SOUTHERN HEALTH NHS FOUNDATION TRUST

Report

Committee:	**Portsmouth Health Overview and Scrutiny Panel**
Date:	**3 November 2015**
Title:	**Care Quality Commission Comprehensive Inspection Action Plan Progress Update**
Presented by:	**Dr Chris Gordon, Chief Operating Officer and Director of Performance, Quality and Safety**

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1. Executive Summary

1.1 This report seeks to update the Portsmouth Health Overview and Scrutiny Panel regarding progress against the Care Quality Commission (CQC) action plan which was implemented following the comprehensive inspection of Southern Health NHS Foundation Trust in October 2014.

1.2 Following the publication of the CQC comprehensive inspection reports in February 2015, Southern Health submitted an action plan containing 129 actions which it agreed to undertake to address the areas for improvement identified.

1.3 As of 31 July 2015, 106 of these actions have been completed and the Trust is on track to complete the other 23 actions within their target dates.

2. Recommendations

2.1 That the Portsmouth Health Overview and Scrutiny Panel notes and discusses the report

3. Care Quality Commission (CQC) Comprehensive Inspection Action Plan Progress Update

3.1 Background

CQC defines areas for improvement within their comprehensive inspection reports as either ‘must do’ or ‘should do’. A total of 129 areas for improvement were highlighted within the 18 reports received by Southern Health NHS Foundation Trust in February 2015 and the Trust has treated these all as ‘must do’ actions. Existing action plans were reviewed further to the inspection reports being received and a comprehensive plan of actions was put into place to deliver required improvements.

The Trust is driving delivery of these improvements through its Quality Programme which is led by Chris Gordon, Director of Performance, Quality & Safety and Chief Operating Officer, with support from Tracey McKenzie as the Quality Programme Manager.

All action plans were agreed with Commissioners and approved by the Strategic Oversight Group and Trust Board - Quality & Safety Committee prior to submission to the CQC on 25 March 2015. Actions were split into ‘Internal’ – those which the Trust is able to deliver and ‘External’ – those which require support from Commissioners to deliver.

The Head of Compliance is responsible for highlighting to the action leads when CQC actions are due to be completed and gaining assurance of completion. They are responsible for holding the CQC action owners to account and securitising evidence supplied to ensure compliance.

Each of the 129 actions are also allocated to one of the eight quality workstreams within the Quality Programme. The actions within the CQC action plan are specific to the service where CQC identified an issue. The remit of the workstreams is to review the issue across all services and put in place quality improvement processes in order to ensure that the issue would not occur elsewhere.

The Quality Programme Steering Group meets monthly and reports progress against the CQC action plan and other quality improvement objectives up to the Quality and Safety Committee via the Quality Improvement and Development Forum.

3.2 Current position

Good progress has been made against the CQC action plan. Status as of end July 2015 – of the 129 actions identified by CQC:

- 106 completed
- 23 on track to be completed by the target date
- None at risk of slippage

- None overdue

Appendix 1 gives a summary of the progress against each action.

Assurance has been gained against each action and plans are in place to validate actions via peer review visits to sites. During July & August 2015 eight units were visited to review progress against the ligature related actions as part of a thematic peer review.

CQC visited three sites during August to carry out a re-inspection – Ravenswood near Fareham a medium-secure unit for adults with serious mental illness, The Ridgeway Centre in High Wycombe and Southfield, a low-secure specialist mental health inpatient service in Calmore. At the time of writing the Trust was still awaiting the draft reports. Once received, the reports will be reviewed and any learning will be shared across the trust to ensure all other services are delivering the standards expected by CQC at their re-visits.

In order to ensure on-going compliance, divisions need to ensure they have processes in place to monitor the effectiveness of the actions they have taken. This should be built into their routine quality assurance processes and validated via their peer review programme.

Action Plan for: CQC inspection Oct 14 - Internal Actions

Southern Health NHS Foundation Trust

Version No: FINAL V1.0

Progress last updated: 27/08/2015 - TM

Date: *25/03/15*

Approved by: *Trust Board - Quality & Safety Committee - 23/03/15*
Commissioners - Strategic Oversight Group - 24/03/15

Produced by: *Tracey McKenzie - Head of Compliance / CQC Programme Manager*

Ref No	Core Service	Sites within core service that action is relevant to	CQC actions required	Action/s to be taken	Who is responsible for completing the action Name & Job Title	Who is accountable for ensuring the action is completed? Name & Job Title	Date action must be completed dd/mm/yyyy	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Progress - to include position statement, risks, obstacles, action taken etc.	Quality Programme workstream
1	Acute Wards/ PICU	Elmleigh	Ensure appropriate and safe staffing levels are consistently maintained	A staffing uplift has been completed to ensure safe levels of staffing on the unit in line with recent configuration of services. Ongoing: 1.1 Continuing daily meetings to discuss staffing 1.2 Rota to be managed by Ward managers to address clinical skill mix 1.3 Ongoing advertisement of posts and actively pursuing recruitment of staff 1.4 Matron to ensure input into weekly safer staffing teleconference across the Trust to report staffing levels 1.5 AMHT Manager to report to monthly performance slot and Quality and Safety Meeting any issues regarding staffing levels	Ward managers- Ben Iihou, Holly Whiteley	Naomi Edge Acute Care Pathway Manager	31/12/2014 Monthly performance slots ongoing	Blue	**Progress to date:** COMPLETED	WORKFORCE
2	Acute Wards/ PICU	Elmleigh	Ensure emergency equipment including resus equipment and defibrillator is located on or close to the wards	2.1 The equipment has been moved to a central point within Elmleigh Unit 2.2 The Resus lead will ensure all policies on equipment are followed and up to date in line with recent Trust wide audit of equipment needs	Emma Mallard Resus Lead	Susan Hampton Modern Matron	30/01/2015	Blue	**Progress to date:** January 2015 Emma Mallard recently completed training and taking lead. COMPLETED 17/04/2015 Elmleigh Emma Mallard: moved emergency bag to the middle of the hospital and we have evidence that the checks are completed monthly as per policy.	PATIENT SAFETY, REPORTING & LEARNING
3	Acute Wards/ PICU	Elmleigh	Ensure high quality clinical supervision and performance appraisal be provided to staff at regular intervals and staff are supported	3.1 Action plan in place to ensure any outstanding appraisal is completed 3.2 Supervision structure in place with additional Band 6 posts to be filled 3.3 Band 6 staff rotated onto nights to spread supervision to all staff throughout 24hours 3.4 Monthly supervision spreadsheet provided by Ward Managers to Modern Matron for sign off.	Ben Lihou and Holly Whiteley -ward managers	Naomi Edge Acute Care Pathway Manager	30/04/2015	Blue	**Progress to date:** 2014/15 Appraisals completed, action tracker produced to monitor completion of 2015/16 Appraisals. Supervision strategy in place for monthly managerial supervision and weekly clinical supervision (encompassing group supervision, reflective practice and skills training). Band 6 nurse recruited to work permenant nights, and all other Band 6 staff working a rotation to cover the remaining night shifts. Spreadsheet to monitor supervision in use.	WORKFORCE
4	Acute Wards/ PICU	Elmleigh	Address shortfalls in BLS and ILS training (shown on Sept14 dashboards)	4.1 Organise training locally for ILS/BLS for staff at Elmleigh 4.2 LEaD and Elmleigh working on dates 4.3 Suitable premises identified 4.4 Area Lead Nurse to monitor all training compliance as Area Lead for Training. 4.5 Ward Managers to report compliance at Monthly Performance Slot	Holly Whiteley and Ben Lihou ward managers	Susan Hampton Modern Matron and Nikki Duffin, Area Lead Nurse	29/05/2015	Blue	**Progress to date** BLS: Male Ward – All staff are complete or booked on to attend, with the exemption of 1 member of staff who DNA'd- this is being investigated and rebooked Female Ward: All staff are complete or booked to attend. ILS: Male ward – all staff are complete Female Ward – all staff are complete or booked to attend	WORKFORCE
5	Acute Wards/ PICU	Elmleigh	Address shortfalls in PRISS training	5.1 Organise local training for PRISS inc. sourcing venue 5.2 Work with LEaD to organise suitable dates 5.3 Area Lead Nurse to monitor all training compliance as Area Lead for Training 5.4 Ward Managers to report compliance at Monthly Performance Slot	Ben Lihou and Holly Whiteley -ward managers	Susan Hampton Modern Matron, Nikki Duffin, Area Lead Nurse.	29/05/2015	Blue	**Progress to date** Male Ward – all staff are complete or booked on to attend with the exception of 2 members of staff who are currently medically exempt and 1 other who is on long term sick. Female Ward – all staff are complete or booked on to attend. The vast majority of those booked onto courses are those that have started in the last 3 months which is why some of the dates are after the deadline	WORKFORCE
6	Acute Wards/ PICU	Elmleigh	Ensure ligature risks identified for removal, are removed	6.1 Door stops were removed in November 2014	Ben Lihou and Holly Whiteley -ward managers	Susan Hampton Modern Matron	28/11/2015	Green	**Progress to date:** All door stops have been replaced and this action complete. Other anti-ligature risks at Elmleigh will form part of the Anti-ligature task and finsh programme of works.	ESTATES
7	Acute Wards/ PICU	Elmleigh	Ensure systems in place to assess and monitor quality of service are effective in bringing about improvement	7.1 Quality and safety report to be shared with staff 7.2 Improvement plans to be shared via business meeting to all staff 7.3 Data warehouse to be used to plan improvements and shared during supervision with ward managers and team leads. 7.4 Audit programme to be utilised to support overall quality and performance elements of the service	Ben Lihou and Holly Whiteley -ward managers with support from ACPM and Modern Matron	ACPM Naomi Edge and Susan Hampton Modern Matron	01/05/2015	Blue	**Progress to date 20.05.15** There is a planned fortnightly Quality and Safety meeting with ward managers and band 6 staff where audit action plans will be managed and reviewed. The Care Navigators at Elmleigh will also do ongoing audit against service standards which will also feed into the Quality and Safety meeting. Evidence supplied	GOVERNANCE

