Southern Health
NHS Foundation Trust

Quality Improvement Plan (CQC inspection 2018)

OUR VALUES

CORE SERVICE	Safe	Effective	Caring	Responsive	Well-led	Overall
	2018					
OVERALL PROVIDER RATING	RI	RI	G	G	RI	RI
Community health services for adults	G	G	O	G	G	G
Community health services for children & young people	G	G	G	G	G	G
Community health inpatient services	G	G	G	G	G	G
Community end of life care	G	RI	G	G	G	G
Urgent care	G	G	G	G	G	G
Acute wards for adults of working age & PICUs	RI	G	G	G	RI	RI
Long-stay or rehab mental health wards	G	G	G	O	O	O
Forensic inpatient or secure wards	G	G	G	G	G	G
Child and adolescent mental health wards	RI	G	G	G	RI	RI
Wards for older people with MH problems	RI	RI	G	I	RI	RI
Wards for people with a learning disability/autism	G	G	O	O	G	O
Community-based mental health services	G	RI	G	G	G	G
MH crisis services / health-based places of safety	G	RI	G	G	RI	RI
Community mental health services for older people	G	RI	G	G	G	G
Community services for people with a learning disability/autism	G	G	O	G	G	G
Eating Disorder service (not inspected in 2018)	G	G	G	G	G	G
Perinatal services (not inspected in 2018)	O	O	O	O	O	O

Southern Health NHS Foundation Trust

CQC Inspection Report 2018

- Community services now rated 'Good' overall
- Learning Disabilities inpatient and Long Stay Mental Health wards rated as 'Outstanding' overall.
- 26 improvements in the core services
- 6 Outstanding ratings
- 43 Core Services remained at a consistent level
- 'Caring' and 'Responsive' domains rated as good overall.

CQC recommended:

- 20 'must' actions
- 74 'should' actions
- A Quality Improvement Plan covering all the actions was developed and submitted to CQC in November 2018

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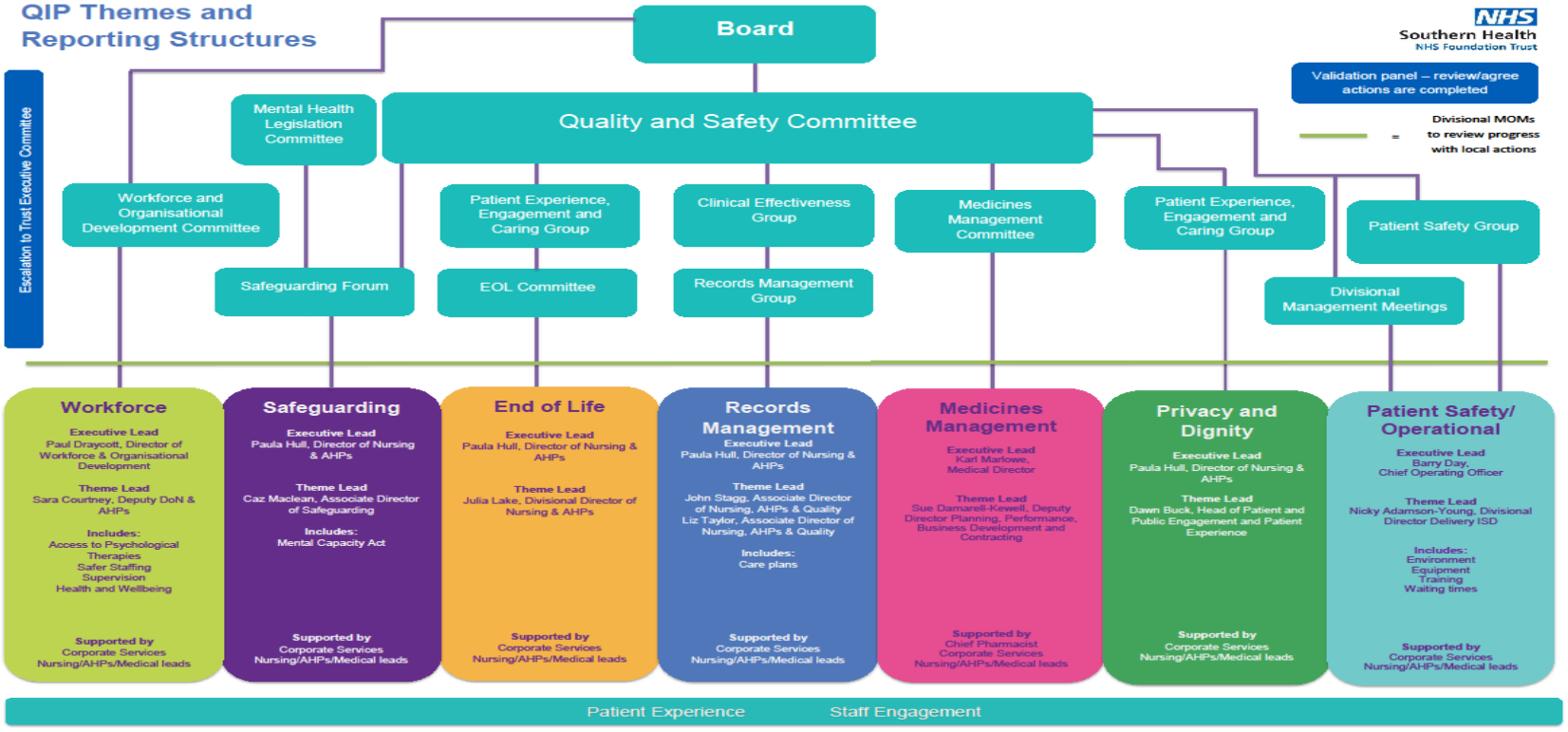
Themes and Reporting Structures



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OUR VALUES

Patients & people first | Partnership | Respect

Southern Health NHS Foundation Trust

Quality Improvement Plan (CQC) 2018 Dashboard

	Overdue (P/O):	6%	3%	At risk (P/O):	3%	3%	On track (P/O):	52%	75%	Unvalidated (P/0):	15%	10%	Completed (P/O):	24%	10%
RAG status	**Nov-18**		**Dec-18**		**Jan-19**		**Feb-19**		**Mar-19**		**Apr-19**		**May-19**		**Jun-19**		**Jul-19**		**Aug-19**	
	Process / Outcome		**Process / Outcome**		**Process / Outcome**		**Process / Outcome**		**Process / Outcome**		**Process / Outcome**		**Process / Outcome**		**Process / Outcome**		**Process / Outcome**		**Process / Outcome**	
Overdue	0	0	1	1	4	2	5	3	4	2										
At risk	0	0	0	0	0	0	0	0	2	2										
On track	64	67	56	61	48	60	40	55	37	53										
Complete-Unvalidated	0	0	7	5	8	4	13	7	11	7										
Completed	7	4	7	4	11	5	13	6	17	7										
TOTAL	**71**	**71**	**71**	**71**	**71**	**71**	**71**	**71**	**71**	**71**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

OUR VALUES

Patients & people first | Partnership | Respect

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Next Steps

- Quality Improvement Methodology and Approach
- Focus on outcome measures and actions being embedded into Business as Usual
- New roles of experts by experience / Working in Partnership

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Any Questions?

NHS Southern Health NHS Foundation Trust

Quality Improvement Plan (CQC) 2018

Version No. 3.9

Date 25.03.19

Lead(s) Paula Hull (Director of Nursing and AHPs)
Briony Cooper (Programme Manager)

Quality Improvement Plan (CQC) 2018 Dashboard

RAG status	Overdue (P/O):	6%	3%	At risk (P/O):	3%	3%	On track (P/O):	52%	75%	Unvalidated (P/0):	15%	10%	Completed (P/O):	24%	10%
	Nov-18		Dec-18		Jan-19		Feb-19		Mar-19		Apr-19		May-19		Jun-19		Jul-19		Aug-19	
	Process / Outcome		Process / Outcome		Process / Outcome		Process / Outcome		Process / Outcome		Process / Outcome		Process / Outcome		Process / Outcome		Process / Outcome		Process / Outcome	
Overdue	0	0	1	1	4	2	5	3	4	2										
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Complete-Unvalidated	0	0	7	5	8	4	13	7	11	7										
Completed	7	4	7	4	11	5	13	6	17	7										
TOTAL	71	71	71	71	71	71	71	71	71	71	0	0	0	0	0	0	0	0	0	0

There are 24 duplicate actions which are not tracked as part of the total actions in the Quality Improvement plan.
There is 1 additional 'should' action uncompleted from the 2017 CQC Improvement Action Plan - 5.h Self-Administration of Medicines.

Quality Improvement Plan for: CQC Inspection Recommendations - October 2018

Version No: 3.9
25/03/2019

Produced by:
Briony Cooper
Programme Manager

Approved by:
Paula Hull
Director of Nursing & AHPs
02/11/2018

Theme	UIN	Core service	CQC action *from the Inspection Report*	Regulation breached	Cause of breach/ issue raised by CQC	Risk register	Trust Action	Process Actions	Evidence of process completion	Progress monitored by	Responsible lead(s)	Executive accountability	Process date	Recovery date	Process progress update	Status *(process)*	Expected Outcome/Improvement	Evidence to show outcome completion	Outcome date	Recovery date	Outcome progress update	Status *(outcome)*
1. Workforce	1.a	Wards for older people with mental health problems	The Trust must ensure patients have access to psychological therapies	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care.	There were no psychological therapies available to patients across the service as recommended by the National Institute for Health and Care Excellence. For example, patients with mental health conditions such as bipolar disorder, depression and anxiety did not receive appropriate psychological therapy.	TBC	To review the provision of psychological therapies across the Trust. To consider and describe the model of psychological therapies for patients. To implement a strategy which enables access to psychological therapies for all patients who require it.	Quality Improvement project into psychology provision, including observation on wards. Recruitment of additional 6 wte psychology posts to work across community and inpatient services, with each new post to provide 0.4wte input to OPMH wards. Develop staff training programme to provide psychologically informed practice.	Quality Improvement project Recruitment of additional posts Staff training programme Patient feedback	Workforce and Organisational Development Committee	Hazel Nicholls Psychological Therapies Lead *supported by* *Operational leads*	Dr Karl Marlowe MD	Jun-19		**Oct-18:** RIPW completed - NICE quality standards reviewed and benchmarked across services and paper written. Proposal written with plan to recruit 6.0 wte 8a clinical psychology posts to work across community and inpatient services. Each new post 0.4 WTE input to OPMH inpatient ward. QI observations of Berrywood Ward need to free up staff time to provide psychological informed practice to patients. Staff training required to provide psychologically informed practice CCC model agreed and being implemented in Berrywood role, with plan to roll out to other wards. Current funding agreed for 2.00 WTE new. Advert currently out for 1.00 wte convert NF East and Berrywood 0.4 WTE. Workforce review required to free up money for additional posts. Should we go at risk and recruit to additional posts now whilst review under way to ensure patients have access to appropriate support right now? QI 90 day implementation plan in place. Measures 1. Time staff spend with patients in psychological informed interactions pre and post training and 3 months after 2. Number of staff trained in CCC formulation model 3. Number of staff attending reflective practice supervision. 4. Percentage of care plans with clear identified formulation and goals. 5. Number of non-psychology staff trained in specific NICE interventions. **Jan-19:** HN/KJ met with senior psychologists to	**On track**	Patients have access to psychological therapies across the Trust based on the National Institute for Health and Care Excellence (NICE) guidance. There will be agreed clinical models within services based on NICE guidance.	Re - review provision of psychological therapies across the Trust. Clinical models within services are embedded.	Sep-19		**Feb-19:** see process update re 2 new posts - 1 starting March 11 and one advertised in Feb.	**On track**
	1.b	Community-based mental health services for older people	The Trust should review the provision of psychologist input to the service to ensure this is equitable across the service	breach - N/A	The provision of psychological therapy varied across the service, with one team having no access to psychological therapy.		**see action 1.a**									**Duplicate**						**Duplicate**
	1.c	Long stay/rehabilitation mental health wards for working age adults	The Trust should review the input of psychologists on both wards	breach - N/A	Both wards had limited input from psychologists		**see action 1.a**	Establish current baseline of psychology provision. Identify issues and root/contributory causes. Develop implementation plan based on analysis.	Baseline information Implementation plan						19.10.18: email sent to current units psychology leads to provide baseline and identify issue and root cause.	**Duplicate**						**Duplicate**
	1.d	Mental health crisis services and health based places of safety	Ensure patients have consistent access to psychiatry and psychology support and treatment	breach - N/A	Patients did not have consistent access to psychologists or psychiatry across the crisis teams. There were delays in patients being able to see a psychiatrist in the crisis teams. For some patients this mean that there were delays to them starting on the appropriate medication and others had not received a medical review when needed. Patients receiving care from the south crisis team had easy access to a psychology team who provided a wide range of psychological therapies and groups but in the north and east teams patients had to be referred to a psychologist (page		**see action 1.a** To review the provision of psychiatry across the crisis teams. To consider and describe the model of psychiatry for patients. To implement a strategy which enables access to psychiatry across the crisis teams.	Establish current baseline of psychology provision and model in place to enable identification of issues. Identify differences in process, practice or investment. Develop standard model and bench mark against best practice.	Baseline information Bench marking data Standard model	Workforce and Organisational Development Committee	~~Debbie Robinson~~ Graham Webb Interim Director of Operations (MH/LD) *supported by* *Hazel Nicholls* *Psychological Therapies lead*	Dr Karl Marlowe MD	Jun-19		**Oct-18:** email sent to psychology leads including OPMH to provide baseline of current service offer and model across Trust to enable clear identification of the issue. Expected response 22.10.18 (except for North as Lead on annual leave). Aim to identify any differences in process, practice or investment and develop standard model and benchmark against best practice.	**On track**	Patients have access to psychiatry based on their needs and best practice recommendations. There will be agreed clinical models within services based on best practice recommendations.	Re-review the provision of psychiatry across the crisis teams. Clinical models within services are embedded.	Sep-19			**On track**
	1.e	Acute wards for adults of working age and psychiatric intensive care units (PICU)	The Trust must ensure that the safer staffing levels are met on all the wards to ensure safe care and treatment of patients. This includes consistent medical cover across the wards.	Regulation 18 HSCA (RA) Regulations 2014 Staffing	The wards at Antelope House (Saxon, Trinity and Hamtun) did not always have adequate staff. While managers tried to ensure that agency cover was in place to ensure appropriate cover, this did not always succeed. On the occasions when staffing was particularly low, this had an impact on safe patient care and a higher level of incidents.	Risk Reg No: 576 SR1. There is a risk that we provide poor quality or ineffective care resulting n serious harm	To deliver Year one of the Five Year People and Organisational Development Strategy (2018 - 2022). To strengthen the operational use of the Safer Staffing policy and procedures.	Delivery of workforce strategy and organisational development. Ensure Safer Staffing policy and procedures are implemented. Weekly staffing calls. Twice yearly Acuity & Dependency audits. Workforce plan which includes Nurse Associates and Associate Practitioners. Consider use of other professions. Ensure consistent medical cover.	Audit and Dependency results Workforce plan Safer staffing incidents reduced	Workforce and Organisational Development Committee	Carole Adcock ADoN & AHPs ~~Stefan Gleeson Consultant Psychiatrist~~ *supported by* *Sara Courtney* *Deputy DoN & AHPs* ~~*Sue Jewell*~~ *Safer Staffing lead*	Paul Draycott Director of Workforce & Organisational Development	Sep-19		**Feb-19:** Safer Staffing AMH Inpatient data - Tableau reports downloaded to evidence folder. **Mar-19:** requested update from Kerry Salmon. Quarterly strategy paper updates saved into evidence folder	**On track**	No clinical teams with a vacancy rate of over 10% at any one time. Agency and locum spend less than 1%. Competency based workforce plans in place for every service - based on demand, capacity, competency and income.	Implementation of People and Organisational Development Strategy. Implementation of Safer Staffing key performance indicators (KPI).	Dec-19			**On track**
	1.f	Wards for older people with mental health problems	The Trust must ensure that staffing is at a safe level on Beaulieu ward at all times	Regulation 18 HSCA (RA) Regulations 2014 Staffing	Most wards were short of staff on some shifts. The biggest impact was seen on Beaulieu ward as recovery workers were filling nursing assistant shifts and therefore, activities were frequently being cancelled.	Risk Reg No: 576 SR1. There is a risk that we provide poor quality or ineffective care resulting in serious harm.	**see action 1.e** To deliver the workforce plan for Older Peoples Mental Health services.	Delivery of workforce strategy and organisational development Safer Staffing policy and procedures are implemented Roll out of 'Safe care' to support eroster system. Consultation on safe staffing shift patterns. Daily staffing call including safer staffing lead. Recruitment strategy developed. Review administrative support for eroster system.	Workforce plan Safer staffing incidents reduced Recruitment completed Safe care rolled-out	Workforce and Organisational Development Committee	~~Susanna Preedy~~ ~~ADoN & AHPs~~ Carole Adcock ADoN & AHPs Kathy Jackson HoN & AHPs *supported by* *Sara Courtney* *Deputy DoN & AHPs* ~~*Sue Jewell*~~ ~~*Safer Staffing lead*~~	Paul Draycott Director of Workforce & Organisational Development	Dec-18	Jun-19	**Oct-18:** consultation re shift patterns/administrative support by 31.12.18. Recruitment strategy drawn up with Penny Smee by 30.11.18. **Nov-18:** Training for Safecare to staff at GWMH and Parklands and roll out. **26-Nov-18:** Beaulieu ward admissions suspended due to understaffing, temporarily closed for a period of up to six months. **Dec-18**: revised date for completion added due to trust wide consultation on changes to divisional structures which will impact on OPMH services. Project plan developed and in place - project managed by Steve Manning. **Feb-19:** Beaulieu ward KJ update - plan to re-open 13 May 2019 - a weekly call between senior managers takes place to ensure traction with plan. Plan led by Graham Webb with Barry Day as executive lead. Have met with estates to look at improvements for ward - capital funding bid submitted to SMC on 20.02.19 for discussion/approval. Recruitment - had Southampton specific recruitment day in Jan with interest shown, attended Surrey University recruitment day last week and had 2 expressions of interest. Proposal to SMC on 20.02.19 re recruitment drive in Australia. B6 to start in May, NQ B5 to start in Sept. **Mar-19:** requested update from SMC. 13.03.19: SMC agreed that action should be recorded as on track as ward due to re-open at end May. Recovery date to be June 2019	**On track**	Services are staffed at levels which enable safe care and treatment of patients as per our policy standard.	Implementation of People and Organisational Development Strategy. Safer Staffing reports.	Dec-18	Dec-19	**Dec-18:** revised date for completion added due to trust wide consultation on changes to divisional structures which will impact on OPMH services. Beaulieu ward closed currently. Beaulieu due to reopen 13 May.	**On track**

