NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
CHIEF INSPECTOR OF HOSPITALS CQC INSPECTION – HIGH LEVEL ACTION PLAN MARCH 2016
Accompanied by Remedial Works Plan and Progress Spreadsheet

Legend: Green actions complete Grey actions not due Amber actions due Red actions past timescale / risk identified

Part 1 Trust *Must Do* actions from Provider Report

Action	Action Detail	Lead Director	Delegated Responsibility (next level)	To be implemented by	Timescale (Month/ Year)	Progress	Key metric/ benefit	Sustainability and Validation (systems/process)	RAG (not validated to date)
To support the must do's and should do's									
Develop process of peer reviews	• Form a peer review working group • Agree a set of standards against each CQC regulation • Create peer review audit tools • Agree pilot of peer review tools in inpatient areas • Agree pilot of peer review tools in community teams • Formally report outcome of peer reviews • Agree annual programme of peer reviews • Report outcome of pilots to QARC and ongoing programme of reviews	Natalie Hammond	Lorianne Martin, Governance Lead West	Corporate governance team Ward Managers	• May 16 • June 16 • July 16 • May 16 • June 16 • July 16 • Aug 16 • Aug 16				
1.0 The Trust must have effective systems in place for the safe prescribing and administration of medicine									
Review prescribing and administration of medication systems	Supporting Safe Prescribing and Administration of Medicines	Dr Malte Flechtner Medical Director	Raj Parekh, Associate Director of Pharmacy	Raj Parekh, Associate Director of Pharmacy	January 2016	Supporting Safe Prescribing and Administration of Medicines: Medicines management training for nurses, training for doctors focussing on prescribing errors, Mental Health training for Pharmacy staff, involvement in POMH UK audits, clinical audits covering medicines including controlled drugs and antimicrobial drugs, analysing, reporting and learning from drug errors via medicines management groups, prescribing quality group, RGE, publishing result on website, newsletters; regular visits to all inpatient units by pharmacists to monitor, give advice and check on prescribing,	Medication incident reporting improved by 5% from baseline of 222 incidents (improvement in no/low harm reporting). Number of pharmacy interventions All inpatient nurses to attend medicines management training. Prescribers attend Safe Prescribing training Participation POMH-UK Audits with increased numbers of	Medication incident rates of reporting monitored monthly via Patient Safety Dashboard (and broken down by level of harm). Pharmacy intervention rates monitored via monthly Pharmacy KPI scorecard. 6 monthly Pharmacy Interventions Audit produced analysing interventions undertaken. Bi-monthly Prescribing Quality Group review prescribing errors medication incidents, outcome of	

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						ordering, administering of medicines. Pharmacy interventions are regularly monitored.	patients audited. All regular doses prescribed should be given or have a documented reason for why they were not given.	POMH-UK audits. Peer reviews developed and embedded for further assurance and learning Annual Missed Doses Medication Audit and weekly medicine card audits by nursing staff.	
	Staff to be reminded/trained in proper completion of prescribing charts to ensure information is complete and medicines used as prescriber intended		Angie Butcher, Area Chief Nurse	Angie Butcher, Area Chief Nurse	2015	Medicine Competency Framework (MCF) in place for all preceptors and new nurses starting in the Trust. Requires an 80% pass and calculations requiring 100%. Nurses involved in drug errors will be required to do all or part of the MCF and be supervised in practice. As at April, 19 preceptors/new starters and 14 qualified staff (due to medication errors) are completing the MCF. Monthly training day for nurses with 18 places available. Joint training with pharmacy. To NMC standards. Bespoke support to ward managers with the MCF, investigating and learning from Datix errors. Bespoke training delivered to teams in the Trust. Training for March included - safe drug administration PMAC (on 1 ward), controlled drugs (1 ward), emergency dispensing (1 ward). April training included – safe drug administration (1 ward), Clozapine (1 ward)	Medication incident reporting improved by 5% from baseline of 222 incidents (improvement in no/low harm reporting). All inpatient nurses to attend medicines management training. 100% MCF compliance by preceptors 100% MCF compliance by new starters AB to advise on any additional metrics	Bi-monthly Prescribing Quality Group review prescribing errors medication incidents. Training and development group Practice Based Educational Facilitator Monitoring Monitoring of MCF compliance figures via monthly Medication Incidents Narrative Report (discussed at RGE). AB to advise on any additional methods of sustainability	
	Improve pharmacy recruitment and retention		Raj Parekh, Associate Director of Pharmacy	Raj Parekh, Associate Director of Pharmacy	August 2015	Completed	Full establishment of pharmacy department	Locum use in pharmacy to remain <5% as monitored via Pharmacy KPI scorecard. Monitor turnover	
	Improve prescribing of PRN medication in relation to reviews		Raj Parekh, Associate Director of Pharmacy	All Prescribers of PRN medication	2016	RP to advise	10% reduction in PRN medication prescribing – how are we monitoring – through the KPI scorecard? RP to monitor/track	Prescribing and Administration of PRN medication re-audit in 2017 Pharmacy audits (not POMH) on PRN prescribing RP to advise on any additional methods of sustainability	
2.0 The Trust must ensure that medical equipment is working effectively and stored									
Review the required medical equipment, both	Emergency responsiveness and supporting systems are	Natalie Hammond Director of	Angie Butcher, Area Chief Nurse	Judith Skargon, Nurse	2015	All wards visited by Nurse Consultant with all systems and equipment reviewed	100% wards visited with their emergency responsiveness and supporting systems and	Monthly review by local matron with evidence documented in the Matron Quality Assurance Checks.	

