Incorporating: Produced by:

UIN	Location	Trust Wide Actions Required	Responsible Leads	Action to be completed by	Action to be completed by	Required Evidence to show completion	Action Progress Update	completed actions (e.g.	Outcome or Improvement the action will deliver	Outcome to be achieved by (date)	Required Evidence to show Outcome Met	Outcome Progress Update	Outcome Status blue
RN001 1.1	Beaulieu Ward, Western Community Hospital	1.1 Safer Staffing Lead to review red flagged staffing incidents and escalate to Associate Directors of Nursing if staffing levels have impacted on one to one nursing observations.	Kathy Jackson, Head of Inpatients supported by Sue Jewell, Safer Staffing Lead.	**30.11.17**		Monthly Safer Staffing reports.	Sept: Monthly safer staffing reports include exception report on red flagged staffing incidents. These are discussed at Patient Safety Group as required. May (Beaulieu 6 incidents) and June (Berrywood 1 incident) Safer Staffing reports highlight red flagged staffing incidents where there was an inability to maintain observations at required levels due to staffing levels. July Safer Staffing Report describes increase to funded establishment for OPMH as a result of previous acuity and dependency measures and ongoing work to reduce agency use. Impact	**On track**	Patients receive safe care and have one to one nursing observations completed as required with observation levels not reduced due to staffing issues.		There are no incidents where a patient is put at risk of harm if one to one observations are not completed as required.		
RN001 1.2		1.2 Circulate correct escalation process for inadequate staffing levels. Staff to report staffing incidents as per Safer Staffing Policy.		**31.10.17**		Escalation process circulated. Staffing incidents are reported - review Ulysses. Safer Staffing reports	Oct: escalation process circulated to staff. Safer staffing reports show that staffing incidents are reported with all red flagged incidents reviewed by Acting Chief Nurse.	**Completed-unvalidated**					
RN001 1.3		1.3. Ensure robust procedure is in place for the review of patient one to one observations within MDT. Identify other staff groups who could support one to one observations eg OTs.		**31.10.17**		Review sample of patient records for one to one observations in MDT discussions.	Oct: SM reviewed sample of 10 patient records and found 9/10 had one to one observations discussed at MDT. Will develop an action with ward to make sure all one to one observations are discussed at MDT.	**Completed-unvalidated**					
RN001 1.4		1.4. Ensure compliance with E-Roster checklist.		**31.10.17**		Completed e-roster checklist.	Oct: all local matrons/ward managers are completing monthly checklist of e-roster - checklists are sent to safer staffing generic inbox with Sue Jewell therefore having oversight of these. E-rosters for 5.11.17-2.12.17 are approved for all OPMH sites.	**Completed-unvalidated**					
RN002 2.1	Stephano Olivieri, Melbury Lodge, Berrywood/Beaulieu wards, Western Community Hospital	2.1 To review the best interests section in the DNACPR Policy and strengthen as required. This will include the development and circulation of flowcharts for staff on a) how to complete DNACPR forms b) what information to check on DNACPR forms completed elsewhere for patients transferring into our care.	Simon Johnson, Head of Essential Training Delivery supported by Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett	**30.09.17**		Revised guidance is circulated to staff. Flowcharts are developed and in place.	Sept: Policy reviewed re best interests and amendments proposed with revised wording checked and approved by trust solicitors. Flowcharts added as appendix 9 and 10 to policy which provides guidance on how DNACPR forms are to be completed. Oct: Revised policy presented to Resuscitation Committee on 5.10.17 for approval. Need to add to policy about cross border patients - Hampshire Hospitals started to use 'Respect ' form for EOL patients - will need to transfer onto lilac form used in trust as per policy. Request to SC/SC to approve policy - once Policy is approved and published, the recommendation is that these flowcharts are printed off and	**Completed-unvalidated**	Patients will have DNACPR forms completed effectively and in a timely manner.		There are no incidents where staff have not followed the DNACPR Policy. There are no complaints regarding use of DNACPR forms.		
RN002 2.2		2.2 The resuscitation team to complete an initial audit of the DNACPR process with actions developed based on audit findings.		**30.09.17**		Results and report of DNACPR audit and action plan.	Sept: audits completed with good practice and improvements identified. Request for audit results to be cascaded to teams via Chief Nurse/Medical Director with request for teams to add actions to local plans. Audit results discussed at End of Life steering group in Sept. Oct: Audit results discussed at Resuscitation Committee on 05.10.17.SM to take audits to OPMH ward managers meeting on 11.10.17 for them to add actions to their local QIP. Resuscitation team have added specific actions relevant to their service. 24.10.17 QIPDG escalated to TEC need for actions to address issues from audits and a request that audits go to Clinical Directors for completion of actions re medical staff. Discussed at TEC and SJ to draft email for Sarah Constantine to send out. 26 .10.17 SJ drafted email and sent to Sarah Constantine to send out re action plans - latter have both medical and nursing issues to be actioned.	**Overdue**					
RN002 2.3		2.3 The resuscitation team to complete 3 x bi-monthly DNACPR audits (Oct/Dec 17/Feb 18) to ensure any actions required are embedded into everyday practice. At end of this period review need for further audit.		**28.02.18**		Results and reports of DNACPR audits and action plans per audit.	Sept: further audits planned. Oct: agreed at Resuscitation Committee to use results from Sept audits as baseline measures with re-audits to take place in Dec and Feb to enable actions to be completed prior to re-audit.	**On track**					
RN002 2.4		2.4 To include the importance of patient and family involvement in DNACPR decisions and documentation of mental capacity in trust training.		**30.11.17**		Training materials.	Oct: Flowcharts include discussion with patient/assessment of mental capacity once Policy approved. Once Policy approved SJ will a) request SC/SG to send out flowcharts to all doctors with message re completion b) send to all staff who are required to complete ILS training. DNACPR covered in BLS /ILS training.	**On track**					
RN003 3.1	Stephano Olivieri, Melbury Lodge	3.1 New windows are on order which will resolve privacy issues. These should be installed by end November 2017.	Kathy Jackson, Head of Inpatients supported by Scott Jones, Deputy Head of Estates Services Gary Rollings, Estates	**30.11.17**		Site visit to confirm installation of windows in place and privacy issues resolved.	August:Capital funding was secured and windows are on order. Site visit by SC on 18.7.17 to inspect issues/solutions proposed - agreed a temporary solution of opaque film on windows but still concerns that patients on another ward can access windows. Risk 1481 on risk register. Sept: new windows to be fitted week beg 16.10.17 - anti-ligature with solid mesh which will prevent passing of objects through window and will be frosted to meet privacy and dignity. To check perimeter plans for garden. Oct: email to Scott Jones for evidence of windows installed.	**On track**	The privacy and dignity of patients will be improved through environmental works.	**30.11.17**	Environmental works are completed.		
RN003 3.2		3.2 To review privacy and dignity PLACE results for Stephano Olivieri (SOU) ward and implement actions based on feedback as appropriate.		**31.10.17**		PLACE feedback and action plan where appropriate.	Sept:annual PLACE report to be presented to Caring Group in October. PLACE site assessments completed, including SOU with most feedback positive. Some privacy and dignity issues identified and have been added to PLACE action tracker eg configuration of 'swing' bedrooms may give rise to different sexes passing through area for opposite sex. Actions need dates for completion. Oct: need wider discussion re use of 'swing' bedrooms across Trust. BC and SM to meet 1.11.17 to discuss. 1.11.17 BC and SM meeting - reviewed wording of PLACE feedback regarding 'swing' rooms which states there is potential privacy/dignity issue, however SM confirmed that bedrooms 'swing' only when it is appropriate to do so with regard to surrounding patient cohort. There have been no breaches of same sex accommodation guidance on SOU.	**Completed-unvalidated**					
RN003 3.3		3.3 Estates team to review the current position of the garden boundary between SOU and adjacent wards and provide options of alternative configurations.		**30.09.17**		Results of estates review and options proposal.	Sept: estates team have reviewed the garden boundary with AMH. Further discussion with OPMH is required. Oct: OPMH to meet with estates and AMH on 17.10.17 to discuss issue. 24.10.17 positive meeting SM and GR with proposed options to widen flowerbed so patients unable to get close to windows and put up privacy screen by office windows to ensure confidentiality. GR currently costing proposals so that decision can be made. Once agreed, works can be completed following completion of window installation.	**Completed-unvalidated**					
RN003 3.4		3.4 Estates solution to be implemented once decision made regarding options at senior level.		**28.02.18**		Site visit to confirm estates work completed per decision made.		**Blank**					
RN004 4.1	Wards for older people with mental health problems	4.1 Estate Services will conduct a review of all OPMH wards to ensure that all remaining ligature works have been undertaken and /or are in progress and that the environmental work plans have been updated to reflect the accurate position.	Kathy Jackson, Head of Inpatients supported by Karen Thomas, Ligature Manager (left Oct 2017) Scott Jones, Deputy Head of Estates Services	**30.11.17**		Completed capital projects signed off in ligature management group.	Aug: Capital funding was secured and programme was agreed and is underway. Oct: Ligature management report to Patient Safety Group in October summarises work completed to date. Berrywood/Dryad and SOU works are completed with new bathrooms that are ligature free. Ligature Manager is revisiting all sites to update environmental risk plans according to a schedule with inpatient sites prioritised. Beechwood - new windows to be completed by end Nov.	**On track**	The safety of patients will be improved through ligature environmental works.		Environmental works are completed. There are no incidents relating to ligature points in OPMH wards.		
