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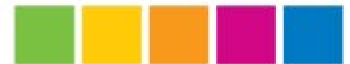
Appendix 1

CQC – Improvement Plan Progress

23 March 2022

Best care by the best people



CQC Must do/ Should do Risks and CQC Improvement plan

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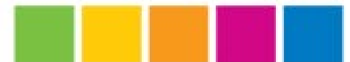
- Following the CQC Well Led inspection in 2019, the Trust progressed an improvement plan in relation to the MUST do actions and SHOULD do actions. In relation to:
- 12 Trust-wide MUST Do's
- 2 Essex & Kent MUST Do's
- 8 Acute and Rehabilitation Directorate

- **22 MUST do risks** and **17 should do risks** were added to the risk register.

The MUST Do and Should do risk progress are fortnightly at the CQC Trust wide oversight meeting.

1 MUST Do risk remains open

5 Should do risks remain open and these have all been added to our CQC Compliance Dashboard which is monitored at our CQC Trust wide Oversight meeting fortnightly.



Improvement plan actions taken in response of Essex & Kent Directorate MUST Do Risks identified

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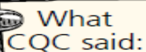
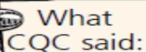


The provider must continue to work to ensure children and young people in Kent have access to treatment within 18 weeks of referral to the service

WHAT WE DID:

- Created a single Neurodevelopment and Learning disability (NDLD) triage administration team based in Single Point of access (SPA) delivering a co-ordinated front of house response to children, young people, and their families
- Implemented a process whereby the main SPA triage all referrals for potential Neurodevelopment and Learning disability cases, requests appropriate additional documentation from the child/young person and family after which a NDLDS clinician reviews all returned documentation to support next steps
- Implemented electronic prescribing in all NDLD clinics
- Increased the number of senior staff that could run clinics to reduce number of children and young people awaiting Autistic Spectrum Conditions
- Extensively cleansed the waiting lists so that appropriate discharge could take place of young people now transitioned to adult services and discharge of those no longer meeting the threshold for this service.
- Ensured that while young people and their families awaited assessment, they receive good communication, signposting and support by completing the 5 by 5 survey with them monthly and acting on feedback.



The provider must ensure that work to improve the Kent single point of access continues. The provider must also ensure that all referrals in Kent are screened in a timely fashion and prioritised for follow up by the correct team

WHAT WE DID:

- Completed a full-service review and implemented a new procedure to ensure all systems and processes are understood by staff
- Monitored the number of referrals for triage daily and employed agency staff to support substantive staff in the week and at weekends to achieve appropriate triage of referrals where risk is identified within 24 hours and routine referrals within 48 hours.

Improvement plan actions taken in response of Essex & Kent Directorate MUST Do Risks identified

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The trust must ensure governance systems are strengthened to provide assurance that services are safe and effective

WHAT WE DID:

- Ensured that the Child and Adolescent Mental Health Service (CAMHS) was embedded trust wide
- Learning cascades in relation to thematic reviews of serious incidents into the suicides of young people was developed and cascaded to all staff working in Specialist Community MHS services for CYP.

The provider must ensure that staff complete Intermediate Life support mandatory (ILS) training

WHAT WE DID:

- Directorate Assistant Medical Directors review ILS training figures monthly and follow up directly with the member of staff to ensure training is either in date or a confirmed training date has been booked.

Must Do Risks 2098 – The provider must take steps to ensure children and young people in Kent have access to treatment within 18 weeks of referral to the service.

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- Actions being implemented in the coming months:

- Funding for additional medical staff has been secured from April 2022.
- The overall model is being transformed via a phased mobilisation plan. Young people on the waiting list for the ADHD pathways and young people already in receipt of treatment will move from the central team into the locality teams. The South Kent team will be the pilot team for this transformation. The locality team will carry out assessment, review, treatment, and prescriptions which will enable young people to have care closer to home. The locality team will have additional staffing resource, including a consultant pharmacist to support prescriptions and oversee the safety aspect of medication management. If successful, this model will be rolled out to other locality teams throughout the coming year.
- Wider system work is planned with Care Navigators within the Primary Care Networks who will work with families to look at additional support needed.

- CQC has been kept informed through reporting and updates at the CQC Oversight group meeting.