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standard and emergency, and accessibility of this	being reviewed by the Nurse Consultant Physical Health	Nursing and Quality		Consultant			processes reviewed. AB to advise on any additional metrics	Issues escalated to local management and Medical Devices Group as needed. AB to advise on any additional methods of sustainability	
	All emergency bags are being assessed and a seal-tag approach introduced		Angie Butcher, Area Chief Nurse	Ward Managers	2015	Completed on all 20 wards	100% sealed emergency bags in situ on all in-patient wards	Regular (weekly) auditing of medical equipment as monitored locally. Peer reviews developed and embedded for further assurance and learning	
	Ligature cutters will be assessed for their availability and storage requirement in the wards		Area Directors, then Ian Carr, Deputy Director In-patient Service	Ward Managers	2015	Completed on all 20 wards Uniform attached ligature cutters being piloted on 1 ward	100% ligature cutters in situ on all in-patient wards	Regular (weekly) auditing of medical equipment as monitored locally. Peer reviews developed and embedded for further assurance and learning	
	A ratified policy on the safe use of ligature cutters		Michelle Appleby, Associate Director	Ward Managers	August 2015	Policy completed and reviewed in the Risk and Governance Executive in February 2016. Circulated to all staff Trust-wide. Review planned for August 2016.	Policy disseminated to all clinical staff to raise their awareness on the safe use of ligature cutters. 85% training compliance with ligature e-learning achieved by March 2017 (for inpatient staff).	Policy reviewed in line with Policy Advisory Group requirements. Monitoring ligature e-learning to reinforce policy with report to August RGE for discussion.	
	Wards to receive simulation training 'in the event of emergency' to test level of awareness and competence		Tanise Brown, Associate Director of Workforce and Education	TASI trainers (delivery) Ward Managers (attendance) SLAM* (delivery) *external delivery of training organised by NEP	February 2016 (ILST) March 2016 First tranche for EST 13th May 2016	Current Basic Life Support training to be enhanced with the roll out of Intermediate Life Support training for inpatient band 6 and above staff beginning February 16. Emergency simulation training to begin in May 2016 with the following dates scheduled: 13th May, 7th June, 8th June. Training will focus upon the following scenarios – hanging, physical deterioration and search (whilst maintaining an individual's privacy and dignity).	60% staff to have received ILS training by end of 2016 (produce training trajectory) 1 emergency simulation training session per month with review report and learning disseminated to staff and operational management. .	Training and development group review usefulness of simulation training (through participant feedback) and on-going need. TASI trainers to support the intermediate LS training at ward level	
	Report to the Board on how NEP will ensure that all emergency equipment is fit for purpose and stored appropriately so that in the event that it is required there is no unnecessary delay in it being made available		Michelle Appleby, Associate Director of Corporate Governance and Risk	Ward Managers (day to day management of emergency equipment)	November 2015	Progress presented to November Board Completed	All emergency equipment is fit for purpose with the Board receiving regular assurance.	Monitoring by Physical Healthcare/Medical Devices Group Daily monitoring of the resuscitation bag via checklist. Monthly matron quality assurance checks to highlight any variation or non-compliance with daily checks.	

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3.0 The Trust must ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight									
Undertake a review of the current ligature policy examining the management of ligature anchor points and clinical responses expected	All in-patient areas to be re-assessed for ligature anchor points.	Natalie Hammond Director of Nursing and Quality	Michelle Appleby, Associate Director of Corporate Governance and Risk	Risk team (annual audits)	November 2015	All 20 wards re-assessed for ligature anchor points. Each area has an action plan relevant to any ligature anchor points. Actions form part of the Estates Remedial action plan. Photo albums on the management of ligatures available on all wards.	Reduction in ligature anchor point incidents in adult in-patient settings with a reduction in the level of patient harm (metric - % reduction required) (elimination of ligature anchor point incidents with serious, major or severe harm caused to patients) Reduction in physical harm (metric - % reduction required) Patient Safety Assessments completed (incorporating ligature risk assessment) .100% of all inpatient areas to have annual re-audit completed by September 2016. Action plans created for Patient Safety Assessment with 100% implementation.	Annual patient safety assessment programme monitored by Risk and Governance Executive Local monitoring of Patient Safety Assessment Action Plans by governance forums and Clinical Boards Thematic analysis of ligature anchor point incidents created through 'Sign up to Safety' campaign and disseminated to staff for learning.	
	A new ligature risk tool is being utilised across the in-patient pathway to provide a more detailed description of ligature risks present and the level of required management and residual clinical risk		Michelle Appleby, Associate Director Corporate Governance and Risk	Risk team (annual audits)	September 2015	Completed, new ligature risk tool launched on all 20 wards. New programme planned for 2016/17. Audit documentation held on Risk Management shared drive.	100% Patient Safety Assessments completed (incorporating ligature risk assessment) with reports 100% Patient Safety Assessment Action Plans completed and implemented	Annual patient safety assessment programme monitored by Risk and Governance Executive Local monitoring of Patient Safety Assessment Action Plans by governance forums and Clinical Boards	
	A picture guide is being developed for each ward on their ligature risk and used to induct staff to the risk present		Michelle Appleby, Associate Director	Ward Managers	December 2015	Completed and displayed on all 20 wards and hand-outs to all relevant staff including bank staff. Photo albums maintained on Risk Management shared drive	Picture guide in place on all wards. 100% relevant staff have hand-outs	Annual patient safety assessment programme monitored by Risk and Governance Executive Peer reviews developed and embedded for further assurance and learning	
	Clinical guidance on what constitutes a ligature anchor point risk and how to manage risk is part of this process		Michelle Appleby, Associate Director	Ward Managers	December 2015	Completed as part of above Subject to ongoing review	Staff have access to clear clinical guidance and are aware of how to manage ligature risk.	Clinical guidance reviewed in line with Policy Advisory Group requirements. Patient Safety Audit Group monitor outcome of annual patient safety assessment programme and estates plan.	
	A strategy on ligature risk		Michelle Appleby	Jonathan	November	Completed – Ligature point	Strategy in place	Annual review of strategy	