RN004 4.2		4.2 To complete estates works to provide all OPMH functional wards with 2 'safe' bedrooms.	John Stagg, ADON LD and new co-chair of Ligature Management Group with Andrew Mosley AD for	**31.12.17**		Site visit to confirm bedrooms are completed.	Oct: estates works ongoing to complete 'safe' rooms. Berrywood,Western Hospital and Dryad, GWMH have 2 'safe' bedrooms each completed with anti-ligature fittings. Tender for 2 'safe' rooms at Beechwood, Parklands is due back at end Oct.	**On track**					

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RN005 5.1	~~Stephano Olivieri, Melbury Lodge, Berrywood~~/Beaulieu wards, Western Community Hospital	5.1 To review current covert medicines guidance, strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	**31.10.17**		Revised covert medicine guidance completed and circulated.	Oct: AW, OPMH Lead pharmacist working with OPMH leads to revise guidance which will be presented to Medicines Management Committee (MMC) 15 Nov for approval prior to publication.	**Completed-unvalidated**	All patients receive their medicines in a safe and effective way.		There are no incidents when staff have not followed covert medication guidance.		
RN005 5.2		5.2 Retrain registered nurses on ~~SOU, Berrywood and~~ Beaulieu wards in administration of covert medicines.		**31.10.17**	**31.12.17**	Training sessions evidenced.	Sept: As discussed at QIPDG on 12/09/17, this action only applies to Beaulieu. Oct: Ward matron will cover guidance at team meeting- however needs to wait for revised guidance to be published. .	**Overdue**					
RN005 5.3		5.3 OPMH ward managers to complete weekly checklists which include covert medicines and take to monthly OPMH managers meeting for review and escalation as required.	Kathy Jackson, Head of Inpatients	**30.11.17**		Minutes of monthly OPMH managers meeting.	Oct: weekly checklists are discussed at monthly OPMH managers meetings.	**On track**					
RN005 5.4		5.4 Medicines Management Committee (bi-monthly) to review incidents across the trust for re-occurrence of covert medication/best interests incidents.	Raj Parekh, Chief Pharmacist	**31.12.17**		Minutes of Medicines Management Committee.	Oct: section on covert medication added to quarterly Medicine Safety Officer report for Q2. Q2 report will be presented to November Patient Safety Group and MMC.	**On track**					
RN006 6.1	Gosport team	6.1 To complete a caseload review with the Gosport team, comparing to other OPMH team caseloads and implement actions where required, including discussions with commissioners about the service needs/capacity.	Helen Neary, Associate Director of Nursing and AHPS supported by Sue Jewell, Safer Staffing Lead	**28.02.18**		Results of caseload review and action plan in place.	Oct: a lot of work completed on OPMH caseloads - see Safer Staffing Reports.	**On track**	?		?		
RN006 6.2		6.2 Caseload review to include active discharge of patients where appropriate.		**28.02.18**		Results of caseload review - caseload figures on tableau to evidence discharge process.	Oct: Memory clinics can make caseloads look large.	**Blank**					
RN007 7.1		7.1 Review Next of Kin compliance at monthly divisional governance/performance meetings to ensure target '80% of patients have next of kin/other relationships recorded' is met and maintained over 3 months. 22 August NoK ISD 80.8%; OPMH 85.1%; MH 74.0%; LD 84.5%.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	**31.12.17**		Minutes of divisional governance/performance meeting with NoK compliance minuted.	Oct: N of K discussed at RKCP meeting - JS to send communications to all staff with examples as to why the recording is important as reminder to support completion. Need to continue focus to ensure target met across all BUs - performance monitored at business performance reviews/team meetings. 12 Oct NoK/other relationship executive flash report of whole caseload: ISD 85.4%, AMH 76.4%, LD 84.9%. (Trust target 80%). AMH continue to focus on increasing this %.	**On track**	Next of kin/other relationship information will be recorded for the majority of patients thereby making it easier to contact family/close relationship if needed.	Once target met - maintain over following 3 months	Next of kin/other relationship performance data shows that 80% target is met and maintained over 3 months.		
RN008 8.1		8.1 Every patient must have an up to date and individualised risk assessment which is clearly accessible within the clinical records (Quality Account Priority). Risk assessment completion to continue to be monitored using Tableau including timeliness. Quarterly record keeping audit will monitor compliance. Target is 95% of patients have a risk assessment as per Risk Assessment Policy.	Associate Directors of Nursing and AHPs: Carol Adcock, John Stagg, Nicky Bennett	**31.03.18**		Results of record keeping audits and actions to be implemented based on recommendations.	Oct: Q1 Quality Account report updates on progress - AMH close to 95% risk assessment target and have reviewed at performance meetings and identified that some individual staff need support to ensure completion.	**On track**	Patients will receive safe effective care if risk assessments are completed as per Trust policy		Risk assessments are completed and are up to date.?%		
RN008 8.2		8.2 Development of a framework and guidance tool to support clinicians developing crisis contingency plans with patient and carer/family input (Quality Account priority).		**completed**		Framework and guidance tools in place.	Framework and guidance tools in place and circulated to staff. Oct: Quality Conference Risk Management presentation by Prof. Kingdon	**Completed-unvalidated**					
RN008 8.3		8.3 Audit of Risk summary to be analysed for quality as part of clinical audit programme and subsequently as part of supervision. The record keeping and holistic assessment audits will be strengthened to focus on the quality of risk assessment and crisis contingency plans and the programme will facilitate a quarterly audit (Quality Account priority).		**31.03.18**		Results of record keeping audits and actions to be implemented based on recommendations.	Oct: Mayura Deshpande is reviewing risk assessment audit tools.	**Blank**					
RN008 8.4		8.4 Associate Directors of Nursing and AHPs (ADONS) will complete a sample review of 2 patients per month using a standard template on risk assessment and crisis plan completion. ADONs will take action as required to address compliance issues.		**31.01.18**		Exception reporting for sample cases reviewed.	Oct: draft standard template circulated - sample review to start in Oct/Nov.	**On track**					
RN008 8.5		8.5 Clinical staff to undertake mandatory risk training as per policy.		**31.12.17**		Training compliance figures (tableau).		**Blank**					
RN009 9.1		9.1 A communication plan to be developed to ensure staff are aware of how to be adherent to the policy: specifically when to complete crisis, safety or combined plans.	Carol Adcock, Associate Director of Nursing and AHPs	**31.10.17**		Copy of the communication plan	Oct: Quality Conference Risk Management presentation by Prof. Kingdon. Carole Adcock to complete communication plan.	**Overdue**	Crisis plans will be completed as per Trust policy				
RN009 9.2		9.2 Monthly compliance with completion of crisis plans to be reported at the Mental Health Quality and Safety Meeting (QSM).		**30.11.17**		Minutes of QSM	Oct: CPA and Risk in minutes of QSM meeting 21.09.17 pages 6 and 7	**On track**					
RN010 10.1		see actions in 7	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor					**Duplicate**					Duplicate
RN011 11.1		11.1 To bring acuity and dependency measurement for Community Mental Health Teams (CMHTs) in line with existing trust establishment review process as identified within the Safer Staffing Policy.	Carol Adcock, Associate Director of Nursing and AHPs supported by Sue Jewell, Safer Staffing Lead	**30.11.17**		Results of acuity and dependency review.	Oct: Sue Jewell meeting with team leads to check if actions from previous acuity and dependency measurement exercise have been completed. To complete a validation exercise on Nov 29th.	**Blank**	Clear understanding of the staffing levels and skill mix required within the community teams.				
RN012 12.1		see actions in 2	Simon Johnson, Head of Essential Training Delivery supported by Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett					**Duplicate**					Duplicate
RN013 13.1		13.1 Appraisals to be completed for community teams and to be in line with Trust target.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	**31.12.17**		Appraisal performance data for community teams.	Oct: Appraisal = 94 % completed on tableau (12.10.17). Increasing compliance shown over year.	**On track**	Appraisals target of 90% achieved for community teams. Increased number of staff are supported through appraisal process.		Appraisal performance data for community teams.		
RN014 14.1		14.1. Roll out of the end of life care plan for use in the community team.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	**31.10.17**		End of Life Care Plan for use in community.	Sep: EofL Steering Group 28.09.17 individualised care plans - aiming to add to RiO with request for change made to RiO Change Board. Where applicable staff to continue to use paper form as per policy which will be reviewed once care plan on RiO. Eof L care plan for use by community staff is on intranet.	**Completed-unvalidated**	Patients who are at end of life at home are effectively supported via an individualised care plan.		Numbers/% of end of life patients at home who have individualised care plans.		
RN014 14.2		14.2. undertake road shows to promote the use of end of life care plan.		**completed**		Dates and attendance at roadshows.	Roadshows taken place - weekly bulletin April 2017 refereences roadshows in May 2017.	**Completed-unvalidated**					
RN014 14.3		14.3. Audit the use of the end of life care plan in quarter 3 thematic review.		**28.02.18**		Results and report on the audit/thematic review.	Sep: terms of reference shared at EofL Steering Group 28.09.17 for thematic review Oct-Dec - will include use of care plans. Thematic review will also look at EOL incidents.	**On track**					
RN015 15.1		15.1. Improve compliance with completion of patient record on the day of care.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	**28.02.18**		RiO change request is actioned.		**Blank**	Patients who are at end of life receive effective well planned care that is based on their wishes.		There are no incidents or complaints relating to availability of information in end of life care.		

