Lancashire Care
NHS Foundation Trust

Care Quality Commission (CQC) Inspection of Lancashire Care NHS Foundation Trust

2018

Quality Improvement Summary Action Plan

Version 1.0 (03 July 2018)

Supporting Health and Wellbeing

Contents

Introduction

The Care Quality Commission (CQC) conducted a focused inspection of Lancashire Care NHS Foundation Trust during January and February 2018. This inspection visit was preceded by data collection and analysis. The inspection reports for the Trust were published on the CQC website in May 2018. A Quality Summit was held on 06 July 2018 to present the final reports to regulators, commissioners and stakeholders.

The Trust received an overall rating of Requires Improvement.

In response, the Trust has developed a **Quality Improvement Action Plan** to address all the requirements and recommendations contained within the CQC inspection reports. The full and detailed Quality Improvement Action Plan will be tracked through the Trust's integrated quality management system and monitored through the Trust's governance framework, as detailed on the next page.

The Trust has grouped actions together by domain. This **Quality Improvement Summary Action Plan** provides details of those domains, the critical actions forming the planned improvement work and the measures for monitoring achievement.

This summary will be made available to the public through the Trust web.

In addition to the grouping of actions 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 are:

- Strengthening the clinical service at the Cove
- Supporting and empowering clinical leaders
- Improving the mental health crisis pathway

The Trust already has established transformation or strategic plans that align with each theme (i.e. DTS programmes, People Plan). The Trust will continue with delivering these transformation and strategic plans as improving these areas will have significant impact, not just on the CQC requirements from this inspection but on wider quality improvement. The Trust recognises that empowering clinical leaders across our services is essential and the active and equal involvement of staff in quality improvement is the only way through which sustainable improvements can be made. The action plan 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.

The executive lead for the plan is the Executive Director of Nursing and Quality, supported by the Associate Director of Safety and Quality Governance. The Non-Executive Director Lead for this plan is the Chair of the Quality Committee.

Arrangements for governance

The **delivery** of the Quality Improvement Action Plan will be led by Networks and Corporate Support Services through established governance and management meetings. Each action has an identified action owner.

The Trust's Quality Delivery Group will provide a Trust-wide **monitoring** role (this is attended by all Networks and relevant Corporate Support Services).

Additionally, actions have been grouped into domains which have an identified executive lead and sub-committee of the Trust Board for added monitoring.

The Datix quality management system has been developed to provide an action tracking capability for the plan with "real time" reporting and live dashboards. When completing actions on this system, action owners will be required to upload evidence of completion. This evidence will validated by the Safety and Quality Governance Department. Unsatisfactory evidence will result in the action being re-opened and targeted support put in place.

The Quality and Safety Sub-committee, chaired by the Executive Director of Nursing and Quality, will lead on **oversight** of delivery and receive regular reporting of the total action plan progress. This Sub-committee is attended by all Network Clinical Directors and relevant Associate Directors from Corporate Support Services.

The Board's Quality Committee, chaired a non-executive director, will receive **assurance** of delivery for the Quality Improvement Action Plan.

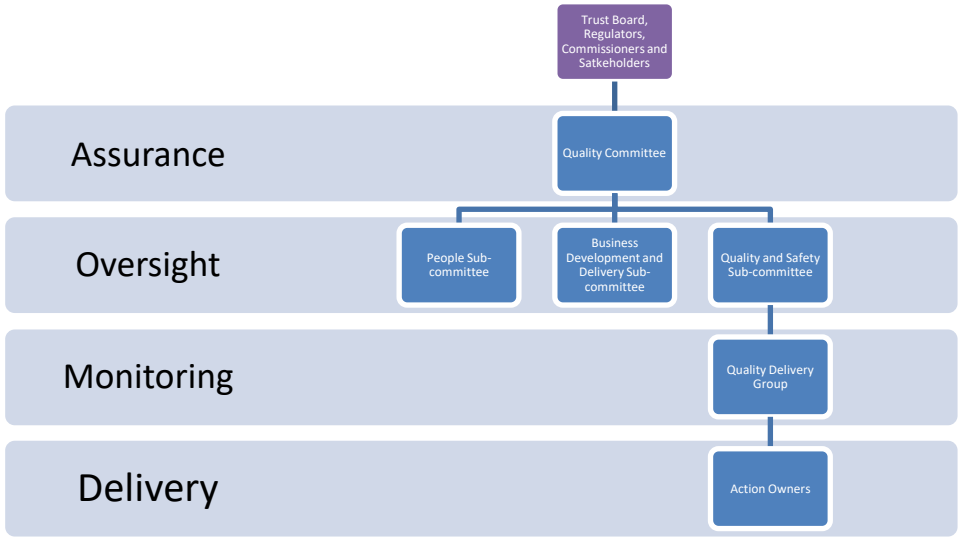

Figure 1 -Arrangements for governance and assurance of the plan

The following ratings are used to easily observe progress against the Quality Improvement Action Plan.

Key: *The following status ratings are assigned to each action:*	
	The action has not started, is delayed beyond its target date or will not be achieved by its target date.
	The action is underway and expected to be completed by the deadline date.
	The action is complete and evidence has been submitted by the action owner.
	The action is complete and evidence has been validated. The outcome measures are being sustainably achieved.