8	Acute Wards/ PICU	Antelope House	Ensure seclusion facility complies with MHA CoP and allows continuous observation of people by staff.	8.1 Undertake an option appraisal and agree a preferred option with capital funding to ensure seclusion room is fit for purpose. 8.2 This will include consideration to fix the bed in a static position, and add mirrors within the room to where required to reduce blind spots.	Fiona Hartfree, Acute Pathway Manager	Joe Jackson General Manager	31/03/2016	Green	**Progress to date:** This action is being led by acute pathway manager and general manager once they have agreed what needs to be done a case for change needs to be submitted to the Trust infrastructure group for funding. 8.2 responsiblty for delivering this action is being led by the on site clinical team who advised bellrock 2 weeks ago of the requirement , mirrors and fixed bed being implemented by bellrock the approved Lift co in house estate service and there is a 10 week lead time for the bed	ESTATES
9	Acute Wards/ PICU	Parklands	Ensure women do not have to walk past male bedrooms to use bathrooms and toilets	9.1 Review ward environment with Estates Project Manager to identify potential solution to existing single sex accommodation concerns. 9.2 Submit Case for Change documentation 9.3 Complete Works. 9.4 Ensure risk documentation is complete to address potential risks prior to works being completed.	Nick Seargent, ACP Manager, Estates Project Manager	Graham Webb General Manager	31/03/2016	Green	**Progress to date:** CP 1 has been submitted to Capital Group for consideration as priority. CQC Requirement was for two rooms to be changed from a bathroom to a shower room. Clinical service has expanded the brief to include 9 rooms which is outside of the CQC requiement and not within the current financial funding source. Decison to proceed resides with clinical manager and Trust infrastructure group.	ESTATES
10	Acute Wards /PICU	All inspected	Ensure there is sufficient & detailed recording of mental capacity and consent to treatment in people's care records.	Capacity and Consent are part of the MDT template. Discussion about decision-specific assessments will be recorded in patients notes on RiO. All using the service to receive as a minimum a weekly capacity and consent to treatment assessment (based on individual decision-specific matters), or when capacity changes or consent to treatment is withdrawn, these will either be incorporated into the Weekly Multidisciplinary Team meeting that is then recorded on RiO or added to RiO as required. This will include key actions: 10.1 the wards are to introduce a template as part of the supervision process to review capacity and consent, and this will be used with all staff. 10.2 the assessment of capacity and consent will be reviewed in relation to decision specific matters and recorded as a minimum each ward round/ weekly and recorded on Rio.	Acute Care Pathway Managers working with ward managers	Acute Care Pathway Managers/ Modern Matrons	30/04/2015	Blue	**Progress to date:** Updated 27/4/15 10.1 The supervision template for Antelope House has been updated to reflect the need to review capacity and consent, and is now currently in service. 10.2 Capacity and consent is captured in the weekly ward review, using the below template . This is now in use. New Form to be implemented from the 1/5/15 to be the same for all areas	CAREPLANNING / RECORDKEEPING
11	Acute Wards /PICU	All inspected	Ensure people using the service are involved in discussions and decisions about their care and this is consistently recorded in their care records.	11.1 To complete an action learning set to identify ideas and approaches that will strengthen involvement of service users in their care within inpatient units. 11.2 Hold a service user engagement event to help identify some solutions and ideas to supporting care planning processes in inpatient areas 11.3 Undertake quality improvement initiatives using PDSA to trial new ideas 11.4 Complete a piece of work to evaluate and progress the most effective solutions	Kate Sault- Trust Care Planning Lead working with the Acute Care Pathway Managers/ Service user groups	Tim Coupland Associate Director of Nursing	30/06/2015	Blue	**Progress to date:** Implementing Hope, Agency and Opportunity Care Plan Pilot implemented in May. Will be reviewed as part of PDSA cycle in July and then rolled out to other teams COMPLETED	CAREPLANNING / RECORDKEEPING
12	Acute Wards /PICU	All inspected	Make clear plans or invest and improve maintenance in the existing buildings.	12.1 Work with estates to complete environmental audits/PLACE and identify priority programmes to improve existing buildings and estates 12.2 Oversee via programme management an estates programme 12.3 Identify key risks and mitigation via the risk register, reviewed at monthly Quality & Safety Meeting.	Nina Davies (Service Improvement Lead) working with Modern Matrons and Estates	Sally Banister Associate Director of Business Development	30/09/2015	Green	**Progress to date:** This action is being led via the anti-ligature task and finish group.	ESTATES
13	Acute Wards /PICU	Elmleigh	Ensure staff are appropriately trained and actively support people to stop smoking	13.1 Smoking cessation programme to be developed for all inpatient areas including: -Smoking cessation training (May 2015) with Quit for Life trainer to start -to agree link worker approach in each inpatient area to support stop smoking initiative -to undertake environmental review in each area to resolve practical challenges in supporting service users regarding smoking cessation	Acute Care Pathway Managers working with ward managers/service users	Tim Coupland Associate Director of Nursing	01/01/2016	Green		WORKFORCE
14	Acute Wards /PICU	Elmleigh	Ensure there are sufficient opportunities for physical exercise for people on PICU	14.1 PICU decommissioned in November 2014	N/A	N/A	N/A	Blue	**Progress to date:** COMPLETED - PICU decommissioned in November 2014. Action will be considered in relation to other PICUs as part of activity of patient experience workstream	PATIENT EXPERIENCE & ENGAGEMENT
15	Acute Wards /PICU	Melbury	Ensure bedroom doors provide sufficient privacy for people whilst enabling staff to maintain adequate observations	15.1 Case for change has been completed and submitted to replace doors with ones that allow adequate observation.	ACP Manager, Estates Project Manager	Graham Webb General Manager	31/03/2016	Green	**Progress to date:** Case for change has been completed and submitted	ESTATES
16	Acute Wards /PICU	Melbury	Ensure recording of people's mental capacity is detailed & includes evidence underpinning the judgement	16.1 Clinical staff will be reminded/supervised and supported in the requirement to meet CoP requirements in relation to recording of informed consent of mental capacity. 16.2 All clinical reviews will include consideration and documentation of capacity & consent within RiO. (see ref 10)	ACP manager working with Ward Manager	Graham Webb General Manager	30/04/2015	Blue	**Progress to date:** Updated 27/4/15 Dr's include an assessment of capacity and consent on their weekly MDT review meeting template and these will then be recorded weekly.	CAREPLANNING / RECORDKEEPING

17	Acute Wards /PICU	Melbury	Ensure explanations of people's rights under S132 are consistently documented	17.1 All staff to be reminded of the CoP. It will be the responsibility of the admitting nurse that when the patient is read his/her rights that it is documented in the diary when this needs to be repeated. 17.2 Undertake reflective practice session for those staff where audits identify deficits in practice 17.3 Use clinical audit of notes to identify and spot manage any times where S132 is not explained	ACP manager working with Ward Manager	Graham Webb General Manager	30/04/2015	Blue	**Progress to date:** Updated 27/4/15 This was recorded as complete in February 2015, The MHA team now provide the ward staff with an updated daily list as to who needs to have their rights given. Charge nurse also carries out weekly checks. As of february 2015 the team have been tasked with completing incident forms for every breach	CAREPLANNING / RECORDKEEPING
18	Acute Wards /PICU	Melbury	Ensure on-going & planned work to improve environment, in terms of removal of ligature risks, is completed	18.1 The 2 bathrooms and shower rooms will be fitted with anti-ligature furniture, work is scheduled to commence 16/02/2015	Estates	Estates	31/12/2015	Green	**Progress to date:** Bathroom, showers and toilets are ligature friendly final changes to the bathroom environment still outstanding and will be complete by end of June due to the lead time for delivery of items such as radiator covers.	ESTATES
19	Acute Wards /PICU	Antelope House	Ensure individual risk assessments are completed for people prior to going on S17 leave	19.1 Ensure the policy and procedure including associated procedures relating to risk assessment adequately supports staff in clear methodical decision-making around S17 leave 19.2 Review using appreciative enquiry, approaches to risk assessing S17 leave and identify themes and perspectives that we can improve on through quality improvement approaches 19.3 Link quality improvement ideas to the development of new consistent tools and checklists to support safe S17 leave 19.4 Engage in AHSN Patient Safety Collaborative to share learning and pilot new ideas using improvement methodology	Acute Care Pathway Managers/ Matrons	Tim Coupland Associate Director of Nursing	30/06/2015	Blue	**Progress to date:** The section 17 leave policy has been revised to include a specific section (section 7) on risk assessment. This pulls the relevant parts of SH CP 27 and 28 policies on risk management into the section 17 policy itself and reminds staff that the risk assessment of section 17 leave needs to be done in conjunction with the principles/practice outlined in those documents.	CAREPLANNING / RECORDKEEPING
20	Acute Wards /PICU	Antelope House	Ensure episodes of restraint are not carried out in 'face down' position	20.1 The Trust to integrate DH guidance into training and policies/procedures 20.2 Trust to employ a Consultant Practitioner for Patient Safety to lead and oversee the programme on driving down episodes of prone restraint 20.3 Trust to use its annual programme of work via the SAFER forum to support services to find other methods of least restrictive practice	Consultant Practitioner for SAFER services (tbc)	Tim Coupland Associate Director of Nursing	31/12/2015	Green	**Progress to date:** Excluding Bluebird we are under the national average for prone restraint (0.23 restraints per 10 beds, national mean is 0.5 per 10beds). Current position for Bluebird House shows a marked reduction use of overall restraint and in particular prone restraint. **17/04/2015** We have a bi-monthly report to QID now in the diary highlighting key issues and the latest report presented covers all the key plans and proposals for (2015/16)	PATIENT SAFETY, REPORTING & LEARNING
21	Acute Wards /PICU	Antelope House	Ensure enhanced observations of people are recorded	21.1 The observation recording sheets will be amended to allow more accurate recording of observations on all MH wards across the Trust 21.2 The observation training will be refined and revised where appropriate to ensure more accurate recording of MH observations	Acute Care Pathway Managers/ Matrons	Tim Coupland Associate Director of Nursing	30/04/2015	Blue	**Progress to date:** Updated 24/4/15 - COMPLETED observation paperwork agreed policy and training matrix has been updated, email matrons to say has training been implemented	CAREPLANNING / RECORDKEEPING
22	Acute Wards /PICU	Antelope House	Ensure, on Hamtun, blanket restrictions in place in respect of two telephone calls a day, no baths after 10.00pm and availability of snacks/drinks are reviewed to make sure individual needs are met.	22.1 The ward is to remove all notices with regard to bathroom use. **(completed)** 22.2There will be no restriction of phone use. All patients will be able to use their mobile phones. Access to a telephone can also gained via the public pay phone on the ward, or staff mobile phones. **(completed)** 22.3 Care plan's will be implemented, where required, should the use of a mobile phone constitute a clinical risk 22.4 A capital bid has been made for a drinks machine to allow patients to make drinks at any time they wish In the interim, a dedicated members of has the responsibility of providing drinks to patients. (Currently awaiting outcome)	Brendan O'Reilly - Area Lead Nurse	Joe Jackson General Manager	30/04/2015	Blue	**Progress to date:** 22.1 & 22.2 have been completed updated 27/4/15 22.1, 22.2, 22.3 : Evidence provided to confirm that the actions have been completed on the ward. 22.4 The capital bid has been approved, and items have been delivered	CAREPLANNING / RECORDKEEPING
23	Acute Wards /PICU	Parklands	Ensure where CCTV cameras are used in communal areas and on wards that people using the service are informed of this	23.1 Place signage on the wards informing SU and visitors to make aware that CCTV is in use within the ward area 23.2 To include information regarding the use of CCTV is included in the Welcome Pack. **Note: A wider review is underway to ensure Trust wide guidance on use of CCTV reflects published CQC guidance**	ACP Manager, Ward Mangers and SU Involvement Manager.	ACP Manager	09/02/2015	Blue	**Progress to date:** COMPLETED - Temporary signage in place and permanent signage on order. Additional action to review of Trust wide guidance to be actioned via Quality Programme as CQC guidance as only just been published Updated 27/4/15 Permanent signs are on order and will replace the existing ones put in place post inspection visit. Details about the use of CCTV has also been added to patient information given to patients on admission.	PATIENT EXPERIENCE & ENGAGEMENT
24	REMOVED BY CQC FOLLOWING FACTUAL ACCURACY CHANGES									
25	Acute Wards /PICU	Parklands	Ensure environmental risk assessments are completed clearly, action taken to remove risks, and a record made of arrangements in place to manage or mitigate the risks.	25.1 Complete environmental assessment in line with Trust policy, Including action taken to mitigate risk. 25.2 Identify works programme to address risks identified in environmental risk assessment. **Note: See ref 12**	Nina Davies (Service Improvement Lead) working with Modern Matrons and Estates	Sally Banister Associate Director of Business Development	31/03/2016	Green	**Progress to date:** Awaiting completion of environmental assessment. CP1's have been submitted where environmental risk has already been identified.	ESTATES
26	Acute Wards /PICU	Parklands	Ensure at Parklands Hospital the dirty utility facilities are not in the laundry room because of the risk of cross contamination.	26.1 Consider option to create separate dirty/clean utility - this might require removal of the macerator from laundry room preventing further use. Estates / Infection Control lead to visit ward and advise.	Ward Manager	ACP Manager	30/04/2015	Blue	**Progress to date:** COMPLETED The Macerator has been removed from the PICU	ESTATES
27	REMOVED BY CQC FOLLOWING FACTUAL ACCURACY CHANGES									
28	REMOVED BY CQC FOLLOWING FACTUAL ACCURACY CHANGES									