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RN015 15.2		15.2 To scope the numbers of staff that are able to use Store and Forward; maximise the use of existing licences and develop a business case for additional licenses if required.		**31.12.17**		Results of scoping exercise- may be part of thematic review.	Sep: EofL Steering Group reviewing electronic document management system with paper records written in patient home to be scanned onto RiO and then destroyed.	**On track**					
RN016 16.1	Romsey Hospital	16.1. Review pathway for transfer of care between Romsey hospital and the acute services.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	**31.01.18**		Pathway Review completed.		**Blank**	Patients who are at end of life receive effective well planned care that is based on their wishes.		There are no incidents or complaints relating to medical support for end of life patients who deteriorate.		
RN016 16.2		16.2. Raise with Consultant responsible for Romsey hospital the importance for having clear plans in place for escalation of care and document in the medical notes.		**30.11.17**		Individual escalation plans for patients at end of life in place.		**Blank**					
RN016 16.3		16.3. To discuss with staff at team meetings the escalation plans in place for patients and the need to act on these as required.		**30.11.17**		Staff follow escalation plans for individual patients.		**Blank**					
RN016 17.1	Gosport War Memorial Hospital	17.1 To review daily staffing levels in line with Safer Staffing Policy and escalate as per real time management of staffing levels guidance. Bespoke policy training can be provided if required.	Helen Neary, Associate Director of Nursing supported by Sue Jewell, Safer Staffing Lead	**31.10.17**		Safer Staffing Policy	Oct: matrons review staffing levels on daily basis - eroster guidance followed with aim to reduce bank/agency spend. Staffing levels can be difficult for stand alone wards if staff off sick etc.	**Completed-unvalidated**	Able to have real time information as to status staffing levels rather than retrospective. Rosters are compliant with best practice. No shifts where staffing was unsafe. Service:				
RN016 17.2		17.2 Implementation of SafeCare which will provide live staffing status of safe staffing levels based upon patient needs and actual staffing levels.		**31.03.18**		SafeCare is in place.	HR are recruiting to project manager post.	**Blank**					
RN018 18.1		18.1 LEaD to continue to review the 5 teams per division with the lowest training compliance and contact managers/individual staff to action where required. Bespoke training can be arranged if whole ward/large team requires training update.	Associate Directors of Nursing Julia Lake, Susanna Preedy, Helen Neary supported by Simon Johnson, Head of Essential Training Delivery	**31.01.18**		Training compliance data per team/division - training target 95% within trust. E-mail reminders to staff /automatic reminders to staff of training requiring completion.	Oct: Tableau report ISD 93.7%, MH 93.2% for current month. BUs monitor training compliance via business performance review. Resuscitation Committee 5.10.17 BLS 84.2% 81.6%	**Blank**	Patients are safe in our care and are seen by staff who have completed the required mandatory training.		Training target of 95% for mandatory training is met.		
RN019 19.1		19.1 To review current guidance on single use of medicines and strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	**31.10.17**		Revised single use of medicines guidance.	Oct: draft poster on use of creams/lotions discussed at senior meds management team meeting and given final approval. Advice from IPC lead re single use received and implemented for poster. Poster circulated.	**Completed-unvalidated**	All patients receive their medicines in a safe and effective way.		There are no incidents or complaints when staff have not followed single use medicine guidance.		
RN019 19.2		19.2 To include single use of medicines in the annual Safe and Secure Medicines audit.		**30.11.17**		Audit tool - Safe and Secure Medicines	Oct: audit tool amended to include single use medicines.	**On track**					
RN019 19.3		19.3 Audit to be completed across all inpatient units/wards with action plans developed based on audit recommendations.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	**31.12.17**		Audit results/reports and completed action plans.	Oct: Safe and Secure Medicines audit is out for data collection in Oct.	**On track**					
RN019 19.4		19.4 To review the current Medicines Management Quality Checklist and add information to check that correct procedure to follow for single use medicines is followed.	Raj Parekh, Chief Pharmacist	**30.09.17**		Revised Medicine Management Quality Checklist.	25/09/17: email to Responsible lead for update 26/09/17: see QIPDG meeting minutes. 28/09/17: email from Responsible lead checklist has been reviewed and approved by MMC 20/09/17. Felt checklist was appropriate for inpatients. Sheila Gascoigne working with Meds team to look at a checklist for community teams.	**Completed-unvalidated**					
RN019 19.5		19.5 Medicines Management Committee (bi-monthly) to review progress with completion of audit actions.	Raj Parekh, Chief Pharmacist	**31.12.17**		Minutes of Medicines Management Committee.	Oct: results of audit will be presented to MMC and Patient Safety Group.	**Blank**					
RN020 20.1		20.1 To develop guidance on expiry dates for medicines for use by staff on wards and circulate. This guidance to include use of stock insulin.	Raj Parekh, Chief Pharmacist supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	**30.09.17**	**13.10.17**	Expiry date guidance.	Oct: senior Medicines Management team meeting on 03/10/17 approved expiry date guidance and has been added as appendix to Medicines Control, Administration and Prescribing Policy (MCAPP) which has been revised and published on website.NEED TO CHECK REVISED POLICY COVERS STOCK INSULIN.	**Completed-unvalidated**	All patients receive their medicines in a safe and effective way.		There are no incidents or complaints when staff have not followed expiry date medicine guidance.		
RN020 20.2		20.2 To design and order expiry date labels for use with all patients' liquid medicines and insulin.	Raj Parekh, Chief Pharmacist	**31.08.17**		Expiry date labels.	Sept: labels ordered and distributed to wards.	**Completed-unvalidated**					
RN020 20.3		20.3 To review the current Medicines Management Quality Checklist and add information to check that correct procedure to follow for medicine expiry dates is followed.	Raj Parekh, Chief Pharmacist	**30.09.17**		Revised Medicine Management Quality Checklist. Audit results	Sept: Checklist reviewed/revised and approved by MMC 20/09/17. Safe and Secure Medicines audit will include expiry date compliance - data collection in Oct.	**Completed-unvalidated**					
RN020 20.4		20.4 Medicines Management Committee (bi-monthly) to review progress with completion of action.	Raj Parekh, Chief Pharmacist	**31.12.17**		Minutes of Medicines Management Committee.	Sept: MMC minutes re actions on plan.	**On track**					
RN021 21.1	Gosport War Memorial Hospital	21.1 Include CQC feedback and actions in quarterly IPC Report and Newsletter.	~~Theresa Lewis, Lead Nurse~~ Jacky Hunt, Lead Nurse Infection, Prevention and Control supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett supported by Bob Beeching, Contracts and Project Manager and Sally Banberry(Trust Waste Manager), Karen Poting (GWMH site waste manager)	**31.12.17**		21.1 IPC Quarterly Report /IPC Newsletter IPC Matters (Quarter 3)	Oct: PMO email out to responsible lead requesting copy of quarterly report Q2' Infection Prevention Matters' newsletter includes range of information	**On track**	Patients receive safe care by staff following the correct process for dealing and disposing of waste materials.	**31.03.18**	Results of Isolation audit due in Feb 2018. Summary of Back to the Floor visits with no/minor concerns raised. There are no incidents or complaints regarding best practice for managing waste disposal not being followed.		
RN021 21.2		21.2 Infection Prevention and Control (IPC) team to discuss best practice /CQC feedback at 'face to face' training sessions.		**31.12.17**		21.2 IPC Quarterly Report to include training sessions.		**Blank**					
RN021 21.3		21.3 IPC team to add CQC feedback and actions for next IPC Link Advisor meeting .		**31.10.17**		Minutes of IPC Link Advisor Meetings due in October 2017.	Oct: presentation to Link Advisors includes feedback from CQC actions as well as results of audits/best practice guidance on key topics.	**Completed-unvalidated**					
RN021 21.4		21.4 IPC advisors to observe staff practice when undertaking 'back to the floor' visits.		**31.12.17**		Back to the floor' visit timetable and feedback by exception from any visit.		**Blank**					
RN021 21.5		21.5 IPC team to circulate waste disposal guidance summary to teams.		**01.09.17**		Waste Disposal Guidance circulated.	Aug: IPC lead circulated waste disposal guidelines to teams. Oct: waste disposal guidnace also in IPC Q2 Infection Prevention Matters newsletter.	**Completed-unvalidated**					
RN021 21.6		21.6 IPC team to monitor that staff are in date with their IPC training (> 95%) and raise low compliance with team managers.		**31.12.17**		IPC training compliance.		**Blank**					
RN021 21.7		21.7 Ensure that IPC is part of the organisational induction checklist for non-permanent staff (in Organisational Induction Policy).		**30.09.17**		Local Induction Checklist in place.	Sept: amendments made to Organisational Induction Policy with appendix C Record of local induction for non permanent staff which includes IPC requirements.	**Completed-unvalidated**					

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RN021 21.8		21.8 Estates services to develop and circulate poster with all relevant laundry guidance and links to web pages which has all the information on linen handling.		**30.09.17**		Poster in place.	Sept: draft poster discussed QIPDG with slight amendments proposed. Poster sent to comms to rpoduec final version. Oct: poster circulated by BB to leads.	**Completed-unvalidated**					
RN021 21.9		21.9 Estates services to lead on completion of laundry audit based on Laundry Policy by site managers and to support development of action plan by teams based on results where required.		**30.11.17**		Results of audit and action plan based on recommendations.	Sept: laundry audit underway	**On track**					
RN022 22.1		22.1. Review the specific fridge in Gosport War Memorial Hospital and check service history with BCAS - complete service if it is overdue.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor supported by Tracey Hammond, Medical Devices Advisor Sally Banberry, BCAS contract manager	**31.08.17**		All equipment has been serviced and is in date - evidenced by the BCAS equipment list.	Review of the fridge observed during the inspection showed there was an old service check sticker on it and a current service one on another area of the fridge. The trust equipment inventory also concurred that the service had been completed. Sept: BCAS contract meeitng minuted that fridge at GWMH in date for servicing and agreed process to ensure all equipment is labelled with correct service sticker.	**Completed-unvalidated**	All equipment to be serviced and within date as per medical devices policy.	**Oct-17**	No equipment is outside of its service date as evidenced by the BCAS equipment list.		
