ANNEX 1

THE RETREAT: RESPONDING TO FOCUSED INSPECTION FEBRUARY 2017

Our quality improvement plans

The Retreat Community

Compassion Collaboration Community

Becoming one of the most important institutions for the care and treatment of mental health

Contents

Introduction

The Retreat is a charity, delivering not-for-profit specialist mental health services. We work closely with the NHS and other service commissioners and individuals to provide services for people whose mental health gives them and their families cause for concern, from the complex and challenging to the less intensive but equally distressing and anxiety-provoking.

The Retreat was established over 200 years ago by the Tukes, a Quaker family. It was the first place in the world to offer humane, dignified and respectful approaches to the treatment of mental health difficulties. The Wellcome Trust (2017) state[1] "The Retreat in York is historically one of the most important institutions for the care and treatment of mental health patients". We would like to work towards ensuring that our importance is not only historical, but that we remain an important force for innovative, high quality compassionate care for people with mental health issues.

The issue

The CQC carried out a focused inspection on The Retreat in February 2017 in response to a number of safeguarding concerns that we had raised with the City of York Council and about which we had notified the CQC. As a result of that focused inspection, on a single current unit for older males, we received an 'inadequate' rating.

This rating has caused our commissioners and partners to ask us how we are responding to the CQC's concerns. However, we have not had any response from the local community in relation to this.

We welcome the opportunity to discuss our rating with the Scrutiny Board and to outline the actions we are taking to address it.

Our response

We have developed a quality improvement plan in response to the focused CQC inspection and in consideration of the future of The Retreat. This plan is embedded within our new and emerging aspirational strategy for The Retreat's future. The plan is provided in Appendix A. We have mapped the quality improvement plan on to our emerging strategy to show how this work is integral to The Retreat's future.

Appendix B outlines the key indicators we will use to show that we have achieved improvements in quality and the flow chart in Appendix C shows how this work will be

[1] See https://wellcomelibrary.org/collections/digital-collections/mental-healthcare/the-retreat/, accessed 10/5/17

monitored and quality assured. Our strategy is aspirational, it outlines what we will do in order to become the best we can be. It considers what capabilities need to be in place and what management systems need to be instituted. This strategy will address all of the concerns raised by the CQC and moreover that it will enable us to become one of the most important institutions for the care and treatment of mental health in the country. Importantly, it is also founded upon our values, which are set out in Appendix D.

Our current position

In the CQC report[2] from our comprehensive inspection in November 2016 the CQC pointed out a number of strengths:-

- **Involvement** - patients and carers are involved in their care and the running of the service.
- **Staff qualities** - carers and patients said that staff were respectful and polite and that described staff as amazing, and that they felt valued and supported by staff.
- **Approach and ethos** - patients said that staff saw them as people and not as a condition
- **Understanding** - the CQC cited evidence that staff knew patients well and had taken time to understand their needs, wishes and preferences.
- **Safeguarding** - they reported that safeguarding is embedded across the organisation and that we have good links with the local authority.
- **Policy** - they felt that our care and treatment records reflected safeguarding concerns and staff knew and acted in line with our safeguarding policy.

This same report identified some areas for improvement, including:-

- **External communication** – we need to become more outward-facing, developing a wider range of appropriate and proactive partnerships
- **Looking after our staff** – we need to ensure that they have the resources needed to do the job, ensure their safety is taken seriously, address concerns about pay and benefits, support them to feel optimistic about the future, work hard to ensure they have confidence in the Leadership Team, communicate openly, honestly and regularly and create a positive environment. Including staff in the development of the staff survey action plan will help.
- **Systems, processes and infrastructure** – we need a more robust operational framework, across the organisation and within units. We also need a more flexible infrastructure that is fit for the purposes we will require for the future.
- **Service development**- our services are somewhat static and require some investment to ensure we are innovating and modernising. We tend to rely on past successes rather than looking to a rather more challenging future context with less

[2] See http://www.cqc.org.uk/sites/default/files/new_reports/AAAG2726.pdf, accessed 10th May 2017

funding and with funders who are only willing to pay for treatment for the most complex mental health needs.

- **Environment** – we have beautiful grounds and buildings, but we need to have a more flexible environment that can meet modern mental healthcare demands.