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	and a ligature removal programme will be presented to the Board		and Jonathan Stewart, Associate Directors	Stewart, Associate Director of Estates/ Facilities	2015	management and remedial works programme presented to November Board	Ligature removal programme in place	Monitoring of programme by monthly Strategic Capital Group and Risk and Governance Executive	
	A ratified policy relating to the management of ligature anchor points		Michelle Appleby, Associate Director	Ward Managers	August 2015	Completed and ratified February 2016 and available on intraNEP	Policy in place	Policy reviewed in line with Policy Advisory Group requirements.	
	Clinical review of policy to ensure robustness		Michelle Appleby, Associate Director	Operational Managers	August 2016		More robust policy in place	Regular review of policy by PAG	
	Review top 10 clinical policies and structured summaries to include management of ligature points		Michelle Appleby, Associate Director	Michelle Appleby, Associate Director	August 2016	Clinical manager development day (9th May) to include group work regarding what policies managers use most frequently in their day-to-day work. Structured summaries to be developed after identification of these policies.	Structured summaries in place and provide an easy reference for staff. Summaries are accessible to all staff.	Structured summaries to be reviewed with full policy in accordance with Policy Advisory Group requirements.	
	Launch new robust management of ligature anchor points policy		Michelle Appleby and Martin Cresswell Associate Directors	Communi-cations and Risk teams and Operational Managers	September 2016		Clinical staff aware of management of ligature anchor points policy	Patient safety audits	
	All relevant staff to be sent all top 10 clinical inpatient and community policy structured summaries		Lisa Mellor Associate Director HR	HR/Payroll	September 2016		Staff awareness of top 10 inpatient/community policies/structured summaries	Structured summaries to be reviewed with full policy in accordance with Policy Advisory Group requirements. Staff knowledge on key policies to be assessed through the developed Peer Reviews.	
	A programme of audit in place and shared with staff to ensure actions taken to mediate risk in terms of practice		Michelle Appleby, Associate Director	Risk Team (Audit) Ward Managers	August 2015	Completed – ongoing programme on all 20 wards throughout the Trust with follow up Re-audits underway for 2016.	Audit tools in place All audits have reports and action plans Action plans implemented within agreed time frames Reduction in ligature anchor point incidents in adult in-patient settings	Monitoring by quality improvement panels Monitoring by R&GE	
Ensure staff are aware of how they clinically manage the risk of ligature points	Leadership weekly safety walk rounds to consider ligature risk management	Natalie Hammond Director of Nursing and Quality	Area Directors	Service, Clinical and Ward Managers	September 2015	Completed – weekly ongoing	100% all tier management walk rounds taking place and recorded	Rolling programme in place	
	Safety alerts to highlight		David Wilmott,	Comms team	July 2015	Completed and ongoing with internal	Increased staff awareness and	Monitoring by Quality Improvement	