RN022 22.2		22.2. Ensure all equipment is labelled with the correct service sticker.		**31.10.17**		Spot check audits.	Aug: BCAS contract meeting (16/08/17) agreed process to ensure all equipment is labelled with correct service sticker.They will remove any old service or PAT testing stickers as they service equipment. Oct: Medical Devices advisor completes mini site audits and checks are included in peer reviews.	**Completed-unvalidated**					
RN022 22.3		22.3. Meet with BCAS to agree that they will check each piece of equipment as they service it and remove any old service to PAT testing stickers.		**31.08.17**		Minutes of Meeting 16.08.17.	Aug: BCAS contract meeting (16/08/17) agreed process to ensure all equipment is labelled with correct service sticker.They will remove any old service or PAT testing stickers as they service equipment.	**Completed-unvalidated**					
RN022 22.4		22.4. Monitor at BCAS contract meetings.		**31.10.17**		Any issue are raised at BCAS contract meetings and actions agreed and minuted.	Oct: monthly meetings with BCAS in place and issues are raised and actioned.	**Completed-unvalidated**					
RN023 23.1		**TM to seek clarity from CQC re this action.** **04/10/17 TM confirmed that CQC have verbally agreed to remove this action from the inspection report. CQC report on website on 04/10/17 continued to include this action.**						**no action required**					**no action required**
RN024 24.1		24.1 Communications to staff: 1. Distribute of NHS England Safeguarding 'Pocket Principles' Cards to all service areas. 2.Design and distribute Safeguarding Poster – when to make a referral (to complement the existing poster about how to make a referral).	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group; Safeguarding Quality Workstream	**1. 31.08.17** **2. 31.10.17**		Communications to staff: 1. Confirmation of receipt of Pocket Principles and dissemination. 2.Safeguarding Poster – when to make a referral on display	15/09/17: email sent out to CM requesting update on actions/evidence in preparation for Tuesdays meeting 25/09/17: email to Responsible lead for update Sept: Safeguarding meeting on 05/10/17 to discuss/approve Oct: NHS 'Pocket Principles' have been being distributed at Safeguarding Training (since May 2017). Distribution is ongoing. Hotspots ongoing. october raised awareness of Modern Slavery.	**Completed-unvalidated**	Staff will recognise and escalate safeguarding concerns thus helping to provide protection to patients.		Safeguarding concerns are raised as incidents on Ulysses.	1. Distribution is ongoing. 2. Hotspots ongoing. October raised awareness of Modern Slavery.	
RN024 24.2		24.2 Training: 1.Design and deliver Safeguarding learning set – how to recognise abuse, neglect, and self-neglect. Bespoke training can be provided as required to identified teams. 2.The team will be carrying out a comprehensive review of mandatory training material, delivery and learning methods, and review compliance on an ongoing basis. An incremental review of Safeguarding Adults sections is underway.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group; Safeguarding Quality Workstream	**1. 30.09.17** **2. 31.08.17**		Training: 1.Learning set materials and attendance sheet 2.Incremental Course Material (in powerpoint presentation. Training compliance data (Tableau system)	15/09/17: email sent out to CM requesting update on actions/evidence in preparation for Tuesdays meeting. 25/09/17: email to Responsible lead for update. Sept: Safeguarding meeting on 05/10/17 to discuss/approve Oct: Learning sets delivered regularly monthly from March 17. Variety of topics, Safeguarding specific session delivered 7 times since March, across ISD areas. Incremental Review completed and first delivered 04/10/2017. Training ongoing.	**Completed-unvalidated**				Delivery of 7 Safeguarding sessions since March 2017 (monthly from April 2017). Additional sessions included the following topics: Self-neglect (multi-agency for Southampton SAB), professional boundaries, MCA and DoLS.	
RN024 24.3		24.3 Team Processes: 1.Confirm that Safeguarding is a standard agenda item in Multi-Disciplinary Team (MDT) meetings. 2. Confirm that Safeguarding is a standard item in all clinical supervision templates. 3.Scope the development of a network of Business Unit Safeguarding Champions, Representatives and Coordinators.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Team; Safeguarding Quality Workstream	**31.10.17**		Team Processes: 1. Blank template of MDT Agenda, sample audit 2. Blank clinical supervision templates, sample audit 3. Report to Safeguarding Forum		**Blank**					
RN025 25.1		25.1 Communications to staff: Confirm Safeguarding Poster on how to make a referral and access to Trust Safeguarding support are prominently displayed in all service staff areas.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group; Safeguarding Quality Workstream	**31.10.17**		Communications to staff: 1. Confirmation of receipt of Pocket Principles and dissemination. 2.Safeguarding Poster – when to make a referral on display	Sept: Safeguarding team meeitng on 05/10/17 to discuss/approve	**On track**	Staff will recognise and escalate safeguarding concerns thus helping to provide protection to patients.		Safeguarding concerns are raised as incidents on Ulysses.		
RN025 25.2		25.2 see 24.2	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group; Safeguarding Quality Workstream					**Duplicate**					Duplicate

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RN025 25.3		25.3 see 24.3	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Team; Safeguarding Quality Workstream					Duplicate					Duplicate
RN026 26.1	Alton Hospital	26.1 To review current guidance on safe and secure storage of medicines on wards and in clinics and strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	**31.12.17**		Revised safe storage of medicines guidance.	Oct: Safe and Secure medicines audit currently out for data collection. Results will highlight any areas where actions may be needed to rectify issues.	On track	All patients receive their medicines in a safe and effective way.		There are no incidents when staff have not followed safe storage of medicine guidance and left medicine doors open/unauthorised staff able to access room.		
RN026 26.2		26.2 Alton Hospital to implement a process whereby the door codes are changed at agreed intervals and there are signs on medicine storage rooms 'doors must be closed'.	Susanna Preedy, Associate Directors for Nursing and AHPs	**31.10.17**		Signs in place - site visits required to check. Process to change door codes in place.	Oct: responsible lead to check with ward regardng action/evidence. 31.10.17 QIPDG Susanna Preedy confirmed that estates had visited and had changed door codes as part of a 6 month programme.	Completed-unvalidated					
RN027 27.1		27.1. To meet with CCG and wheelchair providers to agree improvements to wheelchair provision.	Helen Ludford, Associate Director Quality Governance supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	**30.09.17**		Minutes of contract meetings.	Aug:Meeting took place with the CCG 8/8/17. Millbrook are very committed to working with us to improve services to patients and their relationship with our teams however to do this they need to be aware of our issues and incidents. There is now a reporting route for any incidents but we need to improve the personal relationships to improve patient safety.WHCCG would like us to field a team for a monthly meeting with representatives from the ISD - BU 2 & 3, Childrens - BU 4, LD and Tissue Viability Nurses with Millbrook.Millbrook will be inviting all of the named representatives to visit their facility and understand their internal processes probably in September.	Completed-unvalidated	Patients all receive wheelchairs and services within the agreed timeframes.	**tbc**	There are no incidents where patients do not receive wheelchairs within agreed timescales.		On track
RN027 27.2		27.2. Trust to send Millbrook any incidents that are reported regarding their wheelchair service with the requirement to respond within 1 week. Services to raise any issues related to wheelchair provision on Ulysses.		**30.09.17**		All incidents relating to wheelchairs reported on Ulysses and forwarded to Milbrook.	Sept: joint application with CCG/Milbrook to Wessex Quality Improvement Fellowship 2017/18 to work collaboratively to improve wheelchair services. Regular meetings in place with issues discussed	Completed-unvalidated					
RN027 27.3		27.3. Trust to monitor service provision and raise any on-going concerns with the CCG and Millbrook as part of the contract meetings.		**31.10.17**		Minutes of monthly contract meetings with issues and actions minuted.	Oct: contract meeting with Millbrook planned for 20/10/17. Poster circulated with details of Open Day Nov 20 at Millbrook. 24.10.17 QIPDG HL = meeting 20.10.17 very positive	Completed-unvalidated					
RN028 28.1		28.1 Communication to staff: To provide service areas with pocket guides to the Mental Capacity Act 2005. (These should continue to be issued at mandatory training sessions and by distribution to all service areas).	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group	**completed**		Communications to staff: 1. Copy of pocket guides to the Mental Capacity Act 2005.	pocket guides circulated.	Completed-unvalidated	?		?		
