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Health Overview and Scrutiny Panel

DOCUMENTS FOR THE MEMBERS ROOM

Thursday, 26th October, 2017
at 6.00 pm

MEMBERS ROOM DOCUMENTS ATTACHED TO THE LISTED REPORTS

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MEMBERS ROOM DOCUMENTS

7 UPDATE ON PROGRESS - SOUTHERN HEALTH NHS FOUNDATION TRUST
(Pages 1 - 12)

- MRD 1 - CQC March 2017 Improvement Plan
- MRD 2 - Family Involvement Action Plan

Wednesday, 18 October 2017 SERVICE DIRECTOR, LEGAL AND GOVERNANCE

Improvement Plan for: CQC Inspection Recommendations - March 2017

NHS Southern Health NHS Foundation Trust

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25/08/2017

UIN	Requirement Notice / MUST or SHOULD?	Core Service	Location	CQC Action (from the Inspection Report)	Regulation Breached	Cause of Regulation Breach	Trust Wide Actions Required	Responsible Leads	Executive Accountability	Action to be completed by (date)	Required Evidence to show completion
RN001 1.1	REQUIREMENT NOTICE/ MUST	Wards for older people with mental health problems	Beaulieu Ward, Western Community Hospital	The trust must ensure that where patients are on one to one nursing observations, staff maintain and review these in line with organisational policy and they do not change them in order to manage low staffing levels.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Beaulieu ward staff reduced patient observation levels to manage low staff numbers.	1.1 Safer Staffing Lead to review red flagged staffing incidents and escalate to Associate Directors of Nursing if staffing levels have impacted on one to one nursing observations.	Kathy Jackson, Head of Inpatients supported by Sue Jewell, Safer Staffing Lead.	Sara Courtney, Acting Director of Nursing	30.11.17	Monthly Safer Staffing reports.
RN001 1.2							1.2 Circulate correct escalation process for inadequate staffing levels. Staff to report staffing incidents as per Safer Staffing Policy.			31.10.17	Escalation process circulated. Staffing incidents are reported - review Ulysses.
RN001 1.3							1.3. Ensure robust procedure is in place for the review of patient one to one observations within MDT. Identify other staff groups who could support one to one observations e.g. OTs.			31.10.17	Review sample of patient records for one to one observations in MDT discussions.
RN001 1.4							1.4. Ensure compliance with E-Roster checklist.			31.10.17	Completed e-roster checklist.
RN002 2.1	REQUIREMENT NOTICE/ MUST	Wards for older people with mental health problems	Stephano Olivieri, Melbury Lodge, Berrywood/Beaulieu wards, Western Community Hospital	The trust must ensure that all do not attempt cardiopulmonary resuscitation (DNACPR) records and sharing of DNACPR information are correct and consistent at all times.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	We found on Stefano Olivieri, Berrywood and Beaulieu ward issues relating to best interest meetings and covert medication practices and the sharing of correct information amongst staff related to DNACPR procedures.	2.1 To review the best interests section in the DNACPR Policy and strengthen as required. This will include the development and circulation of flowcharts for staff on a) how to complete DNACPR forms b) what information to check on DNACPR forms completed elsewhere for patients transferring into our care.	Simon Johnson, Head of Essential Training Delivery supported by Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett	Sara Courtney, Acting Director of Nursing	30.09.17	Revised guidance is circulated to staff. Flowcharts are developed and in place.
RN002 2.2							2.2 The resuscitation team to complete an initial audit of the DNACPR process with actions developed based on audit findings.			30.09.17	Results and report of DNACPR audit and action plan.
RN002 2.3							2.3 The resuscitation team to complete 3 x bi-monthly DNACPR audits (Oct/Dec 17/Feb 18) to ensure any actions required are embedded into everyday practice. At end of this period review need for further audit.			28.02.18	Results and reports of DNACPR audits and action plans per audit.
RN002 2.4							2.4 To include the importance of patient and family involvement in DNACPR decisions and documentation of mental capacity in trust training.			30.11.17	Training materials.
RN003 3.1	REQUIREMENT NOTICE/ MUST	Wards for older people with mental health problems	Stephano Olivieri, Melbury Lodge	The trust must ensure that the privacy and dignity of the patients on Stefano Olivieri ward is adequately protected.	Regulation 10 (1) and (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Dignity and respect	There were privacy and dignity issues relating to the bathroom facilities on Stefano Olivieri. Patients from the adjoining acute admissions ward were able to see into the toilet and bathrooms on Stefano Olivieri ward.	3.1 New windows are on order which will resolve privacy issues. These should be installed by end November 2017.	Kathy Jackson, Head of Inpatients supported by Scott Jones, Deputy Head of Estates Services	Paula Hull, Acting Director of Operations (ISD)	30.11.17	Site visit to confirm installation of windows in place and privacy issues resolved.
RN003 3.2							3.2 To review privacy and dignity PLACE results for Stephano Olivieri (SOU) ward and implement actions based on feedback as appropriate.			31.10.17	PLACE feedback and action plan where appropriate.
RN003 3.3							3.3 Estates team to review the current position of the garden boundary between SOU and adjacent wards and provide options of alternative configurations.			31.09.17	Results of estates review and options proposal.
RN003 3.4							3.4 Estates solution to be implemented once decision made regarding options at senior level.			28.02.18	Site visit to confirm estates work completed per decision made.
RN004 4.1	REQUIREMENT NOTICE/ MUST	Wards for older people with mental health problems	Wards for older people with mental health problems	The trust must ensure that it continues with and completes all outstanding ligature works.	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	The environmental improvement plan had not been completed across some wards improvement plan was not yet complete. The trust must complete this to ensure all wards are safe and that ligature risks are mitigated.	4.1 Estate Services will conduct a review of all OPMH wards to ensure that all remaining ligature works have been undertaken and /or are in progress and that the environmental work plans have been updated to reflect the accurate position.	Kathy Jackson, Head of Inpatients supported by Karen Thomas, Ligature Project Manager Scott Jones, Deputy Head of Estates Services	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	30.11.17	Completed capital projects signed off in ligature management group.
RN004 4.2							4.2 To complete estates works to provide all OPMH functional wards with 2 'safe' bedrooms.			31.12.17	Site visit to confirm bedrooms are completed.
RN005 5.1	REQUIREMENT NOTICE/ MUST	Wards for older people with mental health problems	Stephano Olivieri, Melbury Lodge, Berrywood/Beaulieu wards, Western Community Hospital	The trust must ensure that staff use covert medication in a manner that is in line with organisation's policy and procedure.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	We found on Stefano Olivieri, Berrywood and Beaulieu ward issues relating to best interest meetings and covert medication practices and the sharing of correct information amongst staff related to DNACPR procedures.	5.1 To review current covert medicines guidance, strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	Dr Sarah Constantine, Medical Director	31.10.17	Revised covert medicine guidance completed and circulated.
RN005 5.2							5.2 Retrain registered nurses on SOU, Berrywood and Beaulieu wards in administration of covert medicines.			31.10.17	Training sessions evidenced.
RN005 5.3							5.3 OPMH ward managers to complete weekly checklists which include covert medicines and take to monthly OPMH managers meeting for review and escalation as required.	Kathy Jackson, Head of Inpatients		30.11.17	Minutes of monthly OPMH managers meeting.
RN005 5.4							5.4 Medicines Management Committee (bi-monthly) to review incidents across the trust for re-occurrence of covert medication/best interests incidents.	Raj Parekh, Chief Pharmacist		31.12.17	Minutes of Medicines Management Committee.
RN006 6.1	REQUIREMENT NOTICE/ MUST	Community-based mental health services for older people	Gosport team	The trust must assess staff caseloads in the Gosport team and ensure there is sufficient staff capacity to manage allocated caseloads.	Regulation 18 (1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing	The provider had not ensured there were sufficient members of staff at Gosport to meet the numbers of patients on the caseload.	6.1 To complete a caseload review with the Gosport team, comparing to other OPMH team caseloads and implement actions where required, including discussions with commissioners about the service needs/capacity.	Helen Neary, Associate Director of Nursing and AHPS supported by Sue Jewell, Safer Staffing Lead	Paula Hull, Acting Director of Operations (ISD)	28.02.18	Results of caseload review and action plan in place.
RN006 6.2							6.2 Caseload review to include active discharge of patients where appropriate.			28.02.18	Results of caseload review - caseload figures on tableau to evidence discharge process.
RN007 7.1	REQUIREMENT NOTICE/ MUST	Community-based mental health services for older people		The trust must ensure that next of kin details are clearly recorded on the patient care records.	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	There was inconsistent completion of next of kin details in care records	7.1 Review Next of Kin compliance at monthly divisional governance/performance meetings to ensure target '80% of patients have next of kin/other relationships recorded' is met and maintained over 3 months. 22 August NoK ISD 80.8%; OPMH 85.1%; MH 74.0%; LD 84.5%.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	Sara Courtney, Acting Director of Nursing	31.12.17	Minutes of divisional governance/performance meeting with NoK compliance minuted.
RN008 8.1	REQUIREMENT NOTICE/ MUST	Community-based mental health services for adults of working age		The trust must ensure that staff update relevant care records fully and in a timely manner when changes to a patients' risks are identified.	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	There was poor completion of crisis plans and there was risk information missing from care records we reviewed for people accessing the service.	8.1 Every patient must have an up to date and individualised risk assessment which is clearly accessible within the clinical records (Quality Account Priority). Risk assessment completion to continue to be monitored using Tableau including timeliness. Quarterly record keeping audit will monitor compliance. Target is 95% of patients have a risk assessment as per Risk Assessment Policy.	Associate Directors of Nursing and AHPs: Carol Adcock, John Stagg, Nicky Bennett	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	31.03.18	Results of record keeping audits and actions to be implemented based on recommendations.