Theme	UIN	Core service	CQC action *from the Inspection Report*	Regulation breached	Cause of breach/ issue raised by CQC	Risk register	Trust Action	Process Actions	Evidence of process completion	Progress monitored by	Responsible lead(s)	Executive accountability	Process date	Recovery date	Process progress update	Status *(process)*	Expected Outcome/Improvement	Evidence to show outcome completion	Outcome date	Recovery date	Outcome progress update	Status *(outcome)*
	1.g	Child and adolescent mental health wards	The Trust must ensure the improvements made in response to the warning notice are maintained, that it has clear oversight and assurance of all risk issues and that timely action is taken as needed to ensure that young people using the service are kept safe	Regulation 17 HSCA (RA) Regulations 2014 Good governance	At Bluebird House there were insufficient levels of staff on the wards to ensure that young people were protected from avoidable harm. The trust responded immediately to the concerns we raised. The trust provided an action plan that set out how it would make the improvements required by the warning notice. We undertook an unannounced, focussed inspection on 18 July 2018 to check that the trust had taken the actions identified in its action plan. We found a significant number of ligature risks at Leigh House that were not being managed appropriately. However environmental work to address the ligature risks at Leigh House were nearing completion and staff had detailed knowledge of the management of the risks. Staff and young people told us that they now felt safe. As such we lifted the warning notice.	Risk Reg No: 1740 SR1. There is a risk that we provide poor quality or ineffective care resulting in serious harm.	To have governance processes in place, to review issues raised during the inspection and ensure risks are identified and managed.	see action plan in response to warning notice	Minutes of MOM meetings Implementation of action plan	Workforce and Organisational Development Committee	Rachel Coltart Quality & Performance Business Manager ~~Laura Pemberton~~ ~~Interim Associate Director of Nursing~~	Paula Hull DoN & AHPs	Dec-18		Action plan developed July 2018 in immediate response to Warning Notice. **Dec-18:** CQC action plan meeting on 12.12.18 will review the Warning Notice and that progress with issues maintained. Ligature work at Leigh House has been completed. Staffing at Bluebird House - not all newly recruited staff started work therefore still pressures. There is a consultation on new nursing model - Karen Dixon can provide update. 1 patient in long term segregation requires high staffing levels. Interim arrangement that West London i.e. where comes from are co-ordinating a team of HCSW/nurses to support this young person at BH.	**Complete-Unvalidated**	Improved experience for patients who receive safe care and treatment.	Safer staffing reports. Overview of reported incidents.	Jan-19		**Feb-19:** email from RC - has got all of the daily safer staffing reports;Karen Dixon to forward all evidence relating to local reviews etc. on staffing – a lot of work has taken place. Need minutes from meeting held on 12/12/2018. **05.03.19:** updated CAHMs action plan saved to evidence folder. The meeting on 12.12.18 was not minuted, it was a handover of the action plan from RC to LP. **20.03.19:** RC - shared copy of CAMHs new staffing model Consultation paper, plus Recruitment report re marketing, recruitment, vacancy rates, planned initiatives/events. KD - shared copy of CAMHs workforce delivery grp mins and recruitment action plan.	**Complete-Unvalidated**
	1.h	Acute wards for adults of working age and psychiatric intensive care units (PICU)	The Trust should ensure that all patients have access to therapeutic activities and engagement	breach - N/A	On Elmleigh patients told us that often there were (not?) regular scheduled activities and that they were often bored on the ward. The wards calculated the required numbers of staff within safer staffing guidelines but these numbers were not always met. Staff told us that this impacted on patient care due to a reduction in patient one to ones and escorted leave having to be cancelled occasionally, not always having enough staff to hand to deliver safe interventions with patients and therefore a higher level of incidents taking place.		**see action 1.e** To plan activity schedules across whole week.	Delivery of workforce strategy and organisational development Safer Staffing policy and procedures are implemented Seven day planning to provide activities.	Workforce plan Activity schedules	Workforce and Organisational Development Committee	Carole Adcock ADoN & AHPs *supported by* *Sara Courtney* *Deputy DoN & AHPs* ~~*Sue Jewell*~~ *Safer Staffing lead*	Paul Draycott Director of Workforce & Organisational Development	Mar-19		**Feb-19:** all units have activity timetables in place. Kingsley ward QI project included focus on developing more activities. **19.03.19:** Activity timetables received from Kingsley, Elmleigh and Parklands (ISP, H1 & H2). As well as timetables, Parklands also posters put up around the ward to promote activities/meetings.	**On track**	Personalised activities are available to patients based on their need.	Evidence of activity programmes in place. Positive patient feedback.	Dec-19			**On track**
	1.i	Wards for older people with mental health problems	The Trust must ensure patients are supported to use their section 17 leave	breach - N/A	Staff on Beechwood ward were not proactive in ensuring that patients used their section 17 leave as part of the recovery process.	TBC	To review use of Mental Health Act leave across the Trust and establish why it is not available consistently. To develop and implement a plan to address issues based on findings.	To review use of Mental Health Act leave across the Trust and establish why it is not available consistently. To develop and implement a plan to address issues based on findings.	results of review Implementation plan	Workforce and Organisational Development Committee	Siven Rungien MHA Manager *supported by* *Operational leads*	Dr Karl Marlowe MD	Mar-19		**Nov-18:** MHLSC - MHA assessment service experience presentation. To consider development of a Friends and Family Test on discharge from MHA. Analysis of section 17 leave presented - request for presentation of further assurance at Feb meeting. **Feb-19:** MHSLC - Section 17 leave presentation from Ward Manager Kingsley ward. MHLC agreed; I) a revised section 17 policy (specific to Kingsley at this time) to be drafted within 3 months to support the Kingsley changes; II) to develop a plan to roll out the Kingsley changes to all other units within the next 12 months. It was also discussed, including the CQC requirements, at the last MHLC (see page 9, item 14 of the attached). **15 Feb-19:** KJ - OPMH matrons met with transformation team to discuss implementing Kingsley QI project on Beechwood ward.	**On track**	Improved patient experience through leave being available consistently.	Patient/staff feedback. Reported incidents.	Jun-19			**On track**
	1.j	Forensic inpatient / secure wards	The Trust should ensure there are enough staff on each shift to meet the needs of all patients. Patients should be able to participate in activities and use their leave even when staff are supporting other wards	breach - N/A	Patients on Malcom Faulk ward and Ashurst ward told us that access to the courtyard was not always facilitated on time due staff not being available to do so.		**see action 1.i**	All cancellations of leave will be recorded and reported on. Ward Managers to review data monthly to establish any deficits and action as required. Timetable for unit activities is displayed and will be regularly reviewed by the Security and Leadership team. Ward activities will be timetabled and participation recorded.	Leave cancellation records Unit activities timetable Ward activities timetable and individual RIO record for participation							**Duplicate**					**Duplicate**
	1.k	Forensic inpatient / secure wards	The Trust should ensure that patients access to ground leave are assessed on an individual basis at Ravenswood House Medium Secure Unit and are not subject to blanket restrictions	breach - N/A	Ravenswood House Medium Secure Unit had a blanket restriction affecting all patients. Due to the lack of a perimeter fence, all ground leave was escorted by staff and not based on individual risk assessment. This could be overly restrictive for some patients.		**see action 1.i**	All ground leave is classed as community leave, partially for the restricted patients where MoJ restriction is required. For the patients who have unescorted community leave granted, will be individually risk assessed for their appropriateness for unescorted leave in the grounds.	Ground leave policy will be amended. Patients with unescorted community leave will have a consideration to the ground leave on the s17 leave paperwork. Perimeter fence agreed.							**Duplicate**					**Duplicate**
	1.l	Acute wards for adults of working age and psychiatric intensive care units (PICU)	The Trust must ensure that all staff have access to supervision, team meetings and appraisals as is necessary for them to carry out the duties they are employed to perform	Regulation 18 HSCA (RA) Regulations 2014 Staffing	Staff on Trinity, Hamtun and Saxon did not have access to regular supervision and team meetings. This was a concern because regular supervision and team meetings would provide staff with the support and platform for raising concerns and sharing learning and development. We were informed that some staff had not had supervision for over six months.	Risk Reg No: 1612 SR1. There is a risk that we provide poor quality or ineffective care resulting in serious harm.	To review supervision practices across the Trust and establish why it is not being accessed consistently and effectively. To develop and implement a model of supervision and guidance to staff based on the findings of the review.	Trust wide review of supervision - needs of staff, systems and processes. Implementation plan based on analysis	Supervision review Implementation plan	Workforce and Organisational Development Committee	Paula Hull DoN & AHPs	Paul Draycott Director of Workforce & Organisational Development	Jul-19		**Feb-19:** Susanna Preedy leading clinical supervision project. Clinical supervision policy has been revised and approved at DoN meeting. **Mar-19:** Report with clinical supervision on a page to be presented to QSC on 12.03.19 (see evidence folder for copy).	**On track**	Staff are enabled to be part of meaningful reflective practice and supervision which supports their health and well-being and maintains the safety of patients.	Revised Supervision Policy and Procedures. Positive staff feedback on quality and frequency of supervision. Audit of supervision programme.	Sep-19			**On track**
	1.m	Community-based mental health services for adults of working age	The Trust should ensure that relevant staff at the Southampton Central site receive regular clinical supervision in line with Trust policy	breach - N/A	Managers were not effectively supporting staff to improve the quality of care plans and use of electronic systems to keep patient records accurate.		**see action 1.l**									**Duplicate**					**Duplicate**
	1.n	Community-based mental health services for adults of working age	The Trust should ensure that managers support staff to improve the quality of care plans and use electronic patient record systems appropriately	breach - N/A	Staff at the Southampton Central site were not receiving regular clinical supervision.		**see action 1.l**									**Duplicate**					**Duplicate**
	1.o	Community-based mental health services for older people	The Trust should ensure managers can clearly demonstrate that staff receive regular supervision	breach - N/A	Some teams did not keep records of staff receiving regular managerial supervision. Some leaders were not providing regular supervision to staff		**see action 1.l**								**Oct-18:** variety of processes in place to record supervision - not used consistently. Introduce standard record sheet to record clinical and managerial supervision which is completed at each supervision session.	**Duplicate**						**Duplicate**
	1.p	Child and adolescent mental health wards	The Trust should ensure that all staff are supervised in line with Trust policy	breach - N/A	Individual supervision was not in line with the expected completion rate set by the trust.		**see action 1.l**								**19.10.18:** LEaD data Bluebird 65% Leigh House 78% supervision rates. Local protocol in place including reflective practice and debrief - review and refresh. Min 10 sessions in 12 m period.	**Duplicate**						**Duplicate**
	1.q	Forensic inpatient / secure wards	The Trust should ensure management supervision and yearly appraisals are recorded in line with Trust's policy	breach - N/A	Management supervision and yearly appraisal were not always recorded in line with the trust's policy.		**see action 1.l**								**Oct-18:** compliance with appraisals/supervision monitored via Tableau and manual submission. Ward Managers will carry out 6 monthly review of appraisals (incl. objectives) with relevant supervisor. Identify any paperwork not fully completed and address.	**Duplicate**						**Duplicate**
	1.r	Mental health crisis services and health based places of safety	Ensure staff members receive regular one to one managerial supervision in line with the Trusts policy	breach - N/A	Staff did not receive regular one to one managerial supervision.		**see action 1.l**									**Duplicate**						**Duplicate**

