**RWK - CQC Comprehensive Inspection – June 2016**

**Action Plan**

**Actions the Trust MUST take to improve**

| **Issue** | **Relevant Directorate or Core Service** | **Action required** | **Action owner** | **Target completion date** | **Progress** |
| --- | --- | --- | --- | --- | --- |
| The trust must ensure that risk assessments for the use of electronic devices relate to individual patient  care plans and reflect the views of the patient and that all risk assessments for each patient are easily accessible to the staff that need to use them. | Forensic Inpatient | All patients have an individualised care plan for leave which takes into account their individualised risk assessment. The electronic monitoring is discussed with patients when they are granted leave and they are asked for their consent so their views are taken into account.  ACTION 1. Head of Service to write to all Consultants and modern matrons to request that patients views are documented on RiO  Care plans are audited once per month by the ward team and recommendation from this are implemented.  ACTION 2.Continue to audit on monthly basis and feedback to CIG  All risk assessments to be uploaded to RiO  ACTION 3. Head of service to remind Consultants and Modern Matrons that all risk assessments to be uploaded to RiO | Paul Gilluley – Head of Service, Forensic Services | September 2016  On-going  September 2016 | COMPLETED  ONGOING  COMPLETED |
| The trust must make changes to the alarm systems on the learning disability ward to support the needs of patients especially those with an autism spectrum disorder. This should include considering how the use of flashing and noisy alarms could be reduced. | Forensic Inpatient | ACTION 1. Estates and security to review the alarm system on all wards   * Alarm systems have been reviewed and will be set to sound on individual wards * Shoreditch and Clerkenwell wards (learning disabled services) are in the process of localised control of the alarm system which will allow the ward to mute the system to reduce noise on the ward. | Paul Gilluley – Head of Service, Forensic Services | November 2016 | We have quotes for the work and awaiting the contractor to start work on the alarm system. |
| The trust must ensure that as most patients using the service had challenging behaviours that they have care plans reflecting a positive behaviour support approach. | Wards for people with a Learning Disability | 1. All IST staff to receive formal training on Positive Behaviour Support 2. All patients admitted to The Coppice who present with challenging behaviour will have a PBS Plan developed. 3. An audit of PBS Plans will be completed | Michelle Bradley - Service Director, Bedfordshire | November 2016  October 2016  November 2016 | BILD are providing PBS training for all IST/Coppice staff on 23 Sept, 30 Sept & 7 October. All staff will attend these sessions.  All current patients in the Coppice have a PBS plan.  Completion of PBS plan is now a standard admission goal for all patients admitted to the Coppice |
| The trust must ensure that waiting times for patients referred to memory clinics to attend a first appointment and to receive a diagnosis continue to be improved especially across the Bedfordshire services. | MHCOP Community Services | EAST LONDON QI project on waiting times in place since May 2016 which has shown a steady improvement  BEDFORDSHIRE  Wide-ranging action plan in place: | Michael McGhee (East London) – Service Director, CHN and MHCOP  Richard Evans (L&B) - Deputy Medical Director, Luton and Bedfordshire  Michelle Bradley - Service Director, Bedfordshire | January 2017 | Current snapshot of data as of 20.09.16 shows zero number of patients waiting for a first appointment and 7 patients waiting for a diagnosis (outside of the agreed time frame). The service is already showing 95% compliance and expects to achieve 100% compliance by October 2016.  Work is been carried out to address the waiting times for the three Memory Assessment Services in Bedfordshire (Mid Beds, South Beds and Bedford).  There is a current focus to achieve the following waiting times:  Referral to initial face to face assessment to be carried out within 6 weeks.  Referral to diagnosis to be carried out within 18 weeks.  To achieve this, operational processes and practices are being reviewed and improved, data quality issues are being addressed and where additional resource has been brought into the teams.  A Quality Initiative Project concerning reducing waiting times has also commenced.  Weekly reporting of waiting times is being implemented to assist with achieving the above targets. |
| The trust must ensure all patient records are maintained appropriately. This is to ensure that patients have the necessary assessments, that assessments have been reviewed at appropriate timescales, that records of physical health observations are available and care plans in place.  This is to ensure that district nurses in particular, deliver the appropriate care or recognise when the patients’ needs are changing and if it is necessary to involve another care professional such as a tissue viability nurse. | Community Health Services | 1. Raise awareness of the action point and improvement priority, inviting change ideas from front line staff   Promote professional responsibility for record keeping  in line with NMC code of Conduct  ( Preserve safety, Promote professionalism and trust)  All staff to be aware of the  EMIS clinical record templates  Review the competencies of the   assessment skills for all staff  CHN Governance Team to work in partnership with all team managers to re draft team level audit tool. Audit tool to focus on the care record with regards to, risk assessment, goal based care plans, discharge information, falls, nutrition and pain management (where applicable). Quality KPIs and relevant NICE guidelines to be included where appropriate.   1. All team managers to engage   with staff to discuss the new audit tool and to raise awareness of the purpose of the audit and the process to be followed.   1. All redrafted audit tools to be   signed off at the CHN Quality and Assurance Group (QAG) and presented to the CHN Working Together Group for input from service users/carers.   1. Template for managerial   supervision of case note review to be identified and embedded across all CHN Adult teams, CHN Governance Team to then include this on the supervision audit tool.   1. Workshop for staff to be   organised on documentation, CHN Governance Lead to discuss with Associate Director of Assurance for IG input and support, Director of Mental Health Act for MHC and Deputy Director of Nursing for Safeguarding.   1. Re-distribution of the   documentation fact sheet for staff.     1. EMIS provision of appropriate   templates such as care plans and risk assessments (to be extended to teams who are currently on RiO).   1. All team managers to discuss the   CQC action plan at a team meeting and share detailed findings/report with staff to ensure engagement and ownership of actions. | Michael McGhee – Service Director, CHN and MHCOP | October 2016  October 2016  October 2016  December 2016  December 2016  January 2017  January 2017  October 2016  October 2016  October 2016  February 2017  October 2016 |  |

