Leicestershire Partnership NHS
NHS Trust

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REPORT TO THE TRUST BOARD – 26 SEPTEMBER 2013

Title	CQC Compliance review - Bradgate Unit

Executive summary

This report presents the position to date following the Review of Compliance inspection commenced at the Bradgate Mental Health Unit on the 4 July 2013.

The CQC review resulted in Enforcement action in the form of two Warning notices served on 30 July against Essential standards, Outcomes 4 and 6.

The CQC found two areas of major concern and three moderate areas of concern and on 30 July, Leicestershire Partnership Trust was issued with two warning notices with respect to the two major areas of concern, which related to care planning and discharge planning.
http://www.leicspart.nhs.uk/Library/PRCQCresponse30July.pdf

Three further Outcomes were judged as non-compliant resulting in three Compliance actions for Outcome 7, 12 and 16. The inspection report was published on 20 August 2013.

The Trust was given until 30 August to implement changes to return to compliance and ensure the safety and quality of care for service users and an immediate action plan was submitted to the CQC in line with their deadline of 4 September (Appendix 1 attached)

On 29th August a Risk Summit meeting was held with the TDA, Area Team, CCGs, Healthwatch and local authority colleagues, and the outcome of this meeting is shown in Appendix 2 attached)

An Assurance Oversight Group is now in place to ensure that a sustainable Quality Improvement Programme is developed and delivered. This will include input from all key stakeholders, and is the subject of a separate paper on this agenda

On the 9 September the CQC returned to consider whether the unit had returned to compliance following the two Warning notices, and has asked for further information for consideration. At the time of writing this report we have not yet received a formal response on the outcome of the re-inspection but a verbal update on the position will be given at the Board meeting.

Recommendations

The Trust Board is recommended to:

- Receive assurance regarding the actions taken in response to the Warning Notices

- Receive assurance that a Trust action plan has been submitted to the CQC and is under implementation to address the CQC compliance requirements.
- Receive assurance about the ongoing communications and engagement plan with respect to the Trust's response to the CQC report and the involvement of stakeholders in the oversight of actions being taken to achieve sustainable improvements in the quality of care we provide.

Related Trust objectives	We will continuously improve quality, with services shaped from user experience, audit and research.
Risk and assurance	Failing to meet the requirements could affect Trust's statutory duties and impact on continued registration.
Legal implications/ regulatory requirements	Failing to meet the requirements could affect Trust's statutory duties and impact on continued registration.
Evidence for the Quality Governance Framework	All actions referred to in this report provide evidence for all areas of the QGF
Presenter	Adrian Childs, Chief Nurse/Director of Quality
Author(s)	Bal Johal , Head of Quality & Professional Practice Cheryl Davenport, Director of Business Development Satheesh Kumar, Medical Director Paul Miller, Chief Operating Officer
*Disclaimer: This report is submitted for amendment or approval as appropriate. It should not be regarded or published as Trust Policy until it is formally agreed at a Trust Board meeting	

REPORT TO THE TRUST BOARD – 26 September 2013
CQC Compliance review - Bradgate Unit

1. Introduction

1.1 This report presents the position to date following the review of Compliance inspection at the Bradgate Mental Health Unit commencing 4 July 2013 which resulted in Enforcement action for Outcomes 4 and 6. In addition the unit was also judged as non-compliant with three Outcomes resulting in three Compliance actions against Outcomes 7, 14 and 16.

1.2 The inspection report was published on 28 August. Direct link to the CQC report:
http://www.cqc.org.uk/sites/default/files/media/reports/RT5KF_The_Bradgate_Mental_Health_Unit_INS1-711321412_Scheduled_22-08-2013.pdf

For further information about the inspection regime please see the CQC website home page www.cqc.org.uk)

The report and Enforcement notices were shared at the Trust's public Board meeting on Thursday 29 August 2013.