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	staff vigilance in clinical practice and how to manage ligature risk		Associate Director of Quality and Martin Creswell AD Comms	Ward Managers		and national safety alerts. Last safety alert circulated 3rd May highlighting learning from recent inpatient incidents. Safety alerts found on IntraNEP page and disseminated in Core Briefing.	learning through the publication and sharing of all safety alerts. Reduction in ligature anchor point incidents in adult in-patient settings and reduction in harm	Panels and Risk and Governance Executive	
	Themed review in shared organisation learning webpage on clinical management of ligature risk		David Wilmott, Associate Director of Quality and Martin Creswell AD Comms	Comms team Ward Managers	July 2015	Completed and on-going as/when relevant incidents arise.	Shared organisation learning webpage live 100% cascading to all relevant staff	Monitoring by QIP and RGE	
	Examples of changes to practice to manage line of sight observation		Area Directors and Associate Directors for Risk and Estates/ Facilities	Ward Managers and Risk/Estates Teams	February 2016	Convex mirrors installed on all 20 inpatient wards Observation e-learning ready for launch in Feb 16 Heat map and ligature booklet produced for all inpatient wards identifying staff of high risk areas	Staff can maintain clear lines of sight enhancing patient safety and reducing risk on inpatient areas. Reduction in incidents and harm to patients 100% shared learning of positive changes to practice	Monitoring by QIP and RGE Programme of local management walk rounds	
	STORM training – improvement trajectory set for 60% of all registered in-patient clinical staff by 2016		Angie Butcher Area Chief Nurse	Ward Managers	December 2016	22% of clinical registered staff on inpatient units trained. Some units e.g. Finchingfield have exceeded target	60% of all inpatient qualified staff trained by end 2016	Training figures monitoring by QIP and RGE	
	Health and Safety training to include updated ligature management		Michelle Appleby, Associate Director Tanise Brown, Associate Director (training compliance monitoring)	Health and Safety Manager	May 2016	Additional section on ligature management has been added to current Health and Safety for Line Managers training from February 2016 Ligature Management topic to be included in the Health and Safety Awareness week in May 16	Updated health and safety training focusing on ligature awareness. Set improvement targets for H&S training compliance (TB) Improvements in Staff Survey results in comparison with national median for job relevant training, learning and development.	Health and Safety Training participant feedback regularly reviewed by training and development group. Nursing and medics training attendance reviewed as part of their revalidation. Local performance monitoring of Health and Safety training compliance Three non-attendances at Health and Safety training by an individual results in a management meeting.	
	Review of effectiveness of modified ligature risks following action e.g. door top alarms		Associate Directors Risk and Estates/ Facilities	Associate Directors Risk and Estates/ Facilities	November 2015	Evaluation of door top alarm system report submitted to EMT November 2015	Evaluation of effectiveness	Planned preventative maintenance	

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4.0 The Trust must ensure that it complies with the Department of Health guidance in relation to mixed sex accommodation									
Review NEP delivering single sex accommodation processes to confirm changes required as identified in CQC report	Service users are accommodated in same sex wards where the whole ward is occupied by males or females only; or sleeping accommodation is in single rooms within mixed wards with toilet and washing facilities ensuite or very close by and are clearly designated male or female; or sleeping accommodation within mixed wards is in shared rooms used solely by male or female users.	Natalie Hammond Director of Nursing and Quality	Area Directors	Ward Managers	2016 – estimated date	Guidance has been issued with 6 of 7 adult acute wards now single sex Building work is complete in The Christopher Unit (Psychiatric Intensive Care Unit) to allow gender separation. Estate planning in place to move Peter Bruff Ward to more suitable accommodation	100% patient accommodation is appropriately segregated as per DoH guidelines EMSA breaches are agreed at appropriate levels and to agreed set of criteria, followed by root cause analysis All EMSA breaches are reported via Datix.	Daily bed management meetings with correct identification of service for admitted patients. Monthly monitoring of Datix incidents as reported via Quality Dashboard.	
	On mixed wards with single or shared bedrooms giving out onto one corridor, single bedrooms, toilet and bathing facilities are grouped to achieve as much gender separation as possible.		Area Directors	Ward Managers	2015	Completed	Mixed sex wards include clear gender separation All EMSA breaches are reported via Datix	Daily bed management meetings Monthly monitoring of Datix incidents as reported via Quality Dashboard.	
5.0 The Trust must proactively address any practices that could be considered restrictive, for example, the use of the Hub, access to toilets, access to the gardens, and access to snacks and beverages									
Undertake scoping exercise to understand extent of blanket restrictions in NEP	Undertake scoping exercise	Vince McCabe Director of Operations	Area Directors	Ward Managers	2015	Completed on all 20 wards	Scoping exercise complete Eliminate blanket restrictions unless approved at appropriate levels, followed by root cause analysis	Monitor through walk rounds – tiered level of seniority from Matrons, Area Directors to Executive/Non-Executive Directors Patient feedback monitored addressing suspected blanket restrictions. Ongoing review of CQC MHA reports where issues of blanket restrictions may be raised.	
	Ensure toilets are accessible to patients at all times		Area Directors	Ward Managers	2015	Completed	Sufficient toilet facilities available at all times	Monitor through operational management walk rounds, Datix incidents and patient feedback Peer reviews developed and	