RN008 8.2							8.2 Development of a framework and guidance tool to support clinicians developing crisis contingency plans with patient and carer/family input (Quality Account priority).			**completed**	Framework and guidance tools in place.
RN008 8.3							8.3 Audit of Risk summary to be analysed for quality as part of clinical audit programme and subsequently as part of supervision. The record keeping and holistic assessment audits will be strengthened to focus on the quality of risk assessment and crisis contingency plans and the programme will facilitate a quarterly audit (Quality Account priority).			31.03.18	Results of record keeping audits and actions to be implemented based on recommendations.
RN008 8.4							8.4 Associate Directors of Nursing and AHPs (ADONS) will complete a sample review of 2 patients per month using a standard template on risk assessment and crisis plan completion. ADONs will take action as required to address compliance issues.			31.01.18	Exception reporting for sample cases reviewed.
RN008 8.5							8.4 Clinical staff to undertake mandatory risk training as per policy.			31.12.17	Training compliance figures (tableau).
RN009 9.1	**REQUIREMENT NOTICE/ MUST**	Community-based mental health services for adults of working age		The provider must ensure that there are crisis plans in place for patients accessing the service, where risk assessments indicate this is required.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	There was poor completion of crisis plans and there was risk information missing from care records we reviewed for people accessing the service.	9.1 A communication plan to be developed to ensure staff are aware of how to be adherent to the policy: specifically when to complete crisis, safety or combined plans.	Carol Adcock, Associate Director of Nursing and AHPs	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	31.10.17	Copy of the communication plan
RN009 9.2							9.2 Monthly compliance with completion of crisis plans to be reported at the Mental Health Quality and Safety Meeting (QSM).			30.11.17	Minutes of QSM
RN010 10.1	**REQUIREMENT NOTICE/ MUST**	Community-based mental health services for adults of working age		The trust must ensure that next of kin details are clearly recorded on the patient care records	Regulation 17 (1) and (2)(b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	There was inconsistent completion of next of kin details in care records	**see actions in 7 above**				
RN011 11.1	**REQUIREMENT NOTICE/ MUST**	Community-based mental health services for adults of working age		The trust must ensure there are sufficient numbers of suitably qualified/trained and competent staff to meet the needs of the numbers of patients on their caseloads.	Regulation 18 (1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing	There were insufficient members of staff to meet the numbers of patients on the caseload in some of the teams.	11.1 To bring acuity and dependency measurement for Community Mental Health Teams (CMHTs) in line with existing trust establishment review process as identified within the Safer Staffing Policy.	Carol Adcock, Associate Director of Nursing and AHPs supported by Sue Jewell, Safer Staffing Lead	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	30.11.17	Results of acuity and dependency review.
RN012 12.1	**REQUIREMENT NOTICE/ MUST**	End of life care		The trust must ensure that do not attempt cardiopulmonary resuscitation (DNACPR) forms are completed in line with national guidance.	Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent	All of the do not attempt cardio-pulmonary resuscitation (DNACPR) forms we reviewed were not completed in line with national guidance.	**see actions in 2 above**				
RN013 13.1	**REQUIREMENT NOTICE/ MUST**	End of life care		The trust must improve appraisal rates for community nursing staff.	Regulation 18 (1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing	Appraisal rates for community nursing staff were low	13.1 Appraisals to be completed for community teams and to be in line with Trust target.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	Paula Hull, Acting Director of Operations (ISD)	31.12.17	Appraisal performance data for community teams.
RN014 14.1	**REQUIREMENT NOTICE/ MUST**	End of life care		The trust must ensure that individualised care for patients at end of life is planned and delivered for patients cared for at home.	Regulation 9 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Person-centred care	Care was not always provided person centred because: The trust did not use individualised end of life care plans for patients cared for at home.	14.1. Roll out of the end of life care plan for use in the community team.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	Sara Courtney, Acting Director of Nursing	31.10.17	End of Life Care Plan for use in community.
RN014 14.2							14.2. undertake road shows to promote the use of end of life care plan.			**completed**	Dates and attendance at roadshows.
RN014 14.3							14.3. Audit the use of the end of life care plan in quarter 3 thematic review.			28.02.18	Results and report on the audit/thematic review.
RN015 15.1	**REQUIREMENT NOTICE/ MUST**	End of life care		The trust must ensure that community staff have access to up to date information in the record of patients at end of life who are cared for at home.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	All community staff did not have access to up to date information in the record of patients at the end of life.	15.1. Improve compliance with completion of patient record on the day of care.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	Sara Courtney, Acting Director of Nursing	28.02.18	RiO change request is actioned.
RN015 15.2							15.3 To scope the numbers of staff that are able to use Store and Forward; maximise the use of existing licences and develop a business case for additional licenses if required.			31.12.17	Results of scoping exercise- may be part of thematic review.
RN016 16.1	**REQUIREMENT NOTICE/ MUST**	End of life care	Romsey Hospital	The trust must ensure that appropriate support is available to community hospital staff to respond to end of life care patients who deteriorate.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Staff at Romsey Hospital did not have access to timely support to respond to end of life care patients who deteriorated.	16.1. Review pathway for transfer of care between Romsey hospital and the acute services.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	Sara Courtney, Acting Director of Nursing	31.01.18	Pathway Review completed.
RN016 16.2							16.2. Raise with Consultant responsible for Romsey hospital the importance for having clear plans in place for escalation of care and document in the medical notes.			30.11.17	Individual escalation plans for patients at end of life in place.
RN016 16.3							16.3. To discuss with staff at team meetings the escalation plans in place for patients and the need to act on these as required.			30.11.17	Staff follow escalation plans for individual patients.
RN016 17.1	**REQUIREMENT NOTICE/ MUST**	Community Inpatient services	Gosport War Memorial Hospital	The trust must have appropriate measures in place to ensure that staffing levels are safe for every shift and in particular at Gosport War Memorial hospital.	Regulation 18 (1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing	There was not always adequate staffing to meet the assessed needs of people receiving care and treatment. This included patients who required 1:1 support and on night duty.	17.1 To review daily staffing levels in line with Safer Staffing Policy and escalate as per real time management of staffing levels guidance. Bespoke policy training can be provided if required.	Helen Neary, Associate Director of Nursing supported by Sue Jewell, Safer Staffing Lead	Sara Courtney, Acting Director of Nursing	31.10.17	Safer Staffing Policy
RN016 17.2							17.2 Implementation of SafeCare which will provide live staffing status of safe staffing levels based upon patient needs and actual staffing levels.			31.03.18	SafeCare is in place.
RN018 18.1	**REQUIREMENT NOTICE/ MUST**	Community Inpatient services		The trust must ensure that staff complete mandatory training, including basic and advanced life support, to safeguard patients receiving care.	Regulation 18 (1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing	All clinical staff had not completed basic life support training which could impact of the welfare and safety of patients receiving care at the service.	18.1 LEaD to continue to review the 5 teams per division with the lowest training compliance and contact managers/individual staff to action where required. Bespoke training can be arranged if whole ward/large team requires training update.	Associate Directors of Nursing Julia Lake, Susanna Preedy, Helen Neary supported by Simon Johnson, Head of Essential Training Delivery	Sara Courtney, Acting Director of Nursing	31.01.18	Training compliance data per team/division - training target 95% within trust. E-mail reminders to staff /automatic reminders to staff of training requiring completion.
RN019 19.1	**REQUIREMENT NOTICE/ MUST**	Community Inpatient services		The trust must ensure that all medicines are managed in line with manufacturers guidelines, and that when opened they are labelled with the patient's name and administered accordingly.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Staff did not follow policies and procedures about managing medicines. Medicines were not stored safely and systems were not effective to ensure medicines were used within the recommended timescale once opened. Patients were put at risk of receiving medicines that had expired.	19.1 To review current guidance on single use of medicines and strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	Dr Sarah Constantine, Medical Director	31.10.17	Revised single use of medicines guidance.
RN019 19.2							19.2 To include single use of medicines in the annual Safe and Secure Medicines audit.			30.11.17	Audit tool - Safe and Secure Medicines
RN019 19.3							19.3 Audit to be completed across all inpatient units/wards with action plans developed based on audit recommendations.	Associate Directors of Nursing Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky		31.12.17	Audit results/reports and completed action plans.

RN019 19.4							19.4 To review the current Medicines Management Quality Checklist and add information to check that correct procedure to follow for single use medicines is followed.	Raj Parekh, Chief Pharmacist		30.09.17	Revised Medicine Management Quality Checklist.
RN019 19.5							19.5 Medicines Management Committee (bi-monthly) to review progress with completion of audit actions.	Raj Parekh, Chief Pharmacist		31.12.17	Minutes of Medicines Management Committee.
RN020 20.1	**REQUIREMENT NOTICE/ MUST DO**	Community Inpatient services		The trust must ensure that staff adhere to policies and procedures for the safe management of medicines at all times to protect patients from the risk of harm.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Staff did not follow policies and procedures about managing medicines. Medicines were not stored safely and systems were not effective to ensure medicines were used within the recommended timescale once opened. Patients were put at risk of receiving medicines that had expired.	20.1 To develop guidance on expiry dates for medicines for use by staff on wards and circulate. This guidance to include use of stock insulin.	Raj Parekh, Chief Pharmacist supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	Dr Sarah Constantine, Medical Director	30.09.17	Copy of Expiry Guidance for wards and evidence that it has been circulated.
RN020 20.2							20.2 To design and order expiry date labels for use with all patients' liquid medicines and insulin.	Raj Parekh, Chief Pharmacist		31.08.17	Example of expiry date label.
RN020 20.3							20.3 To review the current Medicines Management Quality Checklist and add information to check that correct procedure to follow for medicine expiry dates is followed.	Raj Parekh, Chief Pharmacist		30.09.17	Copy of revised Medicines Management Quality Checklist and completion by wards.
RN020 20.4							20.4 Medicines Management Committee (bi-monthly) to review progress with completion of action.	Raj Parekh, Chief Pharmacist		31.12.17	Minutes of Medicines Management Committee.
RN021 21.1	**REQUIREMENT NOTICE/ MUST**	Community Inpatient services	Gosport War Memorial Hospital	The trust must ensure that all staff follow effective infection control procedures when dealing with and disposing of infected materials. In particular, at Gosport War Memorial Hospital.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Some staff did not follow effective infection control procedures in particular when dealing with and disposing of infected materials at Gosport War Memorial Hospital	21.1 Include CQC feedback and actions in quarterly IPC Report and Newsletter.	Theresa Lewis, Lead Nurse Infection, Prevention and Control supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett supported by Bob Beeching, Contracts and Project Manager and Sally Banbery(Trust Waste Manager), Karen Poting (GWMH site waste manager)	Sara Courtney, Acting Director of Nursing	31.12.17	IPC Quarterly Report /IPC Newsletter IPC Matters (Quarter 3)
RN021 21.2							21.2 Infection Prevention and Control (IPC) team to discuss best practice /CQC feedback at 'face to face' training sessions.			31.12.17	IPC Quarterly Report to include training sessions.
RN021 21.3							21.3 IPC team to add CQC feedback and actions for next IPC Link Advisor meeting .			31.10.17	Minutes of IPC Link Advisor Meetings due in October 2017.
RN021 21.4							21.4 IPC advisors to observe staff practice when undertaking 'back to the floor' visits.			31.12.17	Back to the floor' visit timetable and feedback by exception from any visit.
RN021 21.5							21.5 IPC team to circulate waste disposal guidance summary to teams.			**completed**	Waste Disposal Guidance circulated.
RN021 21.6							21.6 IPC team to monitor that staff are in date with their IPC training (> 95%) and raise low compliance with team managers.			31.12.17	IPC training compliance.
RN021 21.7							21.7 Ensure that IPC is part of the organisational induction checklist for non-permanent staff (in Organisational Induction Policy).			30.09.17	Local Induction Checklist in place.
RN021 21.8							21.8 Estates services to develop and circulate poster with all relevant laundry guidance and links to web pages which has all the information on linen handling.			30.09.17	Poster in place.
RN021 21.9							21.9 Estates services to lead on completion of laundry audit based on Laundry Policy by site managers and to support development of action plan by teams based on results where required.			30.11.17	Results of audit and action plan based on recommendations.
RN022 22.1	**REQUIREMENT NOTICE/ MUST**	Community Inpatient services		The trust must ensure that all equipment used for providing care or treatment is safe for use at all times and meets the needs of the patients.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Equipment was not maintained safely and the drug fridge which was in use had not been serviced in line with recommendations and the trust policy.	22.1. Review the specific fridge in Gosport War Memorial Hospital and check service history with BCAS - complete service if it is overdue.	Associate Directors of Nursing: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor supported by Tracey Hammond, Medical Devices Advisor Sally Banbery, BCAS contract manager	Sara Courtney, Acting Director of Nursing	31.08.17	All equipment has been serviced and is in date - evidenced by the BCAS equipment list.
RN022 22.2							22.2. Ensure all equipment is labelled with the correct service sticker.			31.10.17	Spot check audits.
RN022 22.3							22.3. Meet with BCAS to agree that they will check each piece of equipment as they service it and remove any old service to PAT testing stickers.			31.08.17	Minutes of Meeting 16.08.17.
RN022 22.4							22.4. Monitor at BCAS contract meetings.			31.10.17	Any issue are raised at BCAS contract meetings and actions agreed and minuted.
RN023 23.1	**REQUIREMENT NOTICE**	Community Inpatients Service		(none in report)	Regulation 17 (1) and (2)(b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 -	The governance process to assess, monitor and improve the quality of the service was not robust. Risks were not consistently assessed in order to mitigate these. There	**TM to seek clarity from CQC re this action.**				
RN024 24.1	**REQUIREMENT NOTICE/ MUST**	Community health services for adults		The trust must ensure that all staff understand and recognise safeguarding concerns	Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safeguarding service users from abuse and improper treatment	Staff did not always recognise and escalate safeguarding concerns.	24.1 Communications to staff: 1. Distribute of NHS England Safeguarding 'Pocket Principles' Cards to all service areas. 2.Design and distribute Safeguarding Poster – when to make a referral (to complement the existing poster about how to make a referral).	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group; Safeguarding Quality Workstream	Sara Courtney, Acting Director of Nursing	1. 31.08.17 2. 31.10.17	Communications to staff: 1. Confirmation of receipt of Pocket Principles and dissemination. 2.Safeguarding Poster – when to make a referral on display
RN024 24.2							24.2 Training: 1.Design and deliver Safeguarding learning set – how to recognise abuse, neglect, and self-neglect. Bespoke training can be provided as required to identified teams. 2.The team will be carrying out a comprehensive review of mandatory training material, delivery and learning methods, and review compliance on an ongoing basis. An incremental review of Safeguarding Adults sections is underway.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group; Safeguarding Quality Workstream		1. 30.09.17 2. 31.08.17	Training: 1.Learning set materials and attendance sheet 2.Incremental Course Material (in PowerPoint presentation. Training compliance data (Tableau system)
RN024 24.3							24.3 Team Processes: 1.Confirm that Safeguarding is a standard agenda item in Multi-Disciplinary Team (MDT) meetings. 2. Confirm that Safeguarding is a standard item in all clinical supervision templates. 3.Scope the development of a network of Business Unit Safeguarding Champions, Representatives and Coordinators.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Team; Safeguarding Quality Workstream		1. 31.10.17 2. 31.10.17 3.31.10.17	Team Processes: 1. Blank template of MDT Agenda, sample audit 2. Blank clinical supervision templates, sample audit 3. Report to Safeguarding Forum
RN025 25.1	**REQUIREMENT NOTICE/ MUST**	Community health services for adults		The trust must ensure that all staff escalate safeguarding concerns following the trust and local authority safeguarding procedures	Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safeguarding service users from abuse and improper treatment	Staff did not always recognise and escalate safeguarding concerns.	25.1 Communications to staff: Confirm Safeguarding Poster on how to make a referral and access to Trust Safeguarding support are prominently displayed in all service staff areas.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group; Safeguarding Quality Workstream	Sara Courtney, Acting Director of Nursing	31.10.17	Communications to staff: 1. Confirmation of receipt of Pocket Principles and dissemination. 2.Safeguarding Poster – when to make a referral on display