1.3 A robust action plan was sent to the CQC on Wednesday 4 September 2013, and further information requests were met on Friday 6 September 2013.

1.4 The CQC returned to the Bradgate Mental Health Unit on Monday 9 September to review progress against the Enforcement actions. At the time of writing this report the Trust is awaiting a formal response from the CQC which will assess the impact of the changes we have made so far on improving care quality and further inform our regulatory status.

2. Recommendations

2.1 The Trust Board is recommended to:

- Receive assurance regarding the actions taken in response to the Warning Notices
- Receive assurance that a Trust action plan has been submitted to the CQC and is under implementation to address the CQC compliance requirements
- Receive assurance about the ongoing communications and engagement plan with respect to the Trust's response to the CQC report and the involvement of stakeholders in the oversight of sustainable improvements in the quality of care we provide.

3. DISCUSSION

3.1 Review of Compliance inspection at the Bradgate Mental Health Unit (BMHU)

On 4 July the CQC commenced a Review of Compliance inspection at the BMHU, attending for a second day on 17 July 2013. The inspection judged the following Outcomes as non-complaint;

Outcome 4	Care and welfare of people who use services	Warning Notice
Outcome 6	Cooperating with other providers	Warning Notice
Outcome 7	Safeguarding people who use services from abuse	Compliance Action
Outcome 14	Supporting workers	Compliance Action
Outcome 16	Assessing and monitoring the quality of service provision.	Compliance Action

On Monday 9 September 2013 the CQC returned to the unit to review progress against the two Enforcement notices.

Some informal feedback was provided on the day which indicated that:

- There were improvements demonstrated in care records, assessments and discharge planning
- Issues of clarity of information and variability may still be present in some areas
- Some concern about whether there were 'enough' therapeutic activities/ psychological input into the unit
- The inspectors were made to feel welcome, and found very passionate staff that were open and helpful.
- Further information would be required and a potential further visit could be needed

Further information has been provided in line with timescales, but no further visit has been received and a formal response is now awaited.

3.2 Response to CQC Warning Notices

Implementation of the action plan is being led by the Chief Nurse and Medical Director. The progress against actions is monitored three times weekly and shared with Board members.

The Trust was given until 30 August to return to compliance with Outcomes 4 and 6. The areas for immediate action were identified as follows:

- Assessment of care needs
- Care planning standards
- Discharge planning

Key actions achieved since the previous report include:

- The two posts for additional Senior Matrons on a six month fixed term contract have been advertised and recruited to. These posts will champion sustainable change. Matrons continue to provide on-going peer support, working with medical support from the unit to lead the change process and to drive change.

- The process for review and correction of all records is now supported by a robust weekly audit process to provide assurance that improvements are being sustained. This has included publishing progress by ward and to individual staff if necessary. Where required the Lead Nurses have supported staff through clinical supervision.

- On-going senior manager presence on the unit and three times weekly task force meetings take place to communicate key messages for all Ward Matrons at the unit. Implementation of the actions in the CQC action plan and accountabilities for delivery has been shared and will be reviewed weekly.

- Work continues with all staff on the Bradgate Mental Health Unit to support them, identify any skill deficits and provide the required development.

- Further drill down is being undertaken in relation to weekly audits to identify any rationale for non-compliance with expected standards. These results are shared by ward with Trust Board members and the service.

- Refurbishment of the Bradgate reception area to provide a more welcoming environment for patients and visitors

3.3 Publication of the Review of Compliance inspection report

The final Review of Compliance inspection report was received on 28 August 2013. This report has been circulated to Trust Board in the Board Information pack.

Following publication of the final report on the 28 August 2013 the Trust had to submit a robust action plan to the CQC by Wednesday 4 September 2013, which focussed on the high priority items to be addressed.

This was received at Quality Assurance Committee and is attached at Appendix 1

3.4 Communication and Engagement Activities

Since the last Trust Board report, the Trust has continued with the programme of actions as planned.