The report from the focused inspection in February 2017 reiterated the strengths from the previous report, but pointed out that we also must ensure that:-

- Care and treatment is provided in a safe way for patients.
- Risks to the health and safety of patients receiving the care or treatment are assessed and mitigated.
- All premises are clean and safe with suitable equipment and facilities.
- Patient dignity and respect are considered and acted in accordance with at all times.
- All safeguarding incidents are reported.
- Appropriate planning and governance processes are in place

Our quality improvement plan, in Appendix A, addresses all of these concerns, the indicators we will use to measure the improvement in quality are outlined in Appendix B and the flowchart in Appendix C shows how we will monitor, progress and embed the quality improvement plan.

Appendix A: Quality Improvement Plan

This Plan is responding to the following requirement notice and enforcement action, as detailed in the CQC inspection report of 13th February 2017. It is also in response to the accompanying warning notices - ENF1-3909457876, ENF1-3909457801, ENF1-3672186936. It is part of our emerging strategy and it fits with our ongoing plans for the development of The Retreat.

Requirement notice

The provider did not ensure that each person's privacy must be maintained at all times including when they are asleep, unconscious or lack capacity.

How the regulation was not being met:

One patient on George Jepson unit had been moved to a room that was not personalised and did not offer the patient privacy; there was no privacy film on the door panel or windows. Patient belongings were stored in a basket on the floor in the room.

This was a breach of 10(2)(a).

Enforcement action

The provider did not ensure that systems and processes were established and operated effectively to prevent abuse of patients.

How the regulation was not being met:

Staff did not report safeguarding concerns for patients on Allis unit; this included nurses, support workers, psychologists, dietician, physiotherapy and the chaplain. One member of staff descried the move as a 'done deal' and another told us that they had raised concerns with the manager. This was a breach of 13(2).

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **CQC KLOE Safe:** The provider must ensure that care and treatment is provided in a safe way for patients. **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff						
How the regulation was not being met 1: Both units had ligature risks and blind spots. We found that staff could not always see patients on the unit.	**Immediate:** Update the Environmental Risk Policy (HSR 20) to include: • Changes in roles and responsibilities; • Inclusion of a specific Ligature Risk Assessment Form; • Review the current Risk Assessment Form in place for the overall unit environment (including bedrooms).	7th July 2017	In progress	Minimal - mitigate risks through heightened awareness of environmental risk assessment process	Interim Registered Manager/Audit & Information Manager	New version of the Environmental Risk Policy HSR 20 policy & procedures (which includes formats for the assessment of environmental risks).
	Complete all environmental and ligature risk assessments (including bedrooms) on each Unit as per guidance outlined in the policy. This will involve:	31st July 2017	In progress	Minimal - mitigate risks through heightened awareness of environmental risk assessment process	All Unit Managers	MDT minutes. Individual Risk Assessments. Updated Care Plans. Unit Manager checks of Care Plans

	• Ligature audits being completed annually unless there have been changes made to the room. • Risk assessments for patients should be completed regularly particularly on admission and when there is a change in circumstance with their clinical presentation). • Uploading specific patient risks to individual risk management plans on the Care Partner EPR System. • Including Unit wide risk on the Unit Risk Register via the Ulysses System. This leads to identified risks in the environment consequently feeding into individual risk management plans on the Care Partner EPR System and these will be shared with the wider MDT and staff					and Risk Assessments to be included in managers' monthly report.

	team. • Carrying out periodic checks on individual Care Plan and Risk Assessments to monitor that they reflect current unit environmental risks.					
	Longer term: Improve the awareness, embedding and use of Policy HSR 20 and its procedures through the development and implementation of a staff intranet, which will allow the organisation to monitor awareness and understanding of all policies.	31st December 2017	Development of intranet agreed at Leadership Team; plans in progress	Staff awareness, understanding and use of the environmental risk process is being closely monitored, so patient impact should not be negative	IT Consultant/IT Officer Learning & Development Manager	Implementation of an Intranet. Data from intranet quizzes and read audits.
	We are carrying out a site feasibility study to bring about change to the environments to include mitigation of ligature and blind spot risk. Risk areas that remain will be picked up on the unit environmental risk	1st December for feasibility study report Between June 2018 – June 2020 for the work emerging from the feasibility	Expressions of interest for feasibility study received.	Risks mitigated through observations, environmental risk assessments, MDT discussions, care planning and individual risk assessments	Feasibility Study working Group Leadership Team & the Trustee Directors	Feasibility Study report Works plans