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	1.s	Wards for older people with mental health problems	The Trust should ensure that poor staff performance is managed effectively	breach - N/A	Managers did not always deal with poor performance effectively. On Rose ward and Beaulieu ward, staff performance plans had not been followed through supporting staff to improve their practise.		**see action 1.l**									**Duplicate**						**Duplicate**
	1.t	Wards for older people with mental health problems	The Trust should ensure that staff receive appropriate and effective supervision within the timescales of the Trust policy	breach - N/A	There were inconsistencies in the frequency and quality of staff supervisions across the wards.		**see action 1.l**									**Duplicate**						**Duplicate**
	1.u	Forensic inpatient / secure wards	The Trust should ensure that staff are provided a bully and harassment free working environment to work in	breach - N/A	Some staff at Ravenswood Medium Secure Unit said that they had experienced bullying. This was escalated to senior management and immediate actions were taken.		To have visible senior leadership and mechanisms in place enabling staff to feel confident in raising concerns.	The Leadership team will ensure high visibility on the units and open staff Forums and concerns are addressed appropriately. Team meetings to highlight the mechanisms for raising concerns, including Speak Up, Whistleblowing and comments box	Staff feedback HR investigations minutes of team meetings	Workforce and Organisational Development Committee	Nicki Brown AD of Specialised Services Sarah Shackleton HR Manager	Paul Draycott Director of Workforce & Organisational Development	Dec-18		**Dec-18:** service manager is visible and facilitates monthly staff forum which the modern matrons attend; also chairs monthly patient forum. Emails are sent to all staff with updates. Sarah Shackleton (HR), Rachel Coltart, Nina Davies, Colin Graham met on 13.12.18 to review issues/background/workforce investigations. Two workforce investigations found no evidence of bullying. Some staff had moved between wards and raised issues re new ward manager. Latter followed policies and procedures. Staff already on ward gave positive feedback re manager. **08.01.19 QIPDG:** agreed action completed.	**Completed**	Staff are confident they are listened to when raising issues to managers.	Staff feedback.	Dec-18		**Dec-18:** The Open staff forums with the Matrons are in place on a bi-monthly basis, as is monthly Service Manager open forums. Staff feedback comments boxes are in place. The art therapist is working on designing the feedback 'graffiti board' where staff and patients will be able to feedback comments. **08.01.19 QIPDG:** Specialised Services are also developing a 'back to the floor' programme where nursing leads will spend time on the wards giving opportunity for staff discussion/feedback. Agreed	**Completed**
	1.v	Wards for older people with mental health problems	The Trust should ensure all staff are safely orientated to the ward	breach - N/A	Not all staff received an orientation to the ward. Staff on Beaulieu ward did not receive an orientation when they commenced work on the ward.		To review local induction programme for new staff.	Review current local induction programme and amend based on feedback. To include bank and agency staff.	Revised local induction programme.	Workforce and Organisational Development Committee	Sharon Harwood Matron Kathy Jackson HoN	Paul Draycott Director of Workforce & Organisational Development	Dec-18		**Oct-18:** Reviewed current induction information and revised draft circulated for comments. To include bank and agency staff. **Dec-18:** local induction is one of the current QI projects. The project plan to re-open Beaulieu will include induction needs. **Jan-19:** revised local induction programme across the 7 OPMH wards in place. 08.01.19 QIPDG: agreed action will be recorded as completed once evidence received (see mins page 6, action 1.r) **Feb-19:** KJ to review local induction information per ward and send as evidence. Evidence received and added to folder.	**Completed**	New staff feel welcomed to the Trust and understand their roles and responsibilities.	Staff feedback on local induction.	Dec-18		Beaulieu ward currently closed - due to re-open May 2019. **Jan-19:** OPMH matrons meeting in Jan will check use of local induction programmes and the feedback from new staff as to their use. 08.01.19 QIPDG: agreed action will be recorded as complete once evidence received. 10.01.19: induction forms for Beaulieu and GWMH received - however very different formats used. Request that the induction packs are standardised across wards. **Feb-19:** QI project into local induction led by Bobby Moth - RIPW week beg 4 March. Induction packs for all OPMH wards now received in standard format. OPMH induction packs will be informed by the QI project. Project team includes John Tyson (OPMH) and Panos Prevezanos (Psychiatrist MH). Need to check staff feedback once Beaulieu re-opens in May.	**Complete-Unvalidated**
	1.w	Community mental health services for people with a learning disability or autism	The Trust should ensure change is managed appropriately and minimise the impact of change on staff	breach - N/A	Some staff said there was some stress caused by frequent changes to expectations from senior management and high expectations of them. Staff described having to respond to directives from senior management which they felt were sometimes risk aversive and less relevant than local issues.		To explore and address issues raised by staff and continue the 'open door' sessions.	Explore issues with staff - anonymous feedback via governance meetings. Implementation plan based on findings. Continue monthly 'Open Door' sessions for staff.	"You Said / We Did" re: staff concerns and how addressed. Plans to support staff with change process in place.	Workforce and Organisational Development Committee	John Stagg ADoN, AHPs & Quality	Paul Draycott Director of Workforce & Organisational Development	Mar-19		**Oct-18:** The service will explore with staff what these issues are and make plans with staff to try to address their concerns. The service will do this by posing a question to team governance meetings and asking them collate their answers back to us as an anonymous response. We will then agree the actions required through our Learning Disability Quality & Safety Meeting. We will continue to offer open door sessions to staff every month after our Learning Disability Quality and Safety meetings. **Feb-19:** Within the Division we have reviewed	**On track**	Health and well-being of staff are supported.	You said, we did' feedback. Staff feedback	Apr-19			**On track**
	1.x	Community health inpatient services	The Trust should improve the collection of and complete the actions from clinical audit data results to improve the effectiveness of the service	breach - N/A	In some areas the collection of clinical audit data to monitor the effectiveness of services was not thorough and learning could not always be evidenced. There were gaps in the collection of data and action plans in some areas were not completed.	Risk Reg No: 1583	To review and streamline clinical audit processes using quality improvement methodology.	Review of current system for recording action at team level. Streamlining of actions plans for teams so that there is only one. Quality improvement plans to be reviewed as part of performance reviews. Trust wide Quality Improvement Project to review processes and effectiveness of clinical audit.	Clinical audit participation rates by team Actions from audits to be included in quality improvement plans Learning shared across teams Quality Improvement Project	Clinical Effectiveness Group	Tracey McKenzie Head of Quality, Compliance, Assurance & Quality	Dr Karl Marlowe MD	Mar-19	Apr-19	**Oct-18:** Clinical audit to be subject to a QI project with baseline data collection in November and a stakeholder workshop in early December. Subsequent improvement plans will be based on outcome of workshop. **Feb-19:** clinical audit QI workshop was cancelled due to the snow and has been rescheduled for 22 March (still tbc). Team continue to work with the divisions to improve their response to audit actions. **Mar-19: (TM Email)** Clinical audit QI	**At risk**	Clinical audit leads to improvements in patient care.	Re-audit results demonstrate quality improvements.	Dec-19			**On track**
2. Safeguarding	2.a	Wards for older people with mental health problems	The Trust must ensure that staff apply the Mental Capacity Act if there is doubt about a patient's capacity to consent to admission	Regulation 11 HSCA (RA) Regulations 2014 Need for consent.	Staff did not apply the Mental Capacity Act appropriately on Beechwood ward. Mental Capacity Assessments were not always completed for decisions around admission for patients that may have lacked capacity.	TBC	To review use of the Mental Capacity Act across the Trust and establish why it is not being applied consistently. To develop and implement a plan to address issues based on findings of the review. To strengthen the operational use of the Mental Capacity Act Policy.	Analysis of reasons for non completion of MCA. Based on results implement plan to address issues. Audit use of MCA across wards following plan and have plan for ongoing monitoring.	Analysis Implementation plan in place Assurance check	Safeguarding Forum	Caz MacLean AD of Safeguarding *supported by* ~~*Susanna Preedy*~~ ~~*ADoN & AHPs*~~ *Carole Adcock* *ADoN & AHPs*	Paula Hull DoN & AHPs	Jun-19		**Oct-18:** Safeguarding team have provided additional support and training to staff at Western Hospital. Clinical teams need to undertake analysis as to why this was not happening and identify what is required to ensure this improves. **Nov-18:** MHLSC - thematic review on MCA and DOLS presented. Noted progress made with communication and training to meet this action. **Jan-19**: Q2 Safeguarding Report - page 236 - audit against MCA assessments and best interest decision making processes in trust. **Feb-19:** CM to do presentation to MHLC next week on MCA and DOLS (and SR on MHA). MCA audit just completed - less positive results than audit 2 years ago and highlights areas for improvement - results raise similar issues to those found by CQC. Will be developing implementation plan based on issues found. Issues - training, knowledge sharing, putting training into practice. At present MCA training is part of L2 safeguarding mandatory training with over 90% compliance. However should MCA be separate training? Requests from staff for learning set type workshops using case studies and can practice putting training into practice. Proposal - to have separate MCA/DOLS team to safeguarding team and similar to MHA team. Eliot Smith to lead project on return 01-Apr-19. **27.02.19:** MCA proposals to MHLSC on 12.02. the proposals were supported. They will be discussed at safeguarding forum on the 1st and	**On track**	A patient's mental capacity is appropriately assessed and documented by staff who are knowledgeable and competent in applying the MCA.	Audit use of Mental Capacity Act (MCA). Quality Assessment Tool results.	Aug-19		**Feb-19:** MCA audit just completed - implementation plan being developed. See process notes for update on areas for improvement.	**On track**
	2.b	Community mental health services for people with a learning disability or autism	The Trust should complete and document Mental Capacity Act assessments when they are required, for example, when making best interest decisions or providing treatment without a patient's consent.	breach - N/A	Staff generally completed and documented Mental Capacity Act assessments when they were required. However, there were three examples of staff making best interest decisions to provide treatment without the patient's consent without a documented Mental Capacity Act assessment being in place.		**see action 2.a**	Refresh requirements to undertake and record MCA assessments and Best Interest decision making. Identify Best Practice examples for inclusion in guidance to staff. Sample Best Interest decision making.	Compliance and recording of MCA assessments of capacity and best interest decision making will be evidenced within sampling 100% of the time						**Oct-18:** the service will refresh the requirements to undertake and record MCA assessments of capacity and best interest decision making. This will be done through the Learning Disability records group who will identify the " best Practice" examples for inclusion within Team Process and Open RiO SSG documents. We will set up a period of sampling of Best Interest decision making related to the care that we directly provide to ascertain compliance with assessment and recording of best interest	**Duplicate**						**Duplicate**
	2.c	Child and adolescent mental health wards	The Trust should ensure that staff are aware of how to assess mental capacity and are aware of Gillick Competency when working with young people.	breach - N/A	Across the two sites staff had varying knowledge of the Mental Capacity Act (MCA) and Gillick competency, staff were not always aware of how they might test someone's capacity.		**see action 2.a** To confirm that agencies providing staff for CAMHS include Gillick competency in their training programmes.	Analysis of staff knowledge and understanding of MCA including agency training. Identify all agencies likely to provide staff for CAMHS and check their training programmes include Gillick Competency.	Analysis Implementation plan in place Assurance check	Safeguarding Forum	Caz MacLean AD of Safeguarding *supported by* *Rachel Coltart* *Compliance, Quality, Assurance & Performance lead* ~~*Laura Pondleton*~~ ~~*Interim Associate Director of Nursing*~~	Paula Hull DoN & AHPs	Mar-19		**Oct-18:** Bluebird House and Leigh House completed own training programme on Gillick Competency. MCA/Gillick competency in L2 and 3 safeguarding training within trust. Need to make sure that agency staff have safeguarding training that includes Gillick competency. **Feb-19:** CM confirms all agencies supplying staff include Gillick competencies in their training and that it is to same standard as Trust training. Safeguarding training stats L2=97% , L3=89% **18.03.19 ERP:** agreed that this action is complete.	**Completed**	The Trust has assurance that agency staff are trained to the same level of competency as substantive staff.	Agency training programmes include Gillick competency. Audit use of Mental Capacity Act.	Aug-19		**Feb-19:** CM confirmed agency training programmes include Gillick competency. MCA audit just completed - implementation plan to be developed based on results. **Mar-19:** CM presented proposal to separate MCA and safeguarding training to QSC on 12.03.19. Recent MCA audit found areas of good practice but also that there was little evidence of strategies used to maximise individuals' capacity to	**On track**

Theme	UIN	Core service	CQC action *from the Inspection Report*	Regulation breached	Cause of breach/ issue raised by CQC	Risk register	Trust Action	Process Actions	Evidence of process completion	Progress monitored by	Responsible lead(s)	Executive accountability	Process date	Recovery date	Process progress update	Status *(process)*	Expected Outcome/Improvement	Evidence to show outcome completion	Outcome date	Recovery date	Outcome progress update	Status *(outcome)*
	2.d	Wards for older people with mental health problems	The Trust should monitor the use of the Mental Capacity Act	breach - N/A	The trust did not routinely monitor the use of the Mental Capacity Act across the wards. There was no designated person responsible for the use of the Mental Capacity Act.		To review the current governance structures for the oversight of the Mental Capacity Act. To develop and present for approval a proposal for the operational, governance and reporting processes for the Mental Capacity Act across the Trust.	Review the current position and develop proposal for operational, governance and reporting processes for MCA in the trust. Present proposal to Mental Health Legislation Committee for discussion/approval. Implementation plan developed based on MHL committee decision.	position statement and proposal implementation plan	Safeguarding Forum	Caz MacLean AD of Safeguarding	Paula Hull DoN & AHPs	Jun-19		**Oct-18:** Eliot Smith started to look at how MCA could be better managed within trust. Eliot due to attend MH Legislation Committee as MCA lead in safeguarding team - now has period of leave. **Nov-18:** MCA presentation to MHLSC. **Feb-19:** see 2.a update re presentation on MCA and DOLs to MHLC on 12.02.19.	**On track**	There will be oversight of all patients assessed under the Mental Capacity Act with agreed reporting and monitoring processes across the Trust.	Proposal and implementation plan.	Sep-19			**On track**
	2.e	Wards for older people with mental health problems	The Trust must ensure safeguarding concerns are raised with the local authority	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment.	Staff did not always follow the trust policy for reporting safeguarding concerns. On both Beulieu and Berrywood ward there were examples of alleged and actual abuse which mainly involved patients assaulting one another, these had not been reported to the local authority.	TBC	To amend systems to enable recording and oversight of safeguarding referrals to the Local Authority. To strengthen the operational use of the Safeguarding Policy and Procedures.	Safeguarding team to provide additional support to identified teams. Amend Ulysses to record whether safeguarding/DOLS referral made to local authority and MCA completed. Guidance to staff on revised process. Safeguarding Forum/Team managers to review data, explore reasons for performance and take action to address issues. Audit referrals to Local Authority.	Corporate safeguarding team support to teams Ulysses amended/guidance to staff Tableau reports - performance data Minutes divisional meetings Minutes Safeguarding Forum Audit results and actions	Safeguarding Forum	Caz MacLean AD of Safeguarding *supported by Operational leads*	Paula Hull DoN & AHPs	Mar-19		**Oct-18:** CM met with Ulysses lead to amend system so safeguarding referrals can be recorded. Safeguarding team have provided additional support and training to staff at Western Hospital. **Jan-19:** Safeguarding hotspots reminds staff re responsibilities to refer if safeguarding concerns. Safeguarding Adults Policy v11 and Safeguarding Children's Policy v5 have been reviewed and updated to reflect any local and national changes. Policies approved at QSC on 15.01.19. A review of efficacy of comms bulletin in informing staff will be audited in Q4. **Feb-19:** CM to request Tableau report on safeguarding referrals and to check the communications made re changes to Ulysses and recording safeguarding referrals. It is not possible to check number of safeguarding referrals with local authority as they do not record the organisation, only as 'health'. **Feb-19:** KJ - there is a training prgramme planned for Beaulieu ward staff as part of re-opening plan. A lot of training to staff at Western Hospital delivered - looked at safeguarding but also how to report incidents on Ulysses and language used.	**On track**	The safety of patients is supported with safeguarding concerns identified and reported by staff who are knowledgeable and competent in applying the Safeguarding Policy and Procedures.	Sample case audit to ensure that changes to recording systems and knowledge are embedded and understood. Feedback from staff and local authority.	Mar-19		**Feb-19:** at risk of slippage - need to embed changes to Ulysses before completing sample audit. It is not possible to check number of safeguarding referrals with LA as they do not record the organisation, only as 'health'.	**On track**
	2.f	Community-based mental health services for adults of working age	The Trust should ensure that all staff adhere to the safeguarding policy and raise safeguarding concerns with the relevant local authority	breach - N/A	Each team had different methods for making a safeguarding referral. Staff could not be certain that a referral had been made to the local authority, in line with the trust's safeguarding policy.		**See action 2.e**	See action 2.e								**Duplicate**						**Duplicate**
	2.g	Community-based mental health services for adults of working age	The Trust should ensure that the community mental health teams work with the local authorities to safeguard adults at risk.	breach - N/A			**See action 2.e**	See action 2.e								**Duplicate**						**Duplicate**
	2.h	Mental health crisis services and health based places of safety	Ensure managers monitor the number of safeguarding referrals to the local authority	breach - N/A	Managers of the service did not monitor the number of safeguarding referrals sent to the local authority.		**See action 2.e**	See action 2.e								**Duplicate**						**Duplicate**
	2.i	Community-based mental health services for adults of working age	The Trust should ensure that the Southampton teams, who are due to re-integrate the team back with adult social services, clarify local processes with Southampton City Council to ensure staff follow correct procedures for raising a safeguarding concern.	breach - N/A			To clarify local safeguarding processes with Southampton City Council.	Clarify local processes with Southampton City council. Communication to staff regarding correct procedures.	Process in place	Safeguarding Forum	Sarah Leonard HoN & Quality	Paula Hull DoN & AHPs			Action completed - evidence presented to EOIP.	**Completed**	There are agreed processes in place and staff are clear as to how to raise safeguarding concerns with the Local Authority.	Audit the use of Safeguarding standard operating procedures in Southampton teams.	Aug-19			**Completed**
	2.j	Community health services for children, young people and families	Continue to ensure health reviews for children in care are completed in a timely way.	breach - N/A	There were delays in carrying out the health reviews for children in care, and the team had stopped carrying out health assessments for children based in Hampshire, but under the care of a different local authority, and had stopped delivering training to foster carers.	risk 901	To review the Children in Care service specification with commissioners and key stakeholders.	Review of Children in Care specification with commissioners and stakeholders.	Service review	Safeguarding Forum	Caz MacLean AD of Safeguarding	Paula Hull DoN & AHPs	May-19		**Oct-18:** 'The Children In Care (CIC) service specification is under active review with commissioners and stakeholders. This review is being undertaken to ensure the Trust is commissioned and funded to fulfil its obligations and ensure that all Looked after Children receive a RHA service in a timely and equitable way. The challenges that the Trust are experiencing in providing this level of service mirrors the national picture of an increasing Children In Care population who have complex health care needs	**On track**	There will be agreement with commissioners on the service specification with potentially additional resources to enable health reviews to be completed within timeframes or agreement that the timeframes are extended to allow for the extra demand.	Audit that health assessments are completed within agreed timescales/benchmarks. Feedback from users.	Jun-19		This is an issue resulting from commissioners not funding the service adequately to provide the required health assessments within timeframes.... should this be our action to address. There is no question about the quality of the assessments and processes used, this is beyond our control????	**On track**
3. End of Life Care	3.a	End of Life Care	End of life care must ensure that all do not attempt resuscitation or DNACPR forms are fully completed.	Regulation 11 HSCA (RA) Regulations 2014 Need for consent.	The trust had been told in 2017 they must ensure DNACPR forms were completed in line with national guidance. When we reviewed seven sets of records we saw that DNACPR decisions were not always recorded appropriately and in line with national guidance.	TBC	To continue delivery of the End of Life Care Strategy 2016-2020.	Focus on DNA CPR regulations during induction for all medical staff to the trust Segment on DNACPR documentation in ILS training Debrief from all resuscitation events and peri arrest events where orange bag is opened to include attention to presence and quality of DNA CPR form Mortality review process at Lymington hospital includes attention on quality of DNACPR form Audit of DNACPR forms by resuscitation training officers with results presented at resuscitation committee, patient safety committee and also locally at ward and hospital level Progress to consider use of RESPECT form Wessex wide – this is coming and will improve recording of patient wishes etc.	Induction programme/presentation ILS programme and training compliance Evidence from debriefs Audit data quarterly from LNFH mortality meetings Resuscitation audits Minutes from Wessex End of Life meetings	Resuscitation Group/End of Life Committee	Dr Rachel Anderson Consultant	Dr Karl Marlowe MD	Jun-19		**Oct-18:** ILS is annual and mandatory training for medical staff - allows widespread sharing of information. Consider Respect form Wessex wide - this will improve recording of patient wishes. **Nov-18:** EOL report presented to Caring Group - includes update on work in progress. **Dec-18 QIPDG:** DNAR audit continued. Report due Jan 2019. **Jan-19 EOLC:** discussed DNACPR audit results - improvements can be seen over time. Issue with MCA being documented/completed. Will amend audit tool to clarify question about MCA. Discussion re use of Quality Improvement methodology to understand root cause of any issues with recording/completion of DNACPR forms. Nick Fennemore, Chaplain, has just completed two workshops on having difficult conversations which over 35 staff attended. **Feb-19:** report presented at Patient Safety Grp providing updates on resuscitation activity: training compliance, related risks, events, uDNACPR audit, NEWS 2, PEWS, Scenarios and Community AED's project. There was a one off incident where a resus bag tag was reused and the bag resealed using the same tag.	**On track**	**Ambition 1: Each person is seen as individual.** Where appropriate all patients and those important to them will have the opportunity for honest and well-informed conversations about dying, and death.	Confirmed through clinical audit.	Jul-19		Next DNACPR audit due May/June.	**On track**
	3.b	End of Life Care	End of life care should review recording of the prescribing and administration of medicines for patients receiving end of life and palliative care, to ensure that all medication is prescribed and administered following guidelines.	breach - N/A	Prescribing at end of life had not been audited by the trust, and there was some evidence in the patient records, which did not make clear the reason for the prescribed medicines.		**See action 3.a**	Trust to take part in National end of life audit. Include question on prescribing as part of death reporting process, to ensure robust process for identification of any concerns. Include findings in report for end of life committee to review bimonthly.	National audit. Minutes of end of life strategy group.	End of Life Committee	Julia Lake Divisional DoN & AHPs	Paula Hull DoN & AHPs	Jun-19		**Oct-18:** National EOL audit underway. **Dec-18 QIPDG:** National audit completed, results May 2019. Community audit planned for Q1 2019. Prescription chart revised new version due for implementation in Q4 (2018/19). **Jan-19 EOLC:** Anticipatory Medication audit in May 19. Medicines Policy v17 replaced MCAPP - policy reviewed and now available on intranet. **Mar-19:** National Audit for Care at EoL results received - see evidence folder.	**On track**	**Ambition 3: Maximising comfort and well being** Patients and those important to them, where appropriate should feel informed and involved in the management of their medication.	Feedback from patients and those important to them. Participation in two year National EoL audit.	Aug-19			**On track**
	3.c	End of Life Care	End of life care should ensure there are appropriate arrangements for collecting and reporting on safeguarding referral team's data for patients receiving palliative or care at end of life.	breach - N/A	However, the trust did not collect safeguarding referral information broken down for community, inpatient or specialist end of life or palliative care team individual referral rates. (evidence appendix)		**See action 3.a**	Report for end of life strategy group to include number of incidents that relate to safeguarding for patients who are at the end of their life.	End of life report. Minutes of end of life meeting.	End of Life Committee	Georgie Townsend Governance Business Partner	Paula Hull DoN & AHPs	Feb-19		**Dec-18 QIPDG:** process in place for recording this on Ulysses. Analysis included in End of Life report. **Jan-19 EOLC:** discussed incident which raised safeguarding concerns for EOL patient. QGBP is doing a review of safeguarding/EOL incidents. **Feb-19:** review of EOLC incidents/complaints completed for July - Dec 2018. Will be regular report presented to EOL committee. 2.6% of all reported EOLC incidents involved service users whereby Safeguarding concerns were recorded. At this time is it difficult to acertain a theme due to the low numbers identified. **18.03.19 ERP:** discussion queried what is the definition of EOL for this reporting purpose i.e.	**Complete-Unvalidated**	**Ambition 5: All staff are prepared to care** Any issues that are related to end of life care are quickly identified and responded to through the Trust governance process.	Minutes of End of Life Strategy meeting. Minutes of Caring group meeting.	Feb-19		**Feb-19:** review of EOLC incidents/complaints completed for July - Dec 2018. Will be regular report presented to EOL committee.2.6% of all reported EOLC incidents involved service users whereby Safeguarding concerns were recorded. At this time is it difficult to acertain a theme due to the low numbers identified. **18.03.19 ERP:** discussion queried what is the definition of EOL for this reporting purpose i.e. Terminal illness or actually at	**Complete-Unvalidated**