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								embedded for further assurance and learning	
	Ensure garden areas are accessible to patients		Area Directors	Ward Managers	2015	Completed and any patient requiring to enter the garden at night is risk assessed and supervised	Patients are able to use the garden areas	Monitor through operational management walk rounds, Datix incidents and patient feedback Peer reviews developed and embedded for further assurance and learning	
	Ensure food and drink is available when patients require it		Area Directors	Ward Managers	2015	Completed	Zero complaints from patients about accessibility to food/drink	Monitor through operational management walk rounds, Datix incidents and patient feedback Peer reviews developed and embedded for further assurance and learning	
6.0 The Trust must ensure that there are sufficiently experienced staff on duty at all times to provide skilled care to meet patients' needs									
Develop a systematic approach to determining the number and range of skills of staff required	Undertake review of skill mix and staffing complement of in-patient areas	Natalie Hammond Director of Nursing and Quality	Area Directors and Chief Nurses	Area Directors and Chief Nurses	January 2016 January 2016	Completed with report to the Board January 2016 with 3 approaches: (1) Qualitative survey from all Ward Managers (2) Use of evidence based acuity tool (NHS England) (3) Detailed shift by shift analysis for one week for benchmarking data and current guidance Now undergoing financial analysis and to seek funding from Commissioners Acuity tool now underway in acute mental health wards across the Trust. Workforce Report discussed in March Board, notes 4.8% increase in use of bank and agency to fill shifts during February (as compared to January figures).	85% registered and unregistered shifts are filled as reported through Safer Staffing. XXX Reduction in use of bank and agency staff	Staffing locally monitored via Safer Staffing submissions and Quality Dashboard. Monitoring through local and Trust Quality Improvement Panel. Staffing figures reported to every Trust Board. Contract negotiations include funding for staffing establishments.	
	Undertake specific 'Hub' staff analysis inclusive of AHPs		Area Director West	Area Director and Associate Director OT/AHPs	December 2015	Independent review conducted on Hub model and presented to November Board with a way forward to ensure no blanket restrictions on use of Hub	Staff turnover in line with 10% Trust threshold.	Monitoring through local and Trust Quality Improvement Panel.	
	Implement NHS England Patient Acuity Tool for Mental Health		Area Directors	Area Directors	June 2015	Completed across all wards	All wards to have completed acuity tool for 28 days.	Acuity tool repeated every six months with outcome reported to Trust Board (and operational management) in line with 'Hard Truths' requirements.	
	Establish leadership development days and ward manager leadership		Tanise Brown	Tanise Brown	November 2015	Genesis training programme for new managers implemented in November 2015 to be run quarterly	All ward managers to have participated in Ward Manager Development Programme by	Continuous programme reviewed regularly with the participants.	

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	programme					Ward Manager Development Programme implemented in November 2015 to be run 6 monthly. Ten ward managers have completed the Ward Manager Development Programme to date. Ward Manager Development Programme dates for 2016 established – 6th May, 2nd June, 16th June and 17th June.	2017.		
	DoNQ to hold quarterly ward manager and clinical service manager events as a network of improvement	Natalie Hammond Director of Nursing and Quality	Natalie Hammond	Giena Sumner	2015	Completed and on-going. Next development event scheduled for 9th May.	Quarterly development day event held with topics themed to Quality Star and 21 staff in attendance.	Continuous programme of quarterly events with feedback from participants reviewed regularly Discussions at events are circulated for learning.	
7.0 The Trust must carry out assessments of each patient's mental capacity where concerns have been identified and record these in the care records									
Review systems and processes for the assessment of patient's mental capacity where identified	Review Mental Capacity Act and Deprivation of Liberties Policy	Natalie Hammond Director of Nursing and Quality	Penny Rogers Head of Safeguarding	Ward Managers	April 2016	Head of Safeguarding leading revision of SET MCA & DoLS Policy. Policy drafted. To be approved by ESAB/ESCB for adoption in the new financial year. This proposes some radical changes such as replacing MCA1 & MCA2 forms with a single document for recording MCA assessments. Revision of NEP MCA & DoLS Policy will follow on.	Revised SET MCA and DoLS Policy Revised NEP MCA and DoLS Policy	Policy Advisory Group	
	Make assessment of capacity a mandatory field on Remedy	David Griffiths Director of Resources	Rick Parsons	Remedy Team	June 2016	Agreed by EMT at away day in January 2016	All patients have capacity assessment as it will be a mandatory field in Remedy.	Performance reporting of compliance with capacity assessments via Business Informatics. Monitoring performance data via Quality Improvement Panels	
	Revise ward review paperwork to outline and evidence how consent to treatment and capacity is considered and recorded	Dr Malte Flechtner Medical Director	Malte Flechtner Area Medical Directors	Consultant teams	July 2015	Completed Ward review paperwork has been revised but local auditing has indicated further work is required to ensure consent and capacity is being recorded according to developed guidance.	100% consent to treatment and capacity is recorded in ward reviews according to developed guidance.	Auditing of ward review paperwork	