	assessments.	study				
How the regulation was not being met 2: We found there to be unsafe and unsuitable staffing levels and skill mix on both units; during the move there was only one qualified nurse allocated to cover both units on a regular basis.	**Immediate:** In March 2017 Unit Managers carried out a review of their safe staffing levels which resulted in adjustments to the agreed establishment figures and budgets. Staffing levels are discussed as a daily agenda item at the morning Unit Managers meeting.	31st March 2017	Review completed & staffing levels being checked at the morning Unit Managers meeting each day	Minimal because patient care will only be impacted if staffing issues cannot be resolved. Even if staffing issues cannot be resolved the skill mix in the shift should minimise patient impact.	All Unit Managers	Actual staffing levels (from HR)
	Database of daily staffing records to be developed	31/8/17	In progress	Minimal	Interim Registered Manager	Database records
	Each morning the Site Co-ordinator will contact each of the Units to identify deficits in daily staffing, as will be stated in revised Site Coordinator Procedure.	Ongoing throughout 2017	Changes to the Site Coordinator Procedure in progress	Minimal	Site Co-Ordinators	Site Coordinator records in handover book
	If staffing levels are identified as low it is the role of the Site Coordinator to support and coordinate additional	Ongoing throughout 2017	Changes to Site Coordinator Procedure in progress	Use of agency staff can have a negative impact on patients – mitigated by this action	Site Co-Ordinators	Site Coordinator Procedure

	staffing. The process is as follows: Step 1 - The Site Coordinator will liaise with the nurse in charge to find resource within the hospital Step 2 - Obtain staffing support from Bank. Step 3 - As a last resort obtain staffing support from agency. This procedure is outlined in the Site Coordinator Procedure.					
	Recruiting a Night Site Coordinator to manage the bank and oversee agency use. This will ensure that staffing is more closely monitored and that use of agency and bank are managed more effectively	30th September 2017	Job advertisement currently in place for a Night Site Coordinator		Interim Registered Manager	Presence of a Night Site Coordinator
	Learning & Development Manager will ensure that Site Co-ordinator training supports the requirements of the Site Co-ordinator procedure	31st August 2017	Changes to Site Co-ordinator training in progress		Learning & Development Manager	Site Co-ordinator training programme contents and training stats
	Longer Term:		Work stream		HR Manager & HR	New Recruitment

	Employer of Choice Work stream implemented to develop a Recruitment and Retention Strategy, which will be accompanied by implementation plans. Where additional staffing is required we will use our Proposal for Changes Template. (See Change Management Policy and Procedure for further information)	31st December 2017	established		Consultant	and Retention strategy Fewer staff leaving More staff recruited
	Employer of Choice Strategy Work stream includes a Rostering Project to improve the efficiency and effectiveness of staffing rotas.	31st May 2018	Work stream established		HR Manager & HR Consultant IT Manager & IT Consultant All Unit Managers	New Rostering system in place
	We're conducting a formal review of Bank and Agency usage. This will inform future planning for staff shortages.	31st October 2017	Review started		Interim Registered Manager Night Site Coordinator HR Consultant & IT Consultant	New process for bank and agency use
	We are implementing a staff intranet to improve	31st December 2017	Development of intranet agreed		Marketing and Communications	Staff intranet to improve

	communication and improve access and embedding of operational policies and procedures		at Leadership Team; plans in progress		Manager	communication and improve access and embedding of operational policies and procedures
How the regulation was not being met 3: Patient risk plans were not all up to date and there were no patient risk assessments relating to the flooring work being completed on the George Jepson unit.	**Immediate:** To ensure that risk assessments are always updated each unit has a log to act as a prompt.	31st August 2017	Some units have this log in place (Acorn), the others are being asked to ensure they are putting it in place. Risk Management Policy and Procedures in process of being reviewed and adjusted.	Impact mitigated by additional monitoring by Unit managers are part of their monthly reporting	All Unit Managers Audit & Information Manager Risk & Quality Officer	Unit managers' monthly report and bi-monthly care plan audits as part of the annual Clinical Audit Programme. Monthly patient records check Management supervision notes
	It is the responsibility of the key worker & associate key worker to update the risk assessment. This will be outlined in our Risk Management Policy and Procedures.	31/8/17	In progress	N/A	All Unit Managers All Key workers & associate key workers	Care Partner records and the Care Plan Audit programme
	To address systemic issues relating to decision making around operational and	Ongoing 2017 (already in	In place and being used	N/A	Leadership Team	Log of decisions made at Leadership Team and Board