RN028 28.2		28.2 Training to staff: 1. To deliver bespoke training sessions on MCA & DoLS to identified teams across the Trust as required. 2. The team will be carrying out a comprehensive review of mandatory training material, delivery and learning methods, and review compliance on an ongoing basis.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group	**30.09.17**		Training: 1. Training materials, session dates 2. Training materials	Sept: Safeguarding team meeting on 05/10/17 to discuss/approve. Oct: Learning sets delivered regularly monthly from March 17. Variety of topics, MCA & DoLS session delivered on 8 ocassions since March, across ISD areas. Incremental review completed and first delivered 04/10/2017. Training ongoing.	Completed-unvalidated	Service users will be supported to make decisions. Where a person cannot make a decision their rights will be protected through the appropriate implementation of MCA 2005 - including best interests (s.4) and advocacy.	**1. March 2017** **2. 04.09.17**	Training registers, training presentation and learning materials	Delivery of 8 MCA & DoLS sessions since March 2017.	
RN029 29.1		29.1 To complete an annual programme of record keeping audits with action plans developed and implemented based on results.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett	**31.03.18**			Sept: annual clinical audit programme has record keeping audts planned. Oct: Record Keeping Care Planning workstream now co-chaired by JS and LT. Group now to focus on record keeping only - terms of reference revised with work plan reviewed and amended. Continued work required to ensure staff understand importance of record keeping and adhere to policies. Record keeping on risk register for BU1.	On track					
RN029 29.2		29.2 To complete monthly Quality Assessment tool in ISDs which has record keeping elements. Where required, take actions to address any shortfalls in record keeping standards.	Liz Taylor supported by Tracey McKenzie, Head of Compliance, Assurance and	**31.12.17**			Sept: Quality Assessment tool being used by increasing number of teams but is not yet consistent across trust. Discussion underway re adding results to tableau. QAT presented to B7 development day in BU1 and received positive feedback.	On track				29.2 QAT Inpatient results 18.10.17	
RN030 30.1	Trust wide	**REMOVED BY CQC IN REVISED REPORT**						no action required					no action required
SD031 31.1		31.1 Ligature Risk Management Group to review (environmental ligature) care plan in use by OPMH wards.	Kathy Jackson, Head of Inpatients Karen Thomas, Ligature Manager added Oct 2017 John Stagg ADON for LD co-chair of LRMG Andy Mosley AD for Estates co -chair of LRMG	**31.10.17**		Minutes of Ligature Risk Management Group.	Oct: individualised ligature risk care plan reviewed across trust - Assessment and Management of Ligature Care Policy has been updated and will be presented to Patient Safety Group for approval in Oct. 24.10.17 QIPDG discussion - there is environmental ligature risk care plan which is standard one in use on RiO for all patients - it is not an individualised care plan. OPMH patients are not high risk for ligatures. Discussed that some requirements in Policy may need amending. Ligature Management Group now to be co-chaired by JS and Andy Mosley AD for Estates. Last LRMG had to be cancelled due to low attendance. Need to have rep from each BU on group. Extraordinary meeting date set. Feel need revision to environmental risk plan. Agreed every area should have ligature risk assessment completed and mitigation plans in place. 31.10.17 QIPDG - Nicky Bennett updated that revised Policy was approved subject to minor amendments and will have virtual sign off and then be published.	Completed-unvalidated					
SD031 31.2		31.2 Review use of individualised Ligature Care plan in practice - working with Karen Thomas, Ligature Manager.		**31.10.17**		Results of review.	Oct: individualised ligature risk care plan reviewed for use across trust - ligature manager works closely with all wards.Fewer OPMH patients require ligature risk care plans. 31.10.17 QIPDG new template is included in revised Ligature Management Policy. Group discussed and agreed that OPMH patients are unlikely to require an individualised ligature risk plan and that it is appropriate for the ward to have an environmental ligature risk assessment. BC to request that Ligature Management Group discusses this recommendation from CQC with regards to OPMH patients and minutes decision made.	Completed-unvalidated					
SD032 32.1		32.1 Ligature Risk Management Group to set minimum standards on ligature information to be included in local induction packs by teams.	Kathy Jackson, Head of Inpatients Karen Thomas, Ligature Manager	**31.10.17**		Standard information for inclusion in local induction packs is circulated.	Oct: Assessment and Management of Ligature Care Policy has been updated and will be presented to Patient Safety Group for approval in Oct -includes guidance on information to be included in local induction packs. 31.10.17 QIPDG - Nicky Bennett updated that revised Policy was approved subject to minor amendments and will have virtual sign off and then be published.	Completed-unvalidated					
SD032 32.2		32.2 Wards to ensure local induction packs including ligature information as per trust guidance are available to new staff /agency staff.	Kathy Jackson, Head of Inpatients	**31.12.17**		Local induction packs are in place.		Blank					
SD033 33.1		33.1. Ward assessment to determine which non patient areas are not currently locked.	Kathy Jackson, Head of Inpatients	**xxxxx**		Ward assessments completed	Sept: all non patient areas reviewed across trust as part of ligature risk programme.	Blank					

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SD033 33.2		33.2 Ligature Risk Management Group to circulate mitigation guidance on areas in inpatient settings which are non patient areas eg staff rooms, sluice rooms.	Karen Thomas, Ligature Manager added John Stagg, ADON LD/Andrew Mosley co -chairs of Ligature Management Group	xxxxx		guidance circulated	Oct: non patient areas /ligature risks discussed at the Ligature Risk Management Group in June 2017. Non patient areas reviewed across Trust. Assessment and Management of Ligature Care Policy has been reviewed and is being presented to Patient Safety Group for approval in Oct - includes reference to non patient areas.	Blank					
SD034 34.1		34.1 Review of psychology provision and if this is in line with national standards and that of other Trusts and discuss with commissioners (service not currently commissioned).	Helen Neary, Associate Director of Nursing and AHPs	31.12.17		Results of review and discussions with commissioners.	Oct: some psychology provision in place but not sufficient to meet demands, however not commissioned to provide wider service. Additional psychology post in Petersfield area approved by RAP.	Blank					
SD035 35.1	Chase Petersfield Gosport	35.1 Template to be devised for community mental health teams /older people's mental health teams to use to record information at MDT meetings in Chase/Petersfield and Gosport.	Helen Neary, Associate Director of Nursing and AHPs Supported by Head of Nursing and AHP East ICT	completed		template in place.	14/09/17: email sent to melanie poulter and sandra spong requesting evidence. 22/09/17: email from responsible lead inc. template	Completed-unvalidated					
SD036 36.1	Chase Petersfield Gosport	36.1 To bring acuity and dependency measurement for Community Older People's Mental Health Teams in line with existing trust establishment review process as identified within the Safer Staffing Policy. See 37 for CPA actions.	Helen Neary, Associate Director of Nursing and AHPs supported by Sue Jewell, Safer Staffing Lead	28.02.18				Blank					
SD037 37.1		37.1 CPA(Care Programme Approach) audit tool to be amended to include question on correct application of CPA and Care Planning Frameworks.	Carol Adcock, Associate Director of Nursing and AHPs (MH)	30.09.17		Amended CPA audit tool	CPA audit tool amended	Completed-unvalidated	Consistent approach to CPA via clearly defined criteria				
SD037 37.2		37.2 CPA Audit to be completed. (To include OPMH community services too).		28.02.18		CPA audit report		Blank					
SD037 37.3		37.3. CPA and care plan SOP to be shared with Adult Mental Health staff.		30.11.17		Email cascade trail		Blank					
SD038 38.1		38.1 To raise staff awareness in MIUs of the need to report incidents as per incident reporting policy (*NB: 58 re incidents reporting across Trust*).	Helen Neary, Associate Director of Nursing and AHPs	completed		Petersfield MIU has seen increase in number of incidents reported.	Oct: Incident analysis report from Tableau for last three months saved to evidence folder: July =28, Aug = 25 and Sept = 16. Tableau report Oct 2015-17 shows increase in incident reporting.	Complete	Trust: Increased incidents reported, particularly in areas previously noted to be low reporters. Service:	**Trust:** **31.10.17** **Service:**	Trust: Service:	RETEST DECEMBER	
SD039 39.1		39.1 Develop an audit tool to measure implementation of national guidance in MIU services.	Helen Neary, Associate Director of Nursing and AHPs supported by Tracey McKenzie, Head of Compliance, Assurance and Quality	30.11.17		Audit tool in place.	Aug: there is no national guidance for MIU. TM checking with CQC re this action for clarification. Oct: PMO email out to Clinical Lead, requesting update/evidence. Five audits based on best practice drafted for review, with another three to be written. Audit programme in place and allocated to leads.	On track					
SD039 39.2		39.2 Carry out audits using tool developed in 39.1.		31.12.17		Results and report of audits with action plan developed based on recommendations.	Oct: see 39.1	On track					
SD040 40.1		40.1 The proposal regarding separate children's waiting area (scheme costings £1.7m) to be presented through Capital Funding process for approval.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager Scott Jones, Deputy Head of Estates Services	31.03.18		Minutes of Trust Executive Committee with decision minuted. Options proposal.	Aug: Maintenance Manager will undertake a feasibility study - to have separate childrens waiting area will cost 1.7m and available budget £500k therefore exploring other options. Oct: email from Clinical Lead outlining options for MIU environment. Contract with dental services being explored and could release 8 rooms whcih would resolve issue.	On track	There are separate waiting areas for children and adults in MIU.		There are separate waiting areas for children and adults in MIU.		