RN025 25.2							**25.2 see 24.2 above**					
RN025 25.3							**25.3 see 24.3 above**					
RN026 26.1	**REQUIREMENT NOTICE/ MUST DO**	Community health services for adults	Alton Hospital	The trust must ensure that staff store medicines at the Alton intravenous clinic securely and that only staff that need to access the medicines are able to access them.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Storage of medicines in the intravenous clinic and Alton Hospital was not secure and some medicines had passed their expiry date	26.1 To review current guidance on safe and secure storage of medicines on wards and in clinics and strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	Dr Sarah Constantine, Medical Director	31.12.17	Revised safe storage of medicines guidance.
RN026 26.2							26.3 Alton Hospital to implement a process whereby the door codes are changed at agreed intervals and there are signs on medicine storage rooms 'doors must be closed'.	Susanna Preedy, Associate Directors for Nursing and AHPs		31.10.17	Signs in place - site visits required to check. Process to change door codes in place.
RN027 27.1	**REQUIREMENT NOTICE/ MUST**	Community health services for adults		The trust must work with the commissioners to improve wheelchair provision for community service patients.	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	Systems were not in place to ensure equipment (wheelchairs) was supplied by the service provider, ensuring that there were sufficient quantities to ensure the safety of the service user and to meet their needs.	27.1. To meet with CCG and wheelchair providers to agree improvements to wheelchair provision.	Helen Ludford, Associate Director of Quality Governance supported by Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	Sara Courtney, Acting Director of Nursing	30.09.17	Minutes of contract meetings.
RN027 27.2							27.2. Trust to send Millbrook any incidents that are reported regarding their wheelchair service with the requirement to respond within 1 week. Services to raise any issues related to wheelchair provision on Ulysses.			30.09.17	All incidents relating to wheelchairs reported on Ulysses and forwarded to Millbrook.
RN027 27.3							27.3. Trust to monitor service provision and raise any on-going concerns with the CCG and Millbrook as part of the contract meetings.			31.10.17	Minutes of monthly contract meetings with issues and actions minuted.
RN028 28.1	**REQUIREMENT NOTICE/ MUST**	Community health services for adults		The trust must ensure that all staff understand their responsibilities in respect of the Mental Capacity Act.	Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent	Not all staff demonstrated a full understanding of the mental capacity act or their responsibility towards it.	28.1 Communication to staff: To provide service areas with pocket guides to the Mental Capacity Act 2005. (These should continue to be issued at mandatory training sessions and by distribution to all service areas).	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group	Sara Courtney, Acting Director of Nursing	**completed**	<u>Communications to staff:</u> 1. Copy of pocket guides to the Mental Capacity Act 2005.
RN028 28.2							28.2 Training to staff: 1. To deliver bespoke training sessions on MCA & DoLS to identified teams across the Trust as required. 2. The team will be carrying out a comprehensive review of mandatory training material, delivery and learning methods, and review compliance on an ongoing basis.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group		1. 30.09.17 2.30.09.17	Training: 1. Training materials, session dates 2. Training materials
RN029 29.1	**REQUIREMENT NOTICE/ MUST**	Community health services for adults		The trust must ensure that patient records are accurate and up to date	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	Delays in staff making entries in patients' records increased the risk of incorrect information being recorded. Care plans held at patients home were not up to date.	29.1 To complete an annual programme of record keeping audits with action plans developed and implemented based on results.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor supported by Tracey McKenzie, Head of Compliance, Assurance and Quality	Sara Courtney, Acting Director of Nursing	31.03.18	
RN029 29.2							29.2 To complete monthly Quality Assessment tool in ISDs which has record keeping elements. Where required, take actions to address any shortfalls in record keeping standards.			31.12.17	
MUST				The trust must comply with requirements to provide data as requested by the CQC as a regulatory body.			**To be removed following discussion with CQC - waiting for amended CQC reports to be uploaded before final removal.**				
SD031 31.1	SHOULD	Wards for older people with mental health problems		The trust should review the ligature risk care plans to ensure that that they are individualised to patients needs and risks.	none	none	31.1 Ligature Risk Management Group to review care plan in use by OPMH wards.	Kathy Jackson, Head of Inpatients Karen Thomas, Ligature Manager	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	31.10.17	Minutes of Ligature Risk Management Group.
SD031 31.2							31.2 Review use of individualised Ligature Care plan in practice - working with Karen Thomas, Ligature Manager.			31.10.17	Results of review.
SD032 32.1	SHOULD	Wards for older people with mental health problems		The trust should consider including, in all induction packs for all new starters and agency staff, information relating ligature risks on all wards.	none	none	32.1 Ligature Risk Management Group to set minimum standards on ligature information to be included in local induction packs by teams.	Kathy Jackson, Head of Inpatients supported by Karen Thomas, Ligature Manager	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	31.10.17	Standard information for inclusion in local induction packs is circulated.
SD032 32.2							32.2 Wards to ensure local induction packs including ligature information as per trust guidance are available to new staff /agency staff.			31.12.17	Local induction packs are in place.
SD033 33.1	SHOULD	Wards for older people with mental health problems		The trust should review the trust mitigation plans for areas that are considered locked and inaccessible to patients.	none	none	**Waiting for confirmation of requirement for this action in amended CQC reports.**				
SD034 34.1	SHOULD	Community-based mental health services for older people		The trust should review the provision of psychology in Chase/Petersfield.	none	none	34.1 Review of psychology provision and if this is in line with national standards and that of other Trusts and discuss with commissioners (service not currently commissioned).	Helen Neary, Associate Director of Nursing and AHPs	Paula Hull, Acting Director of Operations (ISD)	31.12.17	Results of review and discussions with commissioners.
SD035 35.1	SHOULD	Community-based mental health services for older people	Chase Petersfield Gosport	Staff should record all multidisciplinary discussions in patient records at Chase / Petersfield and Gosport.	none	none	35.1 Template to be devised for community mental health teams /older people's mental health teams to use to record information at MDT meetings in Chase/Petersfield and Gosport.	Helen Neary, Associate Director of Nursing and AHPs Supported by Head of Nursing and AHP East ICT	Sara Courtney, Acting Director of Nursing	**completed**	template in place.
SD036 36.1	SHOULD	Community-based mental health services for older people	Chase Petersfield Gosport	The trust should review the caseloads across the service to ensure that there is equity of safe workloads and that the CPA framework is consistently applied.	none	none	36.1 To bring acuity and dependency measurement for Community Older People's Mental Health Teams in line with existing trust establishment review process as identified within the Safer Staffing Policy. See 37 for CPA actions.	Helen Neary, Associate Director of Nursing and AHPs supported by Sue Jewell, Safer Staffing Lead	Sara Courtney, Acting Director of Nursing	28.02.18	
SD037 37.1	SHOULD	Community-based mental health services for adults of working age		The trust should complete its review to ensure that the CPA framework is consistently applied and ensure that caseloads are allocated equally	None	None	37.1 CPA audit tool to be amended to include question on correct application of CPA and Care Planning Frameworks.	Carol Adcock, Associate Director of Nursing and AHPs (MH) Helen Neary, Associate Director of Nursing and AHPs	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	30.09.17	Amended CPA audit tool
SD037 37.2							37.2 CPA Audit to be completed. (To include OPMH community services too).			28.02.18	CPA audit report
SD037 37.3							37.3. CPA and care plan SOP to be shared with Adult Mental Health staff.			30.11.17	Email cascade trail
SD038 38.1	SHOULD	Urgent care		The trust should ensure that all staff report all incidents that occur.	none	none	38.1 To raise staff awareness in MIUs of the need to report incidents as per incident reporting policy. (See 58 re incidents reporting).	Helen Neary, Associate Director of Nursing and AHPs	Sara Courtney, Acting Director of Nursing	**completed**	Petersfield MIU has seen increase in number of incidents reported.

