Appendix 7(a)

1.0 INTRODUCTION

1.1 The Care Quality Commission (CQC) inspected the Trust in January and February 2018; which was preceded by the annual provider information request in the summer of 2017. The Trust received the draft reports in April 2018 with publication in May 2018. The Trust submitted factual accuracy challenges which resulted in minor changes.

1.2 The Head of Communications and Associate Director of Safety and Quality Governance have enacted the communications and engagement plan agreed by Board including briefings for staff, commissioners and stakeholders.

1.3 For context, the CQC inspected five "core services" (their mechanism for grouping services) as part of their continual inspection process. Where services did not receive an inspection, the previous ratings remain in effect.

- acute wards for adults of working age and psychiatric intensive care units
- forensic inpatient / secure wards
- child and adolescent mental health wards
- mental health crisis services and health based places of safety
- community health inpatient services

The Trust provides the following 10 core services which the CQC did not inspect:

- community-based mental health services for adults of working age
- wards for older people with mental health problems
- community-based mental health services for older people
- specialist community mental health services for children and young people
- community mental health services for people with a learning disability or autism
- community health services for adults
- community health (sexual services)
- community health services for children, young people and families
- learning disability supported living
- community dental services

In addition, the Trust at the time provided offender healthcare services.

2.0 DEVELOPMENT AND DELIVERY OF THE ACTION PLAN

2.1 As previously agreed by the Executive Directors Group and Trust Board, the Associate Director of Safety and Quality Governance led the development of the action plan. The following arrangements for action plan development formed part of that that overall process:

- The Quality Governance Department identified, from all reports, the Must Do and Should Do requirements identified by the CQC and further identified all possible improvement opportunities mentioned throughout the reports. The CQC issued 22 'Must Do' requirements and 23 'Should Do' issues. These are included in Appendix 1.

- Each requirement or improvement opportunity has an identified outcome measure, centrally developed by the Quality Governance Department that meets the intention of the CQC.

- The Mental Health Network developed actions to meet the requirement/improvement and outcome measure. Each action includes milestones where the action has a long delivery timeframe.

- Where an action links to existing work (such as the wider Mental Health Improvement plan) then the link has been made to avoid duplication of effort.

- Any actions not fully achieved through to completion in the 2017 CQC Inspection have been incorporated into the 2018 action plan and / or transformation and strategic plans as appropriate to the issue.

- Each action has an action lead, action owner and an executive lead – the action owner will be the director level position responsible for the service if they are not already the action lead (i.e. Clinical Director/Head of Operations)

- The actions put forward were scrutinised by the Quality Governance Department. The final action plan was presented to the Executive Directors Group for approval in June 2018, then submitted to the CQC on the 29 June 2018.

2.2 The Quality Summit was held in July 2018, chaired by NHS Improvement.

2.3 Actions that have been completed have been set to 30 June 2018 as target completion date – some actions will have been completed sooner and these are marked clearly as "Complete" with exact dates and evidence to be uploaded to the action tracking system.

2.4 As part of the action planning process, consideration was given to the minimum standard expected for compliance with Trust mandatory training, appraisal and supervision standards. The Senior Leadership Team agreed to set the minimum standard of 80% for all three areas.

2.5 Attached to this report is the summary action plan outlining key actions against the requirements. The full action plan is available.

3.0 MONITORING OF THE ACTION PLAN

3.1 As previously agreed by the Executive Directors Group and Trust Board, the Quality and Safety Department leads the assurance mechanism to ensure delivery of the actions. The following arrangements for action plan monitoring form part of that that overall process:

- All actions were added to the Datix action tracking function by mid-July 2018

- Live dashboards are now available to monitor progress in real-time

- Action completion involves the action owner submitting evidence, that is validated by the Quality Governance Department and approved by the executive lead.

- Monthly reporting is in place to the Quality and Safety Sub-committee, Business Development and Delivery Sub-committee and People Sub-committee, with bi-monthly reporting to the Quality Committee (and through that reporting to Trust Board).

3.2 Any actions moving "overdue" or identified as "at risk" of delivery triggers a summit meeting with the Executive Director of Nursing and Quality, Associate Director of Safety and Quality Governance along with the action lead, action owner and executive lead. The outcome of this is then reported through to the appropriate sub-committee with immediate escalation to the Executive Director Group if needed.

3.3 The CQC is kept informed of progress through monthly engagement meetings attended by the CQC local inspection team, Executive Director of Nursing and Quality, Associate Director of Safety and Quality Governance and Deputy Director of Nursing (using the same report that is presented to the Quality and Safety Sub-committee).