SD040 40.2		40.2 Estates services to review the waiting areas at Petersfield MIU and establish if a temporary install of separation screens could provide a temporary solution whilst the permanent scheme is awaiting a decision and funding. (£1K)	Helen Neary, Associate Director of Nursing and AHPs Scott Jones, Deputy Head of Estates Services	31.10.17		Site visit to confirm area segregated with screens in place.	Oct: Estates/MIU Lead reviewed MIU and looking at options for redistribution of rooms to provide separate childrens area - there would be no need for temporary screens if option re rooms was agreed.	Completed-unvalidated					
SD041 41.1	Petersfield MIU	41.1 To complete review of Complaints Policy and Procedures and circulate to all staff.	Chris Woodfine, Head of Patient Experience and Engagement supported by Associate Directors of Nursing and AHPs: Julie Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	31.12.17		Revised complaints/ policy/procedure	Sept: final draft of revised policy/procedure being circulated for final comments. To go to Caring Group in October for final approval, once approved will be uploaded to website. Oct: revised Policy and procedures approved at Caring Group and published on website.	Completed-unvalidated	80% of complaints are responded to within 30 or 40 day timeframe depending on complexity. The satisfaction of complainants with how their complaint is handled and resolved will show improvement over time as measured by survey results.	31.12.17	Monthly reports on performance to meet 80% target. Quarterly reports on complainant satisfaction survey results.		
SD041 41.2		41.2 To provide a weekly breach report to the Chief Executive/Divisional leads on complaints which are not meeting timescales for the stages of the complaints process. Divisions to address breaches in timescales.		31.12.17		Weekly breach reports.	Sept: weekly breach report sent to CEO. Complaints data is part of executive flash report that is reviewed weekly. There are still pressures on meeting timescales and issues with capcity of divisions to provide investigating officers.	On track		31.12.17			
SD041 41.3		41.3 To improve the visibility of the customer experience team by attending regular divisional governance meetings and other activities.		31.12.17		Meeting attendance.	Sept: Manager attending divisional meetings/AGM.	On track		31.12.17			
SD041 41.4		41.4 To undertake a 3 month trial starting August 1st where the customer experience advisors write the final letter of response to the complainant (rather than the service). After 3 months review the effectiveness of the trial in allowing the Investigating Officer more time to focus on the investigation itself.		31.12.17		Results of trial.	Oct: pilot ongoing - complaints advisors are able to write final response letter if Investigating officer (IO) completes comprehensive investigation but some lack detail so advisor unable to draft letter therefore need to go back to IO.	On track		31.12.17			
SD041 41.5		41.5 To improve response times to complaints with 80% of complaints receiving a response within 30/40 days. To work with divisions to resolve issues and barriers.		31.12.17		Complaints response times.		On track		31.12.17			
SD042 42.1		42.1 To discuss and agree the future of Petersfield MIU with commissioners as part of wider plans for health care in that area.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager	31.03.18		Minutes of meetings with commissioners and any agreements made re future of MIU.	Oct: email from Clinical Lead outlining options for MIU environment. PMO email out to Clinical Lead, requesting update/evidence for actions.Clinical Lead presentation to commissioners in June and site visit by commissioners scheduled for 25.10.17.	On track	Staff are informed and aware of the future plans for MIU.		Communications regarding future of MIU circulated to staff.		

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SD042 42.2		42.2 To have updates as a standard agenda item in monthly team meetings on the plans for refurbishments and future of the service at Petersfield MIU as agreed with commissioners.	Helen Neary, Associate Director of Nursing and AHPs	**30.11.17**		Examples of communication shared with staff.	Oct: minutes of team meetings show future of MIU discussed with staff.	**On track**					
SD043 43.1	Petersfield MIU	43.1 To embed MIU Governance reporting for Petersfield MIU through the Business Unit 1 locality governance frameworks and feeding into the ISD governance framework.	Helen Neary, Associate Director of Nursing and AHPs	**31.10.17**			Oct: ward manager already attends BU1 governance/business meetings which feed up to ISD governance meetings. New template at team level introduced in locality governance process so info feeds both both up/down.	**Completed-unvalidated**	?		?		
SD044 44.1	Petersfield MIU	44.1 To review the MIU support and line management structures through the Quality element of the Business Plan. Currently the line of accountability reporting is through Rob Guile as General Manager and Helen Neary as Associate Director for Nursing and AHPs.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager	**30.09.17**			Sept: there are clear lines of accountability for MIU in place with MIU part of BU1 reporting and governance structures. Agreed these lines of accountability at present are appropriate but that there are ongoing discussions as to where MIU best sits within division as largely provides a primary care function so in future may sit with Willow Group.	**Completed-unvalidated**	?		?		
SD045 45.1	Petersfield MIU	45.1 To review progress made with actions on risk register re staffing at Petersfield MIU and aim to downgrade risk.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager supported by Sue Jewell, Safer Staffing Lead	**30.11.17**		Minutes of BU1 performance/governance meetings to evidence risk is discussed. Risk downgraded on risk register	Oct: risk 1233 re staffing added to risk register March 2017 due to B7 x 0.6 and B4 vacancies. Agreement to recruit to B7 but unsuccessful recruitment therefore developing B5 into B6 role and remaining funding to recruit B2. Risk remains at 12/major. Risk reviewed on monthly basis and due for review end Oct.	**On track**	Patients attending MIU receive safe care.		Staffing levels enable safe, effective and timely care. There are no incidents reported where staffing is recorded as an issue in the safe, effective and timely care provided to patients attending MIU.		
SD045 45.2		45.2 Staffing has been reviewed and monies allocated to fulfil Practitioner B7 underfunding. Advert out for recruitment.		**30.11.17**		B7 post recruited to.	Oct: Advert for B7 is on NHS jobs - no successful appointment therefore reviewing staffing with B5 developed to B6 post and remaining funding to be used to appoint B2.	**On track**					
SD045 45.3		45.3 B4 gap in service provision to be presented and discussed with CCG regarding commissioning requirements of this service.		**30.11.17**		Minutes of meetings with commissioners.	Oct: CCG visit to MIU on 25.10.17. Staffing changes as in 45.2	**Blank**					
SD045 45.4		45.4 As there no national tool for MIU's around staffing, work is currently being undertaken to develop a Trust tool.		**31.03.18**		Trust staffing tool in place.	Oct: ongoing discussions - looking to have 2 emergency practitioners and 1x support staff on each shift.	**On track**					
SD046 46.1	Petersfield MIU	46.1 Training needs analysis (TNA) for MIU's to be completed by LEaD in partnership with service leads. Identified training needs to be met during 2017/18 via the CPPD/Learning Beyond Registration budget.	Helen Neary, Associate Director of Nursing and AHPs supported by Simon Johnson, Head of Essential Training Delivery Sue Jewell, Safer Staffing Lead	**30.09.17**		Results of TNA with recommendations.	25/09/17: email to Responsible lead for update. 27/09/17: responsible lead on leave until 02/10/17. Sept: LEaD have 2x 'managing the unwell child' courses in Nov and have circulated info re these. LEaD have collated spending on LBR funding within division and sent to ADONs. Oct: PMO email out to Clinical Lead, requesting update/evidence for actions Discussed in staff meetings, item 10a and 10b with training being identified by staff - needs to be formalised into TNA and then shared with LNFH MIU to check standardised. LNFH MIU have clear training plan for staff. TNA received from Petersfield MIU.	**Completed-unvalidated**			There are no incidents or complaints where a child did not receive safe care due to availability of appropriately trained staff. Compliments by children/families seen at MIU.		
SD046 46.2		46.2 Review staffing to understand the gap that may be present in achieving this recommendation.		**31.12.17**				**Blank**					
SD046 46.3		46.3 To develop and implement an action plan based on the outcome of 46.1 and 46.2.46.4 .		**31.03.18**		Action plan in place and minutes of meeting to show progress being monitored.		**Blank**					
SD046 46.4		46.4 LEaD to review attendance at 'Recognising the Unwell Child' training and raise awareness of this course to MIU managers. (This training course is already in place - is not mandatory).	Simon Johnson, Head of Essential Training Delivery	**30.09.17**		Attendance data.	25/09/17: email to Responsible lead for update. 27/09/17: email from responsible lead; MLE supplied data showing training courses scheduled and numbers booked onto for November. Oct: LEaD reminder email re training to Petersfield MIU - 16/20 Petersfield/LNFH MIU staff have completed 'Recognising the Unwell Child' training. 2/4 who have not completed this training booked onto course in Nov. LEaD put 'button' on MLE system for registered staff for this course.	**Completed-unvalidated**					
SD047 47.1		47.1 Amend the Ulysses system to enable end of life to be recorded on incidents reported to ensure that themes can be analysed.	Julia Lake, Associate Director of Nursing and AHPs supported by Jake Pursaill, Risk Manager and Simon Beaumont, Head of Information	**30.09.17**		Evidence that Ulysses system has been amended to show end of life data.	Aug:Request made to amend Ulysses system. Sep: Ulysses amended to include tick box Y/N 'was this patient receiivng end of life care?' which would enable incidents to be filtered by E of L.	**Complete**	Patients who are at end of life receive effective well planned care that is based on their wishes.		Incidents can be filtered by end of life so that appropriate action is taken to resolve issues.		