29	Community-based Mental Health Services for Adults of Working Age	All inspected	Work with local commissioners of services to improve access to local acute psychiatric admission beds.	29.1 Area Bed protocol has been developed to ensure that there is a more robust process for access and discharge from acute beds. Protocol has been shared with both Hampshire and Soton commissioners. 29.2 Undertake a broader review of bed provision into the medium to longer term to ensure sustainability and availability of beds within Hampshire.	Area Managers	Kate Brooker-Associate Director MH	30/06/2015	Blue	**Progress to date:** Area protocol has been implemented, pathways and access to acute beds are not currently consistent across all 4 units. This is part of MH Service strategy for 15- 16 Internal actions completed	PATIENT EXPERIENCE
30	Community-based Mental Health Services for Adults of Working Age	Southampton CMHT	Monitor the caseload to assess the impact of the proposed new staffing structure.	30.1 Monitor the overall caseload size of the CTT, against the baseline of the old staffing structure. 30.2 Monitor the size of individual practitioners' caseload three months after the appointment of the new staffing structure. 30.3 Link work around caseloads to national work on caseload modelling for community mental health teams	Marie Finn - Southampton CTT Team Manager	Joe Jackson General Manager/Tim Coupland Associate Director of Nursing	30/06/2015	Blue	**Progress to date:** Event taking place in April ISD-wide to challenge model of caseload management - to include MH Caseload review completed.	WORKFORCE
31	Community-based Mental Health Services for Adults of Working Age	Winchester & Andover CMHT	Winchester community team base was in poor repair in some places and staff were unclear about whether there were plans to move or improved facilities	31.1 The premises has been highlighted as a priority within the local Estates Project Board and the Trust Estates Rationalisation Plan there are discussions around potential moves from the building to more suitable accommodation	Service Manager / Estates Business Partner	Graham Webb General Manager	31/08/2015	Green	**Progress to date:** There are plans to move from Connaught House to Avalon House from September 15. IP&C update - all Housekeeping staff have been reminded of the need to wear PPE when cleaning toilet areas in line with national guidance Mops are washed at Melbury Lodge and transported in different buckets for clean and dirty	ESTATES
32	Community-based Mental Health Services for Adults of Working Age	New Forest CMHT	New Milton community team base was in poor repair in some places and staff were unclear about whether there were plans to move or improved facilities	32.1 There are no current plans to move from the New Milton base, repairs and actions arising from this will be part of the Estates Project Group. Where appropriate capital bid applications will be submitted	Service Manager / Estates Business Partner	Service Manager	31/08/2015	Green	**Progress to date:** Team are unlikley to move for 18months so estates to visit and identify short term measures	ESTATES
33	Crisis Service / S136 Health Based Place of Safety	All inspected	AMHT service must have operational procedures which inform staff how to provide services which include risk assessment, care planning and sharing information and protect people using the service and staff	33.1 The AMHT Service Manager and the AMHT Lead Consultant will draft an operational policy that is to include how to provide services, risk planning, care planning, and also cover how to protect people and staff using the services. 33.2 The draft document will be submitted to the Southampton Area Integrated Governance and will be considered more widely across all Crisis Services for consistency checking and externally in terms of alignment with the Crisis Concordat Hampshire Action Plan. Meeting for review, and onward progression.	Emma Bekefi - Interim Team Manager, South AMHT	Joe Jackson General Manager	30/06/2015	Blue	**Progress to date:** 18-6-2015: Approved at AIGM in Southampton virtually in April 2015, then approved at the AMH Service Board in May 2015.	CAREPLANNING / RECORDKEEPING
34	Crisis Service / S136 Health Based Place of Safety	Elmleigh S136 suite	Ensure there are sufficient appropriately trained staff available to provide care to S136 suite when in use, so that safe staffing levels on PICU and wards are not compromised and people put at risk of unsafe care	34.1 A work programme is advanced to commission a new S136 POS service across the county in partnership with Medisec. This will include: - Further work is being undertaken to match competencies with PRISS -Staffing levels will not be compromised on the PICU wards once Medisec undertake observations within the s136 suites - Trust is compiling a training programme for NIC with regards to the delegation of responsibilities - Trust is compiling a training package for Medisec and Trust staff in the Management of children in Crisis	Nina Davies (Service Improvement Lead) working with Modern Matrons and Estates	Tim Coupland Associate Director of Nursing	31/04/2015	Blue	**Progress to date:** Updated 24/4/15 completed and service in place, monitored under a governance and assurance group which meets monthly	WORKFORCE
35	Crisis Service / S136 Health Based Place of Safety	Elmleigh S136 suite	Ensure that staff working in or covering the S136 suite have up to date training in restraint, break away and de-escalation techniques and BLS/ILS	35.1 A work programme is advanced to commission a new S136 POS service across the county in partnership with Medisec. This will include: - All Medisec staff undertake restraint training - Further work is being undertaken to match competencies with PRISS - All Medisec staff are trained in BLS/ILS - Organise training locally for ILS/BLS for staff at Elmleigh.	ward managers-Ben Lihou, Holly Whiteley . Nina Davies	Tim Coupland Associate Director of Nursing	30/04/2015	Blue	**Progress to date:** Updated 24/4/15 training for ILS and Priss for Elmleigh is picked up in another action 415 which has completion date 29/05. This action specifically relates to the use and function of the 136 Suite and is complete in terms of specific actions in 35.1.	WORKFORCE
36	Crisis Service / S136 Health Based Place of Safety	All inspected	Review S136 policy and consider how those detained under S136 are assessed in more timely manner by a doctor in the first instance.	36.1 The Policy is being reviewed as part of the revised Code of Practice 36.2 The Trust will continue to undertake joint assessment between the Doctor and AMHP, as per the Royal College of Psychiatrists guidelines and best practice described within the CoP	Nina Davies (Service Improvement Lead) working with Modern Matrons and Estates	Tim Coupland Associate Director of Nursing	31/04/2015	Blue	**Progress to date:** Update 24/4/15 Complete - governance and oversight process in place and will be reviewing all standards related to the CoP via dashboard	CAREPLANNING / RECORDKEEPING
37	Crisis Service / S136 Health Based Place of Safety	All inspected	Ensure that AMHPs attend the S136 suite in a timely manner - 'Assessment by the doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety'.	37.1 The Trust is working with the commissioners and Local Authority to improve partnership working and timely attendance of AMHP 37.2 We will develop a 136 dashboard to cover the key components of waiting times for both AMPH and medic response for those detained under section 136. Review of this dashboard will be completed by the 136 quality and governance group to identify the scale of the problem and to drive action to ensure medical and AMHP delays are minimised.	Nina Davies (Service Improvement Lead) working with Modern Matrons and Estates	Tim Coupland Associate Director of Nursing	31/04/2015	Blue	**Progress to date:** Updated 24/4/15 Complete	CAREPLANNING / RECORDKEEPING
38	Crisis Service / S136 Health Based Place of Safety	All inspected	Ensure all staff involved in implementation of S136 receives necessary training	**See ref 34**	**See ref 34**	**See ref 34**	30/04/2015	Blue	**Progress to date:** Updated 24/4/15 Complete - medisec now provide this service and have also received training in terms of provision to children	WORKFORCE

39	Crisis Service / S136 Health Based Place of Safety	All inspected	Review lone working procedures, and ensure they adequately protect staff in the S136 suite and the hospital at home service.	39.1 A work programme is advanced to commission a new S136 POS service across the county in partnership with Medisec. This will ensure: -no lone working situations within the s136 suites, as each service user will be observed by 2 members of Medisec staff -Where exceptionally Lone Working procedure (SH NCP 24) is implemented it will include risk assessment/visit planning, PRISS / conflict resolution training, issue of safety equipment, awareness of incident reporting procedures, checking in with base to include a "safe" password or phrase if visit unsafe.	Nina Davies (Service Improvement Lead) working with Modern Matrons and Estates/ working with AMHT Team Managers	Tim Coupland Associate Director of Nursing	30/04/2015	Blue	**Progress to date:** Updated 24/4/15 COMPLETED	WORKFORCE
40	Long Stay / Rehab Mental Health Wards	All inspected	The programme of activities should be reviewed to ensure that people have access to enough activities to keep them occupied.	40.1 The activities programme will be reviewed regularly to ensure that all people using the services will have a variety of activities to keep them occupied. Hollybank will continue to review activities every 3 months following the patient questionnaire. The activities poster and the OT leaflet are already available in all patients packs.	Carol Barnard, Clinical Manager, Hollybank Alison Vasey, Ward manager, Forest Lodge	Carol Barnard, Clinical Manager, Hollybank Alison Vassey, Ward Manager, Forest Lodge	30/04/2015	Blue	**Progress to date:** COMPLETED	PATIENT EXPERIENCE & ENGAGEMENT
41	Long Stay / Rehab Mental Health Wards	All inspected	People using the service should be supported to have access to a copy of their care plan.	41.1 All people using the service will be given a copy of their care plan, if they do not want a copy, then it will be clearly documented on RIO as to why they declined. The monthly care plan audit will continue to demonstrate compliance.	Carol Barnard, Clinical Manager, Hollybank Alison Vassey, Ward manager, Forest Lodge	Carol Barnard, Clinical Manager, Hollybank Alison Vasey, Ward Manager, Forest Lodge	30/04/2015	Blue	**Progress to date:** COMPLETED	CAREPLANNING / RECORDKEEPING
42	Long Stay / Rehab Mental Health Wards	All inspected	The trust should consider if staff working in these services could have more opportunities to meet senior staff.	42.2 Area Manager and Service Managers to actively encourage visits to Rehab units to meet staff by creating opportunities and pulling together a programme of visits with the senior team	Carol Barnard, Clinical Manager, Hollybank Alison Vasey, Ward manager, Forest Lodge	Carol Barnard, Clinical Manager, Hollybank Alison Vasey, Ward manager, Forest Lodge	30/04/2015	Blue	**Progress to date:** COMPLETED - Kate Brooker & Mary Kloer visited the following units on the following dates and met with staff and Service users: Forest Lodge Wed 4th March Crowlin Friday 13th March Hollybank Wed 25th March	WORKFORCE
43	Long Stay / Rehab Mental Health Wards	Forest Lodge	The findings from the ligature audit at Forest Lodge should be used to ensure a risk based plan of works is in place.	43.1 Forest Lodge service manager and Southampton General Manager will review all outstanding work deemed urgent regarding ligature risk, and raise these at part of the Trust wide programme the work required will be prioritised in line with other divisional ligature work streams	Alison Vasey, Ward Manager Forest Lodge & Joe Jackson, Area Manager	Joe Jackson, General Manager	31/03/2016	Green	**Progress to date:** The original CQC identified works have been completed. Further issues may be identified via the anti-ligature task and finish group	ESTATES
44	MH Secure/Forensic	All inspected	Appropriate measures must be taken to mitigate and manage environmental ligature risks on wards at Ravenswood House and Southfield.	44.1 All patients to have care plans specifically addressing risk of ligature. 44.2 These care plans must be reviewed regularly at times of change of ward or mental state. 44.3 All rooms near the nursing office will have minimised ligatures. 44.4 Work to reduce ligatures across the whole unit. One ward to decant to enable work to be carried out safely. 44.5 review of location of parabolic mirrors 44.6 Development of a full business case for re-provision of Ravenswood	1. CSM, 2. CSM, MM 3. Director of Estates 4. Estates 5. Exec Team	Associate Director & CD & Director of estates	Some completed. Major work 31/12/2015 44.6 30/06/2015	Green	**Progress to date:** 44.1 & 44.2 MINOR WORKS COMPLETED Ligature risk poster in place at Ravenswood MAJOR WORKS IN PROGRESS	CAREPLANNING / RECORDKEEPING
45	MH Secure/Forensic	All inspected	Staff on wards at Ravenswood House and Southfield must ensure they are familiar with the procedure for checking and replacing ligature cutters.	45.1 All staff to complete ligature training using scenarios and ligature packs . Agency staff are included. E learning package to be developed . Scenarios are in place where there are particular concerns. Meeting held with training dept. 12.12.14 to look at resources available for training. 45.2 Standardised ligature pack agreed (16.12.14) 45.3 All clinical staff have easy access to information of the ligature risks within their environment and how these are managed. 45.4 Checking of ligature packs and cutters to be added to Security Checklist and	1. LEaD & ward managers 2. CSM & MM 3. MM	LEaD & CSM	30/06/2015	Blue	**Progress to date:** Date of 30/06/15 confirmed by LEaD for development of e-learning package to support current learning/training in place	WORKFORCE
46	MH Secure/Forensic	All inspected	The provider must record all incidents of restraint and seclusion in line with the Mental Health Act Code of Practice.	46.1 Policy for Seclusion to be reviewed. 46.2 Trust wide review of restraint policy and procedures.	Siven Rungien/Mayura Despande/Nicki Duffin	Tim Coupland Associate Director of Nursing	46.1 completed 46.2 underway to complete 30/04/2015	Blue	**Progress to date:** 46.1 COMPLETED Seclusion policy will be reviewed again in March 2015 to incorporate the provisions within the revised MHA Code of Practice 46.2 complete - Updated 24/4/15 UPDATED POLICY PUBLISHED	PATIENT SAFETY, REPORTING & LEARNING
47	MH Secure/Forensic	Southfield	All staff at Southfield must ensure they are familiar with the trust's Seclusion and Segregation Policy as some patients at Southfield were not afforded the safeguards of the Mental Health Act Code of Practice when being "de-escalated" in the units seclusion area.	47.1 Southfield have used Trust wide seclusion documentation on every occasion the high care suite is used in accordance with the Code of Practice and the policy. Ward manager has been monitoring this. 47.2 Policy for Seclusion to be reviewed.	Seclusion paperwork audited by MHA administration team/ Policy review: Siven Rungien/Mayura Despande	Tim Coupland Associate Director of Nursing	Completed .	Blue	**Progress to date:** Seclusion policy will be reviewed again in March 2015 to incorporate the provisions within the revised MHA Code of Practice We have also achieved a reduction (to date) of use of seclusion by 20%. **17/04/2015**: Seclusion audit completed and reported to QID. Policy updated COMPLETED	PATIENT SAFETY, REPORTING & LEARNING
48	MH Secure/Forensic	All inspected	The majority of staff at ward level at Ravenswood House and Southfield did not feel that the forensic directorate leaders or senior trust managers were visible and approachable.	48.1 All senior staff are doing nursing shifts across the services. There is a regular patient and staff forum which is advertised. 48.2 The service management structures are being redesigned in accordance with the new divisional structures. 48.3 New Clinical Director for services to provide a more visible and effective leadership	Nicki Brown Associate director Specialised Services & Amanda Taylor CD	Nicki Brown Associate director Specialised Services & Amanda Taylor CD	30/04/2015	Blue	**Progress to date:** Updates 24/4/15 New CSD's to be appointed on April 29th Matron appointed for southfield	WORKFORCE

