Improvement Plan for: CQC Warning Notice

Southern Health NHS Foundation Trust

Version No: **Final V1.0**
Progress last updated: 08/06/2016 - TM

Date: ***27/05/2016***

Approved by:
Chris Gordon, COO, Director of Patient Safety
Julie Dawes, Director of Nursing & AHPs

Produced by:
Louisa Felice - Head of Executive Affairs and Projects
Tracey McKenzie - Head of Compliance

Ref No	Requirement Notice?	CQC KEY QUESTION	Core Service	Location	Theme	CQC actions required	Regulation breached	How the regulation was not being met	Outcome or Improvement the action will deliver once completed	Who is accountable for ensuring the action is completed? Name & Job Title	Action/s to be taken	How will completion of the action be evidenced (Evidence and method of review)	Who is responsible for completing the action Name & Job Title	Date action must be completed dd/mm/yyyy	Month	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Progress - to include position statement, risks, obstacles, action taken etc.	How will you evidence that the completion of the actions has led to the intended outcome	Intended Outcome Achieved Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
1	Enforcement Action	WELL-LED	Provider / Trust	Board	Risk Management	Key risks and actions to mitigate risks were not driving the senior management team or the board agenda	Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of Regulation 17 (2) (a) (b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	Key risks and actions to mitigate risks were not driving the senior management team or the board agenda	Board clearly sighted on and assured about the management of key risks and the delivery of the quality improvement agenda with clear sight of the mortality improvement plan and CQC improvement plans	Julie Dawes Director of Nursing	1.1 Central Quality Governance team to be restructured to deliver a Business Partner model (replicated from HR and Finance model) to strengthen the links and accountability lines between the central governance team and divisional quality structures.	New business partner model will be in place and posts will be appointed into (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/08/2016	August	Green	May: New structure redesigned and proposal sent to Finance for final costings. Organisational Change HR Consultation with the central team underway. 2 - 4 week consultation required	Tracking examples of risks being identified and escalated Review of Board and sub-committee agendas at year end against top organisational risks	
									Clear Ward to Board visibility of reporting and accountability	Julie Dawes Director of Nursing	1.2 Review of Ward to Board reporting on quality performance (Board and its sub-committees)	2016/17 reporting schedule will be agreed at Trust Board (submission of documents)	Paul Streat MCP Development Director	30/06/2016	June	Green	May: Draft 2016/17 schedule developed awaiting NED and Executive approval before publication		
									Clear accountability demarkation for the quality agenda between Executive portfolios and shared responsibility for delivery between three clinical Executives to ensure accountability for delivery of quality improvement plan.	Katrina Percy Chief Executive	1.3 Executive Quality Portfolios to be revised and strengthened with the three Clinical Executives forming a 'Quality Team'	Executive portfolio changes will be published and communicated both internally and externally (submission of documents)	Julie Dawes Director of Nursing Chris Gordon Director for Improvement & Safety	30/06/2016	June	Green	May: Changes to portfolios agreed with Executives and NEDs in May 2016. New Director of Nursing commenced in post 03/05/16. Specific responsibilities to be agreed where portfolios overlap.		
									Strengthening of Professional leadership and Quality Governance focus within the Mental Health and Learning Disability Division	Julie Dawes Director of Nursing	1.4 Establishment of and appointment to new role - Deputy Director of Nursing and Quality,Mental Health and Learning Disabilities Division - to provide senior professional and governance leadership. Interim appointment to be made whilst the substantive appointment is recruited to	Interim and then substantive appointments made and individuals in post	Mark Morgan Divisional Director Mental Health and Learning Disabilities	Interim appointment 31/05/2016 Substantive appointment 30/11/2016	November	Green	May: Post agreed at Trust Executive Group. Interim appointment made (Debra Moore) to provide professional leadership pending recruitment of a substantive individual		
									Clear Ward to Board visibility of quality performance	Katrina Percy Chief Executive	1.5 New Divisional Quality Performance Reporting framework to be launched and embedded across the organisation to ensure Ward to Board quality performance reporting and escalation of concerns, including 'hotspot' reporting	Ward to Board audit trail of quality performance reporting (submission of documents)	Julie Dawes Director of Nursing	31/07/2016	July	Green	May: Team level 'hotspot' Tableau reporting directly to Trust Executive Group from April 2016.		
									Improved risk management across the organisation	Julie Dawes Director of Nursing	1.6 Risk Management Policy to be reviewed (including Risk Appetite Statement)	Revised Policy will be published (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/08/2016	August	Green	May: New Director of Nursing reviewing the Risk Policy and Risk Appetite Statement with the Risk Manager		
2	Enforcement Action	SAFE	Provider / Trust	Trust wide	Environment	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements are effective in identifying and prioritising risks to patient safety arising from the physical environment including ligature risks, falls from height and risks from patients absconding	Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of Regulation 17 (2) (a) (b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The trust did not have effective governance arrangements that identified, prioritised and mitigated risks to patient safety, for example, ligature risks, fall from heights and risks from patients absconding	Capital planning process appropriately prioritising bids on the basis of clinical risk	Paula Anderson Chief Finance Officer Julie Dawes Director of Nursing	2.1 The Trust will review and redesign the Trust Infrastructure Group (TIG) decision making framework to ensure Quality Impact Assessment and Risk mitigation is a core element of prioritisation of capital bids. Capital bid applications will need to include a Quality Impact Assessment and Risk Score and all new bids will require a quality impact assessment in year.	Quality impact and risk mitigation will be in place at local unit level for all works (submission of documents)	Paul Johnson Head of Estate Services	30/06/2016	June	Green	May: New capital planning process in place. Clinical panel to review 'rejected' capital bids for 16/17 to ensure appropriate mitigation in place	Site visits consistently show evidence of staff aware of ligature risks associated with their units and of measures in place to mitigate risk.	
									Exception reporting to Trust Executive Group on a monthly basis to allow for early escalation of delays in environmental improvement programme	Paula Anderson Chief Finance Officer	2.2 New process to be designed and fully implemented to ensure delays to any estates work linked to patient safety are escalated to both TIG and Trust Executive Group. This will include a monthly 'capital status report' to the Trust Executive group	Monthly exception reporting to TEG will be in place (submission of documents)	Paul Johnson Head of Estate Services	31/05/2016	May	Blue	May: Head of Estates Services provided a monthly exception report to Trust Executive Group in May and this is now a monthly standing item on the TEG agenda.		
									Strategic Capital plans will be in place improving the prioritisation, risk assesment and risk management of environmental risks at the frontline	Paula Anderson Chief Finance Officer	2.3 Develop a strategic 3 year capital programme to ensure appropriate short/medium/long term planning	Longer term strategic plans for Capital planning will be in place	Paul Johnson Head of Estate Services	31/03/2017	Mar-17	Green			
									Improved interface between estates and clinical services	Paula Anderson Chief Finance Officer	2.4 Each MH/LD/OPMH inpatient unit will have its own site-specific environmental and estate work plan. This will be held on a central sharepoint location in order that frontline staff can view the plan at any time. Capital prioritisation decisions will be formally shared in a set reporting framework with frontline clinical teams following every TIG meeting.	Environmental improvement plans will be in place. These will include estate works timescales (as appropriate). (review of sharepoint files)	Paul Johnson Head of Estate Services	30/06/2016	June	Green	May: Site-specgic work plans being developed to include actions arising from ligature risk assesments, site visits, staff feedback etc		
									Clear, visible plans will be in place on each unit	Paula Anderson Chief Finance Officer	2.5 Estates team to produce and install standardised displays of capital plans for each site	Clear plans will be displayed (site visits)	Paul Johnson Head of Estates Services	31/07/2016	July	Green	May: Examples of unit plans were shared at CQC delivery group on 06/05/2016		
									More robust risk identification and risk mitigation will be in place	Mark Morgan Divisional Director Mental Health and Learning Disabilities Division	2.6 The previous Task and Finish ligature group terms of reference and purpose will be reviewed and a new Trust Ligature Management Group will be formed. Membership will be reviewed and strengthened with increased clinical membership, including the appointment of a senior clinical co-chair with estates. The ToR will include the following elements:- - Act as an expert decision making grup in relation to ligature decisions - Prioritise capital expenditure for ligatures against the capital control total agreed by the Trust executive - Ensure that there are processes in place to deliver the ligature management programme to include risk assessment and identification, operational mitigation and financial allocation - Develop a new risk assesment tool which will help the clinical teams to assess comprehensively - Ensure that the Trust is fully compliant with accepted standards & guidance from external agencies (eg.NICE) - Monitor and audit identified ligature works across the Trust - Monitor the uptake of E-Learning Training and Assessment on Ligature Risk Care - Monitor the quality and completion of Ligature Risk Assesments across the Trust - Ensure that appropriate management information is available for reporting - Continually identify areas for improvement	Minutes of Ligature Management Group Reports to Quality Improvement and Development Forum (QID) (submission of documents)	Paul Johnson Head of Estates Services Nicky Bennett Associate Director of Nursing - Forensic Services	28/02/2016	February	Blue	May: Terms of Reference amended, new clinical co-chair in place, new meeting agenda commenced, new risk assesment template developed - programme of support for teams to complete this in place. All units have been visited by Ligature project manager - posters in place on units.		
									improved understanding of risk assessment and more consistent risk scoring at the frontline and more robust risk mitigation plans will be in place	Mark Morgan Divisional Director Mental Health and Learning Disabilities Division	2.7 The Trust ligature risk assesment tool will be redesigned away from using 'the Manchester Tool', to using industry agreed risk assessment methodology (5x5)	New risk assesment tool (submission of documents)	Paul Johnson Head of Estates Services Nicky Bennett Associate Director of Nursing - Forensic Services	30/04/2016	April	Blue	May: New assessment tool developed and launched in March/April.		