SD047 47.2		47.2. Amend Tableau to ensure that the incidents can be filtered to end of life.		**31.10.17**		Tableau reports can be filtered by end of life incidents.	Oct: tableau has been amended to include 'palliative care' incidents. These incidents will be reviwed as part of thematic review into EOL care.	**Completed-unvalidated**					
SD048 48.1		48.1. AD Quality Governance and Medical Devices advisor to attend Patient User Group (PUG) meeting with CCGs and Hampshire Equipment Store (HES).	Helen Ludford, Associate Director Quality Governance Kate Smith, supported by Julia Lake, Associate Director for Nursing and AHPs	**30.09.17**		Minutes of PUG meetings.	Sept: Helen Ludford and Tracy Hammond will be attending PUG meeting on 6/9/17.	**Completed-unvalidated**	Patients who are at end of life receive equipment within the agreed timeframes.		No incidents of patients not receiving equipment from HES within agreed timescales.		
SD048 48.2		48.2. SLA to be reviewed with commissioners to ensure it meets the needs of our patients.		**31.12.17**		Review of SLA.		**Blank**					
SD048 48.3		48.3. All incidents of delays in receiving equipment from HES to be reported on Ulysses, reported to HES and reviewed at PUG meeting.		**31.12.17**		All incidents reported on to Ulysses and forwarded to CCG		**Blank**					
SD049 49.1		49.1 LEaD to develop e-verification process for monitoring compliance with the End of Life and syringe driver training and competency requirements.	Simon Johnson, Head of Essential Training Delivery	**31.12.17**		Training compliance data.	Sept: EoL Steering Group initial discussion about e-verification and competency requirements for EoL /syringe driver training with further work to be completed.	**On track**	Patients receive safe effective care by appropriately trained staff.		There are no incidents or complaints where a patient did not receive safe effective care due to availability of appropriately trained staff. Compliments received for End of Life care.		
SD049 49.2		49.2 Relevant staff to complete e-verification process with team managers monitoring compliance.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	**31.03.18**		Training compliance data.		**Blank**					
SD049 49.3		49.3 End of Life Steering Group to review training figures on a quarterly basis.		**31.03.18**		Minutes of End of Life Steering Group.		**Blank**					
SD050 50.1		50.1 Undertake a thematic review of End of Life care across the Trust in Oct - December 2017 - to include what services we are commissioned to supply and any gaps in that provision.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	**28.02.18**		Report from Thematic review and evidence that shared through appropriate committees.	Sept: Thematic review is planned to start in Oct. End of Life Strategy 2016-2020 approved by QSC Dec 2016 and disseminated to divisional leads early 2017. Strategy sets out ambitions and actions required.	**On track**	Patients who are at end of life receive effective well planned care that is based on their wishes.		There are no gaps in end of life provision across the trust.		
SD050 50.2		50.2 To develop recommendations for any actions based on outcome of above review.		**31.03.18**		Action plan in place based on review recommendations.		**Blank**					
SD051 51.1		51.1 see 28.2.1	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group					**Duplicate**					Duplicate
SD051 51.2		51.2 see 28.2.2	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group					**Duplicate**					Duplicate

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SD052 52.1		52.1 To review inpatient records in Community Hospitals with clear guidance circulated to staff on completion of patient records, including the signing and adding of staff designation to record.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	**31.12.17**		Results of review of records.	Oct: CH steering group has reviewed records used in CH in both the Trust and by other trusts and have taken best parts of those records reveiwed to be used in CHs.	**On track**	Patients receive safe and effective care as their needs are recorded in a timely effective manner.		Results of record keeping audits.		
SD052 52.2		52.2 To complete record keeping audits with action plans developed and implemented to address shortfalls in practice.		**31.03.18**		Results of record keeping audits. Implementation of action plans based on audits.		**Blank**					
SD053 53.1		53.1 see 21.1	Theresa Lewis, Lead Nurse Infection, Prevention and Control Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary					**Duplicate**					Duplicate
SD053 53.2		53.2 see 21.2						**Duplicate**					Duplicate
SD053 53.3		53.3 see 21.3						**Duplicate**					Duplicate
SD053 53.4		53.4 see 21.4						**Duplicate**					Duplicate
SD053 53.5		53.5 IPC audit programme to be completed for 2017/18 - including isolation audit due February 2018.		**31.03.18**		results of audits	Sept: IPC audit programme in place. Oct: PMO chase-up for Quarterly IPC report Tel+Email Oct: presentation to link advisors includes the results of audits and recommendations for actions and those audits planned for next quarter.	**On track**					
SD054 54.1		54.1 To review the ward environment taking into account the needs of people living with dementia and review the results of the PLACE audits.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary supported by Scott Jones, Deputy Head of Estates Services	**31.10.17**		Results of the review of wards re dementia needs. Results of PLACE audits with regard to needs of people living with dementia.	Sept: annual PLACE report to be presented to Caring group in October. Oct: Dementia group being set up by KJ - meeting with CCG to discuss dementia friendly environments. Rowan ward decorated in dementia friendly colours. PLACE audits for sites are on sharepoint. 1.11.17 Dementia Group had first meeting on 17.10.17 with OPMH /estates representatives - need to expand to include BU representatives. Looking at developing a dementia standard across trust.	**Overdue**	Patients living with dementia are on wards which meet their specific needs.		PLACE audit feedback in 2018.		
SD054 54.2		54.2 An action plan is developed and implemented based on the above reviews to meet the needs of people living with dementia. This will include a list of works in priority order to be completed by Estates services.		**31.03.18**		Action plan is in place and is being implemented.		**Blank**					
SD055 55.1	Gosport War Memorial Hospital	55.1 To complete a joint review of the toilet and washing facilities in Ark Royal and Sultan wards, GWMH by the clinical service leads and estates managers.	Helen Neary, Associate Director of Nursing and AHPs Gary Goodman, Estates Services Capital Projects Manager	**30.09.17**		Results of review of wards.	26/09/17: see QIPDG meeting minutes. 27/09/17: email from Responsible lead, review completed and recommendation made to refurbish all toilets and bathrooms in these wards under PLACE capital funding (to be approved via PEG). Capital team provided indicative costs, awaiting decsion on funding from PEG October meeting 24.10.17 QIPDG - review completed however there are challenges as to whether privacy and dignity issues as per new EMSA guidance can really be met when using 'swing' bedrooms. Potential that there will be breaches of new guidance - will have large impact on taking patients from QAH.	**Completed-unvalidated**	Patients receive care that protects their privacy and dignity.		Action plan is implemented. There are no incidents where mixed sex accommodation guidance is breached.		
SD055 55.2		55.2 An action plan is developed and implemented based on the recommendations from the above review to resolve issues in discussion with commissioners.		**31.03.18**		Action plan in place and being implemented.		**Blank**					
SD056 56.1		56.1 To set up a Task and Finish Group to review medicines reconciliation across the trust - to include staffing, accuracy of data reported on tableau, roles and responsibilities of various staff groups, use of the summary care record, training for staff, policy.	Raj Parekh, Chief Pharmacist	**31.12.17**		Task and Finish Group - terms of reference, minutes and action logs.	Oct: Meds Rec Group led by JW and G - Meds Rec policy has been revised and approved by MMC in Sept. TNA needs to be completed as part of policy. External company approached to provide costings for proviidng training for nurses/doctors - once quote received will be discussed as to feasibility.	**On track**	80% of inpatients will have their medicines reconciled within 2 working days.		Medicine Reconciliation figures per inpatient unit/ward.		
SD056 56.2		56.2 Based on results of Task and Finish group, produce an options paper for medicines reconciliation in line with national guidance for discussion at the Trust Executive Committee.		**31.01.18**		Medicine Reconciliation action plan.		**Blank**					
SD056 56.3		56.3 Medicines Management Committee (bi-monthly) to monitor Task and Finish group progress including action plan; to monitor performance against KPI - 80% of inpatients have their medicines reconciled within 2 working days.		**31.03.18**		Minutes of Medicines Management Committee.		**Blank**					
SD057 57.1		57.1 To identify where patient own drugs (POD) lockers are in place on rehabilitation wards and where there are gaps.	Raj Parekh, Chief Pharmacist to support not lead. supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	**30.09.17**		Results of review of POD lockers.	25/09/17: email to Responsible lead for update 26/09/17: see QIPDG meeting minutes. 28/09/17: email from Responible lead; not responsible this action, is for ADONs to lead on. Oct: HN reviewed availability of POD lockers at CHs (not yet visited Romsey CH). All CHs visited have POD lockers in place - Ford ward need to locate keys for the lockers. 31.10.17 QIPDG Vanessa Lawrenec confirmed Romsey Hospital has POD lockers in place. Susanna Preedy explained Anstey ward had put in bid for POD lockers to charitable funds.	**Completed-unvalidated**	Patients will have support to self administer medicines safely and effectively.		All inpatients have access to POD lockers and staffing support to self administer medicines safely.		