Theme	UIN	Core service	CQC action *from the Inspection Report*	Regulation breached	Cause of breach/ issue raised by CQC	Risk register	Trust Action	Process Actions	Evidence of process completion	Progress monitored by	Responsible lead(s)	Executive accountability	Process date	Recovery date	Process progress update	Status *(process)*	Expected Outcome/Improvement	Evidence to show outcome completion	Outcome date	Recovery date	Outcome progress update	Status *(outcome)*
	3.d	End of Life Care	End of life care should review governance of all mortuary fridge temperature checks to establish responsibility and ensure they take place regularly.	breach - N/A	It was not clear who was responsible for mortuary fridge temperature checks at one hospital.		To develop and implement standard operating procedures for mortuary monitoring across the Trust.	New standard operating procedure and auditable evidence for mortuary monitoring across the Trust. Audit to ensure standard operating procedure effective.	Standard operating procedure. End of life report presented to Patient Experience, Engagement and Caring Forum Audit results Revised Policy/Procedure.	End of Life Committee	Scott Jones Deputy Head of Estate Services Julia Lake Divisional DoN & AHPs	Paula Hull DoN & AHPs	Jan-19		**Jun-18:** standard/bariatric mortuary storage temperature monitoring sheets revised and process to monitor these agreed at LNFH in discussion between Scott Jones and Adam Domeney. To roll out to other sites. **Sept-18:** JL to agree which policy/procedure to add revised process to. **Dec-18 QIPDG:** new standard operating procedure in place on sites. Audit planned for	Completed	**Ambition 4: care is coordinated** All mortuaries are monitored and managed inline with manufactory guidelines to ensure the safe storage of patients body whilst they remain in our care.	Confirmed through clinical audit.	Feb-19		**Jun-18:** standard/bariatric mortuary storage temperature monitoring forms in place. Have one form for Lymington hospital which uses Rydon as its maintenance provider and one form for Petersfield, GWMH & Alton hospitals which use the in-house maintenance team.	Complete-Unvalidated
	3.e	End of Life Care	End of life care service should review the arrangements for paper based end of life and palliative care guidance held by community and inpatient teams to ensure consistency.	breach - N/A			**See action 3.a**	Clear clinical guidance for the use of end of life paper work in the community. Working group to review resources for teams on end of life care. Updating of Trust Webpage.	Trust website updated.	End of Life Committee	Julia Lake Divisional DoN & AHPs	Paula Hull DoN & AHPs	May-19		**Dec-18 QIPDG:** review of current care planning completed. Further guidance required. **Jan-19 EOLC:** retrospective review of care plans of patients who had died as unable to easily pull data from RiO. To review use x 6 months and include in EOL report to Caring Group. **Mar-19:** Evidence added to folder.	On track	**Ambition 1: Each person is treated as an individual** Systems ensure effective assessment, coordination, planning and delivery of care for patients reaching the end of their life.	Feedback from staff, End of Life champions and patient stories.	Jul-19		**Mar-19:** Template monitoring forms for sites saved to evidence folder.	On track
	3.f	End of Life Care	End of life care service should review arrangements for syringe driver training to ensure compliance target set is achieved.	breach - N/A	The trust had been told by us they should monitor the uptake of staff training on syringe driver competency assessment in 2017. The trust had set community teams a target of 60% for syringe driver training and competence in Autumn 2017. At May 2018 there were three community teams still below the 60% target.		**See action 3.a**	Review syringe driver target to ensure that all teams have correct target. All teams outside of target to attend training.	Performance data	End of Life Committee	Julia Lake Divisional DoN & AHPs	Paula Hull DoN & AHPs	Mar-19		**Dec-18 QIPDG:** training in place. Target Compliance is 60%. Compliance monitoring in place; currently 75%. **Feb-19:** Tableau stats report increase in compliance; currently 78.6% **Mar-19:** Tableau stats report increase in compliance: currently 79.6%	On track	**Ambition 5: All staff are prepared to care** Well-trained, competent and confident staff provide, professional, compassionate and skilled care to meet patients needs.	Training results and feedback from patients	Jun-19			On track
	3.g	End of Life Care	End of life care should review availability of bereavement advice and information leaflets, so that it is consistent and widely available for patients and their relatives in inpatient and community settings.	breach - N/A	As part of the thematic review the trust acknowledged they did not have any mechanism to explicitly gather opinions from those who had come into contact with the trust's end of life care provision or for their relatives to enable them to share their experiences. The trust acknowledged without bereavement services it presented a more challenging situation for gathering feedback. However, the method for obtaining feedback was to be reviewed again within the trust as a year two priority (2018-2019). (evidence appendix)		**See action 3.a**	Develop working group to review what information is currently in place for patients and relative. Agree format to be used within community hospitals, this may need to vary between the sites.	Each clinical area has access to leaflets that provide support to patients and those important to them at the end of their lives.	End of Life Committee	Julia Lake Divisional DoN & AHPs *supported by Dawn Buck Head of Pt. & Public Engagement & Pt. Experience*	Paula Hull DoN & AHPs	Jun-19		**Dec-18 QIPDG:** working group commenced and link to Carers group established. **Jan-19 EOLC:** discussion re whether syringe driver training covers all essentials. SC had reviewed and felt covered all essentials but queried whether new staff were doing too soon. Meeting felt NQ staff should be 3 months into role before doing the training. Noted that a lot of NQ nurses started at end of 2018. EOL User Group at Rowans Hospice would also be happy you review info/provide feedback.	On track	**Ambition 6: All communities are prepared to care.** Patients and those important to them will have access to information that provides advice and signposting, resulting in them feeling informed and connected to local services.	Feedback from relatives, carers, friends and staff. Leaflet.	Jul-19			On track
	3.h	End of Life Care	End of life care should review arrangements to gather effective feedback from patients and people receiving end of life or palliative care to ensure service is able to improve informed by patient need.	breach - N/A	The trust did not have a mechanism to explicitly gather experiences and opinions form those who had experienced the trust's end of life care provision.		**See action 3.a**	Develop working group to explore options for gathering patient feedback. Decide on method to be used and trial use. Evaluate feedback of new process, review and amend as required.	Evidence of process for obtaining feedback relating to end of life care being tested. Feedback and examples that learning has been gained and discussed in the end of life strategy meeting.	End of Life Committee	Julia Lake Divisional DoN & AHPs *supported by Dawn Buck Head of Pt. & Public Engagement & Pt. Experience*	Paula Hull DoN & AHPs	Jun-19		**Dec-18 QIPDG:** Working group commenced and link to Carers group established. **Jan-19 EOLC:** JL spoke to trust wide Working in Partnership group and discussed information / how to get feedback. Information - this is currently being pulled together and should be ready in March. Group would be happy to review and comment on. Feedback - group felt a questionnaire was inappropriate and proposed a follow up call following a family members death. Governor on group happy to work with task and finish group to agree questions in F/U call.	On track	**Ambition 1: Each person as an individual** Patients and those important to them have a method that they can quickly and easily feedback their experience to us. This will enable us to be more responsive to changes that may need to be made and improve patient experience at the end of life.	Action taken from feedback from patients and those important to them.	Aug-19			On track
	3.i	End of Life Care	End of life care should review arrangements for non-executive representation at Trust board level for end of life and palliative care.	breach - N/A	There was no non-executive director lead for end of life and palliative care and the roles of leaders for end of life care were not clear from the intranet		**See action 3.a**	Lynne Hunt, Trust Chair, is the non-executive representative for EOLC. Update Trust Website. Lynne to have sight of the end of life minutes. End of life lead to report to board on the progress made against the end of life strategy.	End of life strategy group minutes. Trust Web page. Board minutes.	End of Life Committee	Julia Lake Divisional DoN & AHPs	Paula Hull DoN & AHPs	Apr-19		**Oct-18:** Lynne Hunt, Trust Chair, is the non-executive representative for EOLC. Dec-18 QIPDG: Lead identified as Lynne Hunt. End of Life report presented to Board in December 2018. **Feb-19:** Trust Board Chairs Report 5.3 page 42 .....'as Non-executive lead I will be providing a role of critical friend to the End of life Strategy group. Ensuring that we are aspirational in our ambitions, provide help to navigate challenges and raise the profile	Completed	**Ambition 5: all staff are prepared to care** Provide clear governance at Board level to enable high quality end of life care within the organisation.	Minutes of Board meetings.	Aug-19			On track
	3.j	End of Life Care	End of life care should review arrangements for ensuring all staff are aware of who the leads for end of life care are.	breach - N/A	The trust was acting to shape and improve the services and culture. For example, there were 49 end of life champions. But they were not in all areas. The role of the end of life champion was launched with the strategy. A recent survey identified that from 60 responses 65% were aware there was an end of life champion in the service and some teams did not have an end of life champion during the inspection. There was further work to increase the visibility of this role and increase the numbers particularly in Older Persons Mental Health. (evidence appendix page 215)		**See action 3.a**	Develop end of life champion register. Strengthen the definition of the role and method of communication. Increase the number of end of life champions in OMPH. Yearly end of life champions event to improve net working.	Increased number of Champions. Clear network of communication.	End of Life Committee	Julia Lake Divisional DoN & AHPs	Paula Hull DoN & AHPs	Jul-19		**Dec-18 QIPDG:** website has been updated. Questions added to the QAT for launch in January 2019. **Jan-19 EOLC:** SE Hants has list in area - will circulate.	On track	**Ambition 4: care is coordinated** Organisational leadership is joined up in a way that provides a clear oversight for patients and staff of the respective roles and responsibilities for end of life care.	Staff feedback.	Jul-19			On track
	3.k	End of Life Care	End of life care should review arrangements for the reporting and governance of all meetings and decision making representing end of life and palliative care.	breach - N/A			**See action 3.a**	Review and strengthen reporting framework for end of life care within the Trust. Publish reporting framework on the Trust Website. Strengthen reporting to the Board on end of life care.	End of life report. Meeting frame work and Terms reference Trust Website.	End of Life Strategy Group	Julia Lake Divisional DoN & AHPs	Paula Hull DoN & AHPs	Apr-19		**Dec-18 QIPDG:** clear reporting schedule in place. **Mar-19:** Evidence folder updated with previous years annual report. Other information requested from MB. **12.03.19:** Jan19 minutes and ToR received from MB.	On track	**Ambition 5 All staff are prepared to care.** Clear governance lines in place to ensure prompt response to issues raised enabling share learning and continued improvements in care are made.	Patient and staff feedback. Annual Board Report.	Apr-19			On track
4, Records Management	4.a	Community-based mental health services for adults of working age	The Trust must ensure that patients have a current care plan, that is person-centred, holistic and recovery orientated	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care.	Care plans were not always person-centred, holistic and recovery-orientated. Many patients did not have a care plan or their care plan was out of date. Some patients did not know who their care co-ordinator was, did not know what was in their care plan or if they had one.	SR3: There is a risk that patients have a poor experience with our services due to lack of meaningful engagement.	To review the use of care plans across the Trust and establish why care plans are not always up to date, personalised, developed in partnership, or copies offered to patients/carers. To develop and implement plans to address issues based on review findings.	Undertake baseline enquiry across trust by visiting teams/talking to staff and get baseline understanding of challenges/blocks re care plans. Plan to be developed based on findings and implemented. Divisional Records management groups in place.	Baseline report Implementation plan	Records Management Group	John Stagg ADoN, AHPs & Quality Liz Taylor ADoN & Professions Carole Adcock ADoN & AHPs *supported by Operational leads*	Paula Hull DoN & AHPs	Jun-19		**Oct-18:** Rachel Coltart to lead on baseline enquiry - start in Nov-18 with report in Dec-18. David Kingdon lead for AMH care planning group, working on development of free text care plan for RiO. Hazel Nichols developed care plan for OPMH as part of QI work. **Dec-18 QIPDG:** workstream progress update given by John Stagg - copy of report and presentations saved to evidence. **14-Mar-19:** AMH CRTG minutes (pg 5) from for RK group agenda 15.03.19 "Care plans: Community care plan audit completed. A draft proposal to address inconsistencies approved at AMH CRTG. Personalised care plan work being supported by Carole Adcock and Heads of Nursing."	On track	Patients have a care plan that is up to date, personalised and where possible has been developed in partnership with them or their carers. Patients are offered copies of their care plan which outlines their goals and/or treatment aims. Staff understand their responsibilities and are clear on how to develop, record and store care plans.	Sample audit of care plans. Patient/carer/staff feedback. Quality Assessment Tool and peer review results.	Sep-19			On track
	4.b	Mental health crisis services and health based places of safety	The Trust must ensure that staff members in the crisis teams ensure patients have care plans that are up to date and comprehensive. ii)Staff members from the health and safety place of safety must ensure the ambulance provider working in the 136 suite has access to up to date, accurate and comprehensive information about patients in their care and treatment plans.	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care.	i)Care plans and crisis plans were not up to date or comprehensive so did not support the teams to deliver safe care and treatment to patients. Staff members in both teams were not following the trust policy about the storage of care plans on the electronic records system. ii)Staff members from the ambulance provider working in the section 136 suite did not have access to up to date, accurate and comprehensive information about patients in their care and treatment plans.	TBC	**see action 4.a** To clarify how care plans / 'immediate plan of care' for patients in 136 suites are developed and used consistently across the Trust. To ensure information is available to all services involved in the patients care.	Review governance systems to ensure consistency across 136 suites. Need to clarify who/when care plan written for patients in 136 suites (may not be known to the trust so do not have an existing care plan). Need for 'plan of immediate care' so all services aware.	Governance systems in place guidance re 'immediate plan of care'	Records Management Group	Carole Adcock ADoN & AHPs *supported by John Stagg ADoN, AHPs & Quality* *Liz Taylor ADoN & Professions*	Paula Hull DoN & AHPs	Mar-19		**Oct-18:** Need to discuss patients known/not known to trust as former would have care plan. All involved need to be aware of 'immediate plan of care'. **Dec-18 QIPDG:** workstream progress update given by John Stagg - copy of report and presentations saved to evidence.	On track	Patients safety and care is supported by having up to date care/crisis plans and/or 'immediate plan of care' agreed and available to all services involved.	Guidance on 'immediate plan of care'. Sample audit of care plans. Service User feedback.	Sep-19			On track

