Version Control

Southern Health NHS
NHS Foundation Trust

Version No	3.5
Date	31/05/2017
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Change record

Date	Author	Version	Page	Reason for Change
19.4.17	L Connor	V3.0	All	Set up change record and version number system
27.04.17	B Cooper	V3.1	IP	Updated actions 7.4 and 28.4 from QIPDG meeting on 25.4.17. Added date for completion.
11/05/2017	L. Connor	V3.2	IP	updated 7.4 clinical risk management training from overdue to completed-unvalidated.
24.5.17	B Cooper	v3.3	IP	additions to unvalidated actions.
31.5.17	B Cooper/ LC	v3.5	IP	added info to 28.6 - still on track. 4.10 - added info re validation and need for recovery plan.. Validation of 2.11 and 3.4.

CQC January 2016 Improvement Action Plan

Completion 97%

Action Plan Position Status

RAG status	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Red Overdue	11	6	7	6	6	3	5	1	1	0
Amber At Risk of Slippage	1	0	0	0	0	0	0	0	0	0
Green On track	24	21	15	11	10	12	7	1	1	2
Blue Complete	68	74	78	83	82	82	82	104	104	106
Blue Unvalidated	5	8	9	9	11	12	15	3	3	1
TOTAL	109	109	109	109	109	109	109	109	109	109

Assurance and Validation Process

RAG Status	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Unvalidated - pending Executive validation	2	2	2	1	0	1	3	12	0
Executive validated	1	3	0	0	0	0	0	22	0

UIN	Trust Action	Responsible Lead	Completion Date	Action Status	Recovery Date	Progress Update	Evidence	Evidence Validation	Executive Validation
WN004 4.10	4.10 The Trust will upskill frontline staff in quality improvement methodologies using the existing Team Viral programme to support this	John Monahan Organisational Development	31/03/2017	**on track**	recovery date tbc	Plan in place to develop training day for Quality Ambassadors who will be appointed to teams as part of the implementation of the Quality Improvement Strategy in Q3 2016/17. March 2017: This is an ongoing action as it is part of the Team Viral programme which will continue into 2017/18. John Monahan and his team have delivered Team Viral to 98 teams across the Trust during 2016/17 and there is an activity during the day where different quality improvement techniques are introduced to the team. The teams will then apply a selection to their action plans to give them a methodology to take their actions forward. This has delivered to the teams that have participated in the programme to date and will continue to deliver going forward. Since this action has been complete, they have evaluated that there is further in depth quality improvement training which will be undertaken by Helen Ludford and a pilot for training has been set for Q1 2017/18. The viral course (improving clinical practice through learning) has a live date due in the first quarter of 2017/18/ Training for the Quality Ambassadors will also be delivered in April 2017. NHS England are running patient safety training - which is a new QI methodology. LEaD also have online modules and further work will need to be done to roll this across the Trust for QI. Action is complete however further work is underway to embed the quality improvement to the core of the organisation. Followed up with John Monahan re update of progress/achievements to Committee or Board - needed for Executive validation. May 2017: SC has reviewed programme in place and is checking figures for number of staff who have completed the programme. 25.5.17 Fiona Byrne Interim People Development Lead updated that 1st 'Improving Clinical Practice through Learning ' training due 15.6.17. Earlier date 3.4.17 postponed due to numbers signed up. 26.5.17 SC not validate as completed. Met with Fiona Byrne to quantify number of teams and content of internal quality improvement training. 10 teams have completed year long NHSE Patient Safety Forum service improvement training/project; some teams have accessed Wessex Collaborative training; Viral Quality completed by a number of teams. The Clinical Services Strategy will bring in service transformation teams. The trust will have organisational SI with dedicated SI and quality leads and a Director for Transformation.. Quality ambassadors will also have 1/2 day	IN FOLDER: 4.10 Viral Essentials PowerPoint presentation - Improving Learning Through Clinical Practice 4.10 Module 16 session plan 4.10 Module 16 prospectus 4.10 Email from John Monahan re outline of work undertaken in 2016/17 4.10 Email from Fiona Byrne 25.5.17 re Improving Learning Through Clinical Practice training	YES - MA	SC to action
RN007 7.4	7.4 Devise a clinical risk management training package and establish a programme to roll this out in 2017 that reflects the recommendations of the task and finish group	Louise Hartland, Governance, Quality and Compliance Manager LEaD	31/12/2016	**unvalidated**	30/05/2017	A task and finish group was set up to develop the e-learning RiO Risk/Crisis/Safety Plan training module. Communication was sent out to AMH RiO users in January prior to the release of the new RiO modules. As summary recovery plan was submitted to the PMO as an extension was requested on the completion date. This is because the e-learning could not be developed until the team had information on what forms will be in use on RiO. The new completion date is planned for 31 March 2017. March 2017: The content for the e-learning training package is currently being piloted in AMH through face to face team sessions. The last session was scheduled for the 27th March 2017. Project team is meeting on the 29th March 2017 to finalise the content based on the pilot feedback. The anticipated 'build' time for the e-learning is a minimum of 4-6 weeks. New completion date is planned for 15th May 2017. All AMH RIO users were provided with a guidance document when the new RIO Risk Summary was implemented. The e-learning package is supplementary to this guidance. The guidance document is attached. David Kingdon has done a number of sessions for the Trusts consultants and CMHTs. 25April2017 e-learning package in development and being tested end April. **11/5/17.** The Open RIO Risk Summary Assessment Form e-learning training for AMH Staff was launched today. All AMH RIO users have been emailed to advise them that the training is available and to complete the training at their earliest opportunity. Louise Hartland.	IN FOLDER: 7.4 Recovery plan 7.4 Chaser email 7.4 Update from Louise Hartland (29/3/17 and 11/5/17) 7.4 Important New RIO RISK Summary Assessment Form (AMH Only) E-learning Training launched (Email from Simon Johnson 12may17)	YES - BC	DK to action