This has included attending all three local authority scrutiny committees in September, engagement sessions with patient representatives, a meeting between the Trust's Chairman and Local Healthwatch representatives and a meeting with voluntary and community sector groups representing mental health service users, their carers, families, advocates and communities.

The Trust's AGM and Legacy Towers event on September 7th provided a further opportunity to address questions and concerns from local people.

In all these activities the Trust has continued to be open and transparent and engage in honest dialogue with all stakeholders, sharing information and responding to detailed questions, following up actions as required.

Our programme of internal communications with staff continues via team briefings/meetings, Listening into Action, our clinical leadership routes, and routine communications such as enews.

3.5 Risk Summit Outcome and Assurance Oversight Group

At the Trust Board meeting on 29 August we reported that on that same day the Trust would be attending a risk summit where local agencies and regulators from the health and care sector met with the Trust to share their concerns about care quality and agree next steps.

A statement summarising the outcome of the Risk Summit is given at appendix A of this paper.

Following the completion of the immediate 30 day action plan in response to the CQC warning notices by the end of August, it is recognised that the Trust has now moved into a second phase of development to improve and sustain the quality of care in the medium to longer term including cultural change.

The forward plan for the Trust comprises 4 key areas which incorporate the outcome of the risk summit:

- Participating in the Assurance Oversight Group
- Developing and implementing a comprehensive quality improvement plan to which the Trust Board will be held accountable by the Assurance Oversight Group (see separate report on this agenda on this process)
- Setting in place an operational situation report (SITREP) for commissioners which provides daily/weekly assurance on staffing/bed occupancy and other operational metrics to assure the safety and quality of care at the Bradgate Unit .This is still being developed but details of the information being collated is attached at Appendix 3 to illustrate the metrics now being monitored on a daily basis
- Further collaborative work on the pathway for mental health service users between the acute and community settings of care including

assessing alternatives to admission and re-assessing local bed capacity in light of demand.

The Assurance Oversight Group comprises representatives from local Healthwatch, the Trust Development Authority, local clinical commissioning groups, and a representative from voluntary and community sector organisations representing the interests and views of mental health service users is also being arranged. Attendees are invited from LPT to participate in the oversight group meetings.

The Quality Improvement Programme which is the main focus of the Assurance Oversight Group is presented as a separate agenda item in its own right at this Trust Board meeting, as this process will reach throughout the whole organisation

4.0 Conclusion

Following the CQC review, the initial actions and improvements have been implemented, and the wider, medium term quality improvement plan is now developed.

Regular monitoring arrangements have been established to monitor progress against actions and assure improvements both internally within the Trust and through the work of the Assurance Oversight Group.
The Trust continues a proactive, open and transparent dialogue with all stakeholders and our staff as we continue to address these issues and change the culture of the organisation.

APPENDICES

Appendix 1 CQC action plan
Appendix 2 TDA risk summit
Appendix 3 SITREP framework

Appendix 1
The Final Bradgate Mental Health Unit action plan.

BRADGATE MENTAL HEALTH UNIT
CQC Review of Compliance, FINAL Trust Action Plan

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
Outcome 4: Care and welfare of people who use services – Enforcement Action					
You are failing to take proper steps to ensure that care records contain appropriate care plans to meet the needs of the patients in your care and ensure they are receiving care that is appropriate and safe. You are failing to plan and deliver care that meets the needs of people who are at risk of physical health conditions. Care	**1. We will enhance leadership roles in the unit** (a) A task force has been established to lead a programme of change to address the findings. The task force meet three times weekly, led by the Chief Nurse, monitored by the Trust Board weekly.	Chief Nurse/ Deputy Chief Nurse	N/A	Minutes of meetings	Complete
	(b) Two Matrons* supported by two Consultants are providing peer support to all Ward Matrons on the acute wards to drive team and individual staff improvements.	Chief Nurse	Funding resource for two senior matrons at Band 8a- confirmed	Matrons in post Consultants identified	Complete