									Triangulation of risk assesment will ensure all risks, mitigations and controls are in place	Mark Morgan Divisional Director Mental Health and Learning Disabilities Division	2.8 An annual ligature risk assesment programme will be rolled out to include the newly appointed Project lead, estates lead and clinical lead for the area undertaking a joint risk assesment to ensure continuity, quality and a collective agreement as to the risks, mitigations and controls in place. This will report into the Trust ligature management group	All MH/LD/OPMH inpatient units will have a ligature risk assesment completed on the new paperwork that is accurate and of a high quality (submission of documents)	Paul Johnson Head of Estates Services Nicky Bennett Associate Director of Nursing - Forensic Services	30/06/2016	June	Green	May: 2016/17 annual programme being reported this month		
									Clear policy change and consistent implementation	Mark Morgan Divisional Director Mental Health and Learning Disabilities Division	2.9 The Ligature Management Policy will be updated to ensure the new risk assesment process is clearly documented	New Ligature management policy (submission of documents)	Paul Johnson Head of Estates Services Nicky Bennett Associate Director of Nursing - Forensic Services	30/06/2016	June	Green	May: Policy updated - due to be submitted to QID 03/06/2016 for ratification		
									Named lead will coordinate all elements of Ligature Risk assesment and mitigation	Mark Morgan Divisional Director Mental Health and Learning Disabilities Division	2.10 Appoint a dedicated full time Trust clinical ligature project manager	New manager in post	Nicky Bennett Associate Director of Nursing - Forensic Services	01/03/2016	March	Blue	May: Project manager commenced in role		
									All security risks will be clear to frontline teams and all will have management and mitigation plans in place	Paula Anderson Chief Finance Officer	2.11 Improve the robustness of the Site-specific security management reviews. All new reviews will go back over recommendations from previous years' reports to identify what actions, if any, have not been addressed and what management controls are in place to manage any identified risks	All security risks will be clearly identified, assessed and mitigated	Paul Johnson Head of Estates Services	30/08/2016	August	Green			
									Guttering will minimise the risk of patients accessing the roof	Mark Morgan Divisional Director Mental Health and Learning Disabilities	2.12 Install anti-climb guttering at Melbury Lodge to reduce the risk of service users accessing the roof and garden fencing. During the undertaking of the works, security will be enhanced in the garden area, staffing levels will be increased, risk assesments and admission criteria will be reviewed.	Guttering will be in place. Number of service users successfully accessing the roof will reduce (site visits)	Paul Johnson Head of Estates Services	11/05/2016	May	Blue	May: Installation completed mid May.		
3	Trust wide Must Do	SAFE	Provider / Trust	Trust wide	Environment	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: are effective in recording and implementing interim and long-term control measures to mitigate risks to patient safety arising from the physical environment including ligature risks, falls from height and risks from patients absconding.	n/a	n/a			See actions in 2 above							Clearly auditable evidence of identification and mitigation of risk and of appropriate escalation	
									Identification of themes and trends will be more robust	Julie Dawes Director of Nursing	3.1 The Trust approach to thematic review will be more systematic and robust. This will allow for more meaningful opportunities for staff to identify trends and take appropriate action to implement control measures. Peer review schedule for 2016/17 will include thematic peer reviews over several sites.	Annual Thematic Review schedule will be in place and delivered (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/06/2016	June	Green			
									QID will receive assurance of team-level mitigation of risks associated with the environment.	Julie Dawes Director of Nursing	3.2 The Quality, Improvement and Development Forum (QID) will receive assurance reports regarding the mitigation of risks associated with the environment. This will allow for exception reporting to the Quality & Safety Committee.	QID papers and minutes (submission of documents)	Deputy Directors of Nursing: Sara Courtney Paula Hull Debra Moore	31/07/2016	July	Green			
									Teams will have greater ability to review their own performance and understand how this is linked to their objectives including those around patient safety.	Paul Streat MCP director	3.3 Existing team dashboards will be further enhanced to align them to the Trut's approach to team-level objective setting via the navigational maps.	All teams will have team performance dashboards in place and Trust Board will have visibility of every teams performance (submission of documents)	Simon Beaumont Head of Information Sara Courtney Deputy Director of Nursing and Quality	31/03/2017	Mar-17	Green	May: Information team presenting team level performance to Trust Executive Group on a weekly basis from April 2016. Programme in place to roll out the planned improvements over the financial year.		
									Early intervention to provide support to struggling teams will mitigate the risk of significant deterioration in performance including that linked to the management of environmental risks	Julie Dawes Director of Nursing Sandra Grant Director of Workforce	3.4 A systematic approach to providing 'intensive support' to frontline teams highlighted as having a reduced level/quality of delivery performance will be developed and rolled out across the Trust throughout 2016 . This will include a review of Practice Development roles and capacity	Trust wide team performance will be supported with a systematic approach to 'intensive support' programmes (submission of documents)	Sara Courtney Deputy Director of Nursing and Quality	31/12/2016	December	Green	May: Organisational Development leads presented current programmes of support and a proposed 'intensive support' package to Trust Executive group in April 2016		
									Having a single, team level Improvement plan will enable teams to more accurately monitor and deliver required improvement actions including those linked to environmental risks	Julie Dawes Director of Nursing Chris Gordon COO, Director of Patient Safety	3.5 Team Quality Improvement plans will be in place for every team across the Organisation by the end 2016 These will encompass all elements of the Navigation Maps, will include core measures as well as tailored measures to the specific team objectives	Every team will have its own team level Improvement plan linked to its team Navigation Map, incorporating all improvement actions (submission of documents)	Sara Courtney Deputy Director of Nursing and Quality	31/12/2016	December	Green	May: Many teams within Learning Disabilities, Mental Health, Childrens and the SDs have already initiated the creation of a single Improvement plan as a result of their Nav Map exercise. These are not standardised at present		
4	Enforcement Action	SAFE	Provider / Trust	Trust wide	Investigations & learning	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: are effective at delivering robust incident investigation to ensure opportunities for future risk reduction are identified and acted upon.	Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of Regulation 17 (2) (a) (b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The trust did not have effective governance arrangements to deliver robust incident investigation	New death reporting processes will be embedded across the organisation	Chris Gordon COO, Director of Patient Safety	The Trust will deliver the Mortality and SRI action plan in full and to time.	Monitored through separate SRI and Mortality Action Plan						Internal audit of investigation process to be added to audit schedule for Q4	
									Inpatient deaths in AMH/LD will be investigated in a consistent fashion	Chris Gordon COO, Director of Patient Safety	4.1 Amend Mortality reporting process to ensure all Learning Disability and Adult Mental Health inpatient deaths are reported as SIRIs and undergo full Root Cause Analysis investigation	Updated policies and procedures Ulysses data (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/06/2016	June	Green	May: All MH/LD inpatient deaths being reported as SIRs. Procedure for Reporting and investigating deaths is in the process of being updated to reflect this change.		
									Ensure high quality of investigation and all opportunities for Organisational Learning are identified and actioned regardless of whether a SIRI or not	Chris Gordon COO, Director of Patient Safety	4.2 All Root Cause Analysis investigations that are not SIRs (excluding pressure ulcers) will go through the same processes as SIRs, (this may include a thematic review where appropriate), including corporate panel sign off	Updated policies and procedures Ulysses data (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/06/2016	June	Green	May: New process in place which ensures all RCAs go through corporate panel SIRI and incident policies being updated to reflect this change		
									Mitigate risks inherent in IMA stage of process	Chris Gordon COO, Director of Patient Safety	4.3 IMA audit tool will be amended to ensure it includes adequate checks against RiO	IMA audits undertaken and feedback provided to staff (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/05/2016	May	Blue	May: IMA audit tool amended to include cross check with Patient Notes. Audits taking place on a monthly basis.		
									Improved experience for family members/carers involved in investigations into deaths	Lesley Stevens Medical Director	4.4 The Trust will commission an external review of the experiences of family members in the investigation process to provide recommendations on how this can be improved. Action will be taken based on review findings and recommendations	Review will be completed and clear improvement recommendations will be identified and implemented (submission of documents)	External Reviewer Helen Ludford Associate Director of Quality Governance	30/09/2016	September	Green	May: Review commissioned and investigator appointed. Work underway to contact families and set up interviews		
									A dedicated lead for Patient Experience will ensure maximum focus, coordination and improvement will be delivered across all services	Lesley Stevens Medical Director	4.5 The Trust will appoint a Trust Patient Experience Lead	Postholder will be in place with clear job description and clear objectives	Lesley Stevens Medical Director	30/06/2016	June	Green	May: post holder recruited and commenced in role. Final details of objectives being agreed.		
									Improve the culture of organisational learning from serious incidents	Chris Gordon COO, Director of Patient Safety	4.6 CAS system to be used to disseminate learning from SIRIs where corporate panel has grade these as level 4 or 5	Alert system will be in use and same day dissemination of learning from corporate panels will be evidenced (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/05/2016	May	Blue	May: internal alert procedure already in place via the CAS module on Ulysses. Template for sharing learning from corporate panels via this system has been developed and agreed.		
										Julie Dawes Director of Nursing	4.7 The Oranisational learning strategy will be reviewed and updated	New strategy (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/08/2016	August	Green			