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8.0 The Trust must improve their governance and assurance systems relating to the assessment and management of ligature risks, the quality of care plans and the assessment of the quality of the ward activities programme provided									
Review governance and assurance systems around assessment and management of ligature risks, the quality of care plans and the assessment of the quality of the ward activities programme provided	Develop Quality Improvement Panels at a local and Trust wide level – a forum for looking at the quality star tool, review of ward level quality indicators, local risk registers and workforce indicators	Natalie Hammond Director of Nursing and Quality	Natalie Hammond and Area Directors	Amy Hickey AD PA's	September 2015	Quality Improvement Panels established at all levels of the Trust.	100% Quality Improvement Panels are occurring reviewing Quality Stars, local quality indicators and risk registers.	Local Quality Improvement Panels report to Trust-wide Quality Improvement Panel. Outcomes from Trust-wide Quality Improvement Panel reported to Quality and Risk Committee.	
	Develop and implement Quality Governance Framework		Natalie Hammond and Area Directors	Natalie Hammond	September 2015	Completed – presented to Board September 2015 and implemented – outlines Quality Improvement Panels	100% Quality Improvement Panels are occurring reviewing Quality Stars, local quality indicators and risk registers.	Outputs of Quality Improvement Panels are annually reviewed in line with their Terms of Reference.	
	Review operational management structures and associated corporate functions to streamline delivery of services with a consistent approach, parity and learning		Natalie Hammond Vince McCabe Malte Flechtner Lisa Anastasiou	Operational Management and Corporate Leads	April 2016	Discussed and agreed in EMT; developing consultation documents Consultation currently underway affecting nursing and governance, human resources, communications and operational services. Consultation due to close on 17th May.	Further develop standardised processes across inpatient and community services. Corporate services provide support to operational services enabling services to drive their quality improvements.	EMT	
	Map governance arrangements and hold governance meetings in each area		David Wilmott Associate Director of Quality	David Wilmott	2015	Completed and regular governance meetings in place	Monthly governance forums occur in all areas, always starting with a patient story.	Output from governance forums are reviewed annually in line with their Terms of Reference.	
	Review delivery (and governance) of therapeutic interventions and group programmes across all acute inpatient wards with a focus on gender specificity, recovery, engagement and 7 days per week		Glenn Westrop Associate Director of OTs and AHPs	Professional Leads and Ward Managers	September 2015	In progress in all 7 acute inpatient wards Completed	All inpatient wards have a 7 day (inclusive of some weekends programme) a week activity programme with is age and gender appropriate and covers physical, therapeutic, recreational and cognitive activity for older people's wards.	Designated inpatient OT Consultant Lead Leadership walk rounds monitor levels of staff engagement with patients. Activity programme discussed and reviewed with patients in community meetings (and changes made to the programme in response to discussions). Peer reviews developed and embedded for further assurance and learning	
	Review care plans in the Trust to ensure staff provide person centred care and treatment that is appropriate to meet		Area Directors Associate Director Commun-ications	Martin Cresswell	September 2015	Completed across all adult acute wards	My Care My Recovery plans developed	Monthly care plan audits in the adult acute wards monitor use of the 'My Care, My Recovery' plans. Quality improvement panels review	

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	their needs and reflects their personal preferences and is holistic in approach.							outcomes of care plan audits.	
	Implement 'My Care My Recovery' initiative in acute in-patient wards		Area Directors	Practice Education Facilitators Operational Managers	October 2015	Completed across all acute inpatient wards. Adaptation in development for all older adult inpatient wards "My Care My Support Plan". Considering adaptation for CAMHS inpatient wards. Training completed by Practice Education Facilitators across the Trust. Qualitative audit against care plans carried out.	100% patients in the adult acute wards are offered a 'My Care, My Recovery' plan and supported in the plan's development.	Monthly care plan audits in the adult acute wards monitor use of the 'My Care, My Recovery' plans. Quality improvement panels review outcomes of care plan audits.	
	Review CPA training in line with recovery orientated care		Area Director Mid	Carol Larcombe CPA Co-ordinator	2015	Completed – syllabus incorporates focus on recovery and My Care My Recovery now embedded	Improved CPA training	Evaluation of training from training participants	
	Revise ward review paperwork to outline and evidence how consent to treatment and capacity is considered and recorded		Malte Flechtner	Ward Managers	July 2015	Completed Ward review paperwork has been revised but local auditing has indicated further work is required to ensure consent and capacity is being recorded according to developed guidance.	Consent to treatment and capacity is recorded 100% consent to treatment and capacity is recorded in ward reviews according to developed guidance.	Auditing of ward review paperwork	
9.0 The Trust must address the identified safety concerns in the health-based places of safety									
Ensure that seclusion and health based places of safety are compliant with the Mental Health Act Code of Practice 1983	Review the design and fabric/ furnishings of seclusion and place of safety suites	Natalie Hammond Director of Nursing and Quality	Jonathan Stewart Associate Director Estates/ Facilities	Nick Rippon Head of Capital Development	February 2016	Redesign of the areas has been drawn up and the plans are out for consultation	Revised design of seclusion and place of safety suites		
	Develop and implement a programme of works as a result of the review	David Griffiths, Director of Resources	Jonathan Stewart	Nick Rippon	March 2016	Programme of works to be scheduled to maximise the availability of S136 suites in the Trust	Upgraded seclusion and HBOS suites Compliance with MHA Code of Practice 1983	Evaluation of upgraded facilities and monitoring of seclusion and S136	
	Complete works	David Griffiths, Director of Resources	Jonathan Stewart	Nick Rippon	July 2016				
10.0 The Trust must address the security of the doors within the forensic (low secure) core service									
Identify and rectify the problems with the door security on Edward House	Repair or replace the defective doors within Edward House	David Griffiths Director of Resources	Jonathan Stewart	Nick Rippon	October 2015	Completed – all interior doors with identified weakness have been reinforced to prevent opening with credit card or similar. Airlock and absconsion issue resolved	Zero absconsion due to defective doors as monitored through Datix and local escalation.	Planned preventative maintenance	