SD057 57.2		57.2 To implement Self Administration Policy on wards with risk assessment of wards and individual patients completed.		**31.08.17**		Evidence that risk assessments completed. Results of audit of Self Administration Policy.	Sept: self-administration guideline (SH CP168) is already in place and due for review in November 2017. Need to have POD lockers in place to implement self admin of meds. In MH/OPMH there is individual risk assessment re self admin of meds with care plans developed to capture actions required. New Meds Administration Pharmacy Technician posts x3 funded. 2 posts filled and due to start mid October in Western Hosp and Romsey Hosp. 1 post out to advert for Petersfield Hosp. Oct: QIPDG discussion re wording of action and whether need amendment to reflect issue raised in CQC report. Agreed that some patients on rehab wards would be able to self administer meds. ISD = not routine practice on wards at present to complete risk assessments and support self administration - would need staff training and resources. Current Policy is trust wide. Currently Southfield/Ravenswood/Forest Lodge/Hollybank are implementing self administration. 31.10.17 QIPDG discussed that 57.3 needs to take place prior to 57.2. Vanessa Lawrence/Julia Lake/Helen Neary are meeting to review this action and amend as required.	**Overdue**					
SD057 57.3		57.3 To scope additional staffing resources required in order to implement self administration of medicines during inpatient stay and on discharge.		**31.12.17**		Results of scoping review of staffing requirements.		**Blank**				Trust: Increased incidents reported, particularly in areas previously noted to be low reporters. Service:	Trust: 31/10/17 Service:
SD057 57.4		57.4 Medicines Management Committee (bi-monthly) to review progress with completion of actions.	Raj Parekh, Chief Pharmacist	**31.03.18**		Minutes of Medicines Management Committee.		**Blank**					
SD058 58.1		58.1 To ensure staff complete incident reports within the policy timeframes.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett, Liz Taylor supported by Sarah Pearson, Head of Legal Services, Risk and Patient Safety.	**31.10.17**		Increased number of incidents reported - particularly from areas where reporting is noted to be lower than expected. Staff bulletin to be evidenced to show additional communication re incident reporting.	31.10.17 QIPDG - surveillance pilots in Childrens services and OPMH have reviewed incident reporting as part of pilot. OPMH pilot found that wards are very similar in the number/types of incidents reported. Pilot continues in AMH in early Nov. Results of pilot programme will be reviewed as to whether rolled out across trust.	**Completed-unvalidated**	Increased number of incidents reported without need for further prompting - particularly from areas where reporting is noted to be lower than expected.		Incident data at team level over time.		
SD059 59.1		59.1 see 21.1	~~Theresa Lewis, Lead Nurse~~ Jacky Hunt, Lead Nurse Infection, Prevention and Control					**Duplicate**	Patients will receive safe care in their own homes by trust staff following infection prevention best practice guidelines.		There are no incidents or complaints where IPC guidance was not followed appropriately in a patients home.		Duplicate

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SD059 59.2		59.2 see 21.2	supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary					Duplicate					Duplicate
SD059 59.3		59.3 see 21.3						Duplicate					Duplicate
SD059 59.4		59.4 To continue hand hygiene audits across the trust including community teams.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary supported by the Infection, Prevention and Control Team.	**31.12.17**		IPC Quarterly Report has hand hygiene audit results.	Sept: hand hygiene audits completed regularly with results included in quarterly IPC report to Patient Safety Group. Oct: PMO email out to responsible lead requesting copy of quarterly report. Oct: presentation to link advisors includes results of hand hygiene audits.	**On track**					
SD060 60.1		60.1 To review Track and Trigger Tool and the National Early Warning Score (NEWS) to ensure that boundaries for escalation are the same.	Simon Johnson, Head of Essential Training Delivery	**30.08.17**		Review of early warning systems.	Aug:review of compatibility of early warning systems has been completed. Results shared at Resuscitation Committee May 2017. Physical Assessment and monitoring policy has kept the documents for escalation unchanged, however mental health staff have now been competency assessed for using the tool. Oct: Resuscitation committee 5.10.17 discussed physical health compliance review and key findings - improvements to documentation required.	**Completed-unvalidated**	Patients who deteriorate receive timely and appropriate escalation to ensure all appropriate action is taken to meet their needs.		There are no major/catastrophic incidents where the deteriorating patient is not identified.		
SD060 60.2		60.2 To roll out use of NEWS across the Community Hospitals. To evaluate impact of NEWS prior to consideration for a tool to introduce to community services.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	**31.03.18**		Confirmation of use of NEWS in community hospitals.	Aug: NEWS in use at LNFH. Oct: Resuscitation committee 5.10.17 discussed physical health compliance review and key findings - improvements to documentation required.	**On track**					
SD060 60.3		60.3 To communicate to staff the training courses available on LEaD relevant to the deteriorating patient and monitor training attendance at staff one to ones.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	**30.11.17**		communication - emails/newsletter/team minutes.		**Blank**					
SD061 61.1		61.1 To set up a Task and Finish Group out of the End of Life Steering Group to review the need for a night nursing service across the Trust - including a review of population needs, current access to spot purchase service.	Associate Director of Nursing and AHPs: Julia Lake	**31.12.17**		Task and Finish Group - terms of reference, minutes and action logs.		**Blank**	Patients have access to a night nursing service as required.		Night nursing service available to identified patients.		
SD061 61.2		61.2 To discuss the outcome and recommendations from the Task and Finish Group regrading the need for a night nursing service with commissioners.		**28.02.18**		Minutes of meetings with commissioners.		**Blank**					
SD062 62.1		62.1 see 20.1	Raj Parekh, Chief Pharmacist supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor					**Duplicate**	All patients receive their medicines in a safe and effective way.		There are no incidents where staff have not followed expiry date medicine guidance.		Duplicate
SD062 62.2		62.2 see 20.2	Raj Parekh, Chief Pharmacist					**Duplicate**					Duplicate
SD062 62.3		62.3 see 20.3	Raj Parekh, Chief Pharmacist					**Duplicate**					Duplicate
SD062 62.4		62.4 Inpatient units/wards audit that the correct procedure regarding expiry dates for medicines is followed. ISDs to use Quality Assessment Tool on monthly basis to provide assurance re compliance.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett	**31.10.17**		Quality Assessment Tool results (ISD). Safe and Secure Meds audit results and action plans	Oct: expiry date guidance now included in MCAPP. Expiry date has been added to Safe and Secure Audit which is out for data collection in Oct. Results will be reported to MMC and Patient Safety Group. QAT used by increasing number of teams but not consistently used across all of ISD yet. 31.10.17 QIPDG - data collection for Safe and Secure Medicines audit ends today.	**Completed-unvalidated**					
SD062 62.5		62.5 Medicines Management Committee (bi-monthly) to review compliance to guidance and completion of audit actions.	Raj Parekh, Chief Pharmacist	**31.12.17**		Minutes of Medicines Management Committee.		**Blank**					
SD0.63 63.1	Antelope House							**Blank**					
SD0.64 64.1	Antelope House							**Blank**					
SD0.65 65.1	Antelope House							**Blank**					
SD0.66 66.1	Elmleigh							**Blank**					
SD0.67 67.1	Antelope House							**Blank**					

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68 CQC jan 16 ref WN004 4.10	Trust wide	4.10 The Trust will upskill frontline staff in quality improvement methodologies using the existing Team Viral programme to support this	Paul Streat Support from: Organisational Development Graeme Armitage	**31.12.17**			Carried over from January 2016 CQC Action Plan; part of the Business Delivery Unit activities. Sept: Proposal for procurement of external QI Methodology not approved at TEC and revised options proposal requested. Oct: first training session for Quality Ambassadors on 05/10/17 with 2x more dates in Oct/Nov. Quality Conference on 11/10/17. Quarterly meetings for Quality Ambassadors to share activities and good practice planned.	**On track**					
69 CQC jan 16 ref SD028 28.4	Bluebird House	28.4 Implement the changes to the training programme and roll-out to relevant staff groups	Simon Johnson, Head of Essential Training Delivery	**31.10.17**			Carried over from January 2016 CQC Action plan; 16/8/17. Agreed at QIPDG to set recovery date as 31.10.17 as course expected to be written and delivery schedule agreed in October. 19.10.17 evidence review panel discussed that this action was at risk of slippage as revised training programme needed final approval by QSC/Board prior to roll out. 31.10.17 QIPDG - clarification by Simon Johnson that the course content has been agreed and the revised courses now on LEaD to book onto with first course in eraly Dec. The only decision required by board is whether the refresher training is required after 12 months v 18 months.	**Completed-unvalidated**					
70 CQC sept 16 ref RN043 43.1	Trust-wide	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan.		**31.12.17**			Carried over from September 2016 CQC Action Plan: 14/7/17. Jan CQC16 action plan 98% completed, CQC sep16 Action plan 92% completed and SI &MIP action plan 96% completed. 1.8.17 revised date for completion as the action in Jan 2016 CQC action plan re Quality Improvement Methodology has a recovery date of 31.12.17. Sept: Niche presented draft audit opinion on SI and Mortality action to QSC with final report due 16/10/17. Rated the 6 themes identiifed in plan as either A/B - complete/embedded/impact seen.	**On track**					
71 CQC sept 16 ref RN043 43.4		EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan		**30.11.17**			Carried over from September 2016 CQC Action Plan: 31 Aug 2017 Niche will present report findings to QSC on 19.09.17. Report not yet received and Niche say may struggle to make QSC papers deadline 12.09.17 to send report Sept: Niche presented draft audit opinion on SI and Mortality action to QSC with final report due 16/10/17. Rated the 6 themes identiifed in plan as either A/B - complete/embedded/impact seen.	**On track**					