SD039 39.1	SHOULD	Urgent care		The trust should implement, across both MIUs, an audit plan on the use of national guidance's locally.	none	none	39.1 Develop an audit tool to measure implementation of national guidance in MIU services.	Helen Neary, Associate Director of Nursing and AHPs supported by Tracey McKenzie, Head of Compliance, Assurance and Quality	Sara Courtney, Acting Director of Nursing	31.11.17	Audit tool in place.
SD039 39.2							39.2 Carry out audits using tool developed in 39.1.			31.12.17	Results and report of audits with action plan developed based on
SD040 40.1	SHOULD	Urgent care		The trust should develop children's waiting area at Petersfield MIU to provide visual and audible separation from the adult waiting areas.	none	none	40.1 The proposal regarding separate children's waiting area (scheme costings £1.7m) to be presented through Capital Funding process for approval.	Helen Neary, Associate Director of Nursing and AHPs Scott Jones, Deputy Head of	Paula Anderson, Finance Director	tbc	Minutes of Trust Executive Committee with decision minuted.
SD040 40.2							40.2 Estates services to review the waiting areas at Petersfield MIU and establish if a temporary install of separation screens could provide a temporary solution whilst the permanent scheme is awaiting a decision and funding. (£1K)	Helen Neary, Associate Director of Nursing and AHPs Scott Jones, Deputy Head of		31.10.17	Site visit to confirm area segregated with screens in place.
SD041 41.1	SHOULD	Urgent care	Petersfield MIU	The trust should continue to embed its complaints systems to ensure complainants are responded to in a timely manner.	none	none	41.1 To complete review of Complaints Policy and Procedures and circulate to all staff.	Chris Woodfine, Head of Patient Experience and Engagement supported by Associate Directors of Nursing and AHPs: Julie Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	Sara Courtney, Acting Director of Nursing	31.12.17	Screens in place visual inspection
SD041 41.2							41.2 To provide a weekly breach report to the Chief Executive/Divisional leads on complaints which are not meeting timescales for the stages of the complaints process. Divisions to address breaches in timescales.			31.12.17	Weekly breach reports.
SD041 41.3							41.3 To improve the visibility of the customer experience team by attending regular divisional governance meetings and other activities.			31.12.17	Meeting attendance.
SD041 41.4							41.4 To undertake a 3 month trial starting August 1st where the customer experience advisors write the final letter of response to the complainant (rather than the service). After 3 months review the effectiveness of the trial in allowing the Investigating Officer more time to focus on the investigation itself.			31.12.17	Results of trial.
SD041 41.5							41.5 To improve response times to complaints with 80% of complaints receiving a response within 30/40 days. To work with divisions to resolve issues and barriers.			31.12.17	Complaints response times.
SD042 42.1	SHOULD	Urgent care	Petersfield MIU	The trust should ensure staff across the urgent care provision are informed of the trust plans for the service, including those arising from discussions with the CCGs	none	none	42.1 To discuss and agree the future of Petersfield MIU with commissioners as part of wider plans for health care in that area.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager	Sara Courtney, Acting Director of Nursing	31.03.18	Minutes of meetings with commissioners and any agreements made re future of MIU.
SD042 42.2							42.2 To have updates as a standard agenda item in monthly team meetings on the plans for refurbishments and future of the service at Petersfield MIU as agreed with commissioners.	Helen Neary, Associate Director of Nursing and AHPs	Sara Courtney, Acting Director of Nursing	30.11.17	Examples of communication shared with staff.
SD043 43.1	SHOULD	Urgent care	Petersfield MIU	The trust should review the governance reporting framework for the MIU in Petersfield.	none	none	43.1 To embed MIU Governance reporting for Petersfield MIU through the Business Unit 1 locality governance frameworks and feeding into the ISD governance framework.	Helen Neary, Associate Director of Nursing and AHPs	Sara Courtney, Acting Director of Nursing	30.10.17	
SD044 44.1	SHOULD	Urgent care	Petersfield MIU	The trust should ensure there is clear support structure in place with clear lines of accountability for the MIU in Petersfield.	none	none	44.1 To review the MIU support and line management structures through the Quality element of the Business Plan. Currently the line of accountability reporting is through Rob Guile as General Manager and Helen Neary as Associate Director for Nursing and AHPs.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager	Sara Courtney, Acting Director of Nursing	30.09.17	
SD045 45.1	SHOULD	Urgent care	Petersfield MIU	The trust should review the staffing levels at the MIU in Petersfield to ensure they are able to offer a safe service at all times.	none	none	45.1 To review progress made with actions on risk register re staffing at Petersfield MIU and aim to downgrade risk.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager supported by Sue Jewell, Safer Staffing Lead	Sara Courtney, Acting Director of Nursing	30.11.17	Minutes of BU1 performance/governance meetings to evidence risk is discussed.
SD045 45.2							45.2 Staffing has been reviewed and monies allocated to fulfil Practitioner B7 underfunding. Advert out for recruitment.			30.11.17	B7 post recruited to.
SD045 45.3							45.3 B4 gap in service provision to be presented and discussed with CCG regarding commissioning requirements of this service.			30.11.17	Minutes of meetings with commissioners.
SD045 45.4							45.4 As there no national tool for MIU's around staffing, work is currently being undertaken to develop a Trust tool.			31.03.18	Trust staffing tool in place.
SD046 46.1	SHOULD	Urgent care	Petersfield MIU	The trust should ensure there are sufficient numbers of staff trained in the care of a sick child, on duty at all times in MIUs.	none	none	46.1 Training needs analysis (TNA) for MIU's to be completed by LEaD in partnership with service leads. Identified training needs to be met during 2017/18 via the CPPD/Learning Beyond Registration budget.	Helen Neary, Associate Director of Nursing and AHPs supported by Simon Johnson, Head of Essential Training Delivery Sue Jewell, Safer Staffing Lead	Sara Courtney, Acting Director of Nursing	30.09.17	Results of TNA with recommendations.
SD046 46.2							46.2 Review staffing to understand the gap that may be present in achieving this recommendation.			31.12.17	
SD046 46.3							46.3 To develop and implement an action plan based on the outcome of 46.1 and 46.2.46.4 .			31.03.18	Action plan in place and minutes of meeting to show progress being
SD046 46.4							46.4 LEaD to review attendance at 'Recognising the Unwell Child' training and raise awareness of this course to MIU managers. (This training course is already in place - is not mandatory).	Simon Johnson, Head of Essential Training Delivery		30.09.17	Attendance data.
SD047 47.1	SHOULD	End of life care		The trust should consider analysing themes of incidents in relation to the provision of end of life care for	none	none	47.1 Amend the Ulysses system to enable end of life to be recorded on incidents reported to ensure that themes can be analysed.	Julia Lake, Associate Director of Nursing and AHPs	Sara Courtney, Acting Director of Nursing	30.09.17	Evidence that Ulysses system has been amended to show end of life data.
SD047 47.2							47.2. Amend Tableau to ensure that the incidents can be filtered to end of life.			30.10.17	Tableau reports can be filtered by end of life incidents.
SD048 48.1	SHOULD	End of life care		The trust should work to improve the provision of beds to end of life patients.	none	none	48.1. AD Quality Governance and Medical Devices advisor to attend Patient User Group (PUG) meeting with CCGs and Hampshire Equipment Store (HES).	Helen Ludford, Associate Director Quality Governance Kate Smith, supported by Julia Lake, Associate Director for Nursing and AHPs	Sara Courtney, Acting Director of Nursing	31.09.17	Minutes of PUG meetings.
SD048 48.2							48.2. SLA to be reviewed with commissioners to ensure it meets the needs of our patients.			31.12.17	Review of SLA.
SD048 48.3							48.3. All incidents of delays in receiving equipment from HES to be reported on Ulysses, reported to HES and reviewed at PUG meeting.			31.12.17	All incidents reported on to Ulysses and forwarded to CCG
SD049 49.1	SHOULD	End of life care		The trust should collate and monitor locally held data on the uptake of staff training on end of life care and syringe driver competency assessment.	none	none	49.1 LEaD to develop e-verification process for monitoring compliance with the End of Life and syringe driver training and competency requirements.	Simon Johnson, Head of Essential Training Delivery	Sara Courtney, Acting Director of Nursing	31.12.17	Issues discussed and action agreed at PUG meeting
SD049 49.2							49.2 Relevant staff to complete e-verification process with team managers monitoring compliance.	Julia Lake, Associate Director of Nursing & Allied Health Professionals		31.03.18	Training compliance data.
SD049 49.3							49.3 End of Life Steering Group to review training figures on a quarterly basis.			31.03.18	Minutes of End of Life Steering Group.
SD050 50.1	SHOULD	End of life care		The trust should evaluate the provision of end of life care.	none	none	50.1 Undertake a thematic review of End of Life care across the Trust in Oct - December 2017 - to include what services we are commissioned to supply and any gaps in that provision.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	Sara Courtney, Acting Director of Nursing	28.02.18	Report from Thematic review and evidence that shared through appropriate committees.