Part 2 Trust *Should Do* actions from Provider Report

Action	Action Detail	Lead Director	Delegated Responsibility (next level)	To be implemented by	Timescale	Progress	Key metric/ benefit	Sustainability	RAG (not validated to date)
11.0 The Trust should ensure that systems are in place for the effective recruitment and retention of staff									
Review recruitment and retention processes	Recruitment strategy	Lisa Anastasiou Director of Workforce and Development	Lisa Mellor	Janet Watson	2015	Recruitment strategy in place to address recruitment challenges Board meeting February 16	Reduce vacancies Reduce agency levels	Executive Management Team monitoring	
	Undertake an evaluation of the timeliness of current recruitment processes		Lisa Mellor	HR team	End April 2016	In progress	Improved timelines for recruitment to vacancies (define average time and agree on target reduction)	Regular audit	
	Review ways of retaining staff		Lisa Mellor	HR team	2016	Working towards reducing turnover in line with Trust agreed threshold	Reduction in turnover of staff to Trust threshold of 10%	EMT monitoring	
12.0 The Trust should ensure that care and treatment records, including risk assessments, are sufficiently detailed, personalised and kept up to date									
Demonstrate that service users receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences	Undertake regular audits of the quality of care plans and risk assessments	Natalie Hammond Director of Nursing and Quality	Area Directors	Ward Managers	2016	A number of care plan reviews have taken place. Practice Education Facilitators involved in mentoring and coaching	Improved quality of care plans and risk assessments with care plans meeting 90% of care plan audit standards. Mitigation of risk	Quality improvement panels Regular audit	
	Ensure appropriate referrals and access to, and use of, IMHA/IMCA (advocacy) Advertise comprehensively throughout services Communications campaign jointly with ECC		Lynn Prendergast Associate Director Social Care	Lynn Prendergast	2016	(Speak to Lynn Prendergast re S75)	Improved use of advocacy by service users	Patient feedback Monitor referral activity with ECC Regularly audit/monitoring	
	CPA training to be reviewed in line with recovery orientated care		Area Director Mid	Carol Larcombe CPA Co-ordinator	2015	Syllabus incorporates focus on recovery and My Care My Recovery now embedded	Revised training in place Improved quality of care plans and risk assessments	Regular evaluation of training	
	Review documentation for consent to treatment		Dr Malte Flechtner	AMDs	July 2015	Ward round review paperwork implemented in July 2015	Improved recording of consent to treatment in line with Montgomery v Lanarkshire (2015) UKSC 11	Evaluate documentation templates	
			Martin Cresswell Associate Director Comms	Ward Managers	March 2016	Consent to admission/ treatment form designed summer 2015 to be part of admission packs – going to Policy Advisory Group			
	MHA Administrators to audit documentation to ensure capacity and consent to treatment		Lynn Proctor Business Manager	MHA Administrators	April 2016	MHA Administrators will audit presence of consent form attached to T2 in notes	Improved recording of consent to treatment and appropriate use of MCA	Regular audit	
	Review patient information around treatment choices	Dr Malte Flechtner Medical Director	AMDs AD Comms	Ward Managers Comms Team	2016		Informative patient leaflets Improved patient awareness of treatment choices on admission	Patient feedback	

Action	Action Detail	Lead Director	Delegated Responsibility (next level)	To be implemented by	Timescale	Progress	Key metric/ benefit	Sustainability	RAG (not validated to date)
13.0 The Trust should review the efficacy of the electronic record system in community bases and ensure accurate inputting of data									
Review Remedy use in all community teams	Review current processes within Remedy, changing as appropriate and training available to community staff to ensure accurate and timely inputting of data	David Griffiths Director of Resources	Rick Parsons Head of ICT	Remedy Team	June 2016	Business case to EMT April and reinstate Journeys Implementation Steering Group	Improved recording in Journeys pathways Improved accuracy of data	Quality improvement panels	
	Review of Remedy training capacity		Rick Parsons Head of ICT	Remedy team	June 2016				
14.0 The Trust should ensure all MHA documentation is readily available and in good order									
Review systems and processes for MHA documentation	Centralise the MHA administration function Review administration of MHA including review of electronic locations	Natalie Hammond Director of Nursing and Quality	Lynn Proctor Business Manager	Lynn Proctor Business Manager	July 2016	Business case approved by EMT February 2016	Sharing of resources Economies of scale Central management	On-going evaluation and formal review	
	Clear communication of where documentation should be kept in physical locations (including T2s)		Lynn Proctor Business Manager Area Directors Associate Director of Pharmacy	Lynn Proctor Business Manager Ward Managers Pharmacists		To be scoped with above	Policy/protocols updated Improved availability of documentation	Documentation audits Pharmacy audits	
	Implement accountability at ward level for local availability and correct filing of MHA documentation		Area Directors	Ward Managers	2016	Follow on from above	Improving filing and availability of MHA documentation at ward level	Management supervision Documentation audits	
	Ensure patients receive a copy of their Section 17 leave authority and that it is clear what type of leave is being authorised, together with the numbers of escorts specified Crossing through of previous S17 leave	Vince McCabe Director of Operations	Area Medical Directors	Consultant Psychiatrists	2016	Local audit checklist	100% compliance with Section 17	Feedback loop Audits	