49	MH Secure/Forensic	All inspected	Whilst the provider had a governance structure in place they could not be confident about its efficacy as a significant number of staff were not familiar with it.	49.1 Divisional Structures are being reorganised and the service structures will be redesigned to match these. This will be communicated to all staff. 49.2 The learning from incidents will be better embedded into the team meetings and teaching programmes	Nicki Brown Associate director Specialised Services & Amanda Taylor CD	Nicki Brown Associate director Specialised Services & Amanda Taylor CD	30/04/2015	Blue	**Progress to date:** Updated 24/4/15 New structure to be introduced in May 2015	GOVERNANCE
50	MH Secure/Forensic	All inspected	Some staff at Ravenswood House and Southfield were not familiar with safeguarding procedures or their responsibilities should they be concerned that a patient was at risk of abuse.	50.1 All staff to complete safeguarding as part of mandatory training. 50.2 Junior medical staff also complete this and systems are in place for this to be monitored through the postgraduate education dept and the director of education. Junior Medical staff are not able to engage with other training unless this has been completed. 50.3 Run patient scenarios to test out learning in practice and record learning on team meeting notes	Rachel Coltart Performance lead Jane Hazelgrove Director of Education	Nicki Brown Associate director Specialised Services	50.1/50.2 completed 50.3 30/04/2015	Blue	**Progress to date:** **17/04/2015:** the summary:of 17 medical staff 1 staff member is non-compliant with Safeguarding Children Level 2 training. The y are all compliant with Safeguarding Adults Level 2 training. **19/04/2015 update:** 50.2 Junior medical staff unable to take study leave unless mandatory traing completed. Monitored by DME (email 22nd January). **Updated 24/4/15 -** Induction checklist which goes to all junior doctors includes -section 6; - training and development requirements For trainees who are in the trust and rotating to a new post a reminder goes to them at each rotation	PATIENT SAFETY, REPORTING & LEARNING
51	MH Secure/Forensic	All inspected	Staffing levels on some wards at Ravenswood House and Southfield meant that patients were not able to take Section 17 escorted leave.	51.1 Staffing is under review, recruitment is being reviewed by the Trust. There is a rolling programme of recruitment locally and an annual recruitment programme will be agreed. 51.2 Appointed a member of workforce team to address this specifically for Specialised services. 51.3 Senior staff working in clinical roles to support safer staffing	Nicky Bennet, Clinical Services Manager	Nicki Brown Associate director Specialised Services	30/04/2015	Blue	**Progress to date:** Updated 24/4/15 Internal actions completed - further work will continue to maintain levels	WORKFORCE
52	Child and Adolescent Mental Health	All inspected	There was no policy for the use of restraint and the lack of recording in relation to this did not demonstrate this was carried out appropriately.	52.1 Trust wide review of restraint policy and procedures.	Nicki Duffin, Lead Nurse	Tim Coupland Associate Director of Nursing	30/04/2015	Blue	**Progress to date:** Updated 24/4/15 seclusion policy reviewed again in March 2015 to incorporate the provisions within the revised MHA Code of Practice 46.2 complete COMPLETED - POLICY PUBLISHED	PATIENT SAFETY, REPORTING & LEARNING
53	Child and Adolescent Mental Health	All inspected	The policy for seclusion did not comply with the Code of Practice: Mental Health Act 1983, and there was a lack of sufficient records to demonstrate this had been managed appropriately.	53.1 Policy for Seclusion to be reviewed.	Siven Rungien/Mayura Despande	Tim Coupland Associate Director of Nursing	Completed .	Blue	**Progress to date:** We now have better definitions of time out, seclusion and longer term segregation with associated practice guidance and consistent paperwork Seclusion policy will be reviewed again in March 2015 to incorporate the provisions within the revised MHA Code of Practice We have also achieved a reduction (to date) of use of seclusion by 20%. COMPLETED - POLICY PUBLISHED	CAREPLANNING / RECORDKEEPING
54	Child and Adolescent Mental Health	All inspected	The management of young people nursed on close observations, and general observations were not robust or recorded appropriately to demonstrate that young people were appropriately monitored.	54.1 New Trust observation documentation has been issued and is being consulted widely to incorporate into the observation policy	Sarah Leonard, Acute Care Pathway Manager	Tim Coupland Associate Director of Nursing	30/04/2015	Blue	**Progress to date:** Updated 24/4/15 - COMPLETED observation paperwork agreed policy and training matrix has been updated, email matrons to say has training been implemented	CAREPLANNING / RECORDKEEPING
55	Child and Adolescent Mental Health	All inspected	There was no evidence in relation to capacity assessment and consent in relation to the requirement of the Mental Capacity Act 2005 and Gillick Competencies/ Fraser Guidelines.	55.1 Leigh House has incorporated within the template for weekly clinical meetings the review of capacity and consent of patients. 55.2 SHFT to formulate specific training on capacity and competence assessments in young people. 55.3 Documentation of assessments of capacity/competence in patient records when medication is prescribed. NOTE all patients in Bluebird House subject to detention under the MHA 1983.	Responsible Clinicians & CSD for each service Tim Coupland Associate Director of Nursing (training elements)	Nicki Brown Associate Director of Specialised Service/	30/04/2015	Blue	**Progress to date:** Updated 28/4/15 Capacity and consent has been added to the weekly ward round template and also to the medication agreement form for young people. Dr has also completed some in-house training around DOLS and capacity for the nursing team and with the arrival of new nurses, more are booked in for the future.	CAREPLANNING / RECORDKEEPING
56	Child and Adolescent Mental Health	Leigh House	Ligature risks within the environment were not always appropriately managed. In particular, the seclusion area at Leigh house had a number of ligature risks that had not been assessed or minimised to reduce risks to young people.	56.1 Ligature Risk Assessment completed in October 2014 and an agreed action plan is in place to deal with the risks identified	CSM, Modern Matron & Facilities Manager	Associate Director of Nursing, Associate Director of Specialised MH Services, Modern Matron	TBC, awaiting E&FM finalisation of works programme	Green	**Progress to date:** Note Assessment Completed and Action plan in place, works programme being agreed	ESTATES
57	Child and Adolescent Mental Health	Leigh House	During the night at Leigh House there were three staff on duty, which did not take into account the dependency needs of the young people, or of the management of incidents during this time.	57.1 Staffing has been reviewed and nurse staffing levels increased depending on clinical need. 57.2 The increased staffing required will be made permanent in April 2015.	Modern Matron & CSD	Nicki Brown Associate Director for Specialised Services	30/04/2015	Blue	**Progress to date:** Updated 24/4/15 57.1 Staff recruitment ongoing but otherwise completed Now have right staff levels.	WORKFORCE
58	Child and Adolescent Mental Health	Leigh House	The young people at Leigh House were not encouraged to be involved in the care planning or reviews about their care.	58.1 All young people now have a Collaborative Care Plan. 58.2 Service users have drawn up a ward round feedback document and will be invited to attend	Responsible Clinicians, Clinical Ward Manager & Primary Nurses	Nicki Brown Associate Director for Specialised Services	01/01/2015	Blue	**Progress to date:** Updated 24/4/15 patients are now invited to ward rounds and offered opportunity to comment on care plans Introduction of collaborated care plans and response prevention care plans.	CAREPLANNING / RECORDKEEPING

59	Child and Adolescent Mental Health	Leigh House	The majority of young people using the service of Leigh House felt that the service was planned around needs of the eating disorder specialism, and that those with mental health needs did not receive the same level of support for their needs.	59.1The team are aware of the potential dynamics within the milieu and there is a system in place to consider and balance the differing diagnoses. 59.2 The service will maintain close links with the commissioners to ensure the patient mix is correct on amonthly basis.	Responsible Clinicians, CSD & Modern Matron	CSD & Modern Matron	01/01/2015	Blue	**Progress to date:** Updated 24/4/15 meeting held with commissoners and case managers to discuss case mix Discussed in the weekly business meeting, community meetings, with the advocacy service and attempt to readdress the clinical balance whenever possible.	PATIENT EXPERIENCE & ENGAGEMENT
60	Child and Adolescent Mental Health	All inspected	Health checks were not carried out routinely. Some care plans around physical health checks were lacking, whilst others were generic for the young people.	**LEIGH HOUSE** 60.1 Ensure health checks are carried out routinely on admission, ongoing as part of the care of all patients, following prescribing of medication, at the time of discharge and at any other time as required. 60.2 Ensure all physical observation charts are taken to the MDT handover 5 days per week for review. 60.3 Establish an ECG monitoring for all patients on the Eating Programme, on prescribing of psychotropic medication and if otherwise indicated. 60.4 Establish a liaison service with the local paediatrician to review ECG results. **BLUEBIRD HOUSE** 60.5 Review Physical health care plans for all patients were reviewed and amended where required. 60.6 Ensure Physical health care plans for all patients are reviewed upon admission, at each CPA and whenever clinically indicated.	Admitting Doctor, Responsible Clinicians, Nurse Practitioners , CSD and Modern Matron	CSD	01/01/2015	Blue	**Progress to date:** Updated 24/4/15 completed for BBH and Leigh House All young people have a physical assessment on admission. All have a nutritional care plan and are weighed regularly. Where a physical health issue is identified they will have a physical health care plan. The physical health folder containing the physical observations of young people is taken to the daily MDT handover and reviewed by medical staff.	CAREPLANNING / RECORDKEEPING
61	Child and Adolescent Mental Health	All inspected	There was no trust transition policy to support young people transitioning into adult services, or clear care pathways for young people. The discharge of young people was not discussed or planned as part of the admission to the service.	61.1 The Trust has a Transition Protocol in place; work is underway to review and identify areas for improvement (involving Tier 3 community CAMHS (Sussex Partnership NHS Foundation Trust), Tier 4 CAMHS, adult mental health and EIP services (Southern Health NHS Foundation Trust)). **BLUEBIRD** 61.2 Potential discharge pathways are considered at the patient's first CPA, three months following admission, and this is evidenced in the CPA minutes.	Associate Director of SS	Associate Director of SS	30/06/2015	Blue	**Progress to date:** Updated 28/4/15 1. Transition policy for young people presenting with psychotic symptoms (CAMHS to E.I.P. services) in place 2. Protocol for transition from CAMHS to Adults services 3. study day on transition between services	CAREPLANNING / RECORDKEEPING
62	Child and Adolescent Mental Health	All inspected	The majority of staff we spoke with felt there was a lack of senior management input and understanding as to what happened in the services. Some felt empowered by this, though others said it made them feel disconnected from the trust senior management.	62.1 To put in place a programme to ensure increased visibility and support of senior managers in the units and opportunities to meet with the staff team.	Associate Director of SS	Associate Director of SS	31/05/2015	Blue	**Progress to date:** Updated 28/4/15 Senior leadership programme in place to support visibility- evidenced by senior teams diary and programme of visits to service.	WORKFORCE
63	Child and Adolescent Mental Health	All inspected	The staff we spoke with were not aware of any trustwide initiatives to seek feedback from young people/ other users of the services or staff.	63.1 Ensure the Trust Patient Experience survey is shared with all staff by the organisation once it has been returned by the young person 63.2 Ensure feedback from young people using the service is a standing item on the Integrated Governance meeting agenda, as is the monthly Voices 4 Choices meeting.	Modern Matron	CSM & CSD	30/04/2015	Blue	**Progress to date:** Updated 28/4/15 The awareness of Trust feedback mechanism from young people and staff to the staff induction pack has been added to the induction pack for all nurses and HCSW's.	PATIENT EXPERIENCE & ENGAGEMENT
64	OPMH community	All inspected	Work with local authorities to ensure social services input is flexible, responsive and teams are facilitated to work closely to ensure best outcomes for patients & relatives.	64.1 Integrated rapid response project currently underway 64.2 CMHTs to continue to be actively involved in the Better Care process 64.3 To invite social services staff to health education opportunities 64.4 Via supervision ensure that referrals to social services are made in a timely manner 64.5 With colleagues in social services write a 2 sided sheet clearly stating eligibility for each other services 64.6 Offer hot desk facilities where possible in each others bases 64.7 Exec work currently underway regarding integration with adult services ensure presence at ICT meetings	Sharon Harwood Sharon Osterfield Matthew Sheehan Angela O'Brien	Laura Rothery Michelle Edwards Nicky Seargent	30/04/2015	Blue	**Progress to date:** Linked to joint working with Solent programme Linked to ICT ways of working ICT monthly Steering group joint chaired by SHFT and HCC. Update 24/4/15 Within Southampton every cluster meet monthly to further integration on a local level. 2 awaydays with adult services present have taken place Within the West of Hampshire monthly/bimonthly ICT meetings take place locally to support integration; CQUINS completed with support from adult services - inculding rapid response CQUIN.	WORKFORCE
65	OPMH community	All inspected	Ensure patients have sufficient access to clinical psychology input if needs for talking therapies are too complex to be managed by IAPT.	65.1 Undertake a review of Psychology resources across all CMHTs with a view to creating an appropriate workforce plan. Recruit to plan	Laura Rotherery Michelle Edwards Nicky Seargent	Gethin Hughes Chris Ash	31/07/2015	Blue	**Progress to date:** **East** - Contract signed and vacant post has been approved to be recruited to - recruitment process in progress. **North** - Psychology service in place.	WORKFORCE
66	REMOVED BY CQC FOLLOWING FACTUAL ACCURACY CHANGES									
67	OPMH community	Fareham & Gosport OP CMHT	Systems in place to monitor caseloads need improvement to ensure the wellbeing of patients and staff	67.1 Completed during inspection week	Julie Edwards	Michelle Edwards	complete	Blue	**Progress to date:** Completed during the inspection Review Event planned for 17th April 2015	WORKFORCE
68	OPMH inpatients	All inspected	Ensure that guidelines provided by the DH for same sex accommodation and the MHA CoP regarding same sex accommodation are adhered to and where there are breaches, that there are mechanisms in place within the division and the trust to report them.	68.1 Ward manager and Modern Matron to ensure ward is compliant with same sex accommodation requirements. 68.2 Any concerns to be escalated via ISD management team and appropriate actions agreed. 68.3 All breaches to be reported via Trust incident reporting system.	Ward manager, Modern Matron.	Michelle Edwards	complete	Blue	**Progress to date:** Completed escalation procedures put in place during the inspection week	PATIENT EXPERIENCE & ENGAGEMENT