	environmental changes we have implemented a Change Management system. A set of guidelines are available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy which outlines the process to be followed when proposing operational or environmental change.	place)				Level for operational & environmental change
	To ensure that we have up to date risk plans when change such as the flooring work on George Jepson is proposed the proposal for change	In place	Process being used	N/A	Unit managers Leadership Team	Examples of proposals for change (George Jepson Phase 2 flooring)

	process must always include relevant risk assessment and patient impact assessments. See Proposal for Change Protocol & guidelines **Longer term:** Embed importance of incorporating relevant risk assessments into all Proposals for Change and subsequent project plans we are improving access to related policies & procedures by implementing a staff intranet.	31st December 2017	Development of intranet agreed at Leadership Team; plans in progress	Negative impact mitigated by additional monitoring by unit managers	Unit managers Leadership team IT Consultant Sales & Marketing Manager	Care Partner records
How the regulation was not being met 4: Not all incidents were reported on the provider's incident management system; this meant the provider could not act on minimising all risks	**Immediate:** We have a robust IT incident reporting system that all staff are trained to use to report all incidents. The Risk & Quality Officer visits all units to ensure they understand the system & how to use it. In addition, the Risk & Quality Officer has a session during the staff	Completed	Reporting system and training in place – updating and ensuring its embedding is ongoing.	N/A	Risk & Quality Officer All staff – incident reporting is everyone's business	Daily incident reports Quarterly analysis of incidents for the Clinical Governance Group.

to patients.	induction programme on incident reporting					
	Longer term: To embed the importance of recording incidents we are improving access to policies by implementing a staff intranet.	3/18 & ongoing	Development of intranet agreed at Leadership Team; plans in progress	Negative impact mitigated by Risk manager and unit managers raising awareness through attending unit business meetings and including it in Management Supervision.	Unit Managers Leadership Team IT consultant Marketing and Communications Manager Learning development manager	Intranet Audit of access to policies and procedures
Regulation 17, (1 2 b c), Good Governance, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014: **Safe:** The provider must ensure that risks to the health and safety of patients receiving the care or treatment are assessed and mitigated. **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes						
How the regulation was not being met 1: Neither unit had an environmental risk register relating to the flooring refurbishment of George Jepson.	**Immediate:** To ensure that environmental risks are registered when bringing about operational and environmental changes we have implemented a Change Management system. A set of guidelines	Completed	Implemented	N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational & environmental change

	are available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our new Change Management Policy which outlines the process to be followed when proposing operational or environmental change. Unit managers to familiarise themselves with the Change Management Policy & Procedures	31/8/17	In progress	Minimal	Unit Managers	Part of key policy sign-off
	Longer term: To embed the importance of incorporating	31st March	Development of intranet agreed	Negative impact mitigated by the	Unit Managers	Examples of proposals for

	environmental risks into all proposals for change and subsequent project plans we are implementing a staff intranet.	2018	at Leadership Team; plans in progress	Risk & Quality Officer and Unit Managers raising awareness through attending unit business meetings and including it in Management Supervision.	Leadership Team IT consultant Marketing and Communications Manager	change (George Jepson Phase 2 flooring)