Summary action plan by domain

(Ratings correct as of 26 June 2018)

Domain	Executive Lead	Oversight Sub-committee	Key Improvement Actions	Outcome Measures/Evidence
Training	Damian Gallagher	People Sub-committee	• Review and finalise a new training needs analysis – by 31 July 2018 • Review the content of training courses – by 30 September 2018 • New mandatory training reporting will be in place – by 30 June 2018 • Targeted actions will be taken by managers and clinical leaders to improve compliance • Improvement trajectories will be in place and monitored	• Mandatory and specialist training will be at a minimum of 80%

Domain	Executive Lead	Oversight Sub-committee	Key Improvement Actions	Outcome Measures/Evidence
Supervision	Damian Gallagher	People Sub-committee	• The policy outlining supervision requirements will be reviewed and amended to reflect professional guidelines – by 31 July 2018 • A new supervision recording system will be introduced – by 30 June 2018 • New supervision reporting will be in place – by 15 July 2018 • A project lead will be appointed to champion supervision and support managers – by 31 July 2018 • Targeted actions will be taken by managers and clinical leaders to improve compliance • Improvement trajectories will be in place and monitored	• Clinical supervision will be at a minimum of 80%
Appraisals	Damian Gallagher	People Sub-committee	• The appraisal system will be reviewed to require objective setting in quarter one, and one review in a rolling 12 month period – by 30 June 2018 • New appraisal reporting will be in place – by 30 June 2018 • Targeted actions will be taken by managers and clinical leaders to improve compliance • Improvement trajectories will be in place and monitored	• Appraisals will be at a minimum of 80%

Domain	Executive Lead	Oversight Sub-committee	Key Improvement Actions	Outcome Measures/Evidence
Clinical risk	Max Marshall	Quality and Safety Sub-committee	• Lead Nurses will ensure staff understand the requirements of physical health monitoring after rapid tranquilisation and will undertake weekly monitoring for six months – up to 31 December 2018 • A new handover guidance/checklist will be developed to support effective handover and forward shift planning – by 31 July 2018 • Guidance on the role of the Safety and Security Nurse will be updated and cascaded – by 31 July 2018 • The new Positive and Safe training programme will be finalised and a roll-out plan developed – by 31 July 2018	• All patients will have physical health monitoring completed after the administration of rapid tranquilisation
Staffing	Paul Lumsdon	Quality and Safety Sub-committee	• An establishment review is underway and will be reported to the Trust Board – by 30 September 2018 • Continued extensive recruitment and retention efforts as detailed in the People Plan	• Wards and teams will be safely staffed against the establishment and clinical need

Domain	Executive Lead	Oversight Sub-committee	Key Improvement Actions	Outcome Measures/Evidence
Care planning	Paul Lumsdon	Quality and Safety Sub-committee	• Improvement at the Cove in patient engagement in care planning, patient activities, access to education and record keeping – by 30 June 2018 • Focused work underway to support consistent application of the Nicotine Management Policy – by 3- September 2018	• Patients will be involved in their care planning and will receive the support identified in their care plans • The smoke free policy will be consistently applied across inpatient sites • At the Cove, a programme of activities is available to patients throughout the day and weekend with enhanced education
Safety and learning	Paul Lumsdon	Quality and Safety Sub-committee	• Improvement at the Cove in environment including new doors, courtyard improvements, painting, on-site catering – by 31 August 2018 • Revised safety alerts process implemented – by 31 July 2018 • New lessons learned bulletin in place – by 31 July 2018 • New incident learning on a page from each serious incident – by 31 July 2018 • Revised guidance to teams on effective team meeting and team information boards – by 31 July 2018	• The Cove will have an improved environment, that meets safety and infection control requirements with improved PLACE scores • Lessons learned are shared across the organisation

Domain	Executive Lead	Oversight Sub-committee	Key Improvement Actions	Outcome Measures/Evidence
Mental health crises pathway	Sue Moore	Business Development and Delivery Sub-committee	• Actions from the mental health risk summit will be continued and delivered with the support of system-wide partners • Transformation of the pathway will be undertaken including a review of the Mental Health Decision Units • A review of Section 136 Suites and Mental Health Decision Unit will be undertaken with any estate works planned – by 31 August 2018 • The Section 136 process and checklist will be reviewed and reissued with support for staff to implement, including a dedicated Section 136 Matron – by 31 July 2018	• Patients will not be detained beyond the timescales of the Mental Health Act unless in exceptional clinical circumstances • Patients will not stay for continuous prolonged period in the Mental Health Decision Unit unless in exceptional clinical circumstances • Capacity assessments in the Section 136 Suite will be clearly and consistently documented
Leadership and empowerment	Damian Gallagher	People Sub-committee	• Support will be provided to clinical professional leaders and operational managers to provide role clarity – by 31 August 2018 • Updated guidance will be issued to ward managers and matrons on the level of dedicated clinical time they are expected to undertake – by 31 July 2018 • A team meeting structure and process will be in place on acute wards – by 30 September 2018 • A detailed recovery plan for the Cove will be developed and agreed with Commissioners – by 30 June 2018	• Managers will feel supported and empowered to make improvements across the service • Regular team meetings will be held

Domain	Executive Lead	Oversight Sub-committee	Key Improvement Actions	Outcome Measures/Evidence
Information	Sue Moore	Business Development and Delivery Sub-committee	• The Trust will agree with CQC what information and in what format can be provided in the Provider Information Request for services that sit organisationally across more than one CQC Core Service – by 30 September 2018	• The Trust and CQC will agree a mechanism for data reporting to be provided in future Provider Information Requests