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	4.c	Community-based mental health services for adults of working age	The Trust should ensure that staff always offer patients a copy of their care plan, and document they have done so	breach - N/A	For patients who did have a current care plan, it had not been recorded that they had been offered a copy or were involved in their care planning for example care plans did not always include person-centred goals		**see action 4.a**	see action 4.a	Baseline enquiry report Implementation plan						**Oct-18:** AMH working on guidance for care plans to be recorded in a single place on RiO.	**Duplicate**						**Duplicate**
	4.d	Community-based mental health services for adults of working age	The Trust should ensure that care plans are easily accessible and that staff save them in the correct place in the electronic systems. In addition, the Trust should ensure that when paper copies of patient records are used these are kept up to date.	breach - N/A	Staff saved care plans on the electronic patient record system in multiple places and in multiple formats.		**see action 4.a**	see action 4.a	Baseline enquiry report Implementation plan							**Duplicate**						**Duplicate**
	4.e	Community mental health services for people with a learning disability or autism	The Trust should record whether or not patients have been offered a copy of their care plans	breach - N/A	Staff did not always record if they had offered patients a copy of their care plans.		**see action 4.a**	see action 4.a	Changes to SSG and Team Process documents. Request for Change to OpenRiO to record patient offered care plan or reasons for not offering care plans is available or not depending an ability of SHFT and/ or Servelec						**Oct-18:** The Learning Disability Clinical Records group will review the RiO Service Specific Guidance (SSG) and Team Process document against the best practise in the service and ensure this is specified within the SSG and Team Process documents. The Learning Disability Clinical Records group will establish whether a change can be made to RiO to record	**Duplicate**						**Duplicate**
	4.f	Community-based mental health services for older people	The Trust should ensure that staff always offer patients a copy of their care plan, and document they have done so	breach - N/A	All patients had care plans in place, but they varied in quality across the teams and patients did not always have a copy of their care plan. Staff did not always document if they had offered a copy.		**see action 4.a**	see action 4.a	Baseline enquiry report Implementation plan							**Duplicate**						**Duplicate**
	4.g	Forensic inpatient / secure wards	The Trust should ensure care plans are personalised and ensure that staff involve patients in the care planning process. Care plans should be based on the patient's goals and a copy should be given to the patient	breach - N/A	Patient care plans at Ravenswood House Medium Secure unit lacked patient involvement and were not individualised. We saw no evidence in care plan documentation to indicate patients' involvement and participation in their care plans.		**see action 4.a**	see action 4.a	Baseline enquiry report Implementation plan							**Duplicate**						**Duplicate**
	4.h	Community-based mental health services for older people	The Trust should ensure that patient risk assessments are regularly updated in patient records	breach - N/A	Although all patients had initial risk assessments, records demonstrated they were not always updated regularly. The quality of risk assessments varied across the service.		**see action 4.a**	OPMH: develop records lead post. Records lead to review issues across team and identify training needs. Develop standard operating procedure in line with trust	staff in post Issues review Training needs analysis SOP and evidence of circulation						**Oct-18:** Staff member seconded for 1 year records lead post - starting Nov-18.	**Duplicate**						**Duplicate**
	4.i	Mental health crisis services and health based places of safety	The Trust must ensure that staff members from the health based place of safety service collects and uses information well to support all its activities. Senior Trust members should have full access to information concerning the 24 breaches (patients, who have been not been given an extension by an approved person must not be detained more than 24 hours in the health based place of safety) exceeding the maximum detention period in the health based place of safety. They must ensure there are effective governance systems in place.	Regulation 17 HSCA (RA) Regulations 2014 Good governance	The service did not ensure that staff from the health based place of safety service collected and used information well to support all its activities. Senior trust members did not have full access to information concerning the 24 breaches where the maximum detention period in the health based place of safety had been exceeded (It is a requirement that patients, who have been not been given an extension by an approved person must not be detained more than 24 hours in the health based place of safety). Staff did not follow the trust policy of monitoring patients held in the section 136 suite hourly and the trust did not monitor this.	TBC	To report all section 136 breaches reported as incident and discussed at IMA panel. To invite stakeholders (CCG, AMHP, police, secure care) for discussion of every breach. To report breaches to Mental Health Act Committee.	All section 136 breaches reported as incident and discussed at IMA panel. Invite stakeholders (CCG, AMHP, police, secure care) for discussion of every breach. Report breaches to Pan Hampshire 136 meeting.	Incident data IMA panel discussions minutes of Pan Hampshire meeting Secure Contract meeting minutes	Records Management Group	Carole Adcock ADoN & AHPs Sally-Ann Jones Quality Governance Business Partner	Dr Karl Marlowe MD			**Sept-18:** process introduced whereby all 136 suite breaches are recorded as incidents and discussed at IMA panel. External stakeholders e.g. police invited to IMA panels. IMA checks details of incident and adds narrative to incident - confirms whether a breach or not. All breaches are discussed at Pan Hampshire 136 suite meeting - attended by Graham Webb, Siven Rungien, Paul Thomas. There are contract meetings with external contractor 'secure care' to discuss 136 suites. **Dec-18 QIPDG:** workstream progress update given by John Stagg - copy of report and presentations saved to evidence. **Feb-19:** minutes from Pan Hampshire 136 meetings for Nov-18, Dec-18 and Jan-19 received and saved to evidence.	**Completed**	Oversight and understanding of reasons for 136 breaches leads to improved practice and experience for the patient.	Audit of IMA panel evidence.	Mar-19			**On track**
	4.j	Community health inpatient services	The Trust must ensure all records are stored securely across all hospital sites.	Regulation 17 HSCA (RA) Regulations 2014 Good governance	Some ward areas did not lock their records safely away.	TBC	To review records management across the Trust and establish why the Record Keeping Policy and Procedures are not always followed. To develop and implement plans to address issues based on the findings	Review current process for storage of notes and agree best practice. All inpatient settings to have the means to ensure notes are stored appropriately in line with Trust policy.	Refreshed process for records storage Quality assessment tool	Records management Group	Julia Lake Divisional DoN & AHPs	Paula Hull DoN & AHPs	May-19		**Dec-18** QIPDG: workstream progress update given by John Stagg - copy of report and presentations saved to evidence.	**On track**	Patient clinical records have up to date information, meet the quality standards set by the Trust and are stored safely.	Sample audit of records. Quality Assessment Tool and peer review results.	Sep-19			**On track**
	4.k	Acute wards for adults of working age and psychiatric intensive care units (PICU)	The Trust should ensure that all the wards at Antelope House have clear seclusion records detailing which ward is using the seclusion room.	breach - N/A	Trinity Ward staff used the seclusion room on Hamtun Ward. However, this was not reflected properly in the records, and therefore the Trinity seclusion records were recorded in the Hamtun figures. This meant that the trust did not have oversight of the use of seclusion and developing trends for each ward at Antelope House. On Elmleigh there was both a paper seclusion book and an electronic version, however there were discrepancies between the two with times and dates missing in the paper version.		To revise guidance on recording the use of seclusion rooms and review seclusion information across the Trust.	Review/develop guidance on recording of use of seclusion room. Audit effectiveness of revised guidance.	guidance in place audit results	Records management Group	Carole Adcock ADoN & AHPs Sally-Ann Jones Quality Governance Business Partner	Paula Hull DoN & AHPs	Dec-18		**Oct-18:** seclusion records reviewed monthly at Key Quality Indicator meetings therefore oversight of use/trends is in place. **Dec-18:** AMH QIP meeting x fortnightly reviews actions in plans. S-A J confirmed that discussed with CA - agreed that the patients should continue to be recorded as Trinity ward patients even when in seclusion as they are part of Trinity caseload. Added 09.11.18/14.12.18 KQI minutes and 15.11.18/20.12.18 Quality Safety Management AMH minutes as evidence. **Jan-19:** Ward Manager Lauren Howlett confirmed that Elmleigh had removed the paper copy of seclusion record with all incidents now on Ulysses/RiO. Ben Lihou, matron reviews all the seclusion incidents and is the only person who signs these off. All seclusion incidents are discussed at the weekly safeguarding meeting. **08.01.19 QIPDG:** feel action is complete - to send evidence to Record Keeping Group for validation. **15-Feb-19:** RK Group mins (pg6/7): TM advised she has reviewed the evidence and believes we cannot validate it. The agendas and minutes submitted as evidence do not mention the guidance or the use of seclusion rooms. The minutes do talk about specific seclusions but not about updating the guidance. TM added we do not have a copy of the revised guidance to review so we cannot provide validation. **Mar-19:** guidance information collated for	**Complete-Unvalidated**	Standard reporting on the use of seclusion will provide improved oversight of the use and trends in seclusion.	Review of seclusion records at Key Quality Indicator meetings. Review of seclusion data.	Mar-19			**On track**
	4.l	Mental health crisis services and health based places of safety	Ensure that staff follow the requirements of the revised Mental Health Act 1983 Code of Practice 2015 and collect information about patient's ethnicity on monitoring forms. They should ensure staff members follow their own policy about the frequency of visits to the health based place of safety and complete a record of these visits to ensure patients safety	breach - N/A	Staff did not follow the requirements of the Mental Health Act 1983 Code of Practice 1983 in relation to recording patients' ethnicity on the monitoring form.		To add protected characteristics to monitoring form.	Add protected characteristics to monitoring form. Discuss at Pan Hampshire 136 meetings.	Monitoring form. Minutes from the Pan Hampshire 136 meeting.	Mental Health Act Committee	John Stagg ADoN, AHPS & Quality Liz Taylor ADoN & Professions *supported by Operational leads*	Paula Hull DoN & AHPs			**Oct-18:** 136 Task and Finish group added protected characteristics to monitoring form. Discussed at Pan Hampshire 136 meeting. **Dec-18 QIPDG:** workstream progress update given by John Stagg - copy of report and presentations saved to evidence.	**Completed**	The Trust meets the requirements of the MHA Code of Practice.	Pan Hampshire 136 meeting minutes. Audit use of amended monitoring form.	Jun-19			**On track**

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	4.m	Wards for older people with mental health problems	The Trust should ensure that once patients have received their rights, the records are maintained and accessible to staff	breach - N/A	Aspects of the Mental Health Act were not always followed. Records were not available that showed patients had received their rights under the Mental Health Act in line with timescales.		**see action 4.j** To review recording of MHA across the Trust and ensure MHA requirements are met.	MHA administrators to review MHA records on all wards. Plan to be developed based on audit results.	MHA records audit and plan	Mental Health Act Committee	Kathy Jackson HoN Siven Rungien MHA Manager	Paula Hull DoN & AHPs	Dec-18		**Oct-18:** 132 rights monitored regularly. Weekly reminder to Ward Managers re: Mental Health Act requirements sent on Thursdays. Mental Health Act annual audit completed with action plan in place. 132 rights forms are going to be added to RIO. **Dec-18:** SR - this action is complete. The MHA Administration Teams send a weekly spreadsheet out to Ward Managers, Doctors and the nursing teams setting out the specific MHA compliance required for that week per patient, including 132 rights. This constitutes to the required audit. If ward teams do not complete 132 rights or provide the evidence required, this is raised as an incident on Ulysses. **Dec-18 QIPDG:** workstream progress update given by John Stagg - copy of report and presentations saved to evidence. **08.01.19 QIPDG:** feel action is complete - to send evidence to Record Keeping Group for validation. **Feb-19:** MHA inspection of Berrywood ward positive with no actions required.OPMH matrons have worked with MHA administrators at Western Hospital re processes. **15-Feb-19:** RK Group mins (pg6/7): TM advised this relates to the review undertaken across the Trust; Audits and the update of guidance on the MHA have been submitted as evidence. She has read the reports and each one demonstrates we are not complying with the MHA. The idea is to	**Complete-Unvalidated**	Patient clinical records have up to date information, meet the quality standards set by the Trust and are stored safely. Requirements of the MHA are met by staff who are knowledgeable and competent in applying the MHA.	MHA records audit	Dec-18		Proposal for i) all MHA legal documents to be uploaded and scanned to RIO and ii) phase out of ward copy legal files put to and accepted by MHA Committee 20.12.2018 Current date for ward copy legal files to be removed and all MHA documentation to be available electronically = 1.02.2019. Current system in place for monitoring, regular provision and recording of patients rights, consisting of a section 132 form documenting when rights have been provided; a weekly MHA monitoring spreadsheet advising clinical teams when MHA requirements are due. These are followed up by the MHA Administration team. **08.01.19 QIPDG:** feel action is complete - to send evidence to Record Keeping Group for validation.	**Complete-Unvalidated**
	4.n	Community health services for adults	Continue their work to improve the access, completion and updating of patient records	breach - N/A	One team did not have access to the trust's 'Store and Forward' record system on their laptops which had resulted in patient's paper records stored in their home address not having the most up to date information available.		**see action 4.j** To ensure all community health teams have access to 'Store and Forward' on laptops.	Documented roll out programme for store and forward for each team. New care plan planned for use in clinical team to aid the use of store and forward in the home. Progress monitored through performance meetings.	Tableau report on progress new care plan	Records Management Group	Rachael ~~Marsh~~ Mejia HoN	Paula Hull DoN & AHPs	Apr-19		**Dec-18 QIPDG:** workstream progress update given by John Stagg - copy of report and presentations saved to evidence. **Mar-19:** Tableau report for Store and Forward stats including number of uses and number of users per month by Division/Core Service; see evidence folder for details (20190311).	**On track**	Patient clinical records have up to date information, meet the quality standards set by the Trust and are stored safely.	Tableau report on Store and Forward.	Apr-19			**On track**
5. Medicines Management	5.a	Wards for older people with mental health problems	The Trust must ensure that medication is stored at the correct temperature on all wards	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	The temperature of the clinic rooms across all wards was too high and so medication were stored at the wrong temperatures. This had been raised by Ward managers and pharmacy were aware but had not been acted upon.	Risk Reg No: 1006	To identify the clinic rooms across the Trust where the temperatures were not appropriate for storage of medicines. To develop and implement plan for storage of medicines in temperature controlled environments.	Teams to record as incident any temperature over 25c in clinic rooms where medicine stored. Review data and identify rooms requiring improvement. Develop business case for storage of medicines in temperature controlled environments. On approval of business case, implementation of plan.	Incident data on Ulysses List of identified clinic rooms Business case Implementation plan	Medicines Management Committee	~~Raj Parekh~~ Chief Pharmacist Andrew Mosley AD of Estate Services	Dr Karl Marlowe MD	Jul-19		**Oct-18:** Discussed at July MMC - all teams emailed to record incidents where temperatures over 25 degrees. Interim measures taken - in August destroyed all stock medicines with expiry date in 2018. Added labels for remaining stock - to reduce expiry date by 6 months. **Dec-18 QIPDG:** Short-term actions have been taken brought forward all medicines use by dates by six months, however need to look at Root Causes to establish long-term solutions; large piece of work for an operational Task and Finish Group (due to commence in New Year). Silo working – Estate Services proposed four options at Patient Safety Group but with no consultation with Medicines Management team. **23 Jan-19:** S D-K and VL meeting with estates to plan for fridge temperature action. **21.02.19:** update from VL - action plan developed following meeting with Andy Mosley and S D-K. Two issues - rooms over 25 degrees constantly and those where over for short period due to heatwave. Estates to identify those rooms which have temperatures over 25 degrees throughout year and develop plans to address eg review heating/see if a different clinic room can be used. Room temperatures may be over 25 degrees for short periods therefore propose to introduce more formal process to review stock lists on wards every 6 months and to add guidance into SH CP 87 temperature management control of medicines that if room is over 25 dgerees then to add sticker to medicines	**On track**	Patient safety will be improved by patients receiving medicines which have been stored at the correct temperature.	Incident data from Ulysses. Implementation plan completed. Quality Assessment Tool results.	Sep-19			**On track**
	5.b	Community health inpatient services	The Trust must ensure all medicines are stored safely and in in line with the manufacturers guidelines	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	Medicines were not always stored in line with manufacturers' guidelines or used in line with hospital policy.	TBC	To amend the Medicines Control, Administration and Prescribing Policy to stop re-use of medicines. To strengthen the operational use of the Medicines Control, Administration and Prescribing Policy. To send INTERNAL safety alert	Policy amended to stop re-use of medicines. Immediate CAS alert circulated to services.	CAS alert MCAPP Policy MMC minutes/'chairs actions'	Medicines Management Committee	~~Raj Parekh~~ Chief Pharmacist	Dr Karl Marlowe MD			Policy amended immediately during CQC inspection and CAS alert circulated. Monthly quality checklists provide assurance process. **Dec-18 QIPDG:** Meds team do not have staff capacity to complete the weekly quality checking that was previously in place. Clarification that action referred to re-use of medicines not temperature (although recognise that temperature would be part of manufacturers guidelines). **Jan-19:** MCAPP updated and name changed to	**Completed**	Patient safety will be improved by patients receiving medicines which have been safely stored and used in line with policy and procedures.	Annual safe and secure handling of medicines audit	Jun-19		Safe and Secure Handling of Medicines Audit of all inpatient wards in trust with data collection in Sept 2018. Identified good practice, areas for improvement and key actions. To re-audit in Sept 2019.	**On track**
	5.c	Community-based mental health services for older people	The Trust should ensure medicines are stored within temperatures according to manufacturer's recommendation	breach - N/A	Although medication was stored safely in lockable cabinets, some medicines that needed to be stored below a certain temperature were not stored in a temperature controlled environment.		**see action 5.a**	See action 5.a								**Duplicate**						**Duplicate**
	5.d	Community-based mental health services for adults of working age	The Trust should ensure that in Southampton Central site, patient's medication records only contain the current medication prescription	breach - N/A	At the Southampton Central site, four of the 12 medication records of patients on long acting intramuscular injection medication contained out of date prescriptions. These prescriptions had not been crossed off and could lead to incorrect medication doses being administered.		**see action 5.b (operational use of MCAPP)** To audit correct use of prescription records.	Check all prescriptions in date across AMH teams and OPMH teams. Review guidance for staff. Audit improvements.	prescription check results guidance for staff audit results	Medicines Management Committee	Adam Cox Clinical Service Director (AMH) Shelia Gascoigne (OPMH)	Dr Karl Marlowe MD	Dec-18		**Nov-18:** AC has contacted all consultants in Southampton re issue and to make sure medication charts are completed accurately. **Dec-18:** AC has arranged for a registrar to complete audit check of medication records. **Jan-19:** audit of depot prescription records completed plus follow-on actions - will review in three months following education and cascade. See evidence folder for details. **08-01-19 QIPDG:** agreed that process action completed with audit done but that need to re-audit to check that improvements made. **Feb-19: MMC** - agreed that AMH/OPMH/LD need to carry out audit to check if it is a problem in other areas of the Trust. Leads around the table to take back to respective areas and contact AC and SL for audit tool.	**Completed**	Patient safety will be improved by patients receiving the appropriate medicines recorded on up to date prescription records.	Audit of prescription records shows appropriate recording.	Dec-18	May-19	**Jan-19:** audit completed of 12 prescriptions per CMHT in Southampton area (36 total). Found some prescriptions continued to have out of date information and some didn't have information on the timescale for the injections. Action plan in place, review in three months. 08.01.19 **QIPDG:** agreed action overdue as audit shows further action required. Need to check whether trust wide issue in AMH/OPMH and what is root cause. **21.02.19:** VL to raise at MMC on 27.2.18 re assurance that similar issues not across all AMH. **13.03.19 SMC: requested update on progress from Adam Cox and Graham Webb.**	**Overdue**