										Chris Gordon COO, Director of Patient Safety	4.8 Where corporate panels grade incidents as 4 or 5, a follow-up panel structure will be put in place to gain assurance re competion of action plans.	Panel minutes (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/08/2016	August	Green			
										Chris Gordon COO, Director of Patient Safety	4.9 All SRI investigation reports to include as standard a TOR which requires the investigator to determine whether any similar incidents have taken place within the team/unit in the preceeding 12 months and what action was taken as a result of these. This will allow for improved identification of themes and lead to improved actions to address the root causes. - 48hr panel chairs to be advised of new requirement - Commissioning manager training will include reference to this requirement	Investigation reports (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/08/2016	August	Green			
										Sandra Grant Director of Workforce	4.10 The Trust will upskill frontline staff in quality improvement methodologies using the existing Team Viral programme to support this	Course content and Attendance logs (submission of documents)	John Monahan Organisational Development	31/03/2017	Mar-17	Green			
5	**Trust wide Must Do**	**RESPONSIVE**	Provider / Trust	Trust wide	Supporting staff	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: identify, record and effectively action concerns about patient safety raised by staff.	n/a	n/a	Improved medical leadership throughout the Organisation with standardised Role Descriptors and clear accountabilities and objectives	Lesley Stevens Medical Director	5.1 Medical Director will review Associate Medical Director appointments and Roles and clarify the role of the Clinical Director with Divisional Directors to ensure consistency	Standardised Role descriptors and job plans will be in place (submission of documents)	Divisional Directors	31/07/2016	July	Green	Mar: Review commenced		
									Improved senior leadership visibility at the frontline (including Executives and NEDs) and increased focus on Patient Safety	Julie Dawes Director of Nursing	5.2 A structured leadership visibility programme will be introduced to inlcude executive safety walkabouts, 'Back to the Floor' programme etc.	Programme to be in place and frontline teams to report increased visibility of senior leaders (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/07/2016	July	Green			
									A more engaged workforce who feel supported to raise concerns and are confident they will be dealt with appropriately	Sandra Grant Director of Workforce	5.3 Undertake a review of the Trust's staff engagement strategy	Review report (submission of documents)	Amanda Smith Deputy Director of Workforce Emma McKinney Associate Director of communications	30/09/2016	September	Green			
									Staff clear as to the escalation processes that are in place to raise concerns about patient safety	Sandra Grant Director of Workforce	5.4 A review of staff feedback mechanisms will be undertaken to determine whether there are sufficient processes in place for staff to escalate matters beyond their line manager when these fall below the threshold that would require whistleblowing procedures to be followed. This will include a review of the methods through which feedback is collated and used when this is received at events such as staff briefings, staff survey etc. Promotion of existing/new mechanisms to be communicated to staff	Review report and communications (submission of documents)	Amanda Smith Deputy Director of Workforce Emma McKinney Associate Director of communications	31/10/2016	October	Green			
6	**Trust wide Must Do**	**SAFE**	Provider / Trust	Trust wide	Supporting staff	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: identify, record and effectively action concerns raised by staff about their competence to carry out their roles.	n/a	n/a			See action in 5 above								
									Improve staff engagement in the annual Training Needs Analysis process	Sandra Grant Director of Workforce	6.1 Ensure frontline staff are fully engaged in the Trust's Training Needs Analysis process by reviewing current practice and identifying ways in which this can be improved. Consideration will be given to the hosting of open days by the LEaD department and a communications drive during the months when the TNA process is undertaken.	Staff engagement activities around TNA (submission of documents)	Bobby Moth Associate Director of Leadership, Education and Development	31/10/2016	October	Green			
									Appraisal and revalidation process will be used to assess any skills and competency gaps and staff will be supported to address these.	Sandra Grant Director of Workforce	6.2 Conduct a staff survey to include a question that evaluates whether staff feel that their appraisal and/or revalidation process has adequately addressed their training needs	Survey results (submission of documents)	Amanda Smith Deputy Director of Workforce	30/09/2016	September	Green			
									Standardised approach to supervision to support staff and provide a structured 'space' for concerns around competencies to be raised	Julie Dawes Director of Nursing	6.3 A review of the current supervision policy and procedures to be undertaken to ensure they are fit for purpose and updated as necessary. This will include scoping the possibility of an electronic solution linked to the LEaD system to optimise supervision record keeping	Staff supervision records will be in place and staff will report supervision has taken place and has been effective	Paula Hull Deputy Director of Nursing and Quality	30/09/2016	September	Green			

Appendix 1 Improvement Plan for: CQC Inspection Recommendations - January 2016

Southern Health NHS Foundation Trust

Version No: FINAL V1.0
Progress last updated: 08/06/2016 - TM

Date: ***27/05/2016***

Approved by: *Chris Gordon, COO, Director of Patient Safety*
Julie Dawes, Director of Nursing & AHPs

Produced by: *Louisa Felice - Head of Executive Affairs and Projects*
Tracey McKenzie - Head of Compliance