SD050 50.2							50.2 To develop recommendations for any actions based on outcome of above review.			31.03.18	Action plan in place based on review recommendations.
SD051 51.1	SHOULD	Community Inpatients Service		The trust should ensure that all staff are fully trained in the assessment and competent in the use of the Mental Capacity Act.	none	none	**51.1 see 28.2.1 above**				
SD051 51.2							**51.2 see 28.2.2 above**				
SD052 52.1	SHOULD	Community Inpatients Service		The trust should ensure that all staff complete and sign all patient clinical records with all relevant information.	none	none	52.1 To review inpatient records in Community Hospitals with clear guidance circulated to staff on completion of patient records, including the signing and adding of staff designation to record.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	Sara Courtney, Acting Director of Nursing	31.12.17	Results of review of records.
SD052 52.2							52.2 To complete record keeping audits with action plans developed and implemented to address shortfalls in practice.			31.03.18	Results of record keeping audits. Implementation of action plans based on audits.
SD053 53.1	SHOULD	Community Inpatients Service		The trust should ensure that all staff follow the process for identifying and managing clean and dirty equipment in line with the trust policy.	none	none	**53.1 see 21.1 above**				
SD053 53.2							**53.2 see 21.2 above**				
SD053 53.3							**53.3 see 21.3 above**				
SD053 53.4							**53.4 see 21.4 above**				
SD053 53.5							53.5 IPC audit programme to be completed for 2017/18 - including isolation audit due February 2018.	Theresa Lewis, Lead Nurse Infection, Prevention and Control Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	Sara Courtney, Acting Director of Nursing	31.03.18	Results and reports of IPC audits with action plans completed.
SD054 54.1	SHOULD	Community Inpatients Service		The trust should ensure that staff review the ward environment taking into account the needs of people living with dementia.	none	none	54.1 To review the ward environment taking into account the needs of people living with dementia and review the results of the PLACE audits.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	Sara Courtney, Acting Director of Nursing	31.10.17	Results of the review of wards re dementia needs. Results of PLACE audits with regard to needs of people living with dementia.
SD054 54.2							54.2 An action plan is developed and implemented based on the above reviews to meet the needs of people living with dementia. This will include a list of works in priority order to be completed by Estates services.	supported by Scott Jones, Deputy Head of Estates Services		31.03.18	Action plan is in place and is being implemented.
SD055 55.1	SHOULD	Community Inpatients Service	Gosport War Memorial Hospital	The trust should review the washing and toilet facilities at Gosport hospital to ensure that they promote the privacy and dignity of patients.	none	none	55.1 To complete a joint review of the toilet and washing facilities in Ark Royal and Sultan wards, GWMH by the clinical service leads and estates managers.	Helen Neary, Associate Director of Nursing and AHPs Gary Goodman, Estates Services Capital Projects Manager	Paula Hull, Acting Director of Operations (ISD)	30.09.17	Results of review of wards.
SD055 55.2							55.2 An action plan is developed and implemented based on the recommendations from the above review to resolve issues in discussion with commissioners.			31.03.18	Action plan in place and being implemented.
SD056 56.1	SHOULD DO	Community Inpatients Service		The trust should ensure that there is appropriate pharmacy support for medicines reconciliation.'	none	none	56.1 To set up a Task and Finish Group to review medicines reconciliation across the trust - to include staffing, accuracy of data reported on tableau, roles and responsibilities of various staff groups, use of the summary care record, training for staff, policy.	Raj Parekh, Chief Pharmacist	Dr Sarah Constantine, Medical Director	31.12.17	Task and Finish Group - terms of reference, minutes and action logs.
SD056 56.2							56.2 Based on results of Task and Finish group, produce an options paper for medicines reconciliation in line with national guidance for discussion at the Trust Executive Committee.			31.01.18	Medicine Reconciliation action plan.
SD056 56.3							56.3 Medicines Management Committee (bi-monthly) to monitor Task and Finish group progress including action plan; to monitor performance against KPI - 80% of inpatients have their medicines reconciled within 2 working days.			31.03.18	Minutes of Medicines Management Committee.
SD057 57.1	SHOULD	Community Inpatients Service		The trust should ensure that staff support and enable patients to administer their medicines as part of the discharge process in the rehabilitation wards.	none	none	57.1 To identify where patient own drugs (POD) lockers are in place on rehabilitation wards and where there are gaps.	Raj Parekh, Chief Pharmacist supported by Associate Directors for Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	Dr Sarah Constantine, Medical Director	30.09.17	Results of review of POD lockers.
SD057 57.2							57.2 To implement Self Administration Policy on wards with risk assessment of wards and individual patients completed.			31.08.17	Evidence that risk assessments completed. Results of audit of Self Administration Policy.
SD057 57.3							57.3 To scope additional staffing resources required in order to implement self administration of medicines during inpatient stay and on discharge.			31.12.17	Results of scoping review of staffing requirements.
SD057 57.4							57.4 Medicines Management Committee (bi-monthly) to review progress with completion of actions.	Raj Parekh, Chief Pharmacist		31.03.18	Minutes of Medicines Management Committee.
SD058 58.1	SHOULD	Community health services for adults		The trust should ensure that staff report incidents in a timely manner	none	none	58.1 To ensure staff complete incident reports within the policy timeframes.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett, Liz Taylor	Sara Courtney, Acting Director of Nursing	31.10.17	Increased number of incidents reported - particularly from areas where reporting is noted to be lower than expected. Staff bulletin to be evidenced to show additional communication re incident reporting.
SD059 59.1	SHOULD	Community health services for adults		The trust should ensure that staff follow infection prevention best practice guidelines while providing care in patients' homes.	none	none	**59.1 see 21.1 above**				
SD059 59.2							**59.2 see 21.2 above**				
SD059 59.3							**59.3 see 21.3 above**				
SD059 59.4							59.4 To continue hand hygiene audits across the trust including community teams.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary supported by the Infection, Prevention and Control Team.	Sara Courtney, Acting Director of Nursing	31.12.17	IPC Quarterly Report has hand hygiene audit results.
SD060 60.1	SHOULD	Community health services for adults		The trust should introduce an appropriate tool to monitor and detect deterioration in the condition of patients, receiving care	none	none	60.1 To review Track and Trigger Tool and the National Early Warning Score (NEWS) to ensure that boundaries for escalation are the same.	Simon Johnson, Head of Essential Training Delivery	Dr Sarah Constantine, Medical Director	30.08.17	Review of early warning systems.

SD060 60.2				and treatment in their own homes, who have long term conditions who may routinely have abnormal physical signs.			60.2 To roll out use of NEWS across the Community Hospitals. To evaluate impact of NEWS prior to consideration for a tool to introduce to community services.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary		31.03.18	Confirmation of use of NEWS in community hospitals.
							60.3 To communicate to staff the training courses available on LEaD relevant to the deteriorating patient and monitor training attendance at staff one to ones.			30.11.17	communication - emails/newsletter/team minutes.
SD061 61.1	SHOULD	Community health services for adults		The trust should review whether there is a need for a night nursing service across all areas.	none	none	61.1 To set up a Task and Finish Group out of the End of Life Steering Group to review the need for a night nursing service across the Trust - including a review of population needs, current access to spot purchase service.	Associate Director of Nursing and AHPs: Julia Lake	Paula Hull, Acting Director of Operations (ISD)	31.12.17	Task and Finish Group - terms of reference, minutes and action logs.
SD061 61.2							61.2 To discuss the outcome and recommendations from the Task and Finish Group regrading the need for a night nursing service with commissioners.			28.02.18	Minutes of meetings with commissioners.
SD062 62.1	SHOULD	Community health services for adults		The trust should ensure all medicines are in date.	none	none	**62.1 see 20.1 above**				
SD062 62.2							**62.2 see 20.2 above**				
SD062 62.3							**62.3 see 20.3 above**				
SD062 62.4							62.4 Inpatient units/wards audit that the correct procedure regarding expiry dates for medicines is followed. ISDs to use Quality Assessment Tool on monthly basis to provide assurance re compliance.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary, Carol Adcock, John Stagg, Nicky Bennett	Dr Sarah Constantine, Medical Director	31.10.17	Quality Assessment Tool results (ISD).
SD062 62.5							62.5 Medicines Management Committee (bi-monthly) to review compliance to guidance and completion of audit actions.	Raj Parekh, Chief Pharmacist		31.12.17	Minutes of Medicines Management Committee.