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
planning does not meet the individual needs of the service users and ensure their welfare and safety.	(c) Executive team members are present in the unit daily throughout August to provide direction and reinforce key messages.	Chief Nurse/MD	N/A	Attendance at unit. Visit planners.	Complete
	(d) We will recruit 2 senior matron posts* for a period of 6 months to support matrons in embedding changes to practice and ensure consistency in care planning across the unit.	Chief Nurse/ Deputy Chief Nurse	Band 8a x2 WTE Confirmed	Matrons in post	Interview date 6 September
	2. We will review 100% of patient records across all acute wards to ensure that care plans meet the needs of our service users (a) A three week audit programme has been agreed to review and update 100% of patient records across all acute wards. The standards to be audited cover: 1. Assessment of need and risk	Senior matrons identified above*	Additional 5 staff per shift to provide additional support. Continued	Audit records being fed back to the wards and individual staff	Complete

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	2. Care planning and evaluation 3. Discharge planning 4. Patient Involvement and information		recruitment to band 5 and ward clerk posts - Confirmed	Results from the audit programme	
	(b) Results will be fed back to wards and named nurses to ensure that standards are consistently maintained across the unit.	Senior matrons identified above*	Clinical Audit team resources - Confirmed	A 'Key messages' tool has been distributed to all staff following the results of the first audit	Complete
	3. We will strengthen arrangements for the management of physical health needs (a) We will establish an immediate Task and Finish group to evaluate the effectiveness of admission paperwork to ensure it is adequately screening for physical health needs to include; chronic health diseases and undiagnosed/emerging physical health	Senior matrons identified above*	Staffing resource of time - Confirmed	Assurance that the paperwork is fit for purpose or alternative paperwork introduced. Audit results will provide confirmation	Sep 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	needs.				
	(b) Recruitment of RGN at Band 7 to physical health nurse post to support the unit	Inpatient Lead	Resources for post at Band 7 - Confirmed	Post recruited to	To be advertised Sept 2013
	(c) Standardised MDT meeting recording documentation developed and implemented	Inpatient Service Manager		Documentation in place	Complete
	(d) Implement Early Warning Scoring (EWS) tool and associated training	Inpatient Lead	Staff time for training - Confirmed	EWS in use	Nov 2013
	4. We will launch a new patient Case note file across the unit to ensure ease of use for all members of the multi-disciplinary team (a) A new case note structure has been piloted and shall be rolled out - ward by ward to ensure that a unified and consistent case note supports patient care. This will be used for all new	Inpatient service manager/ Health care records manager/ AMH Lead Nurse	Funding new case note structure - Confirmed	New records in place	Scheduled to commence 30 Sept 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	admissions from 30 September 2013				

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
Outcome 6: Cooperating with other providers - Enforcement Action					
You are failing to take proper steps to ensure that suitable arrangements to protect, health, welfare and safety of patients are shared with or transferred to the appropriate people in order to ensure safe discharge. Discharge plans do not indicate to staff what arrangements are in place nor do they contain patients agreements to plans made. This means that patients do not always benefit from a safe, personalised and	**1. We will review 100% of patient records across all acute wards to ensure that care plans meet the needs of our service users** (a) A three week audit programme has been agreed to review and update 100% of patient records across all acute wards. The standards to be audited cover: 1. Assessment of need and risk 2. Care planning and evaluation 3. Discharge planning 4. Patient Involvement and information	The 2 Senior matrons identified above* and Ward Matrons	Band 8a x2 WTE Confirmed	Audit Reports	Complete
	(b) Results will be fed back to wards and named nurses to ensure that standards are consistently maintained across the unit.	The 2 Senior matrons identified above* and Ward Matrons	N/A	A 'Key messages' tool has been distributed to all staff following the results of the first audit.	Complete