	Requirement Notice?	CQC KEY QUESTION	Core Service	Location	Theme	CQC actions required	Regulation breached	How the regulation was not being met	Outcome or Improvement the action will deliver once completed	Who is accountable for ensuring the action is completed?	Action/s to be taken	How will completion of the action be evidenced (Evidence and method of review)	Who is responsible for completing the action	Date action must be completed dd/mm/yyyy	Month last action will be completed	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Progress update on individual actions	How will you evidence that the completion of the actions has led to the intended outcome	Intended Outcome Achieved Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
WARNING NOTICE ACTIONS 1-6 ARE PRESENTED ON A SEPARATE TAB																			
7	Requirement Notice	SAFE	Community-based mental health services for adults of working age.	Southampton AMH community teams	Risk assessments & care planning (including capacity & consent)	The trust must ensure that staff undertake risk assessments for all patients that use the service and that patients' care plans include the risks that have been identified and the actions required to manage these.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This is a breach of regulation 12(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	There was not consistent use of risk assessment processes. Crisis plans were not used consistently.	100% of risk assessments will be completed. Decreased numbers of patient safety incidents where failures in risk management were a contributory or causative factor.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	7.1 Interim action: Update AMHT/CMHT SOP to limit the places on RiO where risk information is entered. (Risk Assessment module and the latest consultant letter only)	Revised SOP Communications to staff about revised SOP/minutes of team meeting discussions (Submission of documents)	Liz Durrant, Area Manager – Southampton AMH	30/06/2016	June	Green		Increased numbers of patients have a 'My Safety Plan' in place (trajectory to be determined by t&f group and evidenced by RiO report or manual audit) Increased compliance with new training programme (trajectory to be determined by t&f group and evidenced by LEaD reports) Thematic reviews of AMH incidents will be carried out on a 6 monthly basis and will expect to see a reduction in the number of incidents where failings in risk management were a causative or contributory factor.	
											7.2 Task & Finish Group to: - review the functionality of the existing RiO risk assessment tool and determine the improvements required - determine how the new 'My Safety Plan' (collaborative safety care plan) and crisis plans reflect the risk information and are incorporated onto RiO - carry out a gap analysis of the risk assessment and risk care planning training currently available and determine the improvements required - establish trajectory of compliance for My Safety Plans being in place and new risk management training being undertaken	Report from Task and Finish group (Submission of document)	Liz Durrant, Area Manager – Southampton AMH	30/09/2016	September	Green			
											7.3 Make the necessary changes to the risk module on RiO in association with Servelec to reflect the recommendations of the task and finish group	Updated risk assessment module on RiO (Submission of document)	Tony Goodwin, Senior Systems Manager	TBC at end Sept 16 (dependant on extent of changes recommended by T&F group)	TBC	Green			
											7.4 Devise a risk management training package and establish a programme to roll this out in 2017 that reflects the recommendations of the task and finish group	New training materials and schedule for roll out (Submission of documents)	Louise Hartland, Governance, Quality and Compliance Manager LEaD	31/12/2016	December	Green			
8	Requirement Notice	SAFE	Community-based mental health services for adults of working age.	Southampton AMH community teams	Risk assessments & care planning (including capacity & consent)	The trust must ensure that staff follow a consistent procedure for following up on patients who do not attend their appointments, especially those identified as posing a high risk of harm to themselves and/or to others.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This is a breach of regulation 12(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	There was no clear process for following up on patients who did not attend their appointments, even when a person was identified as high risk of harm to themselves and/or others.	A robust system and consistent procedure is in place applied 100% of the time. Decreased numbers of patient safety incidents where poor management of DNA episodes was a contributory or causative factor.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	8.1 Interim action: All multi-disciplinary team meetings to include discussion of patients who DNA as a standard agenda item.	Communications to staff/minutes of team meeting discussion MDT agendas (Submission of documents)	AMH Area Managers: Liz Durrant Karen Guy Graham Webb	31/05/2016	May	Blue	May 16 This is now a standing item on all MDT agendas	Corporate panels will monitor on an ongoing basis whether DNA management continues to be a contributory or causative factor in incidents Biannual audit of DNA management until practice is embedded	
											8.2 Administration of MDT meetings to be changed in order that discussions about patients who DNA and the plans that are agreed as a result are entered onto the individual patient's RiO record rather than in the MDT minutes	Audit of individual patient records who DNA as identified through Tableau report (Submission of documents)	AMH Area Managers: Liz Durrant Karen Guy Graham Webb	31/07/2016	July	Green			
											8.3 Revise the CMHT and AMHT Standard Operating Procedure to reflect the requirement for teams to discuss people who DNA at the MDT meetings	Revised SOP within AMHT and CMHT Communication of SOP amendments to team/discussion of SOP amendments at team meetings (Submission of documents)	Karen Guy. Area Manager- CMHT / Liz Durrant, Area Manager- AMHT	30/06/2016	June	Green	May16 AMHT SOPhas been updated. CMHT SOP is in progress		
											8.4 Complete the review of the current Clinical Disengagement Policy and make any necessary improvements to it. The review process will include a Soton Learning network event which will discuss learning from previous incidents associated with clinical disengagement.	Revised (Version 6) SH CP 97 "Clinical Disengagement / Patients who DNA" policy available on Trust website- (Submission of documents)	Area Heads of Nursing: Carol Adcock Nicky Duffin Liz James	30/09/2016	September	Green			
											8.5 Launch revised Clinical Disengagement policy including headlining it at AMH Learning Network event	Communications to staff and agenda of learning network event (Submission of documents)	Area Heads of Nursing: Carol Adcock Nicky Duffin Liz James	31/10/2016	October	Green			
9	Requirement Notice	SAFE	Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust must ensure that it follows the Mental Health Act Code of Practice (chapter 26, paragraph 26.128). This requires that the responsible clinician or duty doctor (or equivalent) undertakes the first medical review of a young person in seclusion within one hour of the commencement of seclusion, if the seclusion was authorised by an approved clinician who is not a doctor or the professional in charge of the ward.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This is a breach of Regulation 12 (2) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	In Bluebird House medical staff were not able to attend young people's medical reviews, within one hour of the commencement of seclusion, as they had other commitments.	Trust will have a model of on-call cover that is able to meet the requirements of the MHA Code of Practice whilst being cost-effective and sustainable.	Dr Lesley Stevens, Medical Director	9.1 Interim action: Put plans in place to ensure Consultant Psychiatrist on-call or senior registrar on-call undertake the initial medical review for new episodes of seclusion out of hours if on-call trainee doctor is unavailable and that any breaches are reported on Ulysses as an incident.	Communications to staff Minutes of Trust SAFER group meetings Review of Ulysses incidents (Submission of documents)	Dr Mayura Deshpande, Clinical Service Director (SS) Mary Kloer, Clinical Director (AMH) Jennifer Dolman, Clinical Director (LD)	31/05/2016	May	Blue	May 16 Consultant psychiatrists, senior registrars on on-call rota and senior nurses made aware of expectation.	Periodic audit of seclusion medical review until practice is embedded	
											9.2 Carry out a review of all episodes of seclusion in AMH, specialised services and LD from Dec 2015 - April 2016 to determine how many episodes of seclusion were not reviewed within the first hour by the on-call doctors out of hours and thereby establish scale of the problem.	Review report (Submission of documents)	Dr Mayura Deshpande, Clinical Service Director (SS) Mary Kloer, Clinical Director (AMH) John Stagg,Associate Director of Nursing (LD)	31/07/2016	July	Green			
											9.3 Use results of audit to feed into Trust-wide review of junior medical on-call	Trust-wide review report (Submission of documents)	Dr Mayura Deshpande, Clinical Service Director	31/08/2016	August	Green			
10	Requirement Notice	SAFE	Acute wards for adults of working age and psychiatric intensive care units	All wards	Environmental & equipment	The trust must ensure that premises and equipment are safe. The provider must identify and prioritise action required to address environmental risks on the wards, such as management of ligature points.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (b) (d) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	There has been insufficient action taken to identify and prioritise action required to address environmental ligatures on the wards.	A clear understanding by frontline staff of the ligature, environmental and equipment related risks on each inpatient unit and robust systems and processes for prioritising and managing these.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	See Action 2 (warning notice tab) for Trust-wide actions which will include AMH services							Staff understanding of ligature management process evident on peer reviews/site visits and up to date unit-based environmental work plans in place Ongoing monitoring of incidents linked to ligature points or environment	
											10.1 Develop a clear process for identifying and prioritising environmental risks across AMH services that includes the process for escalation and governance responsibilities.	Environmental Process document for AMH Minutes of AMH Environmental Meetings (Submission of documents)	Nina Davies, Transformation Business Partner- Mental Health	31/05/2016	May	Blue	May 16 Process in place across the division. AMH minutes available.		
11	Requirement Notice	SAFE	Acute wards for adults of working age and psychiatric intensive care units	Kingsley Ward, Melbury Lodge	Environmental & equipment	The trust must ensure it takes sufficient action to manage the safety of patients at Kingsley ward, Melbury Lodge, including ensuring staff can clearly observe patients to mitigate environmental risks	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (b) (d) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of regulation 17(1)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	Insufficient action had been taken and to manage the safety of patients at Kingsley ward. Staff could not clearly observe patients and patients could access the roof and climb out of the wards garden. The trust had not ensured security arrangements were in place to keep patients safe whilst receiving care, including, restrictive protection required in relation to the Mental Health Act 1983. Patients detained under the Mental Health Act 1983 have absconded from Kingsley ward via the fence and the roof. The most recent abscond was 21 February 2016.	No incidents linked to AWOLS/falls from Melbury Lodge. Reduction in the number of incidents linked to observations on the unit	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	See action 2 (warning notice tab) in relation to Trust-wide improvements in ligature/estates management and action 2.12 specifically in relation to the Melbury roof								
											11.1 Domed mirrors to be installed on Kingsley Ward, Melbury Lodge to improve the sight lines	Domed mirrors in situ (site visit)	Paul Johnson, Head of Estate Services	31/05/2016	May	Blue	May16 Dome mirrors Installed on 16.5.16	Peer reviews and site visits Regular review of incidents linked to the environment at Melbury Lodge to identify any emerging or unresolved issues. Evidence of action taken in response to patient safety incidents related to the environment	
12	Requirement Notice	SAFE	Acute wards for adults of working age and psychiatric intensive care units	Kingsley Ward, Melbury Lodge	Environmental & equipment	The trust must ensure that it protects patients' privacy and dignity in a safe way on Kingsley ward.	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect This is a breach of Regulation 10(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The trust had not ensured that patients' privacy and dignity is protected in a safe way on Kingsley ward.	Improved privacy and dignity for patients on Kingsley Ward whilst still allowing safe observations	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	12.1 Vistamatic windows to be installed on all 25 bedroom doors, Resource Room and Family Room	New doors installed (site visit)	Paul Johnson, Head of Estate Services	30/04/2016	April	Blue	May16 Vistamatic doors installed in April 2016	Review of patient feedback from Melbury ward to ensure continued patient satisfaction around privacy and dignity	
13	Requirement Notice	SAFE	Acute wards for adults of working age and psychiatric intensive care units	Hamtun PICU, Antelope House	Environmental & equipment	The trust must ensure that the works on the seclusion room on Hamtun psychiatric intensive care unit are completed so that the room is fit for purpose.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (b) (d) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The seclusion room on Hamtun psychiatric intensive care unit is not fit for purpose.	Fit for purpose seclusion room on Hampton ward that complies with MHA Code of Practice Standards	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	13.1 Amend Hamtun seclusion room plans taking into account MHA Code of Practice and additional suggestions made by CQC	Revised seclusion room plans/drawings (submission of documents)	Paul Johnson, Head of Estate Services	31/05/2016	May	Blue	May16 A number of different design options have been provided to the Trust and these have been considered by the clinical team resulting in a preferred design option being agreed.	n/a - evidence of individual actions will provide the necessary assurance	
											13.2 PFI partners to provide costings for new design and issue tender	Costings and tender paperwork (submission of documents)		30/06/2016	June	Green	May16 An intrusive survey is being carried out on 01.06.16 following the design option chosen by the clinical team. Following this, the construction team will provide costs and timescales for the clinical team to sign off on 10th June.		