69	OPMH inpatients	All inspected	Ensure that robust plans exist on each ward to manage identified ligature risks, and where people are at risk that risk management plans relating to ligatures are identified in individual risk assessments and care plans	69.1 All wards have an up to date Ligature risk assessment and action plan. 69.2 All patients on and during admission to have up to date Risk assessment and care plan to support any risk identified. 69.3 All individual patient risk to be reviewed in MDT ward round on a minimum weekly basis adhering to Ward round template.	Ward Manager. Inpatient consultant.	Tracey Eddy - Inpatient Clinical Director OPMH inpatient Matrons	30/04/2015	Blue	**Progress to date:** All wards have updated their ligature risk assessments & action plans. All patients where risks of suicide are prevalent have an up to date risk assessment and care plan. Discussed in ward round.	CAREPLANNING / RECORDKEEPING
71	LD community	Ox/Bucks teams	The trust must ensure it supports staff working in the Oxfordshire and Buckinghamshire community services appropriately in order to facilitate them to perform their roles effectively	71.1 A scoping exercise/ survey will be completed for all staff across the LD Division to ascertain what additional development and training staff need to be able to perform their job which is not currently provided through our training department. 71.2 A scoping exercise/ survey will be completed for all staff across the LD Division to help ascertain what staff support staff need from the senior leadership team in order for staff to be able perform their roles effectively.	John Stagg: Lead for QI	Jennifer Dolman: Clinical Director	30/06/2015	Blue	**Progress to date:** **28.05.15** Survey was completed on 11th May and the information is being analysed now. The survey covered non Stat and Mandatory training and development needs as well as communication and support across all staff at all bands and had a 45% return. 10 focus groups were undertaken across all areas and this information is to be analysed. This action is on track. 30/06/15 - COMPLETED	WORKFORCE
72	LD community	All inspected	The trust should ensure that capacity assessments can be located and accessed with ease in the electronic patient records. they should also ensure that best interest meetings are structured in line with the mental capacity Act and staff are trained to be able to implement this.	72.1 The LD Service Specific Guidance finalised on 06.01.15 details the recording of capacity assessments. This will be disseminated to all staff and be available on the trust web site 72.2 The LD Clinical Records Group (CRG) will devise a short presentation to be utilised by all teams during governance and business meetings and for supervision purposes which provides information on the recording of capacity assessments in both the EPR and secondary care records.	John Stagg: Lead for QI Alistair Upton: Informatics Clinician	Jennifer Dolman: Clinical Director	30/05/2015	Blue	**Progress to date: 28.05.15** SSG is in place and a final version is officially signed off. The LD Clinical Records Group have completed the guidance for recording in RiO for use in team meetings and supervision.	CAREPLANNING / RECORDKEEPING
73	LD community	All inspected	The trust should review the referrals to the community learning disability teams that have breached target timescales to ensure people's needs are met.	73.1 The change to how RiO is used to record referrals was completed in January 2015. The second stage to implement the Team Process in Oxon & Bucks is now in the second stage which relies on Team Managers and Clinicians to follow the guidance for entering referrals, implementing the Service Specific Guidance and for Team Managers to run their case load and manage referrals and MDT plans on completion of core assessment process 28 days after referral. Once the first appointment is booked the waiting time stops.	Heads of Service	John Stagg: Lead for QI Heath Gunn: Divisional Director	31/05/2015	Blue	**Progress to date: 28.05.15** Reported in LD CRG 21.04.15 that CTLDs are following the guidance in terms of new referrals and waiting times. There had been a record of breaches in one Oxon team which was addressed by the HoS and the Team Manager. The guidance, training for clinicains and process are in place - COMPLETED	PATIENT EXPERIENCE & ENGAGEMENT
74	LD inpatients	Ox/Bucks units	The trust must ensure that all staff are aware of incidents that have taken place in the service and where relevant in other parts of the trust and the learning from these incidents	74.1 Quarterly report on incidents will be circulated to all teams services within the division. This will include analysis of incidents along with lessons learnt. This will be shared through Quality and Safety meetings and locality Governance meetings. 74.2 All chairs of County Governance Groups will add incident reporting and learning to the agenda for each governance meeting (Team & County meetings which will in turn be reported through the SPR)	CSD Heads of Service	John Stagg: Lead for QI	30/06/2015	Blue	**Progress to date:** **28.05.15.** Discussed within LD QSM in April 2015. Templates for agendas, reports and minutes are to be standardised. Incident themes, trends and analysis is reported regularly to QSM and this information is cascaded by the QSM reps from different counties and their CSDs to local governance groups. 30/06/15 - COMPLETED	PATIENT SAFETY, REPORTING & LEARNING
75	LD inpatients	All inspected	The trust must ensure the environments where people are cared for are safe.	75.1. Environmental improvements to Evenlode will begin by March 2015. 75.2. A plan for reduction in ligature points, increase in observational mirrors and installation of anti-barricade doors will be submitted to the Trust Capital programme 75.3 A plan for further Anti-Ligature reduction in the Evenlode environment will be submitted to the Trust Capital programme 75.4 Individual risk assessments and safety plans will be put in place for all patients in Evenlode and the Ridgeway Centre	Heads of Service	Divisional Director	31/05/2016	Green	**Progress to date:** E&FM have agreed the first part and work to reduce ligatures at Evenlode started 17.02.15. The other plans are going into the capital bid for 2015/2016 financial year.	ESTATES
76	LD inpatients	Ox/Bucks units	The trust must ensure that all staff including support workers have training to enable them to meet the specific needs of people using the service.	**See point 71** **LEaD** 76.1 A programme of training will initially commence in Oxfordshire and Buckinghamshire with initial topics to include Makaton and autism awareness. Programme will then roll out in Hampshire. 76.2 Programme of training to continue throughout 2015/16 and will include, although will not be limited to, training in mental health awareness, personality disorder and communication skills to meet identified needs. 76.3 Programme of training will be informed by scoping exercise/survey referred to in section 71.	John Stagg: Lead for QI	Jennifer Dolman: Clinical Director	31/05/2016	Green	IN PROGRESS	WORKFORCE
77	LD inpatients	Evenlode	The trust must ensure it supports staff working in the Oxfordshire service Evenlode so they have regular line management input, understand the changes that are taking place and receive support in an appropriate style to facilitate them to perform their roles.	77.1 **Completed** - new management structure in place, regular supervision in place and regular visits and communication with Head of Service	Head of Service	Jennifer Dolman: Clinical Director	01/04/2015	Blue	**Progress to date:** COMPLETED	WORKFORCE
78	LD inpatients	Westview/ Ashford	The trust must ensure on Woodhaven that emergency resuscitation equipment is easily accessible across the two units	78.1 Resuscitation Officer to review arrangements at Westview/ Ashford as to suitability of arrangements by 30.04.15. **Completed.** The equipment is available in under 2 minutes even with traversing locked doors	Simon Johnson	Head of Service	30/04/2015	Blue	**Progress to date:** COMPLETED	PATIENT SAFETY, REPORTING & LEARNING