Action	Action Detail	Lead Director	Delegated Responsibility (next level)	To be implemented by	Timescale	Progress	Key metric/ benefit	Sustainability	RAG (not validated to date)
15.0 The Trust should ensure that all informal complaints are logged and reported centrally									
Review complaints systems and processes	Centralise the reporting and logging of informal/low level complaints	Natalie Hammond Director of Nursing and Quality	Associate Director of Quality Associate Director of Communications	Patient Safety and Complaints Manager	July 2016	NEP is in the process of centralising all low level complaints into the Patient Safety and Complaints Team – now part of restructuring consultation Reporting already centralised	Comprehensive recording/logging on Datix complaints module Improved management and monitoring of complaints	Regular reporting to Risk and Governance Executive Quality Improvement Panel	
16.0 The Trust should formally review each restraint involving the prone position									
Review therapeutic and safe intervention training (formerly control and restraint)	Implement revised Therapeutic and Safe Interventions	Natalie Hammond Director of Nursing and Operations	Tanise Brown Associate Director Workforce and Education	TASI trainers	2015	Completed Action plan to reduce restrictive interventions	Revised TASI training in place Reduced prone interventions	Evaluation of training Training and development group TASI Governance Group	
17.0 The Trust should ensure that patients who are detained under the MHA 1983 have information on how to contact the CQC									
Publicise information on how to contact the CQC	Display posters/leaflets on wards	Natalie Hammond Director of Nursing and Operations	Martin Cresswell Lynn Proctor Area Directors	Comms Team MHA Admin Ward Managers	March 2016	Re-audit posters and leaflets (communications)	Improved awareness	Patient feedback	
	Inform patients of their rights and how to contact the CQC		Area Directors	Ward Managers	2015	Auditing	Improved awareness	Patient feedback	
18.0 The Trust should review its staffing arrangements for the health based place of safety to ensure sufficient staff are available promptly without impacting on other services									
Review health based places of safety	As part of the review of S136 suites consider the staffing arrangements to ensure prompt availability of staff without impact on inpatient wards	Natalie Hammond Director of Nursing and Quality	Vince McCabe? David Griffiths?	Area Directors	2016	Review of seclusion and S136 suites in progress and linked to safer staffing work Financial analysis underway	Improved response to S136 suite admissions Staffing levels increased appropriately through agreement and agreed criteria	Safe staffing reports Monitoring S136 data	
	Implement recommendations from the review	Vince McCabe	Area Directors	Ward Managers	2016	To follow on from above			
19.0 The Trust should identify a lead for the health based place of safety at The St Aubyn Centre and The Christopher Centre [and The Lakes]									
Review the leadership for health based places of safety (nursing and medical)	Ward Managers to take joint leadership for all S136 suites	Natalie Hammond Director of Nursing and Quality	Area Directors	Ward Managers	Jan 2016	Ward Managers jointly manage S136 suites with medical counterpart	Joint leadership in place	Quality Improvement Panel	
	Identify a lead Consultant for joint leadership of	Dr Malte Flechtner	Area Medical Director	Nigel Hughes	March 2016	To be discussed	Lead Consultant identified Clear leadership	Quality Improvement Panel	

Action	Action Detail	Lead Director	Delegated Responsibility (next level)	To be implemented by	Timescale	Progress	Key metric/ benefit	Sustainability	RAG (not validated to date)
	S136 suite at the St Aubyn Centre	Medical Director							
	Identify a lead Consultant for joint leadership of the S136 suite at The Christopher Unit		Area Medical Director	Bola Otun	March 2016	Lead identified	Lead Consultant Identified Clear leadership	Quality Improvement Panel	
	Identify a lead Consultant for joint leadership of the S136 suite at The Lakes		Area Medical Director	Hem raj Pal	March 2016	Lead identified	Lead Consultant identified Clear leadership	Quality Improvement Panel	
20.0 The Trust should ensure learning from some serious incidents is shared across the three access, assessment and brief intervention teams									
Review the way learning is shared across the Access, Assessment and Brief Intervention Teams	Review the operational structure	Natalie Hammond Director of Nursing and Quality	Natalie Hammond Vince McCabe Lisa Anastasiou	Area Directors and Associate Directors	2016	In progress	Improved working relationships Improved sharing of learning of SI's Reduction in SI's	Quality Improvement Panel	
21.0 The Trust should agree target times for assessment for all access and brief intervention teams									
Review assessment times	Develop target times for assessment for all access and brief intervention teams	Vince McCabe Director of Operations	Area Directors	Clinical Managers Information Team	2016	Journeys evaluation has demonstrated waiting times halved. Target times in place	KPI in place for assessment times (for urgent, crisis and routine assessments) Improved assessment times for patients	EMT performance	