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
coordinate service.	**2. We will launch a new Case note file across the unit to ensure ease of use for all members of the multi-disciplinary team all MDT staff** (a) A new case note structure has been piloted and shall be rolled out ward by ward to ensure that a unified and consistent case note supports patient care. This will be used for all new admissions from 30 September 2013	Inpatient Service Manager/ Health care records MH Lead Nurse Inpatient service manager	Resource confirmed Files delivered.	Documentation in place	Roll out commences Sept 2013
	(b) New Discharge care plan devised and implemented	Inpatient service manager/ Access Clinical Directors	N/A	Documentation in place	Complete
	(c) Standardised MDT meeting recording documentation developed and implemented. Care plans reviewed at weekly reviews	Inpatient service manager/ Access Clinical Directors	N/A	MDT Notes	Complete

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	(d) Twice weekly discharge planning meetings, attended by Social Care.	Inpatient service manager/ Access Clinical Directors	Staff time	Meeting Notes	Sept 2013
	(e) Any complex needs or other obstacles to discharge escalated to Social Care managers, including liaising with housing options.	Inpatient service manager/ Access Clinical Directors	N/A	Patient Records Record of escalation	Sept 2013
	(f) Use of the Bed Management team to support discharge processes	Inpatient service manager/ Access Clinical Directors	N/A	Meeting notes	Sept 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	(g) Liaison with Social Care In reach Team	Inpatient service manager/ Access Clinical Directors	N/A	Records of liaison	Sept 2013
	(h) Monthly reporting to Commissioners on DTOC	Inpatient service manager/ Access Clinical Directors	N/A	Monthly report	Sept 2013
	3. We will ensure patients can make secure phone calls and are aware of their access to advocates (a) Additional signage over public telephones clarifying that Office mobile phones are available for patient use	Head of Access Inpatient Service	Resource confirmed	Signs in place	Complete
	(b) Reception area phone to be fitted with a privacy hood	COO	Estates costs	In place	Sept 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	(c) IMHA and Informal patient information leaflets sent out.	Manager MHA Office Manager	Printing costs	Leaflets on the Wards	Sept 2013
	(d) Advocacy needs to be reviewed in ward rounds	Deputy Medical Director	N/A	MDT notes	Sept 2013
	(e) Scrolling TV screens in place on all wards and reception area to update patients on key information.	COO	Estates costs - Confirmed	In place	Oct 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
Outcome 7: Safeguarding people who use services from abuse - Compliance Action					
The provider must make suitable arrangements to ensure that people are safeguarded against the risk of abuse and harm 11.(1) In particular: *The recording of seclusion events and the poor practice that was seen to be documented in records.*	**1. We will complete a professional and environmental check of seclusion facilities following every seclusion episode.** (a) Following every seclusion episode the Ward Matron will complete a review of the seclusion record. This will include an interview with the service user who has been secluded including a spot check of the seclusion room environment to ensure it is clean and tidy.	Ward Matrons & Inpatient Lead	Staff time	Completed forms Minutes of matron meetings	In place Sept 2013
	(b) We will communicate this responsibility to all qualified nurses	Ward Matrons	N/A	Team meeting notes and Ward Matron Meeting Notes	Sept 2013
	(c) Any breach of the seclusion policy to be reported on eIRF and included in incidents monitored by the seclusion group	Inpatient Service Manager	N/A	Minutes of matron meetings/analysis of incident report	Sept 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	(d) The senior team will undertake an immediate review of all seclusion rooms to ensure all en suite facilities are available for use. Where facilities are not of the required standard alternative arrangements will be put in place until the environmental issues are resolved.	COO	Staff time	Seclusion report Mitigating actions	Sept 2013
	(e) A plan will be agreed to instigate building work to agreed timescales to ensure all seclusion rooms meet the required standards	COO	N/A	Plan agreed by Exec Team and documented	Oct 2013
	(f) A report will support monitoring of the outcomes from the Seclusion review records to inform the Seclusion monitoring group. This will monitor timeliness of medical review, length of seclusion, and environmental checks.	In Patient Lead	N/A	Governance reports to divisional governance group	Sept 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	(g)The seclusion group will review its TOR and functions including membership and reports to effectively monitor seclusion practice through qualitative interrogation of monthly seclusion reporting. The revised group will be chaired by the Medical Director	Senior consultant for HPU	N/A	Revised TOR, minutes of meetings Seclusion audit to be undertaken	Oct 2013 Nov 2013
	(h) Replace flooring on Aston ward	COO	Resource confirmed	Flooring in place	Complete