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Cause of Regulation Breach	Trust Action	Evidence of Action Completed	Outcome Measure	Evidence of Intended Outcome Achieved
WN001 1.1	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	Key risks and actions to mitigate risks were not driving the senior management team or the board agenda	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)	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	Tracking examples of risks being identified and escalated Review of Board and sub-committee agendas at year end against top organisational risks
WN001 1.2									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)	Clear Ward to Board visibility of reporting and accountability	
WN001 1.3									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)	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.	
WN001 1.4									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.	Deputy Director of Nursing and Quality, Mental Health and Learning Disabilities Division post is appointed to	Strengthening of Professional leadership and Quality Governance focus within the Mental Health and Learning Disability Division	
WN001 1.5									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 (submisison of documents)	Clear Ward to Board visibility of quality performance	
WN001 1.6									1.6 Risk Management Policy to be reviewed (including Risk Appetite Statement)	Revised Policy will be published (submission of documents)	Improved risk management across the organisation	
WN002 2.1	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	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	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)	Capital planning process appropriately prioritising bids on the basis of clinical risk	Site visits consistently show evidence of staff aware of ligature risks associated with their units and of measures in place to mitigate risk.
WN002 2.2									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)	Exception reporting to Trust Executive Group on a monthly basis to allow for early escalation of delays in environmental improvement programme	
WN002 2.3									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	Strategic Capital plans will be in place improving the prioritisation, risk assessment and risk management of environmental risks at the frontline	