79	LD inpatients		The trust should ensure that patients who are detained have their rights explained to them as frequently as needed and that this is recorded.	79.1 Each patient is written to upon admission, outlining the details of their section and their rights (Complete) 79.2 Each patient is reminded of their rights every three months in line with Trust policy (Complete) 79.3 A poster will be displayed on the ward asking patients if they understand their rights and to discuss with staff if they do not (28.04.2015) 79.4 The Trust's MHA Administration team will be monitoring more closely the provision of MHA information as required. In particular, this will include reporting each breach of the Trust's s.132/130D standard on the Ulysses' incident reporting system. Draft Ulysses pro-forma for MHA Administrators to report s.132/130D breaches (Complete)	Heads of Service John Stagg: Lead for QI	MHA Manager	01/05/2015	Blue	**Progress to date: 21.04.15** There is evidence of reading of rights and the team will include diary of reading of rights and how this is done in a way which meets patient's requirements and is therefore timely in accordance with patient needs. **Update 20/05/15 - ACTION COMPLETED**	CAREPLANNING / RECORDKEEPING
80	LD inpatients	Evenlode	They should also ensure on Evenlode that the times of medical reviews are recorded.	80.1 The time the medic is informed of the seclusion is now recorded in the seclusion documentation and the time of the medical review will also be recorded on RiO.	Siven Rungien	Tim Coupland Associate Director of Nursing	Complete	Blue	**Progress to date:** COMPLETED	CAREPLANNING / RECORDKEEPING
81	LD inpatients	Evenlode	The window in the seclusion room in Evenlode should also be reviewed to ensure people's privacy is maintained.	81.1 Film will be added to the window - **complete**	Head of Service	Divisional Director	Complete	Blue	**Progress to date:** Works completed under PFI	ESTATES
82	LD inpatients	Evenlode	The trust should review the levels of psychology input available at Evenlode to ensure there are sufficient numbers of staff available to support people with complex needs in individual clinical sessions.	82.1 A review of the psychology service will be undertaken with the Consultant Psychologist and Head of Service 82.2 A plan for any changes to the levels of psychology services will be implemented	Head of Service Consultant Clinical Psychologist	Jennifer Dolman: Clinical Director	01/11/2015	Green	IN PROGRESS	WORKFORCE
83	LD inpatients	Evenlode	The trust should explore how people using the service at Evenlode can have access to a more user-friendly copy of their care plan.	83.1 The MDT at Evenlode will agree and implement a care plan format for use with patients (including consultation with the patient group)	Paul Tossi: Service Manager	Head of Service	31/07/2015	Blue	**Progress to date: 28.05.15**: Plans are in place to liaise with the low secure service to collaborate on accessible care plan use for patients. On track. Update from Linda Kent: Ward Manager Careplans implemented - to be monitored as part of ward governance processes	CAREPLANNING / RECORDKEEPING
84	LD inpatients	Evenlode	The trust should ensure that people using the service at Evenlode have sufficient activities available at the weekend.	84.1 The activity programme for the weekend will be reviewed through the patient meetings and patients will be invited to suggest activities they wish to be arranged at the weekends.	Paul Tossi: Service Manager	Head of Service	Complete	Blue	**Progress to date: 21.04.15** There is evidence to support that community meetings have taken place and activities have been discussed. The patients have a meeting on a Saturday morning to plan activities. The evidence to support that these meetings are occurring is to be obtained by the team along with any evidence of samples of patient activities e.g. records of an activity. This also links to action 85.	PATIENT EXPERIENCE & ENGAGEMENT
85	LD inpatients	Evenlode	The trust should ensure that people using the service at Evenlode are satisfied with the lunchtime arrangements where they are served a buffet lunch where people stand up to eat and cutlery is not available.	85.1 Lunchtime arrangements will be discussed through patient meetings to review patient satisfaction and consider alternatives.	Paul Tossi: Service Manager	Head of Service	31/05/2015	Blue	**Progress to date: 28.05.15:** The arrangements have been reviewed and agreed with patients. This includes food at lunchtime and whether the patients wanted a sit down meal once per week. This is evidenced within the community meeting minutes.	PATIENT EXPERIENCE & ENGAGEMENT
86	LD inpatients	Ridgeway Centre	The trust should consider whether it is safe for staff to start working at the Ridgeway Centre prior to their disclosure and barring checks being in place.	86.1 The Ridgeway Centre will document the risk management plan and how it will be monitored for all staff who commence work prior to DBS checks being returned to ensure the safety of patients, carers and staff. 86.2 The risk management plans will be within the personal file of each member of staff and reviewed at each business meeting.	Paul Munday: Clinical Nurse Manager	Head of Service	01/07/2015	Blue	Recruitment processes in place as per trust policy	WORKFORCE
87	LD inpatients	Ridgeway Centre	The trust should record at the Ridgeway Centre what steps are taken to safeguard people who have been involved in a safeguarding alert to ensure that where needed a suitable protection plan is in place.	87.1 . A Safeguarding lead will be in place within the Ridgeway Centre (complete) 87.2 A log of actions relating to safeguarding will be kept (complete) 87.3 Care plans and risk assessments will be updated on RiO to detail the protection plan.	Paul Munday: Clinical Nurse Manager	Head of Service	30/04/2015	Blue	**Progress to date: 21.04.15** There has been good progress made by the team who have developed a method of tracking Adult safeguarding alerts. There is evidence of a protection plan (care plan) and the team have developed their MDT records for each patient to show progress for the patient in terms of A&T. The team are further defining these tools which will provide excellent evidence of the team's ability to track Safeguarding alerts, review of risk assessments, protection plans and MDT reviews of safeguarding issues which will include any safeguarding strategy with the LA team.	PATIENT SAFETY, REPORTING & LEARNING
88	LD inpatients	Ridgeway Centre	The trust should ensure that records of multidisciplinary meetings at the Ridgeway Centre contain a clear record of actions and the dates for these to be completed.	88.1 Individual actions are recorded in the progress notes in RiO 88.2 A rolling action log will be kept for the MDT, with agreed targets for completion	Paul Munday: Clinical Nurse Manager	Head of Service	30/04/2015	Blue	**Progress to date: 21.04.15** The process of MDT records and identification of actions has been devised. This is progressing well and the team are refining the records to ensure that each patient MDT record has SMART actions and that actions are tracked and outcomed for each patient's MDT meeting record. COMPLETED	CAREPLANNING / RECORDKEEPING
89	LD inpatients	Westview/ Ashford	The trust should ensure on Woodhaven that blanket restrictions about the use of pens are kept under review.	89.1 Pens will no longer be restricted across the service, but will be risk assessed on individual need	Gavin Tulk: Senior Clinical Nurse	Head of Service	31/03/2015	Blue	**Progress to date:** COMPLETED	CAREPLANNING / RECORDKEEPING

90	LD inpatients	Westview/ Ashford	The trust should ensure that when people are in seclusion on Woodhaven that they are medically reviewed at the correct time intervals.	90.1 A flow chart has been added to the Seclusion folder for Ashford and Westview, to ensure staff are reminded of the process. 90.2 A review of all seclusions will be undertaken by the Ward Manager/Clinical Services Manager in conjunction with the MHA team as part of their annual programme	Gavin Tulk: Senior Clinical Nurse	Head of Service	Complete	Blue	**Progress to date:** COMPLETED	CAREPLANNING / RECORDKEEPING
91	LD inpatients	Westview/ Ashford	The trust should review the physical environment in the seclusion room located in the Ashford Unit in Woodhaven to ensure peoples privacy and dignity is maintained if they use the toilet.	91.1 Film will be added to the window in the seclusion room to protect the privacy and dignity of patients, whilst ensuring observations are able to safely take place - **complete**	Head of Service	Paul Johnson E&FM	Complete	Blue	**Progress to date:** COMPLETED	PATIENT EXPERIENCE & ENGAGEMENT
92	LD inpatients	Westview/ Ashford	The trust should ensure on Woodhaven that care plans providing specific health related guidance such as how to support a person who has epilepsy are signed by the appropriate care professionals.	92.1 Care plans are recorded on RiO - they are not signed by professionals but RiO automatically records the name of the person who has devised the care plan and who reviewed the care plan. 92.2 Staff have received RiO training in December 2014.	Gavin Tulk: Senior Clinical Nurse	Head of Service	31/03/2015	Blue	**Progress to date: 21.04.15** Evidence file includes a clear care plan for a patient who has needs related to epilepsy. RiO provides a date and time stamp of the care plan being devised and reviewed/ changed along with the details of the person who has compiled the care plan. COMPLETED	CAREPLANNING / RECORDKEEPING
93	LD inpatients	Westview/ Ashford	The trust should try and hold regular community meetings on Woodhaven to support people using the service to be engaged in how the service is operating.	93.1 Community meetings will be in place with minutes available.	Gavin Tulk: Senior Clinical Nurse	Head of Service	30/05/2015	Blue	**Progress to date: 28.05.15:** These meetings are occurring and there are copies of community meeting minutes available as evidence. COMPLETED	PATIENT EXPERIENCE & ENGAGEMENT
94	LD inpatients	Westview/ Ashford	The trust should ensure the oven on the Ashford unit Woodhaven is replaced so that people can develop their skills in preparing food.	94.1 Service users will have access to cooking facilities to develop their skills	Paul Johnson E&FM	Head of Service	31/08/2015	Blue	**Progress to date:** **28.05.15:** There are 2 cookers now available for patients to cook food during OT session etc.	ESTATES
95	Community inpatients	All inspected	the trust must ensure that controlled medicines are safely stored in accordance with legislation, trust polices and national guidance.	95.1 Estates have actioned the cupboards 95.2 Sites to be audited to check compliance 95.3 During matrons walkaround weekly checks are checked	Sarah Olley Sharon Osterfield Matthew Sheehan Fran Campbell	Laura Rothery Michelle Edwards Nicky Seargent	complete	Blue	**Progress to date:** COMPLETED Updated 24/4/15 Lymington has been reviewed and have risk assessmens in place as can not secure to solid wall. Feel risk is mitigated as far as possible and on risk register	MEDICINES MANAGEMENT
96	Community inpatients	All inspected	The trust must ensure that it has accurate assurance that medicines are stored at a temperature that ensures their effectiveness.	96.1 Immediate action taken to ensure consistent use of the thermometers. 96.2 To develop and launch a SOP and record form for fridge temperatures. - Form to support staff to identify when temperatures are not within normal range. - To audit implementation and effectiveness of form in 6 months - To include escalation procedure	Ward Managers	Inpatient Matrons	complete	Blue	**Progress to date:** Completed on the week of the inspection	MEDICINES MANAGEMENT
97	Community inpatients	All inspected	The trust must ensure FP10 prescription pads are securely managed in accordance with trust policies and national guidance.	97.1 Ensure all FP10 orders are coordinated by named individuals who are lead for the division. 97.2 All received FP10 orders are logged inclusive of serial numbers 97.3 Ensure all FP10s are returned if staff member leaves or no longer requires FP10 97.4 Ensure that clinicians store FP10s in accordance with medicines management policy 97.5 Ensure that all medications prescribed on FP10 by NMP are recorded in accordance with medicines management policy 97.6 All staff administering medication to have access to adrenaline for treatment of anaphylaxis 97.7 Controlled drugs storage and transportation in accordance with medicines management policy (All the actions above will be supported by staff briefings/awareness)	Clinical Service Directors	Chief Pharmacist	SOPs in place 30/04/2015 Audit tool developed and rolled out by 01/06/2015	Blue	**Progress 29/05/15** New SOPs in place and available to staff on trust website. Audit conducted on the usage of FP10s and action plan being developed to look at reducing the use of FP10s across the trust - action being picked up as part of CIP workplan and will be monitored via the Medicines Management Quality Programme Workstream	MEDICINES MANAGEMENT
98	Community inpatients	All inspected	The trust should ensure staff are aware of the descriptors for Never Events that relate to their area of working.	98.1 Locality Governance meetings to cover this in their next agenda - this can then be disseminated	Matrons	Helen Ludford SIRI team	30/04/2015	Blue	**Progress to date:15/04/2015** Example minutes of ISD E Locality meetings showing Never Events and Incident discussion, learning and sharing. ISD W Shared at inpatient governance meeting	PATIENT SAFETY, REPORTING & LEARNING
99	Community inpatients	Sultan / Rowan	The trust should ensure that the Mental Capacity Act 2005 is followed where the environment and locked doors could restrict patient's movement in and out of the wards/buildings.	99.1 OPMH wards posters need to be in place in community inpatient wards explaining that although the doors are locked they are free to leave. Rowan already has poster in place.	Ward Managers	Inpatient Ward Matrons	16/02/2015	Blue	**Progress to date:** COMPLETED	CAREPLANNING / RECORDKEEPING
100	Community inpatients	All inspected	The trust should ensure that where required food and fluid monitoring charts are fully completed.	100.1 Ward Managers checklist and Matron Walkabout - OPMH template to be shared with community inpatient matrons 100.2 As part of a handover SOP that is being developed it will be incorporate as part of daily bed side handover 100.3 To audit the SOP	Ward Managers	Inpatient Matrons	30/04/2015	Blue	**Progress to date:** Update 24/4/15 When a patient is identified as needing food/fluid monitoring, sheets are in place and discussed at handover using SBAR New Matrons walk around tool is being piloted and will audit food and fluid charts. COMPLETED	CAREPLANNING / RECORDKEEPING