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UIN	Carolan Theme	Recommendation	Trust Actions	Process Input (measures)	Responsible Lead	Essential Partners	Executive Accountability	Process Completion Date	Process Status	Progress Update	Expected Outcome	Measuring Success Date (Outcome Completion)	Outcome Status	Outcome Measure	Evidence in folders (Process)	Evidence in folders (Outcome)
1.1a	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1a The Trust will work with patients, service users and families to develop and implement best practice on engagement	1.1a Establishment of a Task and Finish Group for the Family Involvement Action Plan and the family first involvement group 1.1a Contacting and engaging with service users, families and staff to establish a network of stakeholders interested in working with the Trust 1.1 Identifying best practice of involvement and engagement of families	Chris Woodfine, Head of Patient Engagement and Experience	Carla Roadnight, Area Head of Nursing and AHPs Pam Sorensen, Engagement Advisor	Sara Courtney, Chief Nurse	30/04/17	Completed-unvalidated	A Family first involvement group was formed in January and continues to meet on a monthly basis. There was a learning network in AMH Southampton to engage staff and hear their ideas. The Triangle of Care has been identified as a collection of best practice that will address issues expressed by families. April 2017 Experience, Involvement and Partnership Strategy developed with patient involvement - with comms dept for final version to be formatted. Implementation plan for strategy in place. Best practice guidance developed and circulated to staff. Task and finish group amended terms of reference so they can continue involvement with this plan. Family First Group continues to meet. Complaints working group had final meeting in April with a planned feedback in 6 m to show improvements made. May 2017 bi-monthly Task and finish group monitors plan.	Divisional champions and accountable leads will work with service users, patients and families to agree a set of principles to support a culture that truly values user involvement in physical and mental health teams.	30/04/17	Completed-unvalidated	A plan that will be developed to ensure that there is a focus on culture which truly recognises the importance of family involvement from the outset.	1.1 Task and Finish Group ToR 1.2 Task and Finish Group Minutes/agendas 1.3 Family First Involvement Group ToR 1.4 Family First Minutes/agendas 10.02.17;06.03.17;31.03.17 1.5 Learning network event AMH 1.6 Best Practice for involvement and engagement of families. 1.7 Task and Finish Group amended ToR 1.8 Story Telling Toolkit (for staff) 1.9 Best practice guidance 2.0 Complaints Working Group T of R 2.1 Complaints working group minutes 06.12.16;07.02.17;14.03.17	1.1 Experience, Involvement and Partnership Strategy draft v7.1 2017/18 1.2 Strategy Implementation Plan 2017/18 1.3 Family Experience in Engagement agenda/minutes 25052017
1.1b	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1b To put in place the enabling strategies to support the successful implementation of the Triangle of Care standards	To launch enabling strategies: 1.1b Carer involvement in developing and co-producing plans and actions as described in actions 1.1 1.1b Creating a communications plan 1.1b Refine/adapt HR processes to support alignment of family involvement to clinical practice e.g. job descriptions, objectives, appraisals, clinical supervision and pre and post qualification training	Chris Woodfine, Head of Patient Experience and Engagement Emma McKinney, Head of Communications Graeme Armitage, Interim Head of HR	Sarah Cole, Family Therapist Specialised Services	Sara Courtney, Chief Nurse	30/09/17	On Track	April 2017 Experience, Involvement and Partnership self assessment for clinical services to complete presented at April PT Exp workstream meeting. May 2017 Quality Account priorities include objectives on care planning - use same evidence. CW meeting JR in comms on 7.6.17 to develop communication plan. CW meeting with F & G CCG to explore carers event with PHT and CCG. 'Sharing information' workshop on 24.5.17 with service users/carers/families/staff - reviewed leaflet for sharing information and made recommendations for changes. Relationship with 3rd sector organisations eg 'Carers together', 'Carers in Southampton'. Divisions have some mechanisms in place to talk with carers.	In the identification of best practice methodologies, there are a set of enabling strategies that need to be delivered.	30/04/18		Co-produced plans which are coherent	1.1 Experience, Involvement and Partnership self assessment April 2017 1.2 examples of above 1.3 Sharing Information workshop agenda and materials 24.5.17 1.3 Sharing Information workshop facilitator notes 24.5.17	
1.1c	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1c Phase 1: Ensure carers are identified at the first contact or as soon as possible thereafter	1.1c Co-produce a carer's charter/statement of principle that aligns with HCC development of a carers strategy 1.1c Develop guidance and training for staff to enable high levels of care planning skill within staff groups, including the importance of involvement of families and service users	Pam Sorensen, Engagement Advisor(now left) Records Keeping and Care Planning work stream (Paula Hull)	Chris Woodfine, Head of Patient Experience and Engagement External carer groups Hampshire County Council MH/LD/SS	Sara Courtney, Chief Nurse	30/06/17	On Track	Guiding principled being drafted (March 2017) following joint work with 'Carers Together'. Draft to be shared more broadly for comment etc. On track to meet June 2017 date. April 2017 Carers Charter in draft format attached. May 2017 Training programme for staff in care planning reviewed with revised programme in development; guidance for staff on expected record keeping standards in development. Clinical audits for holistic assessment and care planning will be repeated this year. Clinical reference cards with top tips on record keeping being printed for clinical staff. Patient Exp workstream to draft principles for patients/engagement in general to complement the guiding principles for carers. Aim to have core principles for any involvement whether patient/carer etc. SJ, Head of Essential Training, reviewing the training portfolio to see how family involvement currently reflected in training and then to look at how to weave principles of family involvement in all relevant training.	Staff understand what is expected of them with regards to family involvement; Equally, families understand what to expect from our services	30/04/18		Staff understand what is expected of them with regards to family involvement; Equally, families understand what to expect from our services	1.1c Carers Charter draft v3 1.2 Families First minutes 31.03.17 1.3 Record keeping and care planning minutes 1.4 QIPDG minutes section 6.6 23052017	1.1 Experience, Involvement and Partnership self assessment April 2017 1.2 examples of above
1.1d	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1d Phase2: Ensure staff are carer aware and trained in carer engagement strategies	1.1d Run staff and carer events and forums to encourage development of practice	Heads of Nursing and AHPs		Sara Courtney, Chief Nurse	30/04/18		May 2017 Quality Conference Oct 2017 will have family/carer involvement.	Divisional champions and accountable leads will work with service users, patients and families to encourage development of practice	30/04/18		Divisional champions and accountable leads will work with service users, patients and families to encourage development of practice		
1.1e	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1e Phase 3: Ensure that the Trust strategy on engagement is linked to the staff engagement strategy	1.1e Develop policy and practice protocols on confidentiality and information sharing (covered under action 2.5)												
1.1f	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1f Phase 4:Ensure families/carers have an introduction to the service and staff, with a relevant range of information across the care pathway	1.1f Co-produce an information leaflet for family with service and care co-ordinator contact information	Carla Roadnight, Area Head of Nursing and AHP	Carer groups	Sara Courtney, Chief Nurse	30/08/17		May 2017 CW to speak to MF who has developed leaflet for her team and discuss whether can be replicated across AMH.	Families know who to contact if they have any questions	28/02/18		Families know who to contact if they have any questions		
1.1g	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1g Phase 5: Develop a range of carer support services or covering all the key points on the care pathway	1.1g Map out the key points of the care pathway 1.1g measures to be developed in later phase	tbc	tbc	tbc	tbc		tbc	Carers needs are assessed and support provided	tbc		Increased levels satisfaction on patient experience survey question and AMH carer survey		
1.1h	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1h Phase 6: Develop defined posts responsible for carers	1.1g Map out the key points of the care pathway 1.1g measures to be developed in later phase	tbc	tbc	tbc	tbc		tbc	Within services there is a local lead/champion	tbc		Within services there is a local lead/champion		
2.1a	Improving the way the Trust communicates and engages with families	2.1 Ensuring that policy, guidance and procedure related to investigations recognises and supports the iterative process of family engagement	The Trust will improve the way communication and engagement is undertaken with families ensuring that there is a recognition of the process of family engagement within the policies and guidance in relation to investigations by: 2.1a Conducting a review of the policies and procedures related to SIRI and complaint investigations to ensure that they are informed by the same principles of engagement with families	2.1a Undertake a review of all policies and procedures relating to SIRI and complaint investigations with input from front-line clinical staff 2.1a Update policies and procedures pertaining to SIRI and complaint investigations which include the elements of engagement with families as principles	Helen Ludford, Associate Director of Quality Governance Paula Hull, Divisional Director of Nursing & AHP (ISD)	Complaints Working Group Family First Involvement Group Mortality Forum	Sara Courtney, Chief Nurse	31/07/17	On Track	January 2017 The SIRI policy and procedure has been reviewed with input from the Family First Involvement Group. Version control tables in policy/procedures show their input. March 2017 Complaints working group reviewed the complaints policy. The policy is to be reviewed by July 2017. May 2017 The SI policy will be reviewed again once national guidance issued. Complaints policy review underway.	All Trust policies and procedures relating to investigations are aligned to ensure that communication with families is meaningful.	30/09/17	On Track	Involvement of families' in the review of the SIRI policy and procedure and complaints policy, as identified by the reviewers/contributors within the policies.	1.1 Family First Involvement meeting minutes (Jan 2017). 1.2 Complaints working group minutes (Feb 2017).	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents 1.3 revised complaints policy
2.1b	Improving the way the Trust communicates and engages with families	2.1 Ensuring that policy, guidance and procedure related to investigations recognises and supports the iterative process of family engagement	The Trust will improve the way communication and engagement is undertaken with families ensuring that there is a recognition of the process of family engagement within the policies and guidance in relation to investigations by: 2.1b Incorporating the principles of engagement with families to the admissions and discharge policy (including inclusion in crisis contingency care plan).	2.1b Update admissions and discharge policy to include the principles of family engagement (care planning, family communication and liaison)	John Stagg, Associate Director of Nursing & AHP (Learning Disabilities)		Sara Courtney, Chief Nurse	30/09/17			All Trust policies and procedures relating to investigations are aligned to ensure that communication with families is meaningful.	30/09/17		Involvement of families' in the review of Admissions discharge and transfer policy as identified by the reviewers/contributors within the policy.		
2.2a	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2a Development of a Trust strategy for involving patients, families and the public with specific reference to families	2.2a Develop a Trust strategy on Experience, Involvement and Partnership	Chris Woodfine, Head of Patient Engagement and Experience	Pam Sorensen, Engagement Advisor	Sara Courtney, Chief Nurse	30/04/17	Completed-unvalidated	March 2017 The Caring group received the final draft of the strategy and is due to be submitted to the QSC at the end of March for final sign-off. April 2017 slight amendment made to strategy and ready for launch. Implementation plan in place. May 2017 Strategy with comms team for final design prior to circulation.	There will be increased levels of involvement of patients and families in their own care and in the way the Trust develops and improves services.	30/04/18		Compliance with the standards outlined in the overarching Trust strategy.	1.1 Experience, Involvement and Partnership Strategy draft v7.1 2017/18 1.2 Strategy Implementation Plan 2017/18	
2.2b	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2b Trust to set the expectation that staff and services will engage with families as a matter of course from the point of first contact with the patient	2.2b All "My assessment of the patient" should include staff making contact with patient/service user's family)	Paula Hull, Divisional Director of Nursing & AHPs (ISD)	Record Keeping and Care Planning Workstreams	Sara Courtney, Chief Nurse	tbc		April 2017 An example of this is within the Children and families business unit who have developed a new template called 'My Plan' which will require a collaborative approach to care planning with parents. May 2017 CW meeting with PH in early July to discuss family involvement in care planning.	Better clinical outcomes and patient experience as well as reduced spend	tbc		Staff are directly involving families in care-planning.		
2.2c	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2c Trust to ensure that staff and services are aware that Duty of Candour is about being honest when things have gone wrong (training of the duty of candour through providing an e-learning training package)	2.2c Develop an e-learning package (short session of 45 minutes) on "Being Open and Duty of Candour to ensure staff and services are aware of being honest when things have gone wrong 2.2c Duty of Candour module in the Investigating Officer training workshop 2.2c Masterclass on sharing findings of investigations	Helen Ludford, Associate Director of Quality Governance Elaine Ridley, Family Liaison Officer	Vicki Tinkler, Project Manager (LeAD) Tom Williams, Ulysses System Developer Nick Fennemore, Head of Chaplaincy, Spiritual & Pastoral Care	Sara Courtney, Chief Nurse	30/06/17	Completed-unvalidated	10/04/17 Bulletin article launching e learning module for duty of candour. April 2017 duty of candour session in the Investigating Officer training has been up dated and is now given by the Family Liaison Officer. May 2017 Masterclass 'sharing investigation reports' developed by FLO and chaplain with two provisional dates set for training - 3.7.17 and 17.7.17.	Staff are aware of the difference between Duty of Candour and family engagement and there is a culture that fosters staff being open with families which also supports a "No Blame" culture	31/03/18		Compliance with Duty of Candour as monitored through the SI and mortality KPI dashboard and audit of records	1.1 Bulletin article 1.2 E-learning programme 1.3 IO programme	1.1 SI KPI dashboard