Regulation 17, (1 2 b c), Good Governance, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014: **Safe:** The provider must ensure that all premises are clean and safe with suitable equipment and facilities. **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff **The Retreat's Strategic Objective 4:** Develop as a Centre of Excellence in compassionate care						
How the regulation was not being met 1: Although there were no patients on Allis unit at the time of inspection, the unit was dirty, damp and cold;	**Immediate:** We have entered into a voluntary agreement with the CQC not to use the Allis unit unless significance works have been completed and approved by the CQC. We have no intention of using this unit again without CQC	Completed	Completed	N/A	Chief Executive	Letter of voluntary agreement

there was limited hot water and unsuitable kitchen, toilet and bathing facilities.	approval. To ensure that a similar situation will never occur again we have introduced a Change Management system for all operational and environmental changes. A set of guidelines are available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy which outlines the process to be followed when proposing operational or environmental change.	Ongoing (already in place)	In place and being used	N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational & environmental change
How the regulation was not being met	**Immediate:** We undertake monthly					Medication audits

2: There was no clinic room on Allis unit and medicines storage was not in keeping with best practice when we visited.	Medication Audits which include a question about the safe storage of medicines. If that indicates any issues with medicines storage the unit manager will take immediate action in line with recommendations from the Clinical Audit Action Plan.	Completed	Implemented	N/A	Pharmacist Unit managers Audit & Information Manager	as part of annual Clinical Audit Programme Log of decisions made at Leadership Team and Board Level for operational & environmental change
	This will not happen again as all operational and environmental changes are now governed by the Change Management Policy.	Completed	Implemented	N/A	Leadership Team	
How the regulation was not being met 3: We did not see, and were told by one nurse that worked on Allis unit, that there was no grab bag on the unit; a grab bag contains items to use in an emergency such as	**Immediate:** All units now have access to grab bags on their unit.	Complete	Implemented	N/A	Unit managers Reception staff Site Coordinator	Presence of grab bags Grab bag audits
	The Resuscitation Policy (PC10) states that the Unit Manager is responsible for the weekly auditing of grab bag contents and location using a checklist.	Complete	Implemented	N/A	Unit managers	Grab bag audits

resuscitation equipment or emergency medications. The provider told us that the closest grab bag was on another unit directly below the Allis unit.	**Longer Term:** Weekly Grab Bag check results are part of unit weekly check records.	31st August 2017	In progress	N/A	Unit managers	Unit weekly checks
How the regulation was not being met 4: On George Jepson unit cleaning charts were not available in all patient bedrooms and support staff were not adequately protected when cleaning	**Immediate:** Discuss cleaning requirements with Unit Managers and implement appropriate improvements as per their recommendations **Longer term:** Create & implement a hospital wide cleaning operational plan with Unit Managers. This will involve:- A review of daily checking system and checklist Domestics' Supervisor to check works complete against a checklist. Once complete checklist	31st July 31st October 2017	In progress Identified as part of work stream developments	N/A The immediate actions will mitigate the impact, ensuring that cleanliness and records of cleaning are maintained	Director of Finance, IT & Support Services Director of Finance, IT & Support Services Unit managers Domestic Supervisors	Immediate actions Place audits Completed checklists Reports from unit managers

	should be signed by Supervisor and Unit Manager.					
	Training needs analysis for domestic team and training plans for the team, including:- Defensible documentation Infection control Mental Health Awareness Safeguarding Incident reporting	30th November 2017	In progress	The immediate actions will mitigate the impact, ensuring that cleanliness and records of cleaning are maintained	Learning & Development Manager	Training records
	As part of our Strategy Work streams: we are conducting a review of culture and systems within Domestic services .	31st March 2018 and ongoing	In progress	PLACE and infection control identifies when things go wrong and immediate actions can be put in place.	Director of Finance, IT & Support Services Interim registered manager	PLACE audits Staff survey Cleaning records Central Services Audit Quarterly Clinical Governance Report
Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect: The provider must ensure that patient dignity and respect are considered and acted in accordance with at all times **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes						

The Retreat's Strategic Objective 3: Improve the recruitment and retention of staff **The Retreat's Strategic Objective 5:** Enable the people who use our services to find meaningful engagement within their communities						
How the regulation was not being met 1: On GJ patients were unable to use the conservatory, quiet room or access the garden.	**Immediate:** Patients now have full access to the conservatory, quiet room and access to the garden.	Complete	Complete	N/A	George Jepson Unit manager Maintenance Lead Porters	Rooms can be viewed - now accessible and usable
How the regulation was not being met 2: On George Jepson unit staff were unable to spend meaningful time engaging with patients as they were responding to other patient needs.	**Immediate:** George Jepson now has a timetabled activity programme in place.	Complete	Complete	Positive impact	George Jepson Unit manager	Briefing sheet outlining what meaningful activity looks like on George Jepson.
	Sharing the Learning: Katherine Allen to share how they record meaningful activity.	30th June 2017	Meetings taking place	Activity already in place so impact negligible	Katherine Allen Unit manager	
	We have a key worker role in place to record individual, meaningful engagement which is fed into the MDT via the OTs.	Complete	Complete, but ongoing		George Jepson Unit manager OTs	MDT notes
	Longer term: George Jepson is taking a	31st December	In progress, but	Negligible because	George Jepson Unit	