Improvement plan actions taken in response of Acute and Rehabilitation Directorate MUST Do Risks identified for MH Acute wards of working age adults and PICU

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The Trust must ensure post-dose physical health monitoring takes place after patients have received medication by rapid tranquilisation in line with the trust's rapid tranquilisation policy.

WHAT WE DID:

- Senior oversight of all rapid tranquilisation on a weekly basis
- Carried out quarterly audits of Physical Health Monitoring post rapid tranquilisation
- Review of the rapid tranquilisation policy post audit
- Supported staff with training.

The Trust must ensure that all MH inpatient staff complete mandatory training in the prevention and management of violence and aggression.

WHAT WE DID:

- Ensured each ward met a training compliance rate of 85% for prevention and management of violence and aggression training through monthly monitoring and reporting to the leadership team.

The Trust must work to address the concerns raised by junior doctors to ensure a good working relationship and safe.

WHAT WE DID:

- Junior doctors' concerns are heard and acted upon at a Junior Doctors Forum
- Put in place a procedure to support junior doctors in raising any concerns
- An additional junior doctor is now on call on the twilight shift since July 2019.

The Trust must develop a governance system to effectively monitor the use of restrictive interventions across the wards.

WHAT WE DID:

Made a commitment to the health and wellbeing of staff and patients by moving from restrictive interventions to therapeutic engagement by:

- Using technology for the safer monitoring of patients at a distance, introduced the wearing of body cams
- Ensure we seek regular feedback from patients and staff using the 5-question respect approach
- Ensure service users are fully involved in their care planning and risk management plans
- Staff work with patients during community meetings to review any blanket rules in place on the wards.
- Implemented zonal observations, safety huddles and safe ward intervention to support early intervention.

Improvement plan actions taken in response of Acute and Rehabilitation Directorate MUST Do Risks identified for Forensic inpatient/secure wards

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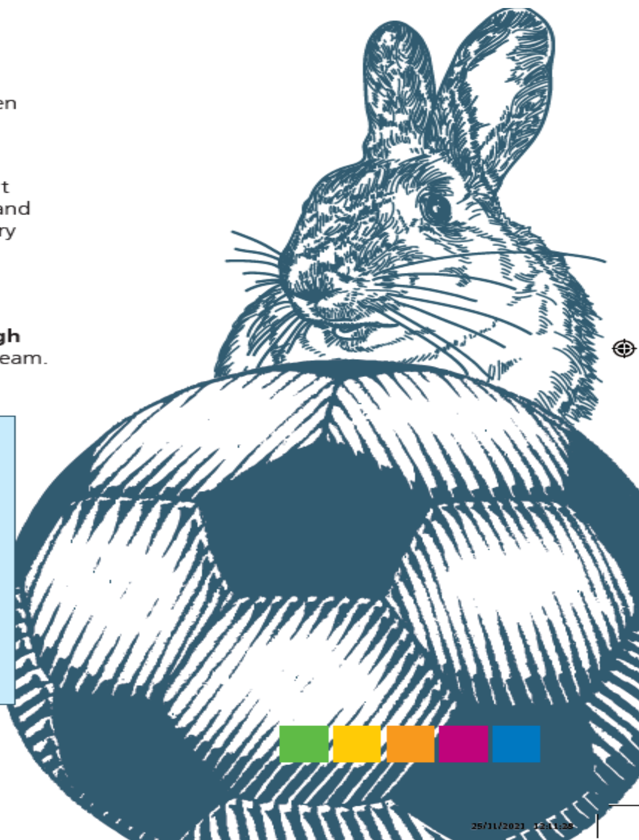
- **Carers** had co-produced with staff an information leaflet about psychosis
- **Innovative plans** to develop and staff a professional kitchen were in hand and capital funding had been applied for
- Since the last inspection the ward had **developed** one its **gardens** to provide an innovative programme where patient looked after a range of small livestock, including **chickens** and **rabbits**. This therapeutic activity supported patient's recovery
- The ward continued to **maintain excellent links** with the **community** and **engaged patients** in a range of activities seven days a week. This included local college attendance, work experience on a farm and attending a '**coping through football programme**' with the local professional football team.

The Trust must develop a governance system to effectively monitor the use of restrictive interventions across the wards.