2.2d	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2d Review policy for Duty of Candour and ensure that it sits under the overarching position statement and ensure that this is interlinked to the complaints policy and the serious incident policy and procedure	2.2d Review the Being Open policy incorporating the legal Duty of Candour 2.2d Review the SI policy and procedure 2.2d Review the complaints policy 2.2d Review the safeguarding policy 2.2d Ensure all the above policies align.	Sarah Pearson, Head of Legal and Insurance Services, Chris Woodfine, Head of Patient Engagement and Experience Caz Maclean, Associate Director of Safeguarding	Complaints Working Group Patient Safety Group Family First Involvement Group	Sara Courtney, Chief Nurse	30/09/17	On track	January 2017 The SI policy and procedure has been reviewed with input from the Family First Involvement Group . February 2017 The complaints working group reviewed the policy. March 2017 DoC Policy agreed through policy ratification group on17/03/17, uploaded to intranet 21/03/17, for sign of via Caring Group on 13/04/17. The documents that have been uploaded state that they are to go to Caring group in April but it was agreed that as changes largely minor it could be uploaded in the meantime. May 2017 Complaints policy under review. Safeguarding adult policy reviewed Feb 2017 and Safeguarding children policy reviewed March 2017. ? Family First group reviews these.	Staff are aware of the difference between Duty of Candour and family engagement and there is a culture that fosters staff being open with families which also supports a "No Blame" culture	31/12/17		Staff are competent in applying the Duty of Candour readily and where appropriate; and there is a clear understanding amongst staff in the difference between family engagement/involvement and duty of candour	1.1 Family First Involvement meeting minutes (Jan 2017). 1.2 Complaints working group minutes (Feb 2017).	add policies
2.3a	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3a The SIRI procedure should state that steps are to be taken to engage families and this should be documented	2.3a Review the SIRI procedure and add statement regarding the engagement of families'	Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group	Sara Courtney, Chief Nurse	31/05/17	Completed-unvalidated	Jan 2017 The SI policy and procedure have been reviewed - section 4.5 in procedure details the involvement of patients/ families/loved ones. Policy is to be reviewed again July 2017 following publication of new national SI Framework.	Staff are consistently documenting the involvement of families during/following an investigation	30/11/17		Investigation and reports demonstrate involvement of families where families wish to be involved.	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents	
2.3b	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3b Consistent use of the CCG Quality checklist at the 48 Hour Panel and Corporate Panel as a reference guide	2.3b Add the use of the CCG Quality checklist as a reference guide at the 48 Hour Panel and the Corporate Panel in the SIRI reporting procedure	Helen Ludford, Associate Director of Quality Governance	SI Team Lead Investigating Officers Chair of the 48 Hour Panels	Sara Courtney, Chief Nurse	31/07/17	On track	Jan 2017 SI policy and procedures reviewed. Appendix 11 contains the commissioner checklist. Use of this is at corporate panel is in section 9.2 of procedure. SI policy /procedure to be reviewed July 2017 following publication of new national SI Framework.	Staff are consistently documenting the involvement of families during/following an investigation	30/11/17		All checklists demonstrate that families have been invited to contribute to the terms of reference		
2.3c	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3c Review and modify the structure of the Ulysses to include specific headings to record any notes/detail on the steps taken to engage with families	2.3c Add consistent headings within Ulysses SIRI reports in family engagement	Helen Ludford, Associate Director of Quality Governance	Tom Williams, Ulysses System Developer	Sara Courtney, Chief Nurse	30/06/17	On track	May 2017 BC discussed possible changes to headings with TW.	Staff are prompted to document the involvement of families during an investigation	31/08/17		The Ulysses systems contains a section to document on the steps taken to engage with families		
2.3d	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3d Add family engagement and its recording to SIRI training workshop	2.3d Add family engagement and its recording to SIRI training workshop	Helen Ludford, Associate Director of Quality Governance	n/a	Sara Courtney, Chief Nurse	31/05/17	Completed-unvalidated	April 2017 Investigating Officer training has information and video on involvement of families, loved ones and patients. Training also has specific session on Duty of Candour. Feedback forms form training very positive with staff feeling better and knowledgeable about carrying out investigations.	Investigating Officers are trained on steps taken to engage families and how to record onto Ulysses	31/12/17		Investigating Officers feel confident on engaging families in investigations	1.1 Investigating Officers 2 day training presentation. 1.2 Investigating Officers training - Duty of Candour presentation.	1.1 Feedback forms Oct 2016 1.2 Feedback forms April 2017 1.3 Feedback forms May 2017
2.4a	Improving the way the Trust communicates and engages with families	2.4 Co-producing with families a leaflet that can be sent to all families following a death that explains how investigations are conducted, how the families can get involved, and signposts families to appropriate support and advice	Families have said that written information is important, but that it should not be sent to families, but should be handed to them, following a discussion with the IO. 2.4a The Family Liaison officer will develop with families a leaflet that will be given by the IO as an aide memoire to their conversation with the family detailing the investigation process and signposting and support; this will form part of the suite of documents that sits within the SIRI procedure - with inclusion from the Family Reference Group.	2.4a Co-produce leaflet for families on the investigation process and support.	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group Chris Woodfine, Head of Engagement and Experience Investigating Officers	Sara Courtney, Chief Nurse	31/03/17	Completed-unvalidated	March 2017 Leaflets have been developed with input from family workshops and the Family First Involvement Group and planned for publication by 31 March 2017. April 2017 leaflets printed - given to IOs on Investigating Officer training days.	Families feel involved in the investigation as they wish to be.	31/03/17	Completed-unvalidated	Families understand how investigations will be conducted, how they can get involved and be signposted to appropriate support and advice	1.1 Leaflet for families on serious incident investigations.	1.1 Family Liaison Officer report
2.4b	Improving the way the Trust communicates and engages with families	2.4 Co-producing with families a leaflet that can be sent to all families following a death that explains how investigations are conducted, how the families can get involved, and signposts families to appropriate support and advice	2.4b Seek regular feedback from families regarding their experience of the investigation process	2.4b Undertake a quarterly survey of families' experience of the investigation process	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group Chris Woodfine, Head of Engagement and Experience Investigating Officers	Sara Courtney, Chief Nurse	31/12/17	On Track	March 2017 The Family Liaison Officer sent 15 questionnaires to families involved in investigations of deaths of loved ones. % questionnaires returned by date of report to Caring Group in March. Feedback positive re contact with IO and support given, however families say reports not easy to understand and unclear on what actions being taken by Trust. To repeat survey on quarterly basis. May 2017 ER completing quarterly surveys with families.	Families feel involved in the investigation as they wish to be.	30/04/18	On track	Families report positive feedback in their involvement and support offered	1.1 Questionnaire appendix 1 Family Engagement FLO report 07/03/17 Caring Group. 1.2 Questionnaire appendix 1 Family Engagement FLO report June Caring Group.	1.1 Family Engagement FLO report 07/03/17 Caring Group 1.2 Family Engagement FLO report June Caring Group
2.5a	Improving the way the Trust communicates and engages with families	2.5 Improving the recording of next of kin data, including where consent to share has not been provided	2.5a Ensure that the Next of Kin section on Rio is made a mandatory field and the Change Control Board oversee a range of training and guidance to ensure that Next of Kin data is completed in all care records	2.5a Amend the Next of Kin section on Rio to ensure that this field is made mandatory 2.5a Embed review of training and guidance for Next of Kin data within the Change Control Board Terms of Reference 2.5a Devise a Trust procedure on what staff should do if there is no Next of Kin data included	Paula Hull, Divisional Director of Nursing & AHP (ISD)	Change Control Board Technology Transformation Team	Paula Anderson, Director of Finance Sara Courtney, Chief Nurse	31/10/17	On track	May 2017 Performance on meeting next of kin recording has been added to Tableau and is monitored closely by divisions. Inconsistent performance with some teams very high % of next of kin details recorded while other teams have low %. Section 8.3 of openRio Standard Operating Procedure and section 8.2 of SyStmOne Standard Operating Procedure has instructions to staff on recording next of kin data. These are to be updated with clarification regarding recording information where there is no known next of kin or the patient declines to give next of kin details.	A strengthened process for Next of Kin recording is standardised across the Trust with staff understanding that this is a crucial aspect of clinical record-keeping and care planning.	31/10/17		Next of kin recording is in place consistently across the Trust	1.1 OpenRio/SystmOne Standard Operating procedures re Next of kin	
2.5	Improving the way the Trust communicates and engages with families	2.5 Improving the recording of next of kin data, including where consent to share has not been provided	2.5b Ensure that the monitoring of next of kin recording is carried out	2.5b Data extraction from Tableau for reporting and remediation	Simon Beaumont, Head of Informatics	Divisional Records User Group	Paula Anderson, Director of Finance	31/10/17	On track	May 2017 Performance on meeting next of kin recording has been added to Tableau and is monitored closely by divisions. Inconsistent performance with some teams very high % of next of kin details recorded while other teams have low %. Not yet meeting 80% target set by Trust across all divisions.	A strengthened process for Next of Kin monitoring is in place across the Trust	31/10/17	Complete	A metric is developed on Tableau for monitoring next of kin data	1.1 screenshots of tableau	1.1. screenshots of tableau
2.5	Improving the way the Trust communicates and engages with families	2.5 Improving the recording of next of kin data, including where consent to share has not been provided	2.5c Co-produce guidance across the Trust for information sharing based on the consensus statement	2.5c Deliver a families workshop to understand their perspective on barriers to engage 2.5c Understanding the staff perspective on blocks to information sharing 2.5c Workshops involving family, service users and staff to develop guidance	Chris Woodfine, Head of Engagement and Experience	Lesley Barrington, Head of Information Governance MH division Sarah Cole, Family Therapist Specialised Services		31/10/17	On track	A family workshop was delivered in January and February 2017 which were highlighted that information sharing was a primary issue The IG training resources now include the consensus statement on information sharing and suicide prevention. May 2017 'Confidentiality' workshop for staff in development. 24.5.17 Sharing Information workshop. Information governance team to rewrite information sharing leaflet based on feedback and reflecting what used by other trusts.	Staff are competent in managing confidentiality and information sharing with families	31/03/18		RiO records show the judgements staff have made on information sharing when working with families and service users	1.1 Sharing Information workshop agenda/materials 24.5.17	
2.6a	Improving the way the Trust communicates and engages with families	2.6a Keeping families fully informed of the progress of the investigation and making this an explicit part of the Investigating Officer's role	2.6a Provide better training for Commissioning Managers as practice	2.6a Scoping of improved training for Commissioning Managers on the SIRI procedure which should be standardised across the Trust 2.6a Ensure roll out of improved training for Commissioning Managers 2.6a Undertake an audit of the findings om implementing improved training of Commissioning Mangers	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance		Sara Courtney, Chief Nurse	31/12/17	On track	Jan 2017 Role of the IO and CM included within the revised SIRI procedure. Investigating officer and commissioning manager role descriptions reviewed and updated version added to the SIRI policy. May 2017 SI policy/procedures to be reviewed in July 2017 following new national SI Framework. More CM training planned.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/12/17		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents	
2.6b	Improving the way the Trust communicates and engages with families	2.6b Keeping families fully informed of the progress of the investigation and making this an explicit part of the Investigating Officer's role	2.6b Ensure that the Investigating Officer and Commissioning Manager training gives clarity of their roles and responsibilities as well as the roles and responsibilities of the Family Liaison Officer role	2.6a Ensure the SIRI policy and procedure clearly outlines the roles of the Investigating Officer, Commissioning Manager and the Family Liaison Officer Remaining actions covered by 3.4	Helen Ludford, Associate Director of Quality Governance	Elaine Ridley, Family Liaison Officer	Sara Courtney, Chief Nurse	31/07/17	On track	Jan 2017 Investigating officer and commissioning manager role descriptions reviewed and updated versions added to the SIRI policy. Need to add role description of Family Liaison Officer to revised policy. May 2017 Serious Incident Policy will be reviewed once national Serious Incident framework is published- to include job description of FLO.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/12/17		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process		