WN002 2.4									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)	Improved interface between estates and clinical services
WN002 2.5									2.5 Estates team to produce and install standardised displays of capital plans for each site	Clear plans will be displayed (site visits)	Clear, visible plans will be in place on each unit
WN002 2.6									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 group 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 assessment 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 Assessments across the Trust - Ensure that appropriate management information is	Minutes of Ligature Management Group Reports to Quality Improvement and Development Forum (QID) (submission of documents)	More robust risk identification and risk mitigation will be in place
WN002 2.7									2.7 The Trust ligature risk assessment tool will be redesigned away from using 'the Manchester Tool', to using industry agreed risk assessment methodology (5x5)	New risk assessment tool (submission of documents)	improved understanding of risk assessment and more consistent risk scoring at the frontline and more robust risk mitigation plans will be in place
WN002 2.8									2.8 An annual ligature risk assessment programme will be rolled out to include the newly appointed Project lead, estates lead and clinical lead for the area undertaking a joint risk assessment 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 assessment completed on the new paperwork that is accurate and of a high quality (submission of documents)	Triangulation of risk assessment will ensure all risks, mitigations and controls are in place
WN002 2.9									2.9 The Ligature Management Policy will be updated to ensure the new risk assessment process is clearly documented	New Ligature management policy (submission of documents)	Clear policy change and consistent implementation
WN002 2.10									2.10 Appoint a dedicated full time Trust clinical ligature project manager	New manager in post	Named lead will coordinate all elements of Ligature Risk assessment and mitigation

WN002 2.11									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	All security risks will be clear to frontline teams and all will have management and mitigation plans in place	
WN002 2.12									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 assessments and admission criteria will be reviewed.	Guttering will be in place. Number of service users successfully accessing the roof will reduce (site visits)	Guttering will minimise the risk of patients accessing the roof	
	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	See actions in 2 above			Clearly auditable evidence of identification and mitigation of risk and of appropriate escalation
MD003 3.1									3.1 The Trust approach to thematic review will be more systematic and robust. This will allow for more meaningful opportunities for staff to idenitfy 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)	Identification of themes and trends will be more robust	
MD003 3.2									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)	QID will receive assurance of team-level mitigation of risks associated with the environment.	
MD003 3.3									3.3 Existing team dashboards will be further enhanced to align them to the Trust'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)	Teams will have greater ability to review their own performance and understand how this is linked to their objectives including those around patient safety.	
MD003 3.4									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)	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	
MD003 3.5									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)	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	
	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.	The trust did not have effective governance arrangements to deliver robust incident investigation	The Trust will deliver the Mortality and SIRI action plan in full and to time. **Monitored through separate SIRI and Mortality Action Plan**	Robust governance of the mortality and serious incident process following assurance to external auditors	New death reporting processes will be embedded across the organisation	Internal audit of investigation process to be added to audit schedule for Q4
WN004 4.1									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 Analyisis investigation	Updated policies and procedures Ulysses data (submission of documents)	Inpatient deaths in AMH/LD will be investigated in a consistent fashion	
WN004 4.2									4.2 All Root Cause Analysis Investigations that are not SIRIs (excluding pressure ulcers) will go through the same processes as SIRIs, (this may include a thematic review where appropriate), including corporate panel sign off	Updated policies and procedures Ulysses data (submission of documents)	Ensure high quality of investigation and all opportunities for Organisational Learning are identified and actioned regardless of whether a SIRI or not	
WN004 4.3									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)	Mitigate risks inherent in IMA stage of process	

WN004 4.4									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)	Improved experience for family members/carers involved in investigations into deaths
WN004 4.5									4.5 The Trust will appoint a Trust Patient Experience Lead	Postholder will be in place with clear job description and clear objectives	A dedicated lead for Patient Experience will ensure maximum focus, coordination and improvement will be delivered across all services
WN004 4.6									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)	Improve the culture of organisational learning from serious incidents
WN004 4.7									4.7 The Organisational learning strategy will be reviewed and updated	New strategy (submission of documents)	
WN004 4.8									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 completion of action plans.	Panel minutes (submission of documents)	
WN004 4.9									4.9 All SIRI investigation reports to include as standard a Terms of Reference 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)	
WN004 4.10									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)	
MD005 5.1	**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	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 desciptors and job plans will be in place (submission of documents)	Improved medical leadership throughout the Organisation with standardised Role Descriptors and clear accountabilities and objectives
MD005 5.2									5.2 A structured leadership visibility programme will be introduced to include 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)	Improved senior leadership visibility at the frontline (including Executives and NEDs) and increased focus on Patient Safety
MD005 5.3									5.3 Undertake a review of the Trust's staff engagement strategy	Review report (submission of documents)	A more engaged workforce who feel supported to raise concerns and are confident they will be dealt with appropriately
MD005 5.4									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 exisiting/new mechanisms to be communicated to staff	Review report and communications (submission of documents)	Staff clear as to the escalation processes that are in place to raise concerns about patient safety
	6	**Trust wide Must Do**	**SAFE**	Provider / Trust	Trust wide	Supporting staff	The trust must make	n/a	See action in 5 above		