WHAT WE DID:

- Implemented an individual risk assessment on every patient which included vital sign monitoring, adjustment of level of safe and supportive observation based on physical and mental health risks.
- Call bell system fully implemented throughout the ward.



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Improvement plan actions taken in response of Acute and Rehabilitation Directorate MUST Do Risks identified for Mental health Crisis and Health – based places of safety

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The Trust must ensure that patients attending out of hours at Sunflowers Court for assessment by the acute crisis assessment team (ACAT) or waiting to be admitted to wards after their ACAT assessment, are appropriately supervised and cared for. A policy and procedure to govern this process must be developed.

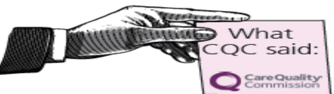
WHAT WE DID:

- Installed CCTV in the main reception area and reception corridors with live feed to ACAT reception
- Carried out a staffing and skill mix review of ACAT undertaken with dedicated out of hours medical cover
- Since Jan 2021 ACAT forms part of the Integrated Crisis Assessment Hub (ICAH) which has a designated area for patients to attend and is used for diversion from Emergency Department, London Ambulance Service and police. This avoids patients coming to Sunflowers Court to be seen. When arriving at the hub patients are with staff throughout their stay
- A standard operating procedure was implemented and all reception staff completed training which included running through scenarios.

The Trust must ensure that effective arrangements are in place for the acute crisis assessment team to work with other professionals and teams, especially medical staff, to ensure patients receive comprehensive assessments and where clinically required an inpatient admission in a timely manner.

WHAT WE DID:

- Enhanced the monitoring of assessment times and outcomes by recording specific information in the Electronic patient record system Rio.
- Ensured leadership attendance at the Junior doctor's forum.
- Designated Consultant Psychiatrist in the team to support assessment and liaison with other professionals as required.



The Trust must ensure that leaders of all levels listen to feedback from staff and take appropriate action to address the safety, risk, and multidisciplinary working issues in the acute crisis assessment team

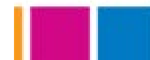
WHAT WE DID:

- Out of hours escalation procedures for clinical and non-clinical escalation were reinforced
- Bite size training was rolled out to all the MHS inpatient wards with pre and post training feedback collated
- Additional incident reporting (Datix) training was provided to medical and nursing staff. Trends and themes are reported weekly.
- Change to Datix trends and themes are identified through the Incident reporting group which meet weekly
- Staff continue to be encouraged to report concerns and patient safety issues through to the Trusts Freedom to Speak Up Guardian (FTSUG) and issues identified are acted upon
- An audit of the daily duty doctor handover was undertaken.

The provider must ensure that all staff complete mandatory training in the prevention and management of violence and aggression.

WHAT WE DID:

- Ensured each ward meet a training compliance rate of 85% for PAMOVA training
- Training report for PAMOVA monitored monthly and reported to Leadership meeting.



Improvement plan actions taken in response of Trust wide MUST Do Risks identified

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The Trust must take steps to ensure the senior executive leadership team work together in a cohesive manner to ensure they work together to address issues that impact on the safety of patients and staff.

WHAT WE DID:

- An independent review of the Executive Management Team was undertaken, this has resulted in the creation of a dedicated chief nurse role and a director of partnerships to build capacity into the nursing directorate and to ensure executive oversight of the Essex and Kent services. An Executive management team development programme was initiated leading to more cohesive and joined up team dynamics. This programme is ongoing.
- A team compact (how the team would work together) was signed by all members of the executive team.

The Trust must ensure that the culture of the trust is improved so that medical staff, particularly in the mental health services, can raise concerns without a blame culture and feel confident that staff will work together to make the necessary changes.

WHAT WE DID:

- Health Education England review undertaken with actions including, ensuring new starters receive shadowing opportunities, ensure there is a clear procedure for how learners raising concerns can receive feedback on actions.
- Implemented actions as a result of the staff survey to include:
  - Roll out of Health and wellbeing initiatives, Increased medical support to HTT's
  - Improved staff confidence in the incident reporting process through guidance, talks and support to staff

The Trust must ensure that staff understand the decision processes within the trust especially the role of the Chief Nurse Group. They must also review the split chief operating officer role

WHAT WE DID:

- Following extensive consultation, a new Governance Structure was put in place. Which helps to articulate how the 'ward to board' approach can be facilitated in our trust
- The Chief Nurses group was removed from the governance structure
- Appointment of Executive Chief Nursing Officer/Executive Director AHP & Psychological Professions to strengthen clinical leadership in the trust
- Appointment of Executive Director of Partnerships

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Improvement plan actions taken in response of Trust wide MUST Do Risks identified

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The Trust must understand that all staff understand lone working practices.