101	Community inpatients	LNFH	The trust should ensure there is better communication between the surgeons and Lymington New Forest Hospital theatre team, to reduce risk of sudden cancellation of day surgery lists.	101.1 There is a policy in place, the division needs to ensure through SPR that when cancellations take place outside policy we raise formally with the surgeon and provider. 101.2 We are now collecting performance data around cancellations and the impact on patients which will be monitored via SPR	Sarah Olley	Laura Rothery	complete	Blue	**Progress to date:** COMPLETED	WORKFORCE
102	Community inpatients	LNFH	The trust should develop processes to effectively monitor outcomes for patients undergoing day surgery at Lymington New Forest Hospital.	102.1 To continue with the shared governance meeting with LNFH and UHS which enables two way communication in relation to sharing best practice and issues concerned. 102.2 The appointment of the Clinical Director based at LNFH has improved communication into safety issues directly. 102.3 Develop outcome measures for day surgery	Nimesh Patel Clinical lead	Peter Hockey	01/06/2015	Blue	**Progress to date:** Clinical service lead for surgery is providing information on Mortality and Mobility information that is discussed at UHS to be shared at Lymington New Forest Hospital. Commencing June 2015. Further work is in progress with UHS to strengthen closer ways of working across the sites to ensure maximum safety for patients. COMPLETED	PATIENT SAFETY, REPORTING & LEARNING
103	Community inpatients	LNFH	The trust should ensure that anaesthetists document their checks of anaesthetic machines prior to surgery.	103.1 Theatre staff to ensure anaethetist comply with equipment checks 103.2 To audit in 3 months	Claire Bycroft	Nimesh Patel	Complete	Blue	**Progress to date:** COMPLETED	WORKFORCE
104	Community inpatients	LNFH	The trust should ensure pre-operative assessment processes are streamlined so patients only have to visit Lymington New Forest Hospital on one occasion.	104.1 Review of nursing staff with recuritment of a pre-operative nurse - this is part of a larger project around processes related to theatres 104.2 Review underway in relation to day surgery - to improve patient experience due to streamlining	Ann Catteau	Sarah Olley	01/06/2015	Blue	**Progress to date:** Recruitment completed and staff in post, staff employed have previous experience of pre assessment and streamlining of services is underway. Work will continue to embed processes. COMPLETED	PATIENT EXPERIENCE & ENGAGEMENT
105	Children	All inspected	The trust should develop a transition process for transfers from child to adult services.	105.1 newly commissioned 16-19 service in School Nursing Specification- project to raise awareness of SN service to colleges and children in this age group and signpost to health services (Project in progress) 105.2 Children in Care Service up to age 25 - Health are part of partnership approach to supporting care leavers transition to adult health services - also with transfer from area to area - maintaining health continuity (This is in place now with an APP and memory stick to 'hold' health records with care leaver as data controller') 105.3 Special School Nurses- Work in partnership with Health team Paediatrician to develop health transition for children with Disabilities/Physical and or Learning (This is in place now) going forward needs commissioner clarity 105.4 Family Nurse Partnership - transition of young parents into adult services- new project as newly commissioned 105.5 Develop guidance within Trust for transition of children (In progress)	1) Ginny Taylor Operational Service Lead 2) Caz Maclean AD Safeguarding 3) Ginny Taylor 4) Liz Taylor AD Nursing Children 5)Liz Taylor AD Nursing Children	Nicky Adamson-Young Director Children's Division and Safeguarding	1) Service spec runs from August 15 - March 16 2) In place now 3)In place now 4)New service starts March 15 Young parent transfer from service in 2-3 years 5) April 2015	Green	**Progress to date:** 1) work commenced with colleges and Young people exploring how they want information - contract does not start until August 2015 2) App and credit card memory stick to form health passport live. 3)This pathway sits in special schools with the paeditrician who are not our Trusts staff and our staff contribute. We are waiting for this service to be tendered with clearer guidance re pathways **Update - 30/04/15** The CIC nurses link with Care Ambassadors who work with HCC as care leavers and represent views of Children in Care. Special School Nursing transition care plans are led by the Local Authority School Nursing 16-18 years - this service starts in August and we will undertake annual audit of 16-18 year old with regards to transition as above	CAREPLANNING / RECORDKEEPING
106	Community adults	All inspected	The trust must take action to ensure sufficient numbers of suitably qualified staff in all community teams and ensure safe caseload levels.	106.1 Maintain safer staffing programme for inpatients and ICT via weekly calls with HOP. 106.2 Daily recording of team status via SITREP. 3. 106.3 Explore Cassandra and identify pilot site. 106.4 Ensure all vacancies and absence are loaded onto NHSP platform 106.5 Access other agencies in discussion with LGM/Duty Manager/HOP	Community Matrons	Area Matrons	30/05/2015	Blue	**Progress to date:** **29/05/15 - all internal actions completed and now to be embedded** 106.1 Winchester District has a rota set in advance for all team leads to call and join in with safer staffing call	WORKFORCE
107	Community adults	Therapy	The trust must take action to ensure sufficient numbers of suitably qualified staff and reduce the waiting time for therapy assessment and treatment in those community teams where waiting times are excessive.	107.1 To review how therapy manage referrals - standardised approach to be embedded 107.2 To implement a change in process on how therapy book appointments, using admin to support and releasing clinical time - audit the amount of clinical time this releases 107.3 To review therapy service spec with Commissioners 107.4 Increase use of clinics for therapy requirements 107.5 Therapy staffing gap analysis undertaken highlighting areas of vacancy and staff turnover. Recruitment paperwork developed and submitted to panel and recruitment underway withn budget. 107.6 Best practice sharing of between sites and from other organisations	Therapy team leaders	Area Matrons	30/04/2015	Blue	**Progress to date:** Work underway with CCG as part of 2015/16 contract to review specification of Therpies and match resoruce to demand - due to be compelted within 6 months. Service Spec being reviewed as part of the ICT change process **29/05/15** 107.1 Winchester District Therapists have now undertaken training and is implementing a new application on RIO for managing AHP waits. The pathway was designed by the therapy staff. It enables a paperless system and an immediate way of managing the waiting list through RAG rating. 107.2 Winchester District has a therapy room within the New Avalon site we are working with other services to scope for equipment to enable the room to start to be used. COMPLETED	PATIENT EXPERIENCE & ENGAGEMENT

108	Community adults	All inspected	The trust must take action to ensure that medicines and prescription (FP10) pads are safely managed.	as 97 above	as 97 above	as 97 above	as 97 above	Blue	**Progress to date:** Progress 29/05/15 New SOPs in place and available to staff on trust website. Audit conducted on the usage of FP10s and action plan being developed to look at reducing the use of FP10s across the trust - action being picked up as part of CIP workplan and will be monitored via the Medicines Management Quality Programme Workstream. COMPLETED	MEDICINES MANAGEMENT
109	Community adults	All inspected	The trust must take action to ensure medication is available and relevant staff are trained in procedures when and where it may be required in a foreseeable emergency.	109.1 Ensure all staff responsible for administration of medicines have access to adrenaline and issue is recorded in a log held by team lead. 109.2 Ensure training for BLS and anaphylaxis is available for all community staff 109.3 Monitor compliance of statutory and mandatory training via service performance reviews and record actions to be taken within management supervision 109.4 Demonstrate completion of clinical competencies for staff members in the treatment of anaphylaxis 109.5 Ensure that NMP complete portfolio of evidence **Medicines Management** 109.6 Across the Hampshire health economy all adrenaline pre-filled pens (Epi-pen, Jext and Emerade) are made on the medicines formulary and available at our supplying pharmacies. 109.7 The medicines policy (MCAPP) will include a statement on the requirement for nursing staff to carry adrenaline when administering higher risk medicines e.g. vaccine, IV iron preparations.	Community Matrons Pharmacists Clinical Trainers	Chief Pharmacist	30/04/2015	Blue	**Progress to date:** **29/05/15** 109.1 Epipens for Winchester District have now been ordered as per instructions awaiting order and dispensing to all staff members however in interim ampules of adrenaline are available as usual. 109.2 All staff in Winchester District have or are booked onto BLS. There are 2 members of staff on LTS and 1 on Mat Leave that cannot complete training until they have returned to work. COMPLETED	MEDICINES MANAGEMENT
110	Community adults	All inspected	The trust must take action to ensure that when staff are administering medicines a risk assessment has been undertaken and if required appropriate arrangements are in place for the management of anaphylactic shock.	110.1 Completion of risk assessment in process for administration of medication under the guidance of a Patient Group Directive specific to specialist nursing respiratory and for immunisations within ICTs 110.2 Ensure annual completion of medicines management risk assessment in association with Pharmacy Leads 110.3 Ensure all staff administering immunisations have adrenaline with them and are in date for BLS **Medicines Management** 110.4 Across the Hampshire health economy all adrenaline pre-filled pens (Epi-pen, Jext and Emerade) are available on the medicines formulary and available at our supplying pharmacies. 110.5 The medicines policy (MCAPP) will include a statement on the requirement for nursing staff to carry adrenaline when administering higher risk medicines e.g. vaccine, IV iron preparations.	Community Matrons Pharmacists Clinical Trainers	Chief Pharmacist	30/04/2015	Blue	**Progress to date:** 1. PGD for respiratory reviewed in November 14 and ICT immunisation PGD due for review and update by teams in September 15 2. Next due July 15 3. BLS compliance monitored through workforce reports, DPR, 1:1 and PDRs. All registered staff have access to adrenaline in ampoules COMPLETED	MEDICINES MANAGEMENT
111	Community adults	All inspected	The trust should take action to ensure timely ordering and provision of specialised equipment. This is so that patients who require items such as mattresses, cushions or similar equipment which are to be used to prevent harm such as pressure ulcers receive the equipment in time to protect their health and welfare.	111.1 Identify the equipment delays reported through Ulysses (**Completed** 12/3/15). In 2014- 37 reports related to equipment supply from equipment store and 11 relate to wheelchair service provision. Thematic review being undertaken and will be shared with HCC at planned meeting 111.2 Ensure that all patients who are in receipt of care receive an assessment of risk in relation to development of pressure ulcers on admission and at weekly intervals thereafter if indicated, as well as on changes to condition (Matrons walkabout tool/Quality Assessment tool and twice yearly Pressure Ulcer audit all pick up exclusions to this regulation and report it to Divisions) 111.3 All staff able to access CEQuip training as part of induction as well as the electronic ordering system 111.4 Promote reporting of delays (and near misses) in provision of equipment through Ulysses as soon as they become apparent. 111.5 Ensure that delivery and provision of equipment is an integral part of handover of care and utilise admin resource to expedite delivery and audit annually 111.6 Once breadth and scale of issues are properly known, review whether there are any issues with contract delivery and discuss with HCC if appropriate. 111.7 If there are no issues with delivery of current contract but the terms of the contract are no longer suitable for the changes in activity level/new models of commissioned care, negotiations to commence with commissioners for support	Patrick Carroll Susanna Preedy	Michelle Edwards Laura Rotherey Nicky Seargent	30/04/2015	Blue	**Progress to date:** 1. Reviewed as part of pre panel decisions around avoidable and unavoidable pressure ulcers. 2 All staff receive training in CEQuip as part of induction 3. No incidents reported on Ulysees of recent 4. Admin sit in on handover within ICTs and are also able to request pressure relieving equipment 5. Staff made aware at development day for band 7s that evidence will be used to challenge contract provision. will attend the NEXT HES User Group (17th June) to discuss the issue/s COMPLETED	PATIENT EXPERIENCE
112	Community adults	All inspected	The trust should take action to ensure timely completion of patient records. Electronic patient record systems were found to be unreliable or difficult to use in the community setting. The trust should review and mitigate against the effects of this on patient safety, information governance and staff welfare.	112.1 Ensure all staff aware of expectation detailed in SOP 112.2 Check all staff are aware/have ROVER downloaded 112.3 Check all staff have Vodafone/3G in rural areas 112.4 Monitor compliance at management supervision and through service performance reviews 112.5 Ensure all admin staff have access to data warehouse in order to ensure reports can be shared weekly with clinicians and exceptions are escalated to team lead 112.6 basis teams are audited on unoutcomed and unvalidated notes 112.7 Forums that have tested Open Rio, user groups which are prioritising the improvements to the system - those that are considered high risk for patient safety are actioned first 112.8 Allocate enough time for record entry as paart of the patient visit	Community Matrons	Area Matrons	30/06/2015	Blue	**Progress to date:** 1. Staff made aware at induction and by exception of SOP and expectation 2 Staff aware of ROVER and poor receivers have loaded on laptops 3 3G authorised by line manager for use 4. Ongoing 5 Completed COMPLETED	CAREPLANNING / RECORDKEEPING
113	Community adults	All inspected	The trust should take action to ensure relevant emergency resuscitation is regularly checked and available use, including in premises not belonging the trust but where services are provided.	113.1 Ensure all staff carry a pocket mask - and review on matrons walkaround 113.2 Review all sites to see what emergency equipment is required and suitable 113.3 When using sites that are not trust sites, clearly assess if appropriate equipment is avaliable or if we should ensure we have our own, and what that needs to be	All Staff	Inpatient and Area Matrons	30/04/2015	Blue	**Progress to date:** 17/04/2015 (Resus Lead email) current policy (and practice) would support "chest compression only" cpr in the community, therefore we do not expect community staff to routinely carry a pocket mask, as this could delay the commencement of cpr. MH N/A (email) 1. Chase to be assessed jointly with Basingstoke Hospital in order to review resus requirements and arrangements. COMPLETED	PATIENT SAFETY, REPORTING & LEARNING
114	EOL	All inspected	The trust must improve the numbers of suitably	114.1 Maintain safer staffing programme for inpatients and ICT via weekly calls with	All staff	ICT Leads	30/05/2015	Blue	**Progress to date:**	WORKFORCE