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
Outcome 14: Supporting workers – Compliance Action					
The provider must have suitable arrangements in place in order to ensure that staff employed are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people safely and to an appropriate standard, including by receiving appropriate training. 23 (1) *(a)Specifically:* *The checking and searching training being available to staff, equality and diversity*	**1. We will ensure that all staff know how to access Interpretation and Translation services (ITS).** (a) Interpreting Services access literature will be distributed across all wards (to include out of hours contacts)	Ward Matron	N/A	Literature on ward and staff aware of access points for information	Complete
	(b) The Equality and Human rights team will deliver staff training on: • Equality and Human rights including what is dignity at work • Cultural awareness and understanding Bullying and harassment awareness training including aspects of staff on staff, service user on staff, and staff on service user.	Equalities and Human rights team(EDS)	Staff time	Training records	Commence Sept 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
issues such as staff being aware of the services available for translators and how to get information translated into other languages. There is also the issue around risk assessment training of staff as while a number of staff had had training there was still the issue around staff perception of what risks were.	(c) All wards will confirm their 'quiet area' for service users and communicate this to service users on the wards where possible	Head of Access	N/A	Confirmation of area	Sept 2013
	(d)Equality Champions will be identified at the unit to champion human rights, dignity and equality issues. The Champions will have direct access to the Equalities and Human rights team for additional on-going support and advice	In patient service manager/ EDS team	N/A	Champions identified	Dec 2013
	2. We will effectively communicate our approach to Checking and Searching service users				

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	with all clinical staff. Staff will be informed that each ward has access to qualified nurses appropriately trained in searching patients –either staff on the ward or the unit co-ordinator. (a) Clinical staff will receive communication confirming the arrangements for accessing staff to carry out a search	In patient service manager	N/A	Minutes of ward meeting /evidence of communication	Sept 2013
	(b) Approval and implementation of the draft revised Searching Policy (policy is currently in final draft)	In patient service manager	Staff time	Approved policy/training records	Oct 2013
	3 We will improve staff's recognition				

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	and response to risk (a) The risk management team will support delivery of a tailored clinical incident reporting training, i.e. recognising clinical risk incidents and near misses, for staff on the unit. This will include the importance of reporting and responding to near miss events.	Lead nurse	Support from risk team /lead	Communication to staff and training information	Nov 2013
	(b) We will develop an approach for inclusion of clinical risk assessment and management in clinical supervision sessions. Review current policy and guidance to reflect and embed the new approach.	Deputy MD/ Consultant and Lead Nurse	Staff time	Training records	Oct 2013
	(c) The divisional patient safety group will monitor the reporting and responding to near misses.	Clinical Director/ Governance	N/A	Evidence of increased near miss reports	Nov 13

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
		lead(AMH)			
	(d) Provide additional clinical supervision and leadership support re risk recognition and response, response to incidents, MDT meetings, shared learning and education.	Lead Nurse	Staff time	Clinical supervision sessions	Nov 2013
	(e) We will continue to provide Integritas Risk Training to staff	Lead Nurse/ Inpatient service manager	Staff time	Confirmation to QAC	Oct 2013
	(f) A Risk Research Steering Group has been established - research to be carried out with a focus on appreciation and perception of risks and also to gain awareness of desensitisation amongst LPT staff.	Head of Research Lead Nurse	Staff time	Mobilisation of research(plan)	Oct 2013
	(g) A programme of suicide awareness sessions for staff across the Trust to	Lead Nurse /Patient	Staff time	Training records	Sept 2013-June 2014