	Requirement Notice?	CQC KEY QUESTION	Core Service	Location	Theme	CQC actions required	Regulation breached	How the regulation was not being met	Outcome or Improvement the action will deliver once completed	Who is accountable for ensuring the action is completed?	Action/s to be taken	How will completion of the action be evidenced (Evidence and method of review)	Who is responsible for completing the action	Date action must be completed dd/mm/yyyy	Month last action will be completed	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Progress update on individual actions	How will you evidence that the completion of the actions has led to the intended outcome	Intended Outcome Achieved Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
											13.3 External contractor to carry out building works of new seclusion room	Building works completed on new seclusion room (site visit)		TBC after 30/06 (dependant on costings and tender process)	TBC	Green	May16 Options arising from the survey/costing stage will dictate the programme length. Building control will be required prior to commencing work (up to 4 week timeframe). It has been agreed with the contractors (Bellrock) that during this time materials will be ordered to allow commencement of building work immediately following building control sign off.		
											13.4 Interim action: Screen to be used as an interim measure, when the seclusion room is in use, to protect privacy and dignity of patients	ward manager spot checks	Liz Durrant, Area Manager – Southampton AMH	15/04/2016	April	Blue	May16 Screen being used for each seclusion episode		
14	Requirement Notice	SAFE	Acute wards for adults of working age and psychiatric intensive care units	Elmleigh & Melbury Lodge	Environmental & equipment	The trust must ensure that staff at Elmleigh and Kingsley ward at Melbury Lodge check and record medicine fridge temperatures to ensure medicines are stored at the correct temperature.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (b) (d) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	Staff did not always check and record medicine fridge temperatures at Elmleigh and on Kingsley ward at Melbury Lodge to ensure medicines were stored at the correct temperature.	Appropriate management of medication fridges	Dr Lesley Stevens, Medical Director	14.1 Medicines Management team to re-issue advice re action to be taken if outside of safe range.	communications from Meds management team (submission of documents)	Ewan Maule, Interim Chief Pharmacist	31/05/2016	May	Blue	May16 Communication regarding the requirements and escalation process sent out to staff from the Medicines Management Team	Site visits and peer reviews consistently find evidence of fridge temperatures being managed appropriately	
											14.2 Fridge temperature monitoring template to be reviewed and re-issued so as to assure standardisation across the trust	New template (submission of documents)	Vanessa Lawrence, Pharmacy Lead	30/06/2016	June	Green			
											14.3 Survey of the maximum temperatures reached in all inpatient dispensing rooms where medicines are stored to be carried out and solutions to be sought to ensure temperatures remain within the recommended limits (e.g. air conditioning installation)	Completed survey results and plans for remedial works (submission of documents)	Paul Johnson, Head of Estate Services Vanessa Lawrence, Pharmacy Lead	30/06/2016	June	Green			
15	Requirement Notice	SAFE	Wards for people with learning disabilities and autism	Evenlode	Environmental & equipment	The trust must ensure that environmental risks are addressed at Evenlode and that appropriate measures are implemented to effectively mitigate the risks to patients using the service.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The environmental risks at Evenlode must be addressed. Until the necessary changes are made to make the environment as safe as possible, appropriate measures must be implemented immediately to mitigate effectively the risks to people using the service.	A safe environment will be provided for patients at Evenlode with remedial estates works completed as appropriate and residual risks managed through clinical risk management processes.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	See action 2 (warning notice tab) regarding Trust-wide improvements in ligature/estates management which will apply to Evenlode								
											15.1 Introduce immediate safeguards to ensure patient safety - shortening of cables - review of ligature risk assessments - review and update patient risk plans - increase night time observations	(Site visits) Evidence was also reviewed by CQC at repeat visit in February 2016.	Linda Kent, Ward Manager	30/03/2016	March	Blue	May16 All actions taken following initial CQC visit and evidence provided to CQC during repeat visit in February 2016	Peer reviews and site visits Regular review of incidents linked to the environment at Evenlode to identify any emerging or unresolved issues. Evidence of action taken in response to patient safety incidents related to the environment	
											15.2 Engage and consult effectively with the patient group around further changes being made to reduce the risk from ligature points.	Minutes from patient engagement meetings,1-1 discussions documented in care notes (submission of documents)		31/05/2016	May	Blue	May16 Patients have been involved and consulted with regarding the planned bedroom refurbishment works.		
											15.3 Schedule of bedroom works to be completed by external contractors	Bedroom works completed (site visits)	Paul Johnson, Head of Estate Services	30/07/2016	July	Green	May16 Programme of refurbishment of bedrooms underway. New doors ordered with integrated hinges and vistamatic panels. Integrated door alarm to be fitted.		
											15.4 Once structural bedroom works are completed, install new ligature-free beds and wardrobes.	New furniture in place (site visits)		31/07/2016	July	Green	May16 Wardrobes and beds ordered and awaiting completion of bedrooms for installation.		
16	Requirement Notice	SAFE	Wards for people with learning disabilities and autism	The Ridgeway Centre	Environmental & equipment	The trust must take action to address the remaining environmental risks at the Ridgeway Centre.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	Known environmental risks at the Ridgeway Centre had not been addressed.	A safe environment will be provided for patients at The Ridgeway Centre with remedial estates works completed as appropriate and residual risks managed through clinical risk management processes.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	See action 2 (warning notice tab) in relation to Trust-wide improvements in ligature/estates management which will apply to The Ridgeway Centre							Peer reviews and site visits Regular review of incidents linked to the environment at Evenlode to identify any emerging or unresolved issues. Evidence of action taken in response to patient safety incidents related to the environment	
											16.1 Address outstanding ligature points in garden as highlighted by CQC	remedial works carried out (site visit)	Paul Johnson, Head of Estate Services	31/05/2016	May	Blue	May16 Work to remove residual ligature risks identified in garden have been undertaken		
17	Requirement Notice	SAFE	Wards for people with learning disabilities and autism	Evenlode	Environmental & equipment	The trust must ensure that that the clinic room at Evenlode is fit for purpose and contains all appropriate essential equipment for resuscitation.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (d) Health and Social Care Act 2008 (Regulated Activities)	The clinic room at Evenlode must be made fit for purpose and contain all appropriate essential equipment for resuscitation.	Safe fit for purpose clinic room facility	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	17.1 Identify gaps in essential resuscitation equipment and purchase any necessary additional equipment	equipment in place (site visit)	Linda Kent, Ward Manager	31/05/2016	May	Blue	May16 Resus bag now equipped as per policy.	Site visits and peer reviews consistently find clinic room fit for purpose	
											17.2 Remove staff lockers currently within clinic room	no unnecessary items in clinic room (site visit)		31/05/2016	May	Blue	May16 Lockers removed from clinic room		
											17.3 Purchase clinic room treatment chair	equipment in place (site visit)		30/06/2016	June	Green	May16 Treatment chair ordered.		
18	Requirement Notice	SAFE	Wards for people with learning disabilities and autism	Evenlode	Supporting staff	The trust must ensure that staff at Evenlode receive appropriate and up to date specialist training to be able to carry out their jobs as safely and effectively as possible.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The training, learning and development needs of staff had not been identified and actions taken to meet any gaps.	Staff feel properly trained to carry out their roles and supported in accessing this.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	18.1 Review all staff training records to ensure compliance with statutory and mandatory training and seek staff views as to additional training they feel is required.	Training Records and 1:1/appraisal paperwork (site visit)	Linda Kent, Ward Manager	30/06/2016	June	Green	May16 Staff have had 2x away days where they identified some training needs over and above stat and man training. Stat and Man compliance is being monitored on a rolling basis through divisional performance meetings Additional training needs analysis to be undertaken.	Report that provides assurance that staff have accessed all the training that they and their line manager agreed was required following individual training needs analysis	