	step by step approach to improving record keeping around meaningful activity.	2017	cultural change so will take time	activity taking place	manager	Care plans Activity records Meaningful engagement strategy document
	As part of our Strategy Work streams: We are developing a Meaningful Engagement Strategy.	31st March 2018	Identified as a work stream and OTs working on this already	Negligible because activity taking place	OT Lead	As part of our Strategy Work streams: We are developing a Meaningful Engagement Strategy.
How the regulation was not being met 3: Doors were locked on the units and patients were not risk assessed to be able to leave the units unescorted or without permission. Not all staff had swipe fobs to be able to leave the unit or access to the duty room.	**Immediate:** Unescorted leave to be included on MDT forms and discussed at MDT and then incorporated into the risk assessment. This will be linked to the Restricted Practice Plan. This will occur on all units, not just to GJ unit.	30th June 2017	In progress	Some possible restrictions relating to unescorted leave, but mitigated by individual approach to patient requirements and MH status	Unit managers	MDT form MDT notes Restricted Practice Plan Risk Assessments Section 17 Leave Policy
	Section 17 Leave Policy revised to include risk assessment.	30th June 2017	In progress		MH Law Lead Policy Development & Ratification Group	Section 17 Leave Policy revised to include risk assessment.

	Agency staff have fobs, which are monitored. All fobs are numbered as part of the sign out process.	30th June 2017	Complete	N/A	George Jepson Unit manager	Fob records
	Longer term: An identified person responsible for Security for each unit - responsible for distributing and recalling keys and alarms.	30/9/17	Role already in place on George Jepson unit.	N/A	Unit managers	Security person role description
	George Jepson is replacing mortice locks with fobs.	30th September 2017	In progress	N/A	George Jepson Unit manager Maintenance Lead	Mortice locks no longer in place

Regulation 17, (1 2 b c), Good Governance, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014:

The provider must ensure that all safeguarding incidents are reported

The Retreat's Strategic Objective 1: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly

The Retreat's Strategic Objective 2: Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes

The Retreat's Strategic Objective 3: Improve the recruitment and retention of staff

How the regulation was not being met: The provider did	**Immediate:** All staff trained on safeguarding prior to working on any clinical	Complete	Though complete, it is an ongoing process	N/A	Safeguarding Lead Learning & Development manager	Training records

not ensure that systems and processes were established and operating effectively to prevent abuse of service users. Staff did not report safeguarding concerns for patients on Allis unit	unit, as part of induction, with regular updates.				Social work team	
	Information about how to raise a safeguarding alert is clearly visible on the ward.	Complete	Complete	N/A	Safeguarding Lead	Check units for presence of poster
	All Management Supervisions include a check on safeguarding – reminder on management supervision template	Complete	Reminder on template now; implementation ongoing	Provided this check is in place and used, there should be no impact on patients	All managers	Management supervision template Management supervision records
	We have a robust IT safeguarding reporting system that all staff are trained to use to record all safeguarding concerns and the Risk & Quality Officer visits all units to ensure they understand the system & how to use it. In addition, the Risk & Quality Officer has a session during all staff inductions on incident reporting which also covers reporting safeguarding concerns.	Ongoing	All units visited, but ongoing process	IT system and training already in place, but until it is all completely embedded culturally the unit managers will need to ensure it's checked regularly to ensure all safeguarding concerns are being reported.	Risk & Quality Officer Unit managers All staff (safeguarding is everyone's business)	Training records Safeguarding reports (quarterly for governance and externally for LSB)