MD006 6.1							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.		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)	Improve staff engagement in the annual Training Needs Analysis process	
MD006 6.2									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)	Appraisal and revalidation process will be used to assess any skills and competency gaps and staff will be supported to address these.	
MD006 6.3									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	Standardised approach to supervision to support staff and provide a structured 'space' for concerns around competencies to be raised	
RN007 7.1	**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.	There was not consistent use of risk assessment processes. Crisis plans were not used consistently.	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)	100% of risk assessments will be completed. Decreased numbers of patient safety incidents where failures in risk management were a contributory or causative factor.	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.
RN007 7.2									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)		
RN007 7.3									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)		
RN007 7.4									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	New training materials and schedule for roll out (Submission of documents)		
RN008 8.1	**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.	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.	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)	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.	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
RN008 8.2									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)		
RN008 8.3									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)		
RN008 8.4									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)		

RN008 8.5									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)		
RN009 9.1	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.	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.	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)	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.	Periodic audit of seclusion medical review until practice is embedded
RN009 9.2									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)		
RN009 9.3									9.3 Use results of audit to feed into Trust-wide review of junior medical on-call rota	Trust-wide review report (Submission of documents)		
	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.	There has been insufficient action taken to identify and prioritise action required to address environmental ligatures on the wards.	See Action 2 (warning notice tab) for Trust-wide actions which will include AMH services		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.	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
RN010 10.1									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)		
	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	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.	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		No incidents linked to AWOLS/falls from Melbury Lodge. Reduction in the number of incidents linked to observations on the unit	
RN011 11.1									11.1 Domed mirrors to be installed on Kingsley Ward, Melbury Lodge to improve the sight lines	Domed mirrors in situ (site visit)		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

RN012 12.1	**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.	The trust had not ensured that patients' privacy and dignity is protected in a safe way on Kingsley ward.	12.1 Vistamatic windows to be installed on all 25 bedroom doors, Resource Room and Family Room	New doors installed (site visit)	Improved privacy and dignity for patients on Kingsley Ward whilst still allowing safe observations	Review of patient feedback from Melbury ward to ensure continued patient satisfaction around privacy and dignity
RN013 13.1	**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.	The seclusion room on Hamtun psychiatric intensive care unit is not fit for purpose.	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)	Fit for purpose seclusion room on Hampton ward that complies with MHA Code of Practice Standards	n/a - evidence of individual actions will provide the necessary assurance
RN013 13.2									13.2 PFI partners to provide costings for new design and issue tender	Costings and tender paperwork (submission of documents)		
RN013 13.3									13.3 External contractor to carry out building works of new seclusion room	Building works completed on new seclusion room (site visit)		
RN013 13.4									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		
RN014 14.1	**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.	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.	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)	Appropriate management of medication fridges	Site visits and peer reviews consistently find evidence of fridge temperatures being managed appropriately Failed validation beacuse random sampling demonstrated lack of consistent application. Identified areas issued with improvement plan and to be folowed-up.
RN014 14.2									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)		
RN014 14.3									*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)* **THIS ACTION HAS BEEN SUPERSEDED.** It was not felt to be sufficiently robust as described originally. Carrying out a survey of rooms using room temperature data collected over the last 6 months is unlikely to give an accurate picture of maximum room temperatures. Instead, the new Interim Chief Pharmacist has suggested the development of a risk assessment tool that will highlight any temperature issues on an ongoing basis rather than as a one off exercise. The new action is as follows: **Develop a risk assessment tool for assessing the impact of temperature excursions over the established limit and circulate guidance for its use**	Completed survey results and plans for remedial works (submission of documents)		
	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.	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	See action 2 (warning notice tab) regarding Trust-wide improvements in ligature/estates management which will apply to Evenlode		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.	
RN015 15.1									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.		Peer reviews and site visits Regular review of incidents linked to the environment at Evenlode to identify any emerging or unresolved issues.

