to ensure they are fit for purpose and updated as necessary.	30/09/2016	Complete									
	MUST DO ACTIONS											
MD 7.1	Interim action: Update AMHT/CMHT SOP to limit the places on RiO where risk information is entered. (Risk Assessment module and the latest consultant letter only)	30/06/2016	Complete									
MD 7.2	Task & Finish Group to: review the functionality of the existing RiO risk assessment tool and determine the improvements required	30/09/2016	Unvalidated									
MD 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	30/09/16 (TBC)	On Track									
MD 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	31/12/2016	On Track									
MD 8.1	Interim action: All multi-disciplinary team meetings to include discussion of patients who DNA as a standard agenda item.	31/05/2016	Complete									
MD 8.2	Administration of MDT meetings to be changed in order that discussions about patients who DNA and the plans that are agreed as a result are entered onto the individual patient's RiO record rather than in the MDT minutes	31/07/2016	Complete									
MD 8.3	Revise the CMHT and AMHT Standard Operating Procedure to reflect the requirement for teams to discuss people who DNA at the MDT meetings	30/06/2016	Complete									
MD 8.4	Complete the review of the current Clinical Disengagement Policy and make any necessary improvements to it.	30/09/2016	Unvalidated									
MD 8.5	Launch revised Clinical Disengagement policy including headlining it at AMH Learning Network event	31/10/2016	On Track									
MD 9.1	Interim action: Put plans in place to ensure Consultant Psychiatrist on-call or senior registrar on-call	31/05/2016	Complete									
MD 9.2	Carry out a review of all episodes of seclusion in AMH, specialised services and LD from Dec 2015 - April 2016 to determine how many episodes of seclusion were not reviewed within the first hour by the on-call doctors out of hours	31/07/2016	Complete									
MD 9.3	Use results of audit to feed into Trust-wide review of junior medical on-call	31/08/2016	Not on track									
MD 10.1	Develop a clear process for identifying and prioritising environmental risks across AMH services that includes the process for escalation and governance responsibilities.	31/05/2016	Complete									
MD 11.1	Domed mirrors to be installed on Kingsley Ward, Melbury Lodge to improve the sight lines	31/05/2016	Complete									
MD 12.1	Vistamatic windows to be installed on all 25 bedroom doors, Resource Room and Family Room	30/04/2016	Complete									
MD 13.1	Amend Hamtun seclusion room plans taking into account MHA Code of Practice and additional suggestions made by CQC	31/05/2016	Complete									
MD 13.2	PFI partners to provide costings for new design and issue tender	30/06/2016	Complete									
MD 13.3	External contractor to carry out building works of new seclusion room (Antelope)	30/10/2016	On Track									

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MD 13.4	Interim action: Screen to be used as an interim measure, when the seclusion room is in use, to protect privacy and dignity of patients	15/04/2016	Complete									
MD 14.1	Medicines Management team to re-issue advice re action to be taken if outside of safe range.	31/05/2016	Complete									
MD 14.2	Fridge temperature monitoring template to be reviewed and re-issued so as to assure standardisation across the trust	30/06/2016	Complete									
MD 14.3	Survey of the maximum temperatures reached in all inpatient dispensing rooms where medicines are stored to be carried out and solutions to be sought to ensure temperatures remain within the recommended limits Action superseded	30/06/2016	Complete									
MD 15.1	Introduce immediate safeguards to ensure patient safety	31/03/2016	Complete									
MD 15.2	Engage and consult effectively with the patient group around further changes being made to reduce the risk from ligature points.	31/05/2016	Complete									
MD 15.3	Schedule of bedroom works to be completed by external contractors	30/07/2016	Unvalidated									
MD 15.4	Once structural bedroom works are completed, install new ligature-free beds and wardrobes.	31/07/2016	Complete									
MD 16.1	Address outstanding ligature points in garden as highlighted by CQC	30/05/2016	Complete									
MD 17.1	Identify gaps in essential resuscitation equipment and purchase any necessary additional equipment	31/05/2016	Complete									
MD 17.2	Remove staff lockers currently within clinic room	31/05/2016	Complete									
MD 17.3	Purchase clinic room treatment chair	30/06/2016	Complete									
MD 18.1	Review all staff training records to ensure compliance with statutory and mandatory training and seek staff views as to additional training they feel is required.	30/06/2016	Complete									
MD 18.2	Liaise with LEaD to establish how best to meet identified training needs on an ongoing basis and ensure all staff are booked onto required courses.	30/06/2016	Complete									
MD 19.1	The protocol will be re-visited with all appropriate staff through discussion in team meetings. Reference to the protocol will be included in local induction checklists.	31/05/2016	Complete									
MD 19.2	Posters to be created and placed in each room with a bath	31/05/2016	Complete									
MD 20.1	Add standing agenda item regarding learning from incidents to local quality and governance meetings.	30/06/2016	Complete									
MD 21.1	Roll out a programme of regular supervision in Evenlode and the Ridgeway Centre ensuring that by end June 2016, all clinical staff have had a clinical supervision session and there is a clear schedule for future supervision in place.	30/06/2016	Complete									
MD 22.1	Install curtains in patient bedroom (RWC)	30/05/2016	Complete									
MD 22.2	Seek options (from various specialist resources / national standards) for door observation panels that do not compromise privacy and dignity (Evenlode)	30/06/2016	Complete									
	SHOULD DO ACTIONS											
SD 23.1	Undertake a thematic peer review of the complete complaints management process involving staff and complainants to review the process in practice and make recommendations for improvements	30/06/2016	Complete									