Theme	UIN	Core service	CQC action *from the Inspection Report*	Regulation breached	Cause of breach/ issue raised by CQC	Risk register	Trust Action	Process Actions	Evidence of process completion	Progress monitored by	Responsible lead(s)	Executive accountability	Process date	Recovery date	Process progress update	Status *(process)*	Expected Outcome/Improvement	Evidence to show outcome completion	Outcome date	Recovery date	Outcome progress update	Status *(outcome)*
	5.e	Community-based mental health services for adults of working age	The Trust should ensure that all patients prescribed Clozapine have a relevant medication care plan in line with Trust policy.	breach - N/A	At the Southampton central site, patients who were prescribed clozapine, an anti-psychotic medication which requires regular physical health monitoring, did not always have a relevant medication care plan. This was not in line with the trust's guidelines on Clozapine medication.		To strengthen operational use of the Trusts guidance on clozapine.	Check all patients on clozapine have a relevant care plan. Ensure staff understand and follow trust guidance on use of clozapine.	sample audit of care plans evidence of discussion with staff	Medicines Management Committee	Sarah Leonard HoN & Quality	Dr Karl Marlowe MD	Jan-19	Apr-19	**Dec-18 QIPDG:** SL to feedback to MMC on this action. North and West patients on clozapine will be having a change in supplier – emails have been sent out to all and hopefully joined up working to follow. Need to consider Learning Disabilities and Older People's Mental Health patients as clozapine clinics are Adult Mental Health led but should be for any patient on clozapine. **Dec-18:** revised clozapine guidelines v4 approved by MMC chair. **31.01.19:** SL - all patients on Clozaril are seen in Clozaril clinics and have physical health checks and blood tests. AMH are rolling out new care plan 'plan on a page' currently. All patients on clozapine will have this discussed with them and included in their care plan. SL has the number of patients on Clozaril therefore will be able to complete check once new 'plan on a page' is rolled out. All patients on Clozaril will be seen within 3 months therefore to have recovery date of Apr-19 for the process and Jun-19 for outcome. SL to contact other HoN to make sure that other areas have clozapine referenced in care plans. SL/BC agreed action overdue. **21.02.19:** VL to raise at MMC on 27.02.19 re assurance that similar issues not across all AMH. Changed clozapine supplier to UHS from HHT. **Feb-19: MMC:** Minutes - clozapine care plan policy. AMH working on this. **13.03.19 SMC:** requested update on progress	**Overdue**	Patient safety will be improved by patients receiving clozapine in line with Trust guidance.	Audit use of clozapine.	Mar-19	Jun-19	**31-01-19:** see process update **21-02-19:** National audit report received - Gill Ritchie to summarise and identify any actions required. **13.03.19 SMC:** requested update on progress with action from Graham Webb/Vanessa Lawrence.	**At risk**
	5.f	Urgent Care	Undertake appropriate recording of stock checks of prescription forms	breach - N/A	The use of prescription forms were not recorded adequately. The trust was not compliant with its own system of stock checks of prescription forms. (evidence appendix)		To audit use of prescription forms.	FP10s - audited every 3 months locally. Annual FP10 audit Trust wide. Investigate FP10 non-compliance at Petersfield MIU.	FP10 audit results	Medicines Management Committee	Ali Lambert / Charlotte Bye Clinical leads MIU	Paula Hull DoN & AHPs			LNFH FP10 audit - compliant. Investigation completed - 1 x human error incident. Process in place/guidance developed for staff at Petersfield. **Dec-18 QIPDG:** only one FP10 form missed, action now complete.	**Completed**	Safe medicines management	FP10 audit results.			FP10 audits show compliance.	**Completed**
	5.g	Community health services for children, young people and families	Ensure medicines are managed to a consistently high standard across all service areas, including special schools.	breach - N/A	However, we found that staff did not manage medicines safely in special schools.(evidence appendix)		To ensure safe medicines management in schools in line with Hampshire County Council (HCC) guidance.	Address individual practice/role/job description. RCA -investigate contributing factors/share learning with staff and stakeholders. Meet with Head teacher to offer support to operate under the HCC guidance managing medicines in Schools.	HR investigation Serious Incident investigation Learning shared with individual/school/commissioners Support to Head teacher	Medicines Management Committee	Liz Taylor ADoN & Professions	Paula Hull DoN & AHPs			HR/RCA investigation completed and learning shared. Support to Head teacher re dialogue with commissioners about the service commissioned. Notice has already been given on this contract. **Dec-18 QIPDG:** only one person involved, action now complete.	**Completed**	Safe medicines management in schools in line with HCC guidance.	The nurse will not administer medication in Special Schools but will support Special School staff to administer medication.			all actions completed	**Completed**
	5.h	Community health Inpatient Services	Transferred from 2017 CQC IAP (57.2 and 57.3) The trust should ensure that staff support and enable patients to administer their medicines as part of the discharge process in the rehabilitation wards.	breach - N/A	None		To implement Self Administration Policy on wards with risk assessment of wards and individual patients completed.	To review and amend the Self-Administration of Medicines policy. To scope additional resources required to implement self-administration of medicines across community hospitals. Pilot to be completed and then roll-out across the Trust.	Evidence that risk assessments completed. Results of audit of Self Administration Policy.	Medicines Management Committee	~~Raj Parekh~~ Chief Pharmacist to jointly lead. *supported by the Associate Directors of Nursing and AHPs: Julia Lake, ~~Susanna Preedy~~ , ~~Helen Neary~~ , Carole Adcock*	Dr Karl Marlowe MD	May-19		**02.10.18 QIPDG:** Self-administration of meds action plan discussed at MMC in September - agreed their support of plan and to monitor progress via MMC. Updates to be presented to QIPDG on fortnightly basis. When new CQC action plan developed to move this action to 2018 CQC action plan. **30.11.18:** VL' I am unable to give more detailed dates at the moment. The SAM guideline/procedure should be approved in the next few weeks but I have been told that the	**On track**	Patients will have support to self administer medicines safely and effectively.	Audit self-administration of medicines.	Aug-19			**On track**
6. Privacy & Dignity	6.a	Wards for older people with mental health problems	The Trust must ensure that all wards have a dedicated female-only room which male patients do not enter	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.	Female patients did not have a designated female-only day area that was only used by females. On wards was a day area for the use of females only, male patients frequently used these.	Risk Reg No: 1732	To ensure compliance with standards of gender separation across the Trust.	Review female only room provision.	Plan in place/ mitigation plan	Patient Experience, Engagement & Caring group	~~Susanna Preedy~~ ~~ADoN & AHPs~~ Carole Adcock ADoN & AHPs	Paula Hull DoN & AHPs	Jan-19	requested a recovery date /plan Jul-19 agreed at SMC 13.03.19	**Oct-18:** Only Poppy ward has no female only lounge. Reviewed ward layout. Other wards have female only lounges - males on organic wards do enter these lounges. **Jan-19:** KJ/SC on meeting next week to review bed model on OPMH wards and plan for gender separation. EW leading a trust wide piece on gender separation.	**Overdue**	There will be access to gender specific areas across all inpatient sites.	Review of compliance in inpatient areas.	Apr-19			**On track**
	6.b	Wards for older people with mental health problems	The Trust must ensure there are rooms available for patients to meet their visitors in private and ensure patients are able to make phone calls in private	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.	On Elmwood and Poppy ward there was no visitors' room. Activities and therapy rooms were limited across the wards which meant that visitors had to meet patients in the day rooms and staff meetings were often held in the patients' day rooms. However, patients could access their own bedrooms or the garden. Patients could not always make a phone call in private.	TBC	To amend 'inpatient welcome packs' to include information on opportunity to talk in private.	Amend welcome information to include information on requesting use of phones in private / private meeting room.	Welcome Information	Divisional MOM	Kathy Jackson HoN	Paula Hull DoN & AHPs	Nov-18		**Feb-19:** KJ sent revised welcome pack with section relating to private phone calls. **Mar-19:** BC discussed need to add sentence to welcome pack to cover that rooms can be arranged for patients to see their visitors in private. Beth Ford working with Comms to produce standard welcome pack across services. Draft to be ready end March.	**Complete-Unvalidated**	Patients and families are available to meet and have phone calls in private.	Revised Welcome Packs. Patient/Family feedback.	Mar-19			**On track**
	6.c	Community health inpatient services	The Trust must improve the privacy and dignity of patients at Romsey hospital	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.	Whilst staff worked hard to maintain patient's privacy and dignity this could not always be achieved. For example, at Romsey hospital where beds were very close together.	Risk Reg No: 911	To ensure privacy and dignity, we will work with our commissioners to reduce bed capacity at Romsey hospital.	Proposal to be written for the management of the environment at Romsey. Options to be discussed with the CCG and agreement on outcome to improve situation. Agree steps to be taken to	Proposal for environment at Romsey hospital. Site visit/discussions with CCG Improvement plan in place.	Patient Experience, Engagement & Caring group	Rachael ~~Marsh~~ Mejia HoN	Paula Hull DoN & AHPs	Jun-19			**On track**	Patients privacy and dignity are maintained.	Proposal for environment at Romsey Hospital. Progress with improvement plan.	Jul-19			**On track**
	6.d	Child and adolescent mental health wards (CAMHS)	The Trust must ensure that prone restraint is only used as a last resort and continue work on minimising the use of prone restraint	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	There was an increase in the use of prone restraint despite the efforts within the trust to reduce the practice. Incidents showed that there was regular use of restraint at Bluebird House and staff said that at times they got injured when having to restrain young people.	Risk Reg No: 810	To participate in a two year national programme to reduce restrictive practices in inpatient CAMHS.	see action plan in response to warning notice Update on progress with national programme.	Restraint incident data	Divisional MOM	Emma Wadey Deputy DoN & AHPs (MH)	Paula Hull DoN & AHPs	Sep-19		**Oct-18:** Project underway to review restraint practices across trust.	**On track**	Improved patient experience on CAMHS wards. Improved health and well-being of staff.	Reduced incidents of restraint. Patient and staff feedback.	Oct-20			**On track**
	6.e	Forensic inpatient / secure wards	The Trust should ensure there are adapted bathroom and toilet facilities for people with physical disabilities at both Ravenswood House Medium Secure Unit and Southfields Low Secure Unit for people	breach - N/A	There was no adapted bathroom or toilet facilities for people with physical disabilities at either site. Ward managers told us that they could request specialised equipment when they had patient with disability.		To ensure compliance with Disability Discrimination Act.	Plans for adapted bathrooms will be included as part of the future redevelopment plans for Southfield and Ravenswood House. During admission assessment, patients' physical needs will be assessed re: suitability for admission/need for minor modifications/referral for	Business Case. Minor adjustments to facilities. Referrals to alternative beds.	Divisional MOM	Nina Davies Service Manager	Paula Anderson	Sep-19		**Feb-19:** ND email "the Capital bid for the DDA compliant bathrooms has been submitted to the Capital team and discussed at the CGG meeting on 20.02.19. It has been agreed that it is to be placed on the list for consideration for next year's funding. The Bids are currently due for review on the 20th of April the next QPP." See evidence folder for email trails.	**On track**	Improved consideration to physical needs and improved environment to meet DDA regulations.	Future redevelopment plans to include adapted bathrooms. Review inpatient areas. Patient feedback.	Oct-19			**On track**
	6.f	Mental health crisis services and health based places of safety	Ensure the toilet door in the section 136 suite at Antelope House is replaced quickly	breach - N/A	There was no toilet door in the section 136 suite at Antelope House which compromised patient's privacy when using the facilities.		To review appropriateness of current toilet door which is locked back.	To ensure current door which is locked back can be opened/closed as needed. To review appropriateness of current door which is locked back and develop alternate methods for ensuring patient privacy if required.	site visit	Patient Experience, Engagement & Caring group	Sarah Leonard HoN & Quality	Paula Hull DoN & AHPs	Nov-18		**Nov-18:** door is in place and is locked back flush to the wall - however door unable to be opened on CQC site visit. **Nov-18:** estates have resolved issue and door can now be unlocked and used. **18-Dec-18:** MMK has confirmed door is now in use; photographic evidence received and stored in evidence folder. Action now complete and ready for validation. Carol Adcock has viewed door in place.	**Completed**	Patients privacy and dignity are maintained.	If review finds the locked back door is not appropriate then alternate solution to be agreed. Patient feedback.	Dec-18		Toilet door is now able to be unlocked from its position flush to the wall and so can be used which maintains patients privacy and dignity.	**Completed**
	6.g	Wards for older people with mental health problems	The Trust should ensure that patient privacy and dignity is prioritised at all times even if they do not have their own bedrooms	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.	Female patients on Rose ward had to walk past the nurse's station and communal day area to get to the shower; this compromised their dignity. Patients did not all have their own bedrooms. On both Stefano Olivieri Unit, Poppy and Rose wards, patients had to sleep in dormitories with other patients of the same gender. This had the potential to compromise the patients' privacy and dignity; although patients did not report any concerns about this at the time of our inspection.		**see action 6.a**	Review current bed model based on best environments for patients and how we can make best use of provision and ensure privacy and dignity of patients.	Bed model paper and implementation plan.	Patient Experience, Engagement & Caring group	Kathy Jackson HoN	Paula Hull DoN & AHPs	Jan-19	requested a recovery date /plan. Jul-19 agreed at SMC 13.03.19	**Oct-18:** Bed model paper in draft. **Jan-19:** KJ/Scon meeting next week to review bed model on OPMH wards and plan for gender separation. EW leading a trust wide piece on gender separation. **Feb-19:** KJ/SC presenting paper on single sex accommodation to SMC on 20.02.19. Paper includes proposed options e.g. could make GWMH female only OPMH wards - would need approval by commissioners. **13.03.19 SMC**: paper on single sex accomodation proposals - to present to TEC for decision in 2 weeks. Wok on Beaulieu ward is underway, work on Berrywood and SOU if approved will likely to be started in June; issue is GWMH where there are no easy solutions; in discussion with Solent Trust re Limes with	**Overdue**	There will be access to gender specific areas across all inpatient sites.	Review of compliance in inpatient areas.	Apr-19			**On track**