	Social Work Team visit all units to ensure they understand roles and responsibilities within safeguarding	Implemented	This is already implemented, but will be an ongoing process, constant updates		Social work Lead All managers All staff	Social work team log
	Robust IT systems in place to report on and identify safeguarding themes.	Completed	Implemented	N/A	Risk & Quality Officer All staff	Quarterly Clinical Governance report
	Service users and carers are also trained / and or provided with information on safeguarding.	Completed	Implemented	Positive impact because they understand safeguarding	Social work team Involvement team with Unit staff	Service users and carers' reporting
	Positive working with the CYC, Director sits on Local Safeguarding Board, Multiagency agency best practice Group, Safeguarding Training Group.	Completed	Implemented	N/A	Director responsible for safeguarding Safeguarding Lead	Minutes of LSB meetings
	Longer term: We have a safeguarding group within the new governance structure.	31st July 2017	Ongoing	N/A	Audit & Information Manager Safeguarding lead	Terms of Reference for the Safeguarding Group Minutes of the Safeguarding Group meetings

	Safeguarding strategy developed and implemented.	31st December 2017	Safeguarding strategy written in the process of being implemented	N/A	Safeguarding Lead	Safeguarding strategy document Safeguarding strategy implementation updates
	To embed the importance of recording safeguarding concerns we are implementing a staff intranet so that this is fully communicated and monitored.	31st March 2018	Development of intranet agreed at Leadership Team; plans in progress	N/A	IT Consultant Marketing and Communications manager	Use of intranet Audits carried out through intranet
	Develop plan to address the issue of agency nurses accessing Care Partner and Ulysses	31st March 2018	Planned as part of the strategy work streams	N/A	Interim Registered Manager	Training records Agency use of electronic care records and reporting systems

Regulation 17, (1 2 b c), Good Governance, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014: The provider must ensure that appropriate planning and governance processes are in place; this includes ensuring that environmental and patient risks are identified, captured, managed and communicated with patients, families and staff when making decisions that affect the service. **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff						
How the regulation was not being met: The provider did not ensure that systems and processes were established and operating effectively to prevent abuse of service users. Staff did not report safeguarding concerns for patients on Allis unit	**Immediate:** New governance structure	31st July 2017	The new Governance groups have been identified; implementation has begun.	N/A	Audit & Information Manager Leadership Team	Governance structure Terms of Reference for Governance Groups
	We have implemented a system to manage operational or environmental changes across the organisation. A set of guidelines are available to all staff together with a Proposal for Change template to ensure that all operational/ environmental change proposals are presented in	Completed	Implemented	N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational & environmental change

	a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy, which outlines the process to be followed when proposing operational or environmental change.					
	Ensure works programme is communicated to all involved personnel and that it links to relevant strategic change procedures	31st December 2017	In progress	Should not be any significant impact because of other measures	Director of Finance, IT & Support Services Maintenance Lead	Works programme documentation

Appendix B: Measuring our Quality Improvement

How will we know when we have achieved improvements in quality?

1. **Improved quality**, as measured by an improvement in CQC inspection grading, levels of complaints, accreditation of services

2. **Financial stability** from a day to day operations point of view.

3. **At least 90% occupancy**. We will require high occupancy levels but may reduce the number of beds we offer, if we find we can fund alternative services such as day patients, outpatients, inreach and outreach.

4. **Improved staff satisfaction**, as measured by the staff survey, by sick leave figures, by staff turnover, which should be reduced, by managers through management supervision and through the staff friends and family test

5. **High service user and family satisfaction**, as measured by service user and carer surveys, friends and family test, levels of complaints

6. **Positive outcomes** for service users, as measured by appropriate formal outcomes measures, long term mental wellbeing and no return to inpatient services, level of safeguarding incidents, comparison with similar patients in other services