RN015 15.2								to mitigate effectively the risks to people using the service.	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)			Evidence of action taken in response to patient safety incidents related to the environment
RN015 15.3									15.3 Schedule of bedroom works to be completed by external contractors	Bedroom works completed (site visits)			
RN015 15.4									15.4 Once structural bedroom works are completed, install new ligature-free beds and wardrobes.	New furniture in place (site visits)			
	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.	Known environmental risks at the Ridgeway Centre had not been addressed.	See action 2 (warning notice tab) in relation to Trust-wide improvements in ligature/estates management which will apply to The Ridgeway Centre			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.	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
RN016 16.1									16.1 Address outstanding ligature points in garden as highlighted by CQC	remedial works carried out (site visit)			
RN017 17.1	**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	The clinic room at Evenlode must be made fit for purpose and contain all appropriate essential equipment for resuscitation.	17.1 Identify gaps in essential resuscitation equipment and purchase any necessary additional equipment	equipment in place (site visit)		Safe fit for purpose clinic room facility	Site visits and peer reviews consistently find clinic room fit for purpose. Failed validation because site visits evidenced inconsistent approach. Improvement plans in place. Further site visits to be carried out.
RN017 17.2									17.2 Remove staff lockers currently within clinic room	no unnecessary items in clinic room (site visit)			
RN017 17.3									17.3 Purchase clinic room treatment chair	equipment in place (site visit)			
RN018 18.1	**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.	The training, learning and development needs of staff had not been identified and actions taken to meet any gaps.	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)		Staff feel properly trained to carry out their roles and supported in accessing this.	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
RN018 18.2									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.				
MD019 19.1	**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	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)		100% compliance with 'Protocol for the Safe Bathing and showering of People with Epilepsy' for inpatients with epilepsy.	Bathing care plan audits Staff awareness demonstrated at peer review/site visits
MD019 19.2									19.2 Posters to be created and placed in each room with a bath	Posters visible in each bathroom (site visits)			
	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.	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	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.			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.	
RN020 20.1									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)			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.	Staff did not receive appropriate on-going supervision in their role.	See action 5 (warning notice tab) for Trust-wide actions in relation to the supervision process.			100% of available staff have received supervision in the last 6 weeks.	
RN021 21.1									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)			Site visits and peer reviews consistently find that supervision records on staff files show 4-6 weekly supervision sessions

RN022 22.1	**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.	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.	22.1 Install curtains in patient bedroom (RWC)	Environmental modifications in place (Site visits)	Privacy and dignity will be maintained.	Site visits, peer reviews and patient feedback consistently report privacy and dignity being managed appropriately at the two sites
RN022 22.2									22.2 Seek options (from various specialist resources / national standards) for door observation panels that do not compromise privacy and dignity (Evenlode)			
SD023 23.1	**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	n/a	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)	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.	Improved feedback from all staff involved in complaints process/response sign off and feedback from complainants
SD023 23.2									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)		
SD024 24.1	**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	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)	More informative Board sub-committee reports to present themes and assure Board that learning from complaints is being implemented	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 plan. Supervision should include a review of caseloads and monitoring of care records.	n/a	See action 6 (warning notice tab) re Trust-wide plans relating to the supervision process		100% of available staff have received supervision in the last 6 weeks.	
SD025 25.1									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)		Site visits and peer reviews consistently find that staff feel supported and have clinical supervision in place
SD025 25.2									25.2 AMH specific clinical supervision template to be designed	Standardised template in use across all AMH teams (site visits)		
SD025 25.3									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)		
SD026 26.1	**26**	**SHOULD**	**EFFECTIVE**	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	26.1 Consultant psychiatrists and ward managers to ensure that all patients have advanced statements	Audits of patient records (submission of documents)	Increased young persons' engagement in their care planning	Consistent evidence at site visits, peer review and through patient feedback of involvement in care planning.
SD026 26.2									26.2 Template of CPA meeting to be changed to ensure wishes of young people are formally captured	New template (submission of documents)		
SD026 26.3									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)		
SD027 27.1	**27**	**SHOULD**	**SAFE**	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	n/a	27.1 Remind all clinical staff of the risks associated with using Rapid Tranquilisation intramuscular medication and the benefits of the Track and Trigger	Communications to staff (submission of documents)	Improved aftercare for patients receiving intramuscular rapid tranquilisation medication.	Consistent evidence at site visits, peer review and through audit of track and trigger tool being used post administration of rapid tranquilisation IM.
SD027 27.2									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)		