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	commence in September 2013 and run until June 2014.	safety lead			
	(h) Ensure mandatory training is undertaken by all staff re clinical risk.	Ward Matrons	Staff time	Training records	Sept 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
Outcome 16: Assessing and monitoring the quality of service provision – Compliance Action					
The provider did not always have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. 10.(1) Specifically: It was disappointing to see that the care plan and risk assessment audits which were beginning in February had ceased. There was no apparent checking of staff's perception of what a risk was through auditing of care plans and risk assessments in line with what Louis	**1. We will explore ways of improving staff's recognition and response to risk** (a) Development of an approach for inclusion of clinical risk assessment and management in supervision sessions. Review current policy and guidance to reflect and embed the new approach.	Deputy MD/ Consultant and Lead Nurse	Staff time	Supervision policy and associated documents	Oct 2013
	(b) Provide additional clinical supervision and leadership support re risk recognition and response, response to incidents, MDT meetings, shared learning and education	Lead Nurse Inpatient Service manager	Staff time	Supervision evidence	Nov 2013
	(c) We will provide Integritas Risk training to staff	Lead Nurse/ Inpatient service manager	Staff time	Confirmation to QAC	Oct 2013
	(d) A Risk Research Steering Group	Head of	N/A	Steering group	Mobilisation of

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
Appleby had said in his report in 2012.	has been established - research to be carried out with a focus on appreciation and perception of risks and also to gain awareness of desensitisation amongst LPT staff.	Research and Development/AMH Lead Nurse		minutes	research(plan) Nov 2013
	2. We will continue with our schedule of quality assurance visits (a) Executive and Non-executive members of the Board will support our programme of quality assurance visits across all inpatient wards. During these visits staff consider the '15 Steps Challenge' and review compliance of up to four Essential Standards Outcomes. Results are fed back to wards which identify where improvements are required	Exec and review teams	N/A	Identification of risks	Aug – Sep 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	(b) Review approach to regulation in light of CQC inspection regime consultation	Chief Nurse	N/A	Revised approach agreed	Nov 2013
	3. We will monitor the quality of services and report progress through our Trust governance structures (a) A Record keeping action plan is under implementation and a record keeping re-audit will be completed across the unit in October 2013.	AMH Lead Nurse Inpatient	Staff time	Audit reports and action plans	As per audit schedule
	(b) The Observations (Handover) re-audit will be undertaken in October 2013	In Patient lead	Staff time	Audit report	As per audit schedule
	c) We will introduce an Early Warning Signs tool and ensure all staff are trained how to use it	Inpatient Lead	Staff time for training	EWS in use	Nov 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	(d) We will introduce a Patient Safety working group for staff at the unit	Lead Nurse/ Inpatient service manager	Printing costs for resources	Prompt cards	Sept 2013
	(e) Develop prompt cards to use as a training and awareness tool for high risk processes such as observation, escorting patients and absconsion etc.				
	(f) All current ward ligature risk assessments to be reviewed at Matrons Meeting and Ward meetings, all staff to confirm they are conversant with their ward's ligature risk assessment	Inpatient service manager, Matrons and relevant leads across the service	Staff time	Completed signature sheets	Sept 2013
	(g) Targeted piece of additional work for the Quality Assurance Committee to explore options and develop costing for required actions, to include: • Review all ligature risk assessments and outstanding actions	CG project lead	Staff time	Report to QAC	Sept 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	• Exploration of products on the market and best practice in other trusts within the context of clinical risk in general.				
	4. We will devise a cultural change programme for the AMH Division including a 'culture' dashboard. Milestones have been agreed with commissioners and a bespoke model is being worked through with an external provider – a steering group has been convened to scope the project and develop the audit. 1. Formation of a stakeholder Steering Group – July (completed) 2. Familiarisation and understanding – July/August (completed) 3. Design, development and distribution of a tailored culture audit survey - August 4. Culture analysis and first stage	Senior HR Business partner	Staff time	Final report	Initial findings - to inform change Sept 2013