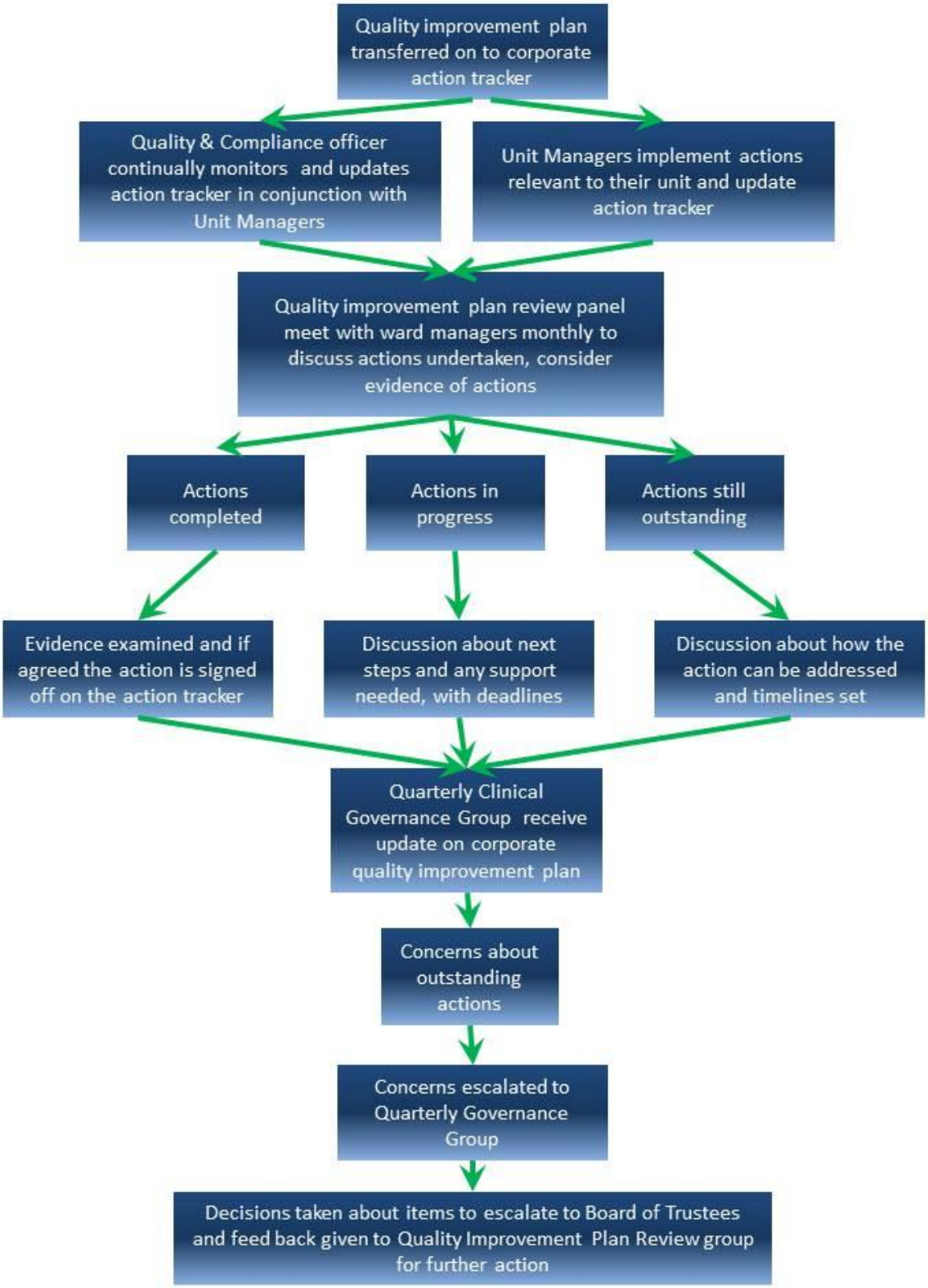
7. **Positive reputation**, as measured by levels of referrals, commissioner feedback, publications, press coverage, waiting lists for patients and for recruitment, invitations to conferences, fewer agency staff (because more employees), visitors from all over the world, invitations to become involved in policy development activities, numbers of appropriate and successful partnerships

8. **Development of practice based evidence**, as measured by numbers and quality of research publications, research grants awarded, presentations at conferences

9. **Expansion,** as measured by financial returns and number of Retreat locations

10. **Modern buildings,** resulting from actions taken from our Options Appraisal.

Appendix C: Progress Monitoring flowchart



Appendix D: The Retreat's Values

Our values are rooted in the Quaker values of Hope, Equality and Community, Courage, Care for our Environment, Peace, Honesty and Integrity. We aim to implement these values in every aspect of our work. The diagram below shows what this set of values means for The Retreat currently.

Our values