SD027 27.3							observations monitored on the format within their care files.		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)		
SD028 28.1	**28**	**SHOULD**	**SAFE**	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	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,	Position statement (submission of documents)	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.	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
SD028 28.2									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)		
SD028 28.3									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)		
SD028 28.4									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)		
SD028 28.5									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)		
SD029 29.1	**29**	**SHOULD**	**EFFECTIVE**	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	n/a	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)	All clinicians who undertake therapeutic activities with patients will record the patients' consent in their electronic patient record.	Consistent evidence at site visits and peer reviews and through documentation audit of capacity to consent to treatment being recorded appropriately.
SD030 30.1	**30**	**SHOULD**	**SAFE**	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	30.1 Design seclusion flow chart	New flow-chart (submission of documents)	All episodes of seclusion will be carried out in accordance with the Mental Health Act 1983 Code of Practice and Trust policy	Seclusion paperwork consistently found to be compliant with MHA Code of practice on audit or peer review/site visit spot checks
SD030 30.2									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)		
SD030 30.3									30.3 Carry out a scoping exercise to look at the possibility of moving seclusion paperwork to RiO	Feasibility paper (submission of documents)		
	31	**SHOULD**	**SAFE**	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	See action 28 above.		All episodes of restraint recorded as per Trust policy	
SD032 32.1	**32**	**SHOULD**	**SAFE**	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	32.1 New emergency bags to be ordered and placed on each ward.	Emergency bags in situ on each ward (site visit)	Medical emergency bags are available for use on each ward	n/a - evidence of individual actions will provide the necessary assurance

SD033 33.1	**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	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)	The inpatient's mental capacity to consent will have been recorded and staff will be able to see and monitor any changes.	Consistent evidence at site visits and peer reviews and through documentation audit of capacity to consent to treatment being recorded appropriately. Failed validation because site visits evidenced inconsistent approach. Improvement plans in place. Further site visits to be carried out.
SD034 34.1	**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	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)	The care plans will be completed in a person centred way with person's view recorded	Documentation audits and spot checks at peer review and site visits consistently show evidence of patient involvement in developing care plans.
SD035 35.1	**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	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)	Full nursing establishment in place in order to provide safe services	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.
SD036 36.1	**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	n/a	36.1 Establish programme of patient meetings that include planned changes within service.	Patient Community Meeting Agenda (submission of documents)	Patients are informed and consulted when any changes within the service are planned	Patient satisfaction with level of information being provided about service change as evidenced at patient meetings and through monitoring of complaints and other feedback.
SD036 36.2									36.2 Extra-ordinary Meetings to be held if changes need to be made rapidly.	Minutes of Meetings with Patients (submission of documents)		
SD036 36.3									36.3 Meetings minuted and copies of minutes available for patients to access.	Minutes of Meetings with Patients (submission of documents)		
SD037 37.1	**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	n/a	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)	Patients have range of activities that meets their needs and wishes.	Patient satisfaction with activities on offer as evidenced through site visits/peer review and from monitoring of complaints and other feedback.
SD037 37.2									37.2 OT to develop activity programme that meets people's needs and wishes and is linked to their goal setting to promote discharge			
SD038 38.1	**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	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	Staff kept informed of the future of Evenlode.	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.