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	6.h	Wards for older people with mental health problems	The Trust should continue to develop the dementia friendly environments on the organic wards	breach - N/A	Not all wards for patients with a dementia were environmentally dementia friendly. However, the trust was updating the signage across all wards and refurbing bathrooms, floors and colour schemes.		To continue programme to provide dementia friendly environments in inpatient areas.	Dementia Friendly Group to continue implementation of dementia friendly environments	Dementia Friendly Group minutes PLACE/Estates plan	Patient Experience, Engagement & Caring group	Sharon Craddock Matron *supported by* *Annette Chalmers* *Estate Services Q&A Manager*	Paula Hull DoN & AHPs	May-19		**Oct-18:** Dementia Friendly environmental plan already in place. **Feb-19:** progress update on plan received. Dementia Environment Group is overseeing this work, reporting to Dementia Strategy Steering Group; new dementia strategy focusses closely on the provision of dementia friendly environments. Continue to be assessed by PLACE whilst pursuing accreditation by various bodies including AIMS and the 'Dementia Friendly Hospital Charter'. • Despite focus across the trust there has been no funding identified for any works captured in the 2018 PLACE assessment. All current works have been put on hold and there is no funding to continue providing dementia friendly environments anywhere in the trust. **Feb-19:** KJ - dementia friendly signage being rolled out with OPMH a priority. There are 2 groups - Dementia Strategy Group (Robert Hamm with BD as sponsor) and Dementia Environment Group (Sharon Craddock chair). Capital funding bid to SMC on 20.02.1 for approval. Draft dementia strategy developed and out for consultation. - 2 meetings so far - both well attended by Trust and CCGs. Mar-19 status changed to at risk - see report by Annette Chalmers.	At risk	Patients have an improved experience in dementia friendly environments which better meet their needs.	Progress with PLACE/Estates plan to provide dementia friendly environments. PLACE feedback. Carers and family feedback.	Jul-19			On track
	6.i	Community-based mental health services for older people	The Trust should review the pathway to access crisis response for this patient group	breach - N/A			To develop and implement a needs led strategy for Older People's Mental Health services.	OPMH strategy based on needs led service to be developed and implemented. OPMH representation at crisis pathway planning and discussions.	OPMH Strategy Crisis response pathway for OPMH	Divisional MOM	~~Susanna Preedy~~ ~~ADoN & AHPs~~ Carole Adcock ADoN & AHPs	Barry Day COO	Jul-19		**Feb-19:** KJ - There will be one business plan for MH with focus on moving towards age less service.In SE the crisis pathway project started in AMH with OPMH now linked into this project. **Mar-19:** BD - There is no established out of hours service for OPMH patients currently. If there is a requirement for this then the OPMH Team/Consultant contact the AMH out of hours service in the respective area on a case by case basis to provide support. The OPMH On Call Manager can provide advice. The South East Area are working towards the Out of Hours Crisis model which is set to include OPMH.	On track	Patients have access to crisis pathways based on their needs.	OPMH strategy and implementation plan.	Aug-19			On track
	6.j	Community-based mental health services for older people	The Trust should review the provision of office space for the Gosport, New Forest East and Parklands CMHT	breach - N/A	The provision of office space in New Forest East, Parklands and Gosport was not sufficient to allow staff to complete their roles adequately.		**see action 6.i** To review CMHT office provision. The OPMH strategy will include a review of estates provision.	OPMH strategy based on needs led service to be developed and implemented. To include a review of estates provision for OPMH.	OPMH strategy and implementation plan Review of estates provision and programme of works.	Divisional MOM	~~Susanna Preedy~~ ~~ADoN & AHPs~~ Carole Adcock ADoN & AHPs *supported by* *Estate Services*	Barry Day COO	Jan-19		**Oct-18:** Met with estates. Richard Ilsley reviewing estates provision in North. **Jan-19:** monthly clinical premises and environment meeting at Parklands. Will be auditing use of rooms and room space and put forward proposals. **Feb-19:** KJ - site meetings in place across trust. In North CMHT moved to bigger offices. Barry Edwards leading on planning with estates for New Forest.	Complete-Unvalidated	Changes to estates provision will enable staff to carry out their roles more effectively.	OPMH strategy and implementation plan.	Mar-19			On track
7. Operational	7.a	Urgent Care	Undertake appropriate recording of clinical competency books given to advance nurse practitioners	breach - N/A	However, there were concerns raised over how clinical competency books that were given to advance nurse practitioners regarding safeguarding don't get signed off as competent because the shifts were busy. We considered this as an example of poor practice not to have clinical competency books signed off. (evidence appendix)		To discuss clinical competencies at 1 to 1s and appraisals with staff.	Competencies discussed with All staff at 1-1s and yearly appraisals where they are revisited and any training or development required is discussed. Staff undertaking development roles or developing enhanced levels of competency may not have all competencies signed - these staff work under supervision in these areas.	Appraisals completed		Ali Lambert / Charlotte Bye Clinical leads MIU	Paula Hull DoN & AHPs			Action completed	Completed	Staff are supported to complete and record clinical competencies.	Clinical competency books are completed.				Completed
	7.b	Community-based mental health services for adults of working age	The Trust should mitigate the risk posed by the location of the clinic room at the Petersfield site	breach - N/A	The clinic room in the Petersfield site was in a remote part of the building and presented a risk to lone-workers should an incident occur.		To remodel use of rooms at Petersfield hospital which will mitigate lone working risk.	Changes to clinical space will take place as part of the Petersfield remodelling. Until this happens the room is not used for seeing patients.	Petersfield remodelling plan	Divisional MOM	Richard Webb Area Manager (AMH)	Paula Anderson Finance Director			Clinic room is not being used until remodelling of site - therefore removed risk re lone working.	Completed	Health and well-being of staff are supported.	Progress update with Petersfield hospital remodelling plans.	Dec-19			On track
	7.c	Community health inpatient services	The Trust should ensure staff are always able to deliver safe care at night at Romsey hospital	breach - N/A	Staff told us and we saw how Romsey hospital had a layout that made the delivery of safe care at night time a challenge.		To review current staffing levels and the environment at Romsey hospital to ensure safe patient care.	Review current staffing levels in line with acuity and dependency tool. Make necessary amendments in staffing levels in line with recommendations of safer staffing guidance. Link to issues with the environment.	Safer staffing report Proposal for environment	Divisional MOM	Rachael ~~Marsh~~ Mejia HoN	Paula Hull DoN & AHPs	Feb-19		There was model of 2 RNs and 1 HCSW on duty at night when CQC carried out inspection. Following their inspection increased the staffing to 2 RNs and 2 HCSWs on duty at night to ensure sight of all patients at Romsey Hospital. There are also ongoing discussions with commissioners to reduce number of beds from 19 to 15 which would allow redistribution of beds and address privacy and dignity issues. This reduction in bed numbers is planned for 15 March - CCG some concern at reduction inbed numbers. Contract letter sent to Rachel King at CCG. The model of 2RNs and 2 HCSWs on duty at night would remain in place and would be staffed form current complement. **18.03.19 ERP:** requested safer staffing reports are added to evidence - I red flag incident in Dec 2018 where 1 x RN not at safer staffing requirements at night. PH had suggested on recent visit to Romsey Hospital that nurses stations could be developed at end of Nightingale ward to help with oversight of patients. At present office is half way along main corridor. ERP agreed that action is completed as action focused on staffing levels.	Completed	Patients will receive safe care at night.	Safer staffing reports. Staff feedback on environment at Romsey hospital.	Feb-19		There was model of 2 RNs and 1 HCSW on duty at night when CQC carried out inspection. Following their inspection increased the staffing to 2 RNs and 2 HCSWs on duty at night to ensure sight of all patients at Romsey Hospital. There are also ongoing discussions with commissioners to reduce number of beds from 19 to 15 which would allow redistribution of beds and address privacy and dignity issues. This reduction in bed numbers is planned for 15 March - CCG some concern at reduction inbed numbers. Contract letter sent to Rachel King at CCG. The model of 2RNs and 2 HCSWs on duty at night would remain in place and would be staffed form current complement. **18.03.19 ERP:** requested safer staffing reports are added to evidence - I red flag incident in Dec 2018 where 1 x RN not at safer staffing requirements at night. PH had suggested on recent visit to Romsey Hospital that	Completed
	7.d	Urgent Care	Continue its plans to reconfigure the Minor Injury Unit at Petersfield Hospital	breach - N/A	The Petersfield MIU was small with two clinical areas and was not fit for purpose due to the workload and this had been acknowledged by the trust. There were plans in place to reconfigure the area to increase to five clinical spaces. The present arrangements did not breech the privacy or dignity of patients.		To complete reconfiguration plans for the Minor Injury Unit at Petersfield hospital.	meetings between clinical leads and estates to progress development of plans. business case developed and funding agreed. Building works to reconfigure MIU.	Meeting minutes, plans developed Business case developed funding in place Project plan, completion of works	Divisional MOM	Ali Lambert Clinical lead MIU *supported by* *Andrew Mosley* *AD of Estate Services*	Paula Anderson Finance Director	Dec-18		**Oct-18:** plans developed - AL worked with architect. Monthly meetings AL and estates lead to discuss progress. business case being developed by estates with request to be made for central government funding. **Dec-18:** business case for reconfiguration completed and being presented in December for approval. **Mar-19:** Marie Corner and Richard Newman refered to by AL for further updates **Mar-19 -** email from Marie Corner: The transformation Team have submitted a bid for the reconfiguration of Petersfield hospital [18066]. This bid is on the list for prioritisation. However, the risk of gaining funding is low as it is a recommendation and not subject to any enforcement notification so the chances of gaining funding are low. See evidence folder for copy of Bid.	Complete-Unvalidated	Patients will have an improved experience and safe care in an appropriate environment.	Reconfigured MIU at Petersfield hospital - site visit/photographs.	Dec-19			On track