WHAT WE DID:

- A buddy system was implemented in all teams
- Allocated SMART phones to staff who work in front line services
- Implemented a revised lone worker protocol to accompany the policy which can be found on the policy section of the internet under Health and Safety policies.

The Trust must ensure that the systems in place to identify and address risk is robust, consistent, and effective.

WHAT WE DID:

- Ensured all clinical staff undertook Clinical Risk Assessment and Management mandatory training and that training compliance was 85% or above
- Carried out a review of the Risk assessment and clinical harm review process which included implementing a revised risk assessment template in the patient electronic records (Rio).

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Improvement plan actions taken in response of Trust wide MUST Do Risks identified

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The Trust must ensure managers and leaders have access to accurate data to monitor their performance.

WHAT WE DID:

- Implemented a Trust wide performance data system called Power BI which is being rolled out trust wide and is accessible to all staff.

The Trust must ensure safe systems for storing, prescribing, administering and recording medicines.

WHAT WE DID:

- Increased staffing establishment and leadership positions to strengthen the clinical pharmacy service provided and support the wider MDT.
- Increased specialists support within the community, inpatient and crisis pathway services.
- Introduction of the lead medicine safety nurse role to bridge the gap between pharmacy and nursing.
- Deployment of EPMA (WellSky) and Automated Dispensing Cabinets (Omnicell) across all inpatient wards.
- Implemented wireless temperature monitoring across the Trust to provide greater visibility and improved processes for management of temperature breaches in medicine areas.
- The development of a Medicines Safety Training which is being launched as essential to role for all clinical staff
- Ensured closer working with the patient safety team, clinical effectiveness team and service leads to improve communication of safety messages, quality initiatives and shared learning from incidents.
- Improved Medicines Governance, through revised audit programme to support the revised Medicines and Controlled Drugs Policy
- Reviewed all medicines related policies, documents rationalised and new guidance produced where gaps in knowledge and skills were identified.
- A dedicated Pharmacy and Medicines Improvement QI Programme which has delivered a number of improvements.
- Re-tendering of the out-sourced pharmacy supply service and plans to re-locate on site with a view to strengthening service provision and collaborative working.

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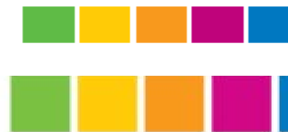

Improvement plan actions taken in response of Trust wide MUST Do Risks identified

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The Trust must ensure staff are appropriately supported to raise concerns.

WHAT WE DID:

- Created an online anonymous form for staff to raise concerns which are then acted upon by the Freedom to Speak up Guardian (FTSU)
- Members of the board and of the operational leadership teams carries out a programme of visits to teams at all locations to listen to the feedback of staff
- Implemented FTSU online training
- Implemented at FTSU strategy
- Continue to promote the FTSU culture with the trust through newsletters, screen savers and regular reports to Board.

The Trust must ensure systems to ensure consistency from learning.

WHAT WE DID:

- Implemented a serious incident twitter page and intranet page
- Refreshed the Trust wide learning strategy that has since been embedded in the Trust Quality and Patient Safety Strategy.
- Established a monthly patient safety and learning meeting, that includes the directorate ADoN for quality and patient safety in it's membership. This enables learning to be shared across all services and teams.
- Carried out a review of the Serious Incident policy
- Commenced quarterly Trust wide learning events to share learning and best practice more widely
- Use screen savers and IT pop ups to update staff on learning information
- Undertook a thematic review of all unexpected deaths over a two-year retrospective process to benchmark against the National Confidential enquiry report into suicides and homicides.
- Created a shared learning desktop icon where staff can access learning cascades and patient safety information
- Recruited to the lead patient safety role that supports learning across the organisation.
- Created the patient safety learning champion role, with representation from all directorates.

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