What the CQC said on how the regulation had not been met	Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	Who is responsible for the action?	What resources (if any) are needed to implement the change(s) and are these resources available?	What will evidence that the action has been implemented?	Insert the date the actions will be complete
	feedback (translation) - September 5. Reporting and action planning – September/October 6. Evaluation				

APPENDIX 2

Summary of NHS England Risk Summit
for Leicestershire Partnership NHS Trust

Background

Risk summits are a tried and tested approach to understanding and mitigating risks within an NHS organisation.

They aim to address potential or actual service quality problems which may mean providers, such as hospitals, failing to meet the essential standards of quality and patient safety. Such problems may relate to a specific service or be indicative of more serious and systemic problems within a provider organisation.

A risk summit may be triggered in a number of ways. It could be the result of regular performance and quality reviews between the provider and commissioners, an external regulator (such as the Care Quality Commission or Monitor) or from concerns raised by staff, patients or other parties.

When NHS England calls a risk summit it brings together representatives from the provider organisation, commissioners, key clinical leaders and other regulatory and stakeholders to explore and understand the issue. Together they agree what interventions, if any, may be necessary to ensure patient safety and quality can be guaranteed in the short, medium and longer term and whether further risk summits are required.

Action
On Thursday 29 August 2013, NHS England hosted a risk summit for Leicestershire Partnership NHS Trust relating to concerns about patient care and safety at the Bradgate Unit, including the findings outlined in the recently published CQC report. All key partner agencies were represented at this summit.

Outcomes
Following in depth discussion of the issues raised the following outcomes were agreed:

1) An urgent meeting on Friday 30 August 2013 between the Trust, Clinical Commissioning Groups and the Local Authorities to agree what immediate actions are required to ensure safe patient care at the Bradgate Unit in the short term.
2) NHS Trust Development Authority, in partnership with local Clinical Commissioning Groups, to develop a plan to provide additional support to the Trust Board of Leicestershire Partnerships NHS Trust in order that the Trust can provide assurance and move forward their plans to improve patient safety on a longer term basis.
3) No follow up risk summit would be required at this stage.

APPENDIX 3 SITREP CONTENTS

LPT Bradgate Unit Tuesday Situation Report - Adult Mental Health

Date:

(Covers Previous Friday, Saturday, Sunday and Monday)

		Workforce														Ward Statistics														Triggers					
		553 Achieved	Qualified/unqualified split	Normalised Qualified/Unqualified Split (allowing for Obs levels)	Total Ward Acuity Index	Number substantive staff	Number of bank staff	Number of agency staff	Substantive % vs Temporary (not no	Sickness absence levels	Staff on leave	Number of staff on study days	Ward Establishment WTE (total of Q-	Ward Actual WTE Substantive	Ward Vacancies WTE (total of Q+UQ	Vacancy Rate	Obs Level 1	Obs Level 2	Total Beds	Bed Occupancy	Bed Occupancy %	Admissions	Discharges	DToCs	Seclusions	Absconsions – previous 24 hours up to 1pm only	SIs	Weekly Ward Reviews Scheduled	Weekly Ward Review Attended by Nurse+Doctor	Patient overnight leave	Level 1 – 553 is met with ward staff	Level 2 – 553 is met with staff from other wards	Level 3 – 553 is met with bank staff	Level 4 – 553 is met with agency use	Level 5 – 553 not met and mitigation through other measures	Trigger Mitigation Narrative (if applicable)
ASHBY	Fri																																		
	Sat																																		
	Sun																																		
	Mon																																		
ASTON	Fri																																		
	Sat																																		
	Sun																																		
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