2.7	Improving the way the Trust communicates and engages with families	2.7 Providing counselling (as appropriate) or signposting families to suitable organisations that can provide bereavement or post-traumatic stress counselling	The Trust accepts responsibility for the need to signpost to families relevant support and to be proactive in seeking support where it is not immediately available. 2.7a Increase awareness of the FLO role amongst staff and families.	2.7a FLO to attend governance and business meetings across divisions to raise awareness of her role and follow up after 6 months 2.7a Investigating Officer makes contact with the FLO via the IMA panel	Elaine Ridley, Family Liaison Officer	Investigating Officers	Sara Courtney, Chief Nurse	31/12/17	On track	May 2017 FLO is regularly attending the Caring Group and makes contact with Investigating Officers and attends panels. FLO has attended some governance meetings in services and will continue to go out to teams.FLO is receiving referrals from IO.	FLO post is embedded within the Trust	30/06/17	On track	FLO receives referrals from Investigating Officers in a timely manner	Caring group minutes	FLO reports
2.7	Improving the way the Trust communicates and engages with families	2.7 Providing counselling (as appropriate) or signposting families to suitable organisations that can provide bereavement or post-traumatic stress counselling	The Trust accepts responsibility for the need to signpost to families relevant support and to be proactive in seeking support where it is not immediately available. 2.7b FLO to identify the key resources that families may need access to	2.7b Family Liaison Officer to identify the key resources that families may need access to 2.7b FLO to develop a resource bank of community resources	Elaine Ridley, Family Liaison Officer	Third sector networks (external)	Sara Courtney, Chief Nurse	31/12/17			Families receive information for support according to their needs	30/06/18		The Trust has robust processes in place to ensure that families are provided with comprehensive information and resources regarding how an investigation is undertaken and signposts to appropriate support and advice		
2.8	Improving the way the Trust communicates and engages with families	2.8 Providing a central telephone number and email address for families so that they can contact the investigating team and not be reliant upon Investigating Officers who may have changed role or changed organisation	The Trust accepts the principle that families need to contact someone who is informed. 2.8a Commissioning Managers to create a communications plans with families at the outset and ensure that there is a proactive mechanism for advising families upon change of IO	2.8a Communication plans to be created including contact details of CM and IO Also covered under action 2.4a and 4.6a	Commissioning Managers	Investigating Officers	Sara Courtney, Chief Nurse	31/10/17			Staff provide the right contact details to the families and that there are clear processes of handover when a staff member changes their role	31/12/17		All investigations to have in place a communication plan with families		
3.1	Increasing the competency of staff to engage with families	3.1 Co-producing with families training for staff on engaging with families	3.1a Conduct a review of training for staff on the importance of engaging with families in investigations with input from the Family First Involvement Group.	3.1a Conduct a review of training for staff on the importance of engaging with families in investigations with input from the Family First Involvement Group. 3.1a Conduct a training needs analysis with IOs and CMs 3.1a Review of the training programme	Helen Ludford, Associate Director of Quality Governance	Chris Woodfine, Head of Engagement and Experience	Sara Courtney, Chief Nurse	31/10/17	On track	May 2017 SJ, Head of Essential Training, reviewing the training portfolio to see how family involvement currently reflected in training and then to look at how to weave principles of family involvement in all relevant training.	Training for Investigating Officers and CMs are co-produced with families	31/12/17		Training for Investigating Officers and CMs are co-produced with families		
3.2	Increasing the competency of staff to engage with families	3.2 Involving families in the delivery of training to staff, which can be achieved through co-delivery of the training, or through video or written case studies/testimonies.	3.2a The training content includes personal stories, videos, case studies/testimonies	3.2a Scope improved training programme including training content 3.2a The training content includes personal stories, videos, case studies/testimonies 3.2a Include and implement competency documents to assess fitness to practice and testing communication skills of staff training as well as best practice models	Elaine Ridley, Family Liaison Officer	Chris Woodfine, Head of Engagement and Experience Learning Education and Development (LEaD)	Sara Courtney, Chief Nurse	31/12/17	On track	May 2017 CW to link with SC training lead who is undertaking a review of competencies staff require for care planning, risk assessment.	Training resources includes personal accounts of families	31/12/17		Training resources includes personal accounts of families		
3.3	Increasing the competency of staff to engage with families	3.3 Increasing the amount of training on working with families offered to Investigating Officers as part of their core training	Training for Investigating Officers and also crucially for Commissioning Managers will align within the context of the Trust position statement on engaging with families following death of a service user 3.3a Deliver the training programme as defined by action 3.2	3.3a Training to be made available online or a folder resource 3.3a Ensure roll out of training programme through LEaD	Helen Ludford, Associate Director of Quality Governance	Learning, Education and Development (LEaD)	Sara Courtney, Chief Nurse	31/03/18			Staff have a detailed resource on training for their roles as Commissioning Manager and Investigating Officer	30/06/18		Undertake an audit on implementation of improved training for Commissioning Mangers and IOs		
3.4	Increasing the competency of staff to engage with families	3.4 Developing person specifications for the Investigating Officer role that includes the competencies needed for successfully engaging with families	Training for Investigating Officers and also crucially for Commissioning Managers will align within the context of the Trust position statement on engaging with families following death of a service user 3.4a Review the role description and person specification for the CM and IO role and develop specific competencies	3.4a Undertake a review job descriptions of the IO, CM and FLO 3.4a Ensure clarity of roles and responsibilities 3.4a Include competencies needed for successful engagement with families	Helen Ludford, Associate Director of Quality Governance	Associate Directors of Nursing & AHPs (all divisions)	Sara Courtney, Chief Nurse	31/07/17	On track	May 2017 job descriptions reviewed.	IOs and CMs are clear about their roles and meet the person specification	31/07/17		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process		
3.5	Increasing the competency of staff to engage with families	3.5 Providing clarity about the role of lead Investigating Officers in supporting Investigating Officers with the role	As covered in action 3.4. In addition: 3.5a To review the capacity of the central investigation team	3.5a To review the capacity of the central investigation team 3.5 Produce a business case following the review as appropriate	Helen Ludford, Associate Director of Quality Governance	SIRI team	Sara Courtney, Chief Nurse	30/06/17	On track	May 2017 project to review investigating officer role underway - will look at capacity;training and feedback on the role.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/10/17		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process	1.1 Investigating Officer Review terms of reference	
3.6	Increasing the competency of staff to engage with families	3.6 Providing peer support opportunities and administrative help for Investigating Officers	3.6a To assess the IOs need for supervision and support and devise a programme	3.6a Undertake an anonymised questionnaire survey and quantitative analysis of current lead Investigating Officers to ascertain their experience of role so far, and clarify what resources they may require 3.6a Commission Psychologists to review roles and conduct an analysis and feedback 3.6a Develop a peer support network of lead Investigating Officers 3.6a Scope a programme of psychological supervision for divisional investigating Officers	Helen Ludford, Associate Director of Quality Governance Hazel Nicholls, Clinical Director, Primary Care & IAPT	Lead IOs Divisional IOs	Sara Courtney, Chief Nurse	31/10/17			Staff have a strong network of support and information sharing to enable their role competencies	31/12/17		Staff have a strong network of support and information sharing to enable their role competencies		
4.1	Improving the quality of reports	4.1 Ensuring that investigators contact the families as soon as possible and that any concerns or questions that the family may have are incorporated into the terms of reference for the investigation	Covered under actions 2.3 and 3.4	Covered under actions 2.3 and 3.4												
4.2	Improving the quality of reports	4.2 Giving families access to findings of any investigation including interim findings.	4.2a Establish a protocol on sharing interim findings with families whilst maintaining factual accuracy and adhering to timescales	4.2a Establish a protocol on sharing interim findings with families whilst maintaining factual accuracy and adhering to timescales	Helen Ludford, Associate Director of Quality Governance	Elaine Ridley, Family Liaison Officer Families with experience of an investigation	Sara Courtney, Chief Nurse	30/09/17			Reports are accurate and sensitive to the feelings of the families	31/12/17		Reports are accurate and sensitive to the feelings of the families		
4.3	Improving the quality of reports	4.3 Giving families the opportunity to respond/comment on the findings and recommendations outlined in the final report and be assured that this will be considered as part of the quality assurance and closure process undertaken by the commissioners	4.3a Ensure that families are given the opportunity to comment on the findings and that this is a clear step in protocol	4.3a Ensure that families are given the opportunity to comment on the findings and that this is a clear step in protocol	Helen Ludford, Associate Director of Quality Governance	Investigating Officers	Sara Courtney, Chief Nurse	31/12/17			Reports are accurate and sensitive to the feelings of the families	31/03/18		Reports are accurate and sensitive to the feelings of the families		
4.4	Improving the quality of reports	4.4 Sharing updated action plans with the families six months after the report has been completed	4.4a Revise SIRI procedure to include the updated action plan to be shared with families subject to families agreement	As covered in action 2.1a and 2.3a. In addition: 4.4a Action planning with families to be monitored at the WAGs and MOMs 4.4a Revise the SIRI procedure to include that the IO should establish with families on an individual basis whether they would like to see the updated action plan	Helen Ludford, Associate Director of Quality Governance	Complaints Working Group Family First Involvement Group Mortality Forum	Sara Courtney, Chief Nurse	31/12/17			Families are informed where they wish to be of progress made on agreed actions	31/12/17		Families are informed where they wish to be of progress made on agreed actions		
4.5	Improving the quality of reports	4.5 Writing the report in plain English, avoiding jargon, or provide comprehensive glossary of terms and a list of abbreviations	4.5a Ensure that the reports are written in plain English, avoiding jargon, or provide comprehensive glossary of terms and a list of abbreviations	4.5a A new revised checklist to be incorporated into the Area and Trust Corporate Panels to including the criteria that all reports must be written in plain English 4.5a Each divisional SIR panels and corporate SIRI panel will have a lay member representative 4.5a Provision of a checklist for Ulysses, to ensure that the author includes a glossary 4.5a Develop training or resources for staff on report writing	Helen Ludford, Associate Director of Quality Governance	Associate Director of Nursing & AHPs (all divisions) Investigating Officers Tom Williams, Ulysses System Developer	Sara Courtney, Chief Nurse	31/12/17		May 2017 quality of serious incident reports is being reviewed. Workshop on best practice in June 2017.	All reports are clear and easy to understand for families	30/06/18		All reports are clear and easy to understand for families		
4.6	Improving the quality of reports	4.6 When families do not feel able to engage with the investigation immediately following the death of their loved one, ensuring that they have the opportunity to raise questions and concerns and input into the review at a time of their choosing	4.6a Ensure adherence to timescales of the 60 day limit whilst also ensuring that staff are aware that they should open the investigation at any stage/allow an opportunity for discussion with the families	As covered in action 2.8a. In addition: 4.6a Communications plan to include detail/note of family preference for timely contact 4.6a Ensuring that SIRI procedure details clear arrangement for point of contact following closure of an investigation	Investigating Officer		Sara Courtney, Chief Nurse	31/12/17			Families are able to be involved at a time that is suitable to them	31/03/18		Families are able to be involved at a time that is suitable to them		
4.7	Improving the quality of reports	4.7 Considering how the resulting improvements in services following changes recommended by investigations can be measured	4.7a Develop mechanisms for feedback from families to enable Trust to measure changes in involvement of families in investigations	4.7a Generate qualitative data from surveys and interviews with families to evidence families' involvement 4.7a Evidence of families attending the Improvement Panel to observe the improvements made as a result of the recommendations from the investigations 4.7a Inviting families to visit the service to illustrate the changes 4.7a Consider a review to be repeated in 2 years time to ascertain embedding of improvements	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance Associate Director of Nursing & AHPs (all divisions)	SIRI team	Sara Courtney, Chief Nurse	31/03/18		May 2017 FLO is sending questionnaires to families for feedback. Results are included in reports to Caring Group.	Families are assured that the improvement within the services are embedding following the actions developed from the recommendations of the investigation have been completed	31/06/2018		Survey responses are positive and attendance levels of families at improvement panels	FLO reports	

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