Theme	UIN	Core service	CQC action *from the Inspection Report*	Regulation breached	Cause of breach/ issue raised by CQC	Risk register	Trust Action	Process Actions	Evidence of process completion	Progress monitored by	Responsible lead(s)	Executive accountability	Process date	Recovery date	Process progress update	Status *(process)*	Expected Outcome/Improvement	Evidence to show outcome completion	Outcome date	Recovery date	Outcome progress update	Status *(outcome)*
	7.e	Community health services for adults	Ensure service provision at Hythe Hospital can i) meet patient needs and ii) the environment meets infection and prevention control guidelines	breach - N/A	i) Patients continued to be scheduled to attend appointments at Hythe hospital where a failure in x-ray equipment meant not all patients were able to have all their clinical needs met for diagnostic imaging services. ii)The environment at Hythe radiology department did not demonstrate safe infection prevent and control practices. Fabric changing room curtains had not been cleaned for four years leading to an increased risk of patients being exposed to cross infection concerns.		To communicate in advance to patients and other key stakeholders any closures to the walk in X-ray service. To ensure the environment at Hythe hospital meets Trust Infection, Control and Prevention standards.	Ensure equipment meets the needs of the patients attending x-ray at Hythe. Curtains to be changed and process put in place to ensure that Hythe is included on the audit programme.	Cleaning audit	Divisional MOM	Adam Domeney Clinical Services Manager	Barry Day COO	Jan-19		Patients are not booked / scheduled appointments at the site for X-Ray as this is a walk in service. Site closures have occurred due to equipment breakdown (£85k replacement cost) and staffing. These are communicated in advance to GP Practices, Practice Managers and also internally within SHFT via Twitter and Facebook as well as internal teams, such as MSK and SHFT Trust Communications. Cubicle curtains have been changed w/c 24th September, with a 6 month replacement required. Lead Radiographer at Hythe has responsibility for replacement as has scheduled reminder in place. Changing / tea & coffee area now decluttered and non-essential items removed / disposed of. Sink now confirmed as condemned and no longer in use (not a clinical sink and alternative available for staff). Will be	Complete-Unvalidated	Hythe hospital is compliant with IPC requirements in line with IPC Policy and Procedures.	Replacement programme for curtains. Site visit to Hythe hospital.	Jan-19		Curtains on 6m replacement programme. **13.02.19:** Medical Devices Forum - IPC visited X ray and wound clinic at Hythe Hospital in Sept and completed follow up visit and confirmed that compliant with IPC standards. Nasendoscopy audit 20180703 - compliant with IPC standards. Further IPC visit on 20190222 to check continued IPC compliance. **28.02.19:** IPC visit completed curtain has been changed and is on 6m rotation, sink appears to be in use again, some clutter however curtain in the entrance	Complete-Unvalidated
	7.f	Community mental health services for people with a learning disability or autism	The Trust should progress action to resolve information technology connectivity issues on two of the sites	breach - N/A	Two of the sites had information technology connectivity issues that were causing stress to staff. These had been escalated but due to the buildings not belonging to the trust, the issues had not yet been resolved.		To review alternate accommodation and move staff where possible.	Risk mitigation - dedicated project reviewing/moving staff to alternative accommodation. Risk on Divisional risk register since 2016, reviewed monthly through MOM to help ensure that information is shared with staff	Project plan will have been completed and teams will have moved to more appropriate premises	Divisional MOM	Nicky MacDonald Head of Learning Disability Services Andrew Mosley AD of Estate Services	Paula Anderson Finance Director	Mar-19		**Oct-18:** We are mitigating this risk by having a project dedicated to reviewing and moving the staff based in these buildings to alternative accommodation. Since the inspection we now have a date to move one team to another base. We have also had a risk on the Divisional risk register since 2016 in relation to the team bases which is reviewed on a monthly basis through	On track	Changes to accommodation will enable staff to better carry out their roles.	Progress with project plan.	Jun-19			On track
	7.g	Community-based mental health services for adults of working age	The Trust should ensure that mobile phones given to staff to use in the community are fit for purpose	breach - N/A	Staff were using mobile phones that were not fit for purpose.		To renegotiate contract with mobile telephone provider and consider upgrades to existing mobile phones.	Ongoing discussions with mobile phone provider re contracts.	contract negotiations		Helen Grieves Technology Business Manager	Barry Day COO	Apr-19		**Mar-19:** mobile phone contract has been renegotiated and contract awarded. Re upgrade of mobile phones: Smartphones – we have moved to providing a new Samsung device following testing with end users as the feedback indicated that these were	On track	Community staff have mobile phones which are fit for purpose.	Contract renegotiation and agreed future provision.	Apr-19			On track
	7.h	Wards for older people with mental health problems	The Trust should ensure all staff are issued with personal alarms	breach - N/A	Domestic staff on Elmwood ward were not issued personal alarms. All other staff were issued personal alarms.		To review current security systems across OPMH wards and implement plan to address issues.	Review current security systems across all OPMH wards and implement plan to address issues, including guidance for visitors/colleagues.	Security system review and implementation plan. Security system in place.	Divisional MOM	Kathy Jackson HoN *supported by* *Tracey Edwards* *Local Security Management Specialist*	Paula Anderson Finance Director	Dec-18	Mar-19	**Oct-18:** Personal alarms ordered for nursing/housekeeping teams. Need to review how to implement system e.g. pin boards. Inconsistent practice across wards. **Dec-18:** Ongoing discussion re plan for personal alarms with Jan McAvoy/Tracey Edwards. Need to involve ward managers re implementation. **08.01.19 QIPDG:** SM discussed issues with implementation of personal alarm system in open environments in CHs. It is not possible to replicate similar systems as used in secure environments. Alarms have gone missing on wards. Ongoing discussions re implementation taking place - may need different solutions for different wards. QIPDG agreed action overdue and to have recovery date of July 2019.	Overdue	Security systems are in place on OPMH wards which enable staff to feel and be safe.	Staff feedback. Security systems in place.	Dec-18	Jul-19	**Oct-18:** Personal alarms ordered for nursing/housekeeping teams. Need to review how to implement system e.g. pin boards. Inconsistent practice across wards. **Dec-18:** Ongoing discussion re plan for personal alarms with Jan McAvoy/Tracey Edwards. Need to involve ward managers. **08.01.19 QIPDG:** SM discussed issues with implementation of personal alarm system in open environments in CHs. It is not possible to replicate similar	Overdue
	7.i	Wards for older people with mental health problems	The Trust should ensure that equipment is maintained	breach - N/A	Staff had not maintained equipment on Beaulieu ward or Stefano Olivieri Unit. On Beaulieu ward mattress pumps had not been serviced in line with legislation. On Stefano Olivieri ward the stand aid was out of date for servicing.		To strengthen the operational use of the Medical Device Management Policy and Toolkit.	Review current systems and processes and amend. Staff to understand their role and responsibilities in the maintenance of equipment.	Systems and processes for equipment monitoring and maintenance.	Divisional MOM Medical Devices Group	Shelly Mason Matron Tracy Hammond Medical Devices lead	Paula Hull DoN & AHPs	Jan-19		**Oct-18:** Wider than OPMH only issue - needs trust level solution. **Jan-19:** Medical Devices Policy/Procedure currently being reviewed. New Medical Devices SharePoint site developed. Equipment maintenance discussed at OPMH divisional MOM on 31.01.19. Beaulieu ward - spare batteries for hoist - BCAS confirmed that these were not part of maintenance prog. SOU - stand not in use. CQC actions discussed at Medical Devices meeting. OPMH QAT is being reviewed and will add to check that equipment is in date. At present only checks whether equipment clean. **13 Feb-19:** Medical Devices Forum - Strategy in final draft with a few comments to be added - will then be recirculated for final approval. Medical Devices Policy/Procedure - need to add flowchart re change in process by BCAS - will be presented to Patient Safety for final approval. **Feb-19:** KJ - equipment needs being reviewed at Beaulieu as part of re-opening plan. **Mar-19:** Policy and Procedure (renamed from Toolkit) awaiting final approval from Medical devices group, Patient safety that was due this month now a workshop, TH to send over Policy and Procedure as evidence as soon as approval has gone through.	Complete-Unvalidated	Staff understand their responsibilities and are clear on the procedures to follow to maintain equipment safely.	Peer review of inpatient sites. Maintenance logs for equipment.	Feb-19		**13 Feb-19:** Medical Devices Forum - Claire Bennett /Tracey Hammond check QAT results every month and will do site visits to those where issues plus will do random checks of sites. CB did 5 audits in Jan and found 3/5 sites failed audits - issues raised with Ward Managers. CB will re-visit those wards to check improvements made.	Complete-Unvalidated
	7.j	Community health services for adults	Continue their work to improve the timeliness of equipment provision with external providers	breach - N/A	Staff continued to report inconsistencies with equipment provision. However, we saw that the trust was continuing to liaise with the external provider to improve the quality of the service provided.		To continue liaison with external providers to improve equipment provision with issues continued to be raised with commissioners.	Write report to CCG regarding issues. Continue to raise issues through CQRM. Monitor incidents through internal Governance. Continue trust wide meetings with external provider to resolve issues.	Minutes of CQRM and CRM Number of reported incidents Trust wide meetings with external providers	Divisional MOM Medical Devices Group	Julia Lake (interim) Divisional DoN & AHPs	Paula Hull DoN & AHPs	Apr-19		**13.02.19:** Medical Devices Forum - Regular high level meetings with Millbrook and commissioners to discuss issues. TH attended CQRM to present report - HCC has responsibility for Hants Equipment store therefore need to be involved in discussions. **23-02-19**: Mins of patient safety group (page 2) TH - Millbrook Wheelchair Services QI Presentation "this QI Project did bring all the organisations together". **Mar-19:** Med devices forum minutes pending - SAJ/GW to send over once available	On track	Equipment is available based on the patient's needs.	Information on reported incidents. Minutes of meetings with commissioners/external providers.	Apr-19			On track
	7.k	Forensic inpatient / secure wards	The Trust should ensure patients are offered a variety of food, taking account special dietary requirement such as veganism	breach - N/A	We received mixed feedback from patients at Ravenswood House Medium Secure Unit about the variety of food which was prepared from the canteen and the portion sizes that were served. For example, patient said there were limited vegan meals available.		To develop and offer a wider range of food options for restricted diets.	*16.a Develop and offer wider range of food options for restricted diets.*	*Menus and special dietary requirements.*	Patient Experience, Engagement & Caring group	Stella Gardener Catering Manager	Paula Anderson Finance Director	Apr-19		**Mar-19:** "a variety of food options are available however when a patient is in a restricted diet due to choice (veganism) or condition (nut allergy) there are occasions when the choice is limited. Increased choice for vegans will be introduced - recipes to be trialled and analysed". Examples of Gluten/Dairy free menus plus menu coding explanation page saved to evidence folder.	On track	Improved patient satisfaction with food choices.	Patient satisfaction feedback. Menu choices for restricted diets.	Jun-19		*Refer to the Patient Engagement Improvement Plan*	On track
	7.l	Mental health crisis services and health based places of safety	Ensure the staff team seek feedback from patients who have used the health based place of safety	breach - N/A	Staff members did not seek feedback from patients who use the health based place of safety.		To research independent ways of gathering feedback to improve services.	*15.a Research independent ways of gathering feedback. This will include feedback from patients who have used the health based place of safety.*	*Feedback plan* *Health based place of safety feedback*	Patient Experience, Engagement & Caring group	Dawn Buck Head of Pt. & Public Engagement & Pt. Experience *supported by* *s136 committee*	Paula Hull DoN & AHPs	Feb-19		*Refer to the Patient Engagement Improvement Plan* **Feb-19:** Community Health Survey results and Young People's survey results will be published in late spring. **Mar-19:** Patient insight, involvement and partnership report (Jul to Dec-18); key patient insight information that has been fed back to Southern Health during the last six months; with positive feedback being provided, as well as	Complete-Unvalidated	Use of independent feedback to improve our services.	Evidence of improvements made.	May-19		*Refer to the Patient Engagement Improvement Plan*	On track
	7.m	Wards for older people with mental health problems	The Trust should ensure that complaints are investigated within the timescales set out by the Trust	breach - N/A	Managers in the service did not always respond to complaints within the timescales of the trust complaints policy. On Rose ward, there were two recent examples of complaints from patients or carers which were outside of the trust response timescale and were yet to be actioned.		To review complaints processes across the Trust and establish why response targets are not met. To strengthen the operational use of the Complaints Policy and Procedures.	*14a Meet senior leaders and attend divisional/team meetings to discuss complaints and raise awareness.*	*Weekly breach reports* *complaints performance report*	Patient Experience, Engagement & Caring group	Kate Oliver Complaints & Pt. Experience Manager	Paula Hull DoN & AHPs	Mar-19		*Refer to the Patient Engagement Improvement Plan* Trust set target to achieve 90% of all complaints closed within agreed timescale by Dec 2018. **Nov-18:** 76% compliance. **Dec-18:** 67% compliance **Jan-19:** 43% compliance. Majority outside timescales = AMH with 29% complaints closed in Jan within timescale. Reasons for delays in Q3 include allocation of Investigating Officer and completeness of initial investigations, amendments required to final letter/delays in sign off. **Feb-19:** 37% compliance. Majority outside	Complete-Unvalidated	Increased satisfaction of compalnants with the Trust response to their complaint.	Complaints Performance. Positive complaint satisfaction surveys.	Mar-19		*Refer to the Patient Engagement Improvement Plan* **Jan-19:** QI project on complaints system started with current state analysis and RIPW in early March. 13/19 (68%) cases closed in December were sent within their agreed timeframe with the complainant. Complaints manager has weekly calls with MH and ISD ADONs to ensure focus on complaints. Weekly breach reports sent. **Mar-19:** QI project - RPIW	At risk
	7.n	Community health services for adults	The investigation of complaints to be completed fully and complaints responded to in line with Trust policy	breach - N/A	The investigation of complaints did not take place in a timely way leading to delays in responding to the complainant. The service did not complete investigation of, respond to, and close complaints within agreed timescales.		**see action 7.m**	*14.b Undertake deep dives into specific areas to better understand improvements to be made.*	*Achieve and maintain Trust Trajectory* *Complaints performance report* *Deep dive reports*	Patient Experience, Engagement & Caring group					*Refer to the Patient Engagement Improvement Plan*	Duplicate						Duplicate
	7.o	Community health inpatient services	The Trust must ensure all staff are up to date with their basic and immediate life support	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment		Risk Reg No: 1619	To ensure training compliance in basic and immediate life support.	All staff that are non compliant with training to be booked on training. Key performance indicator as part of the Trust flash report.	Performance data	Divisional MOM	Julia Lake (interim) Divisional DoN & AHPs	Paula Hull DoN & AHPs	Apr-19		**Feb-19:** ISD Quality report for Jan-19 added to evidence (page 13 ref 2.1); compliance Resus BLS=86.2% ILS=84.4% **Mar-19:** BLS compliance showing an increase from previous month. Tableau data report compliance Resus BLS=88.2% ILS=87.6%.	On track	Patients safety is improved by having staff who are knowledgeable and competent in life support.	Training compliance.	Apr-19			On track

Theme	UIN	Core service	CQC action *from the Inspection Report*	Regulation breached	Cause of breach/ issue raised by CQC	Risk register	Trust Action	Process Actions	Evidence of process completion	Progress monitored by	Responsible lead(s)	Executive accountability	Process date	Recovery date	Process progress update	Status *(process)*	Expected Outcome/Improvement	Evidence to show outcome completion	Outcome date	Recovery date	Outcome progress update	Status *(outcome)*
	7.p	Acute wards for adults of working age and psychiatric intensive care units (PICU)	The Trust should ensure that all staff on Kingsley are trained in physical interventions and restraint so that appropriate support can be provided on Melbury Lodge when needed.	breach - N/A	On Kingsley, the acute ward, we were told that not all staff working at Melbury Lodge were trained in physical intervention. Kingsley ward relied on the support of other wards for emergency support ((such as when carrying out seclusion or physical interventions). As the other wards did not have regular physical interventions, the staff were not trained in this technique. The staff from the mother and baby unit, and older people's unit could not always provide staff on Kingsley ward with the necessary support. Staff on Kingsley ward told us that they sometimes felt vulnerable when not enough people trained in restraint and physical intervention were around to support them.		To ensure sufficient numbers of staff are trained in physical intervention to enable appropriate support across inpatient areas when needed.	Overview of staff requiring sSs training at Melbury Lodge to ensure sufficient numbers are trained to provide appropriate support.	Training data	Divisional MOM	~~Susanna Proady ADoN & AHPs~~ Carole Adcock ADoN & AHPs	Paula Hull DoN & AHPs	Feb-19		**Oct-18:** all Kingsley ward staff are trained. OPMH staff to complete sSs training. **Feb-19:** training stats reflect Melbury OPMH team currently at 100% compliance at 05.02.19 (service overall are 94% compliant). **12.02.19:** CA - figures for Melbury Lodge for sSs training - MBU 94.1%, SOU 97.2%, Kingsley 97.7% **07.03.19:** Two out of the three wards showing a decrease in compliance however still within tolerance. Tableau stats for Melbury lodge for sSs training - MBU=90.6%, SOU=97.2%, Kingsley=95.7% **18.03.19 ERP:** Agreed that action in plan completed, however noted that wider piece of work underway to review effectiveness of sSs training. Requested sSs training data for all PICUs added to evidence.	**Completed**	Staff feel safe and supported by colleagues who have attended specific physical intervention training.	sSs training compliance. Staff feedback.	Apr-19		**18.03.19 ERP:** discussed that review of effectiveness of SSs training is underway with a Task and finish group set up by Sally-Ann Jones/Emma Wadey. Some staff have fedback that do not feel safe as unable to use all the holds previously used. Request for feedback from Sally-Ann.	**On track**
	7.q	Community-based mental health services for adults of working age	The Trust should ensure that the Basingstoke site can account for all patients currently on the waiting list and their allocation status	breach - N/A	The Basingstoke team was not meeting the trust targets for referral to initial assessment waiting times.		To review referrals, caseloads and waiting times and develop a standard procedure to monitor waiting lists.	Referral review and cleanse caseload. Review/develop standard process for overview of waiting lists. Review waiting lists at operational meetings.	Waiting times data.	Divisional MOM	Graham Webb Area Manager (AMH)	Barry Day COO	Apr-19		**Feb-19:** Tableau report saved to evidence, Basingstoke CMHT current waiting time stats (external/internal referals): North=83%/100%, South=69.4%/100%. **Mar-19:** External referral waiting times decreased. Tableau report saved to evidence, Basingstoke CMHT current waiting time stats (external/internal referals): North=94%/100%	**On track**	Patients have an improved experience by receiving an initial assessment within the Trust targets.	Information on waiting times.	Jun-19			**On track**
	7.r	Community mental health services for people with a learning disability or autism	The Trust should address the waiting times of up to six months for specific interventions such as dementia assessments and physiotherapy in West Hampshire, art therapy and occupational therapy in Southampton	breach - N/A	There were waiting times of up to six months for specific interventions in some areas including physiotherapy in West Hampshire, art therapy and occupational therapy in Southampton.		To review and understand the waiting times for specific interventions/professions. To implement effective pathways based on above review.	Review of waiting time issues for specific professions/patient need. Review pathways across LD. Implement effective pathways based on findings. Overall service review to include acuity & dependency, patient need, pathways and commissioning arrangements to ensure that there is sufficient resource to meet needs.	Waiting times will be reduced to a time frame set within a pathway for needs	Divisional MOM	John Stagg ADoN, AHPs & Quality	Barry Day COO	Aug-19		**Oct-18:** The service waiting times will be reviewed to understand the waiting time issues for specific professions or related to specific needs e.g. dementia assessment. Specific needs will be reviewed to address the pathway that is undertaken across learning disability services and a plan made to implement an effective pathway based on what is effective within the services e.g. dementia assessment and treatment. The overall service review will take account of acuity & dependency, patient need, pathways and commissioning arrangements to ensure that there is sufficient	**On track**	Pathways are in place which support patients being seen within agreed time standards.	Information on waiting times for interventions. Clinical pathways in place.	Aug-19			**On track**

Quality Workstreams Framework

NHS Southern Health NHS Foundation Trust

Executive Directors

- Provide support and guidance
- Help find solutions to unblock issues
- Ultimate accountability for completion of actions

Action owners/Core services	Quality Workstream Lead	Facilitation/Support
Scoping exercise • To be responsible for completion of allocated actions in plan • to liaise with workstream lead to discuss the current state within services • to discuss the actions already taken to address issues • to discuss options for additional support if required	**Scoping exercise** • to understand the range of actions included in workstream • to identify what actions services have taken already to address issues • to identify who needs to be involved in workstream • to identify need for additional support • to discuss whether a Quality Improvement (QI) approach would be applicable for some actions	**Patient and Public Engagement and Patient Experience** • to support communication of improvement plan to patients, families and key stakeholders • to support gaining feedback from patients and families on achieving the desired outcomes
Triangulation of information • to liaise with workstream lead on the understanding of local issues	**Triangulation of information** • to review other information available to help a fuller understanding of issues e.g. complaints; incidents; peer reviews; Quality Assessment Tool; audits; risk register; training; performance • to identify if issues are Trust wide or in specific locations only	**Staff Engagement** • to communicate with staff the actions; desired outcomes and plans for improvements • to involve staff in workstreams and decisions to agree and implement improvements to services
Root Cause Analysis (RCA) • to support the RCA analysis and identification of root causes and contributory factors • to be involved in the QI approach and bespoke training	**Root Cause Analysis (RCA)** • to identify root causes and contributory factors underlying the required actions • to use QI methodology to analyse issues as appropriate	**Transformation Team** • to facilitate identification of actions where QI methodology would be beneficial • to provide training in QI tools and techniques • to facilitate the identification, testing and implementation of changes
Improvement programme • to engage in the identification/planning/implementation of changes • to be involved in QI workshops / release staff to attend • to involve staff in the discussion/planning/implementation of improvements • to support the communication of next steps to teams • to support teams to make and embed identified improvements	**Improvement programme** • to engage with service leads/action leads to discuss and agree Change Management Approach based on results of analysis • to use Quality Improvement tools and techniques to identify, test and implement changes where applicable • to communicate with staff the results of analysis and discuss the next steps to take to enable improvements to be made and embedded • to support the services to make the identified changes	**Quality Governance PMO** • to collate evidence to demonstrate actions completed • to attend workstream meetings and jointly validate action completion • to update quality improvement plans and dashboards with progress status • to report progress and exceptions to QSC/Board
Evaluation of progress • To escalate to workstream lead any actions which are not on track/need support to unblock issues • To present progress updates as requested • to propose amendments required to original actions following PDSA cycle • to escalate risks to completion of actions to the workstream leads • to send evidence of action progress and completion	**Evaluation of progress** • to send evidence of action progress and completion to Quality PMO for collation • to jointly validate that actions are completed based on evidence collated • to identify and escalate risks to completion of actions by agreed deadlines and provide recovery plans • to present progress updates to Committees/Groups/Forums	**Senior Management Committee (SMC)** • to have Trust wide oversight of plan status • to address risks to non-completion of actions

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