											18.2 Liaise with LEaD to establish how best to meet identified training needs on an ongoing basis and ensure all staff are booked onto required courses.			30/06/2016	June	Green	May16 External specialist training in forensic risk assessment and general update in forensic practice has been organised.		
19	MUST	SAFE	Wards for people with learning disabilities and autism	Trust wide	Supporting staff	The trust must ensure that its 'Protocol for the Safe Bathing and showering of People with Epilepsy' is embedded as swiftly as possible and that staff receive appropriate training to ensure understanding and consistency of practice.	n/a	n/a	100% compliance with 'Protocol for the Safe Bathing and showering of People with Epilepsy' for inpatients with epilepsy.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	19.1 The protocol will be re-visited with all appropriate staff through discussion in team meetings. Reference to the protocol will be included in local induction checklists.	Staff to sign to evidence reading and understanding of bathing protocol Updated local induction checklists (submission of documents)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	31/05/2016	May	Blue	May16 Evenlode - 100% of currently available staff have signed to say have read.. RWC - 100% of staff currently available to work have received and signed for in respect of receiving the protocol.	Bathing care plan audits Staff awareness demonstrated at peer review/site visits	
											19.2 Posters to be created and placed in each room with a bath	Posters visible in each bathroom (site visits)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	31/05/2016	May	Blue	Local induction checklist for LD inpatient services has been amended to add reference to Bathing protocol Posters created and in place		
20	Requirement Notice	SAFE	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Investigations & learning	The trust must ensure that learning takes place following serious incidents.	Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of Regulation 17(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The trust had not analysed and responded to information gathered from internal reviews to take action to address issues where they were raised, or used information to make improvements and demonstrated they have been made. The trust had not monitored progress against plans	Learning is shared. Actions and recommendations have been considered and, where appropriate, applied not only within the team but across the service, the division or the entire Trust.	Julie Dawes, Director of Nursing & AHPs	See action 3 (warning notice tab) re plans for team-based improvement plans that will apply across the organisation and action 4 (warning notice tab) re sharing learning across the Trust.								
											20.1 Add standing agenda item regarding learning from incidents to local quality and governance meetings.	Agendas and minutes of local quality and governance meetings (submission of documents)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	30/06/2016	June	Green	May16 Local Quality Governance meetings (monthly) now include a standing agenda item "Learning from Experience"	Site visits and peer reviews consistently find that staff are able to describe learning from incidents across the Trust	
21	Requirement Notice	EFFECTIVE	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Supporting staff	The trust must ensure that staff at the Ridgeway Centre and Evenlode receive consistent and regular supervision and senior management oversight.	Regulation 18 HSCA (RA) Regulations 2014 Staffing This is a breach of Regulation 18(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	Staff did not receive appropriate on-going supervision in their role.	100% of available staff have received supervision in the last 6 weeks.	Julie Dawes, Director of Nursing & AHPs	See action 5 (warning notice tab) for Trust-wide actions in relation to the supervision process.								
											21.1 Roll out a programme of regular supervision in Evenlode and the Ridgeway Centre ensuring that by end June 2016, all clinical staff have had a clinical supervision session and there is a clear schedule for future supervision in place.	Supervision records (submission of documents)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	30/06/2016	June	Green	May16 Evenlode - Dates booked for staff to receive supervision in May. Supervision data to be collated weekly RWC - Supervision database available.	Site visits and peer reviews consistently find that supervision records on staff files show 4-6 weekly supervision sessions	
22	Requirement Notice	RESPONSIVE	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Environmental & equipment	The trust must make the necessary improvements to the environment at both services in order to protect people's dignity and privacy at all times.	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect This is a breach of Regulation 10(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The provider must make the necessary improvements to the environment at both services in order to protect people's dignity and privacy at all times.	Privacy and dignity will be maintained.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	22.1 Install curtains in patient bedroom (RWC)	Environmental modifications in place (Site visits)	Paul Munday, Clinical Service Manager	31/05/2016	May	Blue	May16 Curtains purchased and fitted in relevant bedroom.	Site visits, peer reviews and patient feedback consistently report privacy and dignity being managed appropriately at the two sites	
											22.2 Seek options (from various specialist resources / national standards) for door observation panels that do not compromise privacy and dignity (Evenlode)		Linda Kent, Ward Manager	30/06/2016	June	Green	May16 Doors with integrated hinges and Vistamatic viewing panels have been identified as part of programme of works. Doors will be fitted with integrated alarms. Estates negotiating alarm fitting with manufacturer		
23	SHOULD	RESPONSIVE	Provider / Trust	Trust wide	Investigations & learning	The trust should review its policies relating to complaints to ensure they reflect current legislation, best practice, role and responsibilities and the management of local concerns. It should continue to improve the way it responds to complaints and ensure robust, consistent systems for sharing and learning from complaints across the trust.	n/a	n/a	Up to date policy and procedure which reflect best practice and National Guidance and lead to an improved complaints process reflected by feedback from complainants and staff.	Helen Ludford - Associate Director Quality Governance	23.1 Undertake a thematic peer review of the complete complaints management process involving staff and complainants to review the process in practice and make recommendations for improvements	Thematic peer review report with recommendations and SMART action plan which will be presented to QID (submission of documents)	Tracey McKenzie - Head of Compliance	30/06/2016	June	Green	May16 Working group established, thematic review TOR agreed, review in progress and on target for draft report to be written by mid June.	Improved feedback from all staff involved in complaints process/response sign off and feedback from complainants	
											23.2 Review complaint policy and procedure to ensure that they are aligned with national best practice guidance and incorporate recommendations from the thematic peer review	Revised policy and procedure available for staff on website & communicated via weekly bulletin and incorporated into relevant training (submission of documents)	Cathy Lakin - Complaints Manager	31/07/2016	July	Green	May16 Initial review of policy against national guidance completed. Further review to take place following peer review		
24	SHOULD	RESPONSIVE	Provider / Trust	Trust wide	Investigations & learning	The trust should continue to develop its complaints reports to the board to contain more detailed analysis and explanation so the board is provided with more robust information for assurance.	n/a	n/a	More informative Board sub-committee reports to present themes and assure Board that learning from complaints is being implemented	Helen Ludford - Associate Director Quality Governance	24.1 Enhance the reports submitted to Quality & Safety Committee and the Exec Board Report to include: - evidence of specific learning and service improvement as a result of complaints - case trend analysis related to areas, services and staff groups - evaluation of quality of complaint response letters (6 monthly)	Revised reports to QSC & Board (submission of documents)	Cathy Lakin - Complaints Manager	30/06/2016	June	Green		Positive feedback from Board members that they are assured through reports they receive that service improvements are taking place as a result of complaints	
25	SHOULD	EFFECTIVE	Community-based mental health services for adults of working age	Southampton AMH community teams	Supporting staff	The trust should ensure that staff in all teams receive regular supervision and that this is used to support implementation of the improvement	n/a	n/a	100% of available staff have received supervision in the last 6 weeks.	Kate Brooker, Associate Director- MH	See action 6 (warning notice tab) re Trust-wide plans relating to the supervision process								