**Actions the Trust SHOULD take to improve**

| **Issue** | **Relevant Directorate or Core Service** | **Action required** | **Action owner** | **Target completion date** | **Progress** |
| --- | --- | --- | --- | --- | --- |
| The trust should continue to reduce the use of prone restraint | Trust wide | 1. The violence collaborative has been spread to all directorates collaboration  with a core aim of reducing violence and aggression in turn reducing the use of restraints 2. The Human Rights based approach training to be disseminated to all PICUS initially with the aim for spreading to all acute wards 3. Prone restraint reduction continues to be part to the Trust wide restraint reduction programme. 4. Restrictive interventions reduction to be part of all lead nurses, Matrons and Ward managers objectives. 5. Restraint audit to be completed annually as part of the Trust annual restrictive intervention audit and to highlight use of Prone with action plan from services. | Lorraine Sunduza – Deputy Director of Nursing | Ongoing  January 2017  Ongoing  March 2017  January 2017 | Restraint information is sent to all Borough Lead Nurses  on a monthly basis.  The Trust has a restrictive practices action plan in place, part of which is concerned with reducing the use of prone restraint: |
| The trust should continue to implement the changes in its patient record system, especially in Luton and Bedfordshire to promote ease of access for staff to essential patient information and improve the potential information governance risks linked to confidential information being in a paper format or across a number of electronic systems. | Trust wide | 1. The Trust has completed the roll out of the RiO clinical system to the service. All active patient records were migrated into RiO and are up to date. Inactive records are available in the legacy systems which ELFT still has access to via an SLA with SEPT. All staff have received training on RiO, but ongoing refresher sessions and support are currently underway to assist clinical teams in recording data in an accurate and timely manner | Daniel Woodruffe – Chief Information Officer | March 2017 | RiO roll out completed. RiO facilitators are employed full time to provide ongoing support |
| The trust should ensure the seclusion room on Gardiner ward has a fully working two way intercom and a visor to preserve the privacy of patients using the toilet. | Acute wards for adults of working age and psychiatric intensive care units – City and Hackney | COMPLETED | John Hill – Director of Estates and Facilities | September 2016  September 2016 | The intercom is now fully operational.  The privacy curtain has been ordered and will be installed on 28/09 |
| The trust should ensure recorded risk assessments include all the updated information. | Acute wards for adults of working age and psychiatric intensive care units – East London | 1. Review of current risk assessment training to include recording of risk as the format has changed. 2. Recording of risks to be highlighted to all staff in safety huddles and away days. 3. Deputy Director of Nursing to audit monthly for  3 months to review progress | Lorraine Sunduza – Deputy Director of Nursing | December 2017  On-going  January