4.0 DOMAINS AND THEMES

4.1 The requirements and actions have been grouped into a series of domains that group together similar issues. Each domain has been mapped to an executive lead and a relevant sub-committee of the Board as follows (with further detail in the summary action plan):

Domain	Executive Lead	Sub-committee
Training	Damian Gallagher	People Sub-committee
Supervision	Damian Gallagher	People Sub-committee
Appraisals	Damian Gallagher	People Sub-committee
Clinical risk	Max Marshall	Quality and Safety Sub-committee
Staffing	Paul Lumsdon	Quality and Safety Sub-committee
Care planning	Paul Lumsdon	Quality and Safety Sub-committee
Safety	Paul Lumsdon	Quality and Safety Sub-committee
Mental health crises pathway	Sue Moore	Business Development and Delivery Sub-committee
Leadership and empowerment	Damian Gallagher	People Sub-committee
Information	Sue Moore	Business Development and Delivery Sub-committee

4.2 As detailed above in 3.1, each executive lead and sub-committee receives a monthly report on progress against the CQC action plan relevant to their domain of responsibility. This focus by domain allows the relevant executive lead and sub-committee to consider any Trust-wide learning or improvement from actions underway (beyond the service directly affected).

4.3 In addition to the grouping by domain, a number of high level themes were identified that are contributing factors to both the issues identified by CQC and the solutions. These themes include:

- Supporting and empowering clinical leaders
- Improving the mental health crisis pathway

4.4 Actions have not been developed against these themes as strategic or transformation plans already exist that align with these (i.e. DTS programmes, People Plan etc.). However it is important to note the impact that improving these areas will have, not just on the CQC requirements but on wider quality improvement. The action plan therefore represents the transactional actions required to make changes in response to the CQC findings, whilst these three themes and the relevant strategies to improve represent the transformation required to sustain the changes and improvements.

5.0 MENTAL HEALTH IMPROVEMENT PLAN (MHIP)

5.1 The MHIP was developed in July 2018 to bring together a number of projects and schemes that were identified as necessary support improvement in the delivery of mental health services across Primary, Community and Acute care. The schemes are identified in the following programmes:

Primary Care Model
A&E
Integrated Front Door
Inpatient Flow
Discharge
Recovery

5.2 The Mental Health Improvement Oversight Group is Chaired by the Director of Operations and works to align the schemes Any issues or risks that cannot be managed by this group are escalated through the highlight report. The steering group is supported by a task and finish group in each locality that is chaired by the Care Group Manager.

5.3 Discussions are underway to develop a steering group to oversee the Inpatient Flow and discharge schemes. This group will coordinate the schemes identified and ensure close alignment and forward planning.

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 The Committee is asked to note this report.

APPENDIX 1 – CQC Must Do and Should Do Requirements (relating to Adult Mental Health Services)

Action the trust must take to improve:

Trust wide:

- The trust must ensure that staff receive the required training for their role.
- The trust must ensure that staff receive supervision in line with trust policy. Effective systems must be in place to evidence compliance.
- The trust must ensure that staff receive appraisals in line with trust policy.

Acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that patients are monitored appropriately following the administration of rapid tranquilisation.
- The trust must ensure staff are compliant with essential training requirements.
- The trust must ensure staff receive supervision and that this is accurately recorded.
- The trust must ensure staff receive an annual appraisal and that this is accurately recorded.

Mental health crisis services and health-based places of safety:

- The trust must ensure that patients are not held in the 136 suites for longer than 24 hours, in accordance with the Mental Health Act.
- The trust must ensure that patients in the crisis support unit/mental health decision units are comfortable, and have their privacy and dignity maintained.
- The trust must ensure that it has robust governance structures in place, so that it can provide a definitive list of its teams and their function within this core service; and information in relation to the teams which includes mandatory training and supervision.

Action the trust should take to improve:

Acute wards for adults of working age and psychiatric intensive care units:

- The trust should ensure ward managers and modern matrons have sufficient capacity to deliver their managerial responsibilities.
- The trust should ensure the smoke free policy is implemented consistently and that staff are supported to achieve this.
- The trust should ensure wards have regular team meetings for staff.
- The trust should ensure there is shared learning between locations and different services within the trust.
- The trust should ensure patients are offered copies of their care plan and that this is recorded.

Mental health crisis services and health based places of safety:

- The trust should ensure that when patients have their capacity assessed, this is clearly and consistently documented.
- The trust should ensure that the section 136 suites are reviewed regularly to ensure they are fit for purpose, and meet the requirements of the Mental Health Act and its code of practice.

- The trust should ensure incidents that occur in the section 136 suites are clearly identifiable, and that this information can be monitored and analysed across all the suites to look for themes or trends, and implement learning from this.
- The trust should ensure that consideration is given to the use of seclusion of people who are not inpatients, but are being held once their section 136 has lapsed.
- The trust should ensure that staffing levels are kept under review, to ensure that suites are adequately staffed but do not deplete the staffing levels on the inpatient wards.
- The trust should ensure that the role of crisis support units or mental health decision units is clear.
- The trust should ensure that the showering facilities in the Preston crisis support unit/mental health decision unit are fit for purpose.