	Requirement Notice?	CQC KEY QUESTION	Core Service	Location	Theme	CQC actions required	Regulation breached	How the regulation was not being met	Outcome or Improvement the action will deliver once completed	Who is accountable for ensuring the action is completed?	Action/s to be taken	How will completion of the action be evidenced (Evidence and method of review)	Who is responsible for completing the action	Date action must be completed dd/mm/yyyy	Month last action will be completed	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Progress update on individual actions	How will you evidence that the completion of the actions has led to the intended outcome	Intended Outcome Achieved Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
						plan. Supervision should include a review of caseloads and monitoring of care records.					25.1 Supervision templates developed by LD and Specialised services to be reviewed and the most appropriate one circulated for interim use within AMH	Communication of template to staff/minutes of team meeting discussions (submission of documents)	AMH Area Managers: Liz Durrant Karen Guy Graham Webb	31/05/2016	May	Blue	May16 Interim template has been circulated to teams	Site visits and peer reviews consistently find that staff feel supported and have clinical supervision in place	
											25.2 AMH specific clinical supervision template to be designed	Standardised template in use across all AMH teams (site visits)		30/06/2016	June	Green			
											25.3 All Soton community staff to have had first supervision session and planned schedule of supervision sessions in place	Monthly supervision date reports reviewed by area managers monthly and submitted quarterly to AMH Performance and Assurance Board, evidenced in minutes (submission of documents)		31/07/2016	July	Green			
26	SHOULD		Child and adolescent mental health wards.	Bluebird House	Involving patients	The trust should ensure that there are suitable arrangements in place to ensure that all young people are involved in all aspects of planning their care and treatment in Bluebird House	n/a	n/a	Increased young persons' engagement in their care planning	Nicki Brown, Associate Director, Specialised Services	26.1 Consultant psychiatrists and ward managers to ensure that all patients have advanced statements	Audits of patient records (submission of documents)	Dr Mayura Deshpande, Clinical Service Director, Bluebird House	30/06/2016	June	Green	May16 Communication sent to consultants by clinical services director outlining expectations	Consistent evidence at site visits, peer review and through patient feedback of involvement in care planning.	
											26.2 Template of CPA meeting to be changed to ensure wishes of young people are formally captured	New template (submission of documents)	Karen Dixon, Modern Matron	31/05/2016	May	Blue	May16 New template in use		
											26.3 Additional staff to be trained in graphic facilitation so as to roll it out to all CPA meetings to help improve patients' understanding and involvement in treatment planning	Training records for graphic facilitation and CPA minutes (submission of documents)		31/12/2016	December	Green			
27	SHOULD		Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that where rapid tranquilisation is used by intramuscular injection, young people in Bluebird House have their physical health observations monitored on the format within their care files.	n/a	n/a	Improved aftercare for patients receiving intramuscular rapid tranquilisation medication.	Nicky Bennett, Clinical Service Manager	27.1 Remind all clinical staff of the risks associated with using Rapid Tranquilisation intramuscular medication and the benefits of the Track and Trigger tool	Communications to staff (submission of documents)	Dr Mayura Deshpande, Clinical Service Director, Bluebird House	31/05/2016	May	Blue	May16 Communication has been sent out to staff	Consistent evidence at site visits, peer review and through audit of track and trigger tool being used post administration of rapid tranquilisation IM.	
											27.2 Ensure reference to Track and Trigger Tool is included on local induction checklist for agency staff.	Amended local induction checklist (submission of documents)	Karen Dixon, Modern Matron	30/06/2016	June	Green			
											27.3 Carry out an audit of compliance with the Track and Trigger tool from March-May 2016 to determine scale of compliance issues and allow better targeted future interventions aimed at increasing compliance with its use.	Audit report (submission of documents)		31/07/2016	July	Green			
28	SHOULD		Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. The provider should ensure that they address the high levels of prone restraint and provide staff at Bluebird House with appropriate restraint training as agreed.		n/a	A clear restraint reduction strategy will be in place and there will be robust Trust systems for monitoring the numbers, positions and durations of restraints with the wishes of patients will be taken into account.	Dr Lesley Stevens, Medical Director	28.1 Develop a Trust position statement that sets out the principles staff should work to with regards to restrictive practice. This will sit above a suite of policy documents and protocols that address restraint, seclusion, rapid tranquillisation and relational security.	Position statement (submission of documents)	Dr Mayura Deshpande, Clinical Service Director, Bluebird House & Chair of Safer Forum Debra Moore, Deputy Director of Nursing - MH/LD	31/07/2016	July	Green		Monitoring of restraint by Safer Forum will show restraint techniques being used in accordance with Trust position statement and policy. Duration of restraint will be closely monitored with outlying trends investigated	
											28.2 Review the restrictive interventions policy, in line with the position statement and address any identified gaps	Revised restrictive interventions policy (submission of documents)				Green			
											28.3 Review the training programme, in line with the new restrictive interventions policy, and produce a paper with recommendations for future training	Recommendations paper presented to TEG Minutes of TEG discussion (submission of documents)				Green			
											28.4 Implement the changes to the training programme and roll-out to relevant staff groups	Revised training materials and roll-out schedule (submission of documents)	Simon Johnson, Head of Essential Training Delivery	TBC following outcome of recommendations paper	TBC	Green			
											28.5 Ulysses to be updated and staff to record the duration of each type of restraint as part of the incident reporting processes. Statistics from these incidents will be reviewed as part of the services governance arrangements and issues will be escalated via the SAFER forum.	Through regular reports to the Trust Quality Improvement and Development Forum. Monthly review via local governance and Monthly review at Safer forum (submission of documents)	Tom Williams, Risk Manager & Ulysses System Developer Dr Mayura Deshpande, Clinical Service Director, Bluebird House & Chair of Safer Forum	31/07/2016	July	Green			
29	SHOULD		Child and adolescent mental health wards.	Bluebird House	Risk assessments & care planning (including capacity & consent)	The trust should ensure that suitable arrangements are in place to obtain the consent of patients in relation to the care and treatment provided in Moss and Steward wards in Bluebird House.	n/a	n/a	All clinicians who undertake therapeutic activities with patients will record the patients' consent in their electronic patient record.	Nicki Brown, Associate Director, Specialised Services	29.1 Staff to be trained in assessing and recording of capacity and consent as part of their local induction (open to all staff).	Training records held by the Modern Matron Audit of records (submission of documents)	Karen Dixon, Modern Matron Dr Mayura Deshpande, Clinical Service Director, Bluebird House	31/07/2016	July	Green		Consistent evidence at site visits and peer reviews and through documentation audit of capacity to consent to treatment being recorded appropriately.	