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SD 23.2	Review complaint policy and procedure to ensure that they are aligned with national best practice guidance and incorporate recommendations from the thematic peer review	31/07/2016	Complete									
SD 24.1	Enhance the reports submitted to Quality & Safety Committee and the Exec Board Report to include: - evidence of specific learning and service improvement as a result of complaints - case trend analysis related to areas, services and staff groups - evaluation of quality of complaint response letters (6 monthly)	30/06/2016	Complete									
SD 25.1	Launch revised Clinical Disengagement policy including headlining it at AMH Learning Network event	31/05/2016	Complete									
SD 25.2	AMH specific clinical supervision template to be designed	30/06/2016	Complete									
SD 25.3	All Soton community staff to have had first supervision session and planned schedule of supervision sessions in place	31/07/2016	Complete									
SD 26.1	Consultant psychiatrists and ward managers to ensure that all patients have advanced statements	30/06/2016	Complete									
SD 26.2	Template of CPA meeting to be changed to ensure wishes of young people are formally capture red.	31/05/2016	Complete									
SD 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	31/12/2016	On Track									
SD 27.1	Remind all clinical staff of the risks associated with using Rapid Tranquilisation intramuscular medication and the benefits of the Track and Trigger tool	31/05/2016	Complete									
SD 27.2	Ensure reference to Track and Trigger Tool is included on local induction checklist for agency staff.	30/06/2016	Complete									
SD 27.3	Carry out an audit of compliance with the Track and Trigger tool from March-May 2016 to determine scale of compliance issues and allow better targeted future interventions aimed at increasing compliance with its use.	31/07/2016	Unvalidated									
SD 28.1	Develop a Trust position statement that sets out the principles staff should work to with regards to restrictive practice.	31/07/2016	Complete									
SD 28.2	Review the restrictive interventions policy, in line with the position statement and address any identified gaps	31/07/2016	Not on Track									
SD 28.3	Review the training programme, in line with the new restrictive interventions policy, and produce a paper with recommendations for future training	31/07/2016	Unvalidated									
SD 28.4	Implement the changes to the training programme and roll-out to relevant staff groups	31/07/2016 (TBC)	On Track									
SD 28.5	Ulysses to be updated and staff to record the duration of each type of restraint as part of the incident reporting processes.	31/07/16	Complete									
SD 29.1	Staff to be trained in assessing and recording of capacity and consent as part of their local induction (open to all staff).	31/07/2016	Complete									
SD 30.1	Design seclusion flow chart	30/06/2016	Complete									
SD 30.2	Review Trust seclusion documentation to ensure it is as simple as it can be for staff to complete.	30/06/2016	Complete									
SD 30.3	Carry out a scoping exercise to look at the possibility of moving seclusion paperwork to RiO	31/12/2016	On Track									
SD 31	See action 28 above.											

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SD 32.1	New emergency bags to be ordered and placed on each ward.	10/06/2016	Complete											
SD 33.1	The Ward round proforma which is copied to each patient's RiO record will be amended and standardised for all inpatient units	30/06/2016	Complete											
SD 34.1	Supervision template to be amended to include requirement for care plans to be reviewed.	31/07/2016	Complete											
SD 35.1	Ensure staff establishment is met with Trust recruitment processes being followed.	31/05/2016	Complete											
SD 36.1	Establish programme of patient meetings that include planned changes within service.	30/06/2016	Complete											
SD 36.2	Extra-ordinary Meetings to be held if changes need to be made rapidly.	30/06/2016	Complete											
SD 36.3	Meetings minuted and copies of minutes available for patients to access.	30/06/2016	Complete											
SD 37.1	OT to consult with Patient group to discuss and understand their needs and preferences	30/06/2016	Complete											
SD 37.2	OT to develop activity programme that meets people's needs and wishes and is linked to their goal setting to promote discharge	30/06/2016	Complete											
SD 38.1	Ensure regular communications to the team either by letter, email or face to face to keep them up to date with future plans regarding the Evenlode service.	30/06/2016	Complete											