117	EOL	All inspected	The trust should improve the processes for reporting and learning from incidents, accidents, near misses, complaints and safeguarding concerns.	117.1 Ensure learning is shared at team meetings from complaints and concerns. 117.2 Share wider learning through business and governance meetings held by LGM and ICT clinical leads 117.3Promote debriefing with MDT where safeguarding or challenging EOL cases occur. 117.4 Share patient stories through quality and safety report through CQRM and SHFT quality committee. 117.5 Maintain MDT and clinical reflection amongst specailist palliative care team 117.6 Promote clinical discussion and reflection at ICT meetings in order to maximise learning opportunities 117.7 Completion of IMAs with ICT clinical leads 117.8 Encourage teams to report all clinical incidences which impact upon staff/ patient or family experience 117.9 Establish LOOC group in order to share learning	Gina Winter-Bates Rachel Wilkins	Della Warren	30/04/2015	Blue	**Progress to date:** 1 Feedback given at team meetings following complaints 2. Evidenced through minutes of governance meetings 3. Debrief facilitated with childrens services and SPC. Shared routinely with CCG at 6 monthly specialist nurse reports, quarterly quality and safety report and CQRM. 5. Weekly caseload review multidisciplinary in nature 6 Evidenced on RIO and careplanning documentation at point of admission and discussion 7 Embedded in practice 8Evidenced on Ulysees and includes OOH contract discussions if issues arise within external stakeholder provision COMPLETED	PATIENT SAFETY, REPORTING & LEARNING
118	EOL	All inspected	The trust should improve the timeliness of the provision of equipment to patients receiving end of life care at home.	As 111 above	As 111 above	As 111 above	As 111 above	Blue	As action 111	PATIENT EXPERIENCE
119	Urgent care (MIU)	All inspected	The trust must ensure that appropriate arrangements are in place to support the administration of appropriate medicines to meet the needs of patients	119.1 External review currently taking place of of MIU services 119.2 PGDs in place	MIU Team Lead	Gina WinterBates	completed during inspection week	Blue	**Progress to date:** completed during inspection week	MEDICINES MANAGEMENT
120	Urgent care (MIU)	All inspected	The trust must ensure that Patient Group Directions are authorised by the trust are agreed by staff and are aligned to the medicines stocked in the MIUs.	120.1 PGD review has been completed and all PGDs are now up to date. 120.2 Encouraging practitioners to complete their NMP courses	MIU Team Lead	Gina WinterBates	completed during inspection week	Blue	**Progress to date:** completed during inspection week	MEDICINES MANAGEMENT
121	Urgent care (MIU)	All inspected	The trust must improve the management of FP10s and ensure an audit trail for safe and appropriate use.	Actions as above - 108 and 97	MIU Team Lead MIU Pharmacists	Chief Pharmacist	in place	Blue	**Progress to date:** COMPLETED	MEDICINES MANAGEMENT
122	Urgent care (MIU)	LNFH MIU	The trust must review the storage and security of medicines held in the Lymington MIU.	122.1 This will form part of the external review	Chief Pharmicist Tracy England - PFI contracts manager - carrying out any work required	Chief Pharmicist Tracy England - PFI contracts manager - carrying out any work required	As early as practical within 2015/16 financial year, following approval of the capital programme.	Green	IN PROGRESS	MEDICINES MANAGEMENT
123	Urgent care (MIU)	All inspected	The trust should ensure that up to date treatment protocols that reflect NICE and evidence based practice guidance are in place and used by staff in MIUs	123.1 External review underway - will determine models of care 123.2 All treatment protocols to be updated and maintained by ENP's in accordance with current best practice.	MIU Team Leads	MIU Matrons Clinical Services Directors	in place	Blue	**Progress to date:** The staff all have access to the NICE guidance website and follow the pathways COMPLETED	GOVERNANCE
124	Urgent care (MIU)	All inspected	The trust should consider developing the use of technology and telemedicine to support the delivery of effective clinical care.	124.1 Included in the Trust wide MIU review and redesign. Recommendations to be taken forward with Commissioners	Inpatient Matrons	Sara Courtney and Paula Hull	review completes end Feb 15. Redesign workshop planned March 15	Green	**Progress to date:** All internal actions identified have been completed. External review commenced Jan 15. 17/04/2015 This is part of the MIU review and away day with the CCG – which will be arranged once the external review report has been received	PATIENT SAFETY / LEARNING
125	Urgent care (MIU)	Petersfield MIU	The trust should consider how X-ray services and fracture clinics can become more assessable to patients attending Lymington and Petersfield MIU's.	125.1 X-ray services at Petersfield currently provided by PHT who do not operate for the whole time that MIU is open 125.2 MIU external review to recommend model of care - including diagnostic support to units 125.3 Contracting negotiations to take forward review recommendations	Inpatient Matrons	Michelle Edwards Faye Prestleton	review completes end Feb 15. Redesign workshop planned March 15	Green	**Progress to date:** All internal actions identified have been completed. External review commenced Jan 15. 17/04/2015 This is part of the MIU review and away day with the CCG – which will be arranged once the external review report	PATIENT SAFETY, REPORTING & LEARNING
126	Urgent care (MIU)	All inspected	The trust should ensure that MIU staff have opportunities for training and development to enhance their clinical practice	126.1 To ensure use of LBR training includes all staff 126.2 To ensure staff development is discussed at Appraisals	MIU Team Leads	Inpatient Matrons	01/06/2015	Blue	**Progress to date: 29/05/15** All appraisals are booked in line with the annual plan.	WORKFORCE
127	Urgent care (MIU)	All inspected	The trust should ensure that MIUs are able to support the needs of patients in vulnerable circumstances.	127.1 Ensure Level 3 Safeguarding training remains up to date; prevent training is ongoing to achieve compliance 127.2 All staff to receive Dementia awarness training. Need to ensure that when MIU at Petersfield is refurbished/relocated that Dementia friendly areas are incorporated 127.3 Develop easy read leaflets for patients with learning disabilities / dementia to aid understanding of the service provided.	MIU Team Leads	Inpatient Matrons	01/06/2015	Blue	**Progress to date: 17/04/2015** 127.1 Dates booked for all staff to attend PREVENT and Safeguarding Level 3 training (last one being 30/06/15) Also specific Safeguarding action plan for the department in place COMPLETED	PATIENT SAFETY, REPORTING & LEARNING
128	Urgent care (MIU)	All inspected	The trust should work with staff, patients and partner organisations to develop a service strategy and vision for the MIU's based on assessment of needs of the local population and health economy.	128.1 Regular meetings with CCG to discuss service level agreements and ensure we are addressing needs 128.2 Delivery of the external review recommendations	Inpatient matrons	Sara Courtney and Paula Hull	review completes end Feb 15. Redesign workshop planned March 15	Green	**Progress to date:** All internal actions identified have been completed. review commenced Jan 15 17/04/2015 This is part of the MIU review and away day with the CCG – which will be arranged once the external review report has been received	PATIENT SAFETY, REPORTING & LEARNING

129	Urgent care (MIU)	Petersfield MIU	The trust should consider how Petersfield MIU can access electronic systems of other emergency departments and accesses the child at risk register.	129.2 Awaiting outcome of Trust Safeguarding visit although Safeguarding team were satisfied that sufficient systems were in place to safeguard children despite not having access to at risk register	Inpatient matron for Petersfield and Lymington Hospitals	Sara Courtney and Paula Hull	review completes end Feb 15. Redesign workshop planned March 15	Green	**Progress to date:** All internal actions identified have been completed. External review commenced Jan 15 16/04/2015: This is part of the MIU review and away day with the CCG – which will be arranged once the external review report has been received The Safeguarding team inspected the unit after the CQC inspection and were happy with current state. The post review away day will review additional ICT requirements re Cedar unit	PATIENT SAFETY, REPORTING & LEARNING
27a NEW	Community-based Mental Health Services for Adults of Working Age	Winchester & Andover CMHT	Consider following infection control best practice to have a sink in the clinic room.	27.1 Work with estates project management team to identify options. When complete identify whether capital bid application would be required. If required install a clinical hand wash sink into the clinic room Winchester CMHT noting this will lead to a fully service wide review of CMHT clinic facilities.	Site Manager	Service Manager	11/06/2015	Blue	**Progress to date:** Consideration should be given to the estates rationalisation programme which has identified that the CMHT base may be closing in the near future. Clinical staff continue to use effective hand hygiene practices utilising alcohol gel whilst the decision is being finalised. IP&C agreed provision is adequate for the service provided	ESTATES
70 *	OPMH inpatients	Dryad Ward	Improvement in understanding on Dryad of interplay between the MHA and MCA to ensure that people are protected from risk of unauthorised deprivations of liberty.	70.1 Ward Manager/Modern Matron to ensure team training compliance with MHA and MCA. 70.2 Ward manager to check with team/ individual understanding and action appropriately. 70.3 Modern matron/service manager to review MHA administration cover to ensure appropriate support is available for periods of Annual leave/unexpected leave. 70.4 Weekly MHA administrators spreadsheet to be implemented	Ward Manager. Karen Scott. Modern Matron Toni Scammell. OPMH Inpatient Service Manager. Kathy Jackson. MHA administrator.	Tracey Eddy - Inpatient Clinical Director OPMH inpatient Matrons	30/04/2015	Blue	**Progress to date:** Ward staff completed training in appropriate aspects of mental health Act and mental capacity Act recognising that training will be ongoing for new starters & refresher training. Weekly spreadsheet now available and mental health act administrator cover being arranged for when current post holder on leave.	CAREPLANNING / RECORDKEEPING
70a *	OPMH inpatients	All inspected	Ensure that recruitment continues so that staffing levels and stability of staff teams can be embedded.	70a.1 All wards have agreed staffing establishments. 70a.2 Ward manager and modern matron review each vacancies and agree skill mix is appropriate. 70a.3 Administrator has been allocated to process all vacancy applications to fortnightly ISD panel. 70a.4 There are difficult geographical area's to recruit to, these have ongoing additional recruiting process.	Ward Manager. Modern Matron. Recruitment administrator. ISD panel.	Tracey Eddy - Inpatient Clinical Director OPMH inpatient Matrons	30/04/2015	Blue	**Progress to date:** Some success with recruitment. Rolling adverts continue. OPMH Inpatients participating in recruitment initiatives. One administrator coordinating recruitment for five OPMH Wards. Bank & Agency fill rates being monitored weekly via flash reports, conference calls & trust wide meetings.	WORKFORCE
70b *	OPMH inpatients	All inspected	Ensure that relevant learning from the Mental Health division is not lost and the specialism within older people's mental health is retained on a ward level and that teams are aware of their responsibilities under the Mental Health Act.	70b.1 Modern matron's to coninue to link with MH division PAG. Inpatient staff to continue to meet training requirements for mental health.	Ward manager. Modern Matron. Team members.	Tracey Eddy - Inpatient Clinical Director OPMH inpatient Matrons	30/04/2015	Blue	**Progress to date:** OPMH Inpatients Modern Matron attending MH PAG for the East Division. All mental health staff complete relevant mental health training.	PATIENT SAFETY, REPORTING & LEARNING
70c	OPMH inpatients	All inspected	Ensure that there are systems in place to report and follow up safeguarding alerts which are raised with the local authority to ensure that learning from alerts and referrals can be brought back into the service.	Divisional Safeguarding lead Kathy Jackson to ensure regular lisiaon with corporate Safeguarding team to improve communication from the clinical teams through to safeguarding panels	Kathy Jackson	Sara Courtney	01/04/2015	Blue	**Progress to date:** Divisional lead in place who meets a minimum of monthly with the named nurse for safeguarding. Lead attends Trustwide safeguarding forum. Structures being developed in East Division. Named nurse for safeguarding or representative will attend the OPMH Inpatients Operational/Patient Safety/Governance meeting on a monthly basis.	
70d	REMOVED BY CQC FOLLOWING FACTUAL ACCURACY CHANGES										

Total = 129		
	Blue	106
	Green	23
	Amber	0
	Red	0
	Not begun	0
		129