30	SHOULD		Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that staff in Bluebird House always record the length of seclusion and the time when seclusion has ended.	n/a	n/a	All episodes of seclusion will be carried out in accordance with the Mental Health Act 1983 Code of Practice and Trust policy	Nicki Brown, Associate Director, Specialised Services	30.1 Design seclusion flow chart	New flow-chart (submission of documents)	Dr Mayura Deshpande, Clinical Service Director Karen Dixon, Modern Matron	30/06/2016	June	Green		Seclusion paperwork consistently found to be compliant with MHA Code of practice on audit or peer review/site visit spot checks	
											30.2 Review Trust seclusion documentation to ensure it is as simple as it can be for staff to complete.	Revised seclusion documentation (submission of documents)		30/06/2016	June	Green			
											30.3 Carry out a scoping exercise to look at the possibility of moving seclusion paperwork to RiO	Feasibility paper (submission of documents)		31/12/2016	December	Green			
31	SHOULD		Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that staff in Bluebird House continue to monitor the use of prone restraint and there is senior oversight of this.	n/a	n/a	All episodes of restraint recorded as per Trust policy	Dr Lesley Stevens, Medical Director	See action 28 above.								
32	SHOULD		Child and adolescent mental health wards.	Bluebird House	Environmental & equipment	The trust should ensure that a medical emergency bag is available on all wards at Bluebird House. We noted the wards were spread out and it would take staff in the region of five minutes to go to Hill ward where the bag was kept, potentially putting young people at risk.	n/a	n/a	Medical emergency bags are available for use on each ward	Nicky Bennett, Clinical Service Manager	32.1 New emergency bags to be ordered and placed on each ward.	Emergency bags in situ on each ward (site visit)	Karen Dixon, Modern Matron	10/06/2016	June	Green	May16 New bags have been ordered and are due for delivery beginning June	n/a - evidence of individual actions will provide the necessary assurance	
33	SHOULD	EFFECTIVE	Acute wards for adults of working age and psychiatric intensive care units	All wards	Risk assessments & care planning (including capacity & consent)	The trust should ensure that it clearly documents the decision-making behind judgements of a patient's capacity to make a decision.	n/a	n/a	The inpatient's mental capacity to consent will have been recorded and staff will be able to see and monitor any changes.	Kate Brooker, Associate Director- MH	33.1 The Ward round proforma which is copied to each patient's RiO record will be amended and standardised for all inpatient units to include the following: - Does the person have the capacity to consent to treatment? Y/N, Why? - Are there any other decisions that require capacity testing? Y/N/ Who will test/ When? This is to be discussed and documented in all MDT meetings and the additional prompts around the capacity to consent will be contained within the MDT pro forma.	Compliance to be monitored as part of recordkeeping audits (submission of documents)	AMH Area Managers: Liz Durrant Karen Guy Graham Webb	30/06/2016	June	Green	May16 The pilot to be implemented within the AMH Wards by end of May, with embedding and evaluation period during June 2016.	Consistent evidence at site visits and peer reviews and through documentation audit of capacity to consent to treatment being recorded appropriately.	
34	SHOULD	CARING	Acute wards for adults of working age and psychiatric intensive care units	All wards	Involving patients	The trust should ensure it clearly documents when patients have been involved in the development of their care plan.	n/a	n/a	The care plans will be completed in a person centred way with person's view recorded	Kate Brooker, Associate Director- MH	34.1 Supervision template to be amended to include requirement for care plans to be reviewed. This will allow documentation around patient involvement to be picked up and discussed on an individual basis with staff.	Documentation audits Patient experience surveys (submission of documents)	Area Heads of Nursing: Carol Adcock Nicky Duffin Liz James	31/07/2016	July	Green		Documentation audits and spot checks at peer review and site visits consistently show evidence of patient involvement in developing care plans.	
35	SHOULD	SAFE	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Supporting staff	The trust should make every effort to ensure there are enough qualified nursing staff recruited to fully staff both services.	n/a	n/a	Full nursing establishment in place in order to provide safe services	Simon Tarrant	35.1 Ensure staff establishment is met with Trust recruitment processes being followed.	Budget and staffing in post reflect WTE. Recruitment drive in place to deliver any shortfall. (submission of documents)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	31/05/2016	May	blue	May16 Evenlode - All posts filled, no current need for recruitment. RWC - as all staff are at risk pending divestment of service from SHFT, recruitment will not go ahead. Safe services will be maintained through a balance of number of admissions, use of NHS P staff (incl agency) together with consideration of remaining numbers of substantive staff. This will be reviewed on a weekly basis.	Ongoing monitoring of staffing levels and review of patient safety incidents to ensure there are no themes or trends that emerge relating to staffing levels.	
36	SHOULD	CARING	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Involving patients	The trust should ensure it engages and consults effectively with patients whenever significant changes are to be made that will affect them or will impact on the service they receive.	n/a	n/a	Patients are informed and consulted when any changes within the service are planned	Donna Schell, Strategic Change Lead	36.1 Establish programme of patient meetings that include planned changes within service.	Patient Community Meeting Agenda (submission of documents)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	30/06/2016	June	Green		Patient satisfaction with level of information being provided about service change as evidenced at patient meetings and through monitoring of complaints and other feedback.	
											36.2 Extra-ordinary Meetings to be held if changes need to be made rapidly.	Minutes of Meetings with Patients (submission of documents)		30/06/2016	June	Green			
											36.3 Meetings minuted and copies of minutes available for patients to access.	Minutes of Meetings with Patients (submission of documents)		30/06/2016	June	Green			
37	SHOULD	CARING	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Involving patients	The trust should consult with patients and review the activities provided for them at both services, to make sure that the activities provided meet people's needs and are in line with their wishes.	n/a	n/a	Patients have range of activities that meets their needs and wishes.	Simon Tarrant, Forensic Service Manager	37.1 OT to consult with Patient group to discuss and understand their needs and preferences	Revised activity programme and evidence of patient engagement (submission of documents)	Catherine Loadman / Michelle Dale	30/06/2016	June	Green		Patient satisfaction with activities on offer as evidenced through site visits/peer review and from monitoring of complaints and other feedback.	
											37.2 OT to develop activity programme that meets people's needs and wishes and is linked to their goal setting to promote discharge			30/06/2016	June	Green			
38	SHOULD	WELL-LED	Wards for people with learning disabilities and autism	Evenlode	Supporting staff	The trust should consult openly with the staff at Evenlode about the long-term future of the service. The trust should take steps to improve staff morale, to ensure all staff at the service feel fully supported and are able to share in the trust's vision and values.	n/a	n/a	Staff kept informed of the future of Evenlode.	Donna Schell, Strategic Change Lead	38.1 Ensure regular communications to the team either by letter, email or face to face to keep them up to date with future plans regarding the Evenlode service.	Evidence of regular communication / meetings with the Team	Simon Tarrant, Forensic Services Manager	30/06/2016	June	Green	May16 Updates provided to team at Away Days (April)	Staff satisfaction with level of information being provided to them as evidenced through site visits/peer review and from monitoring of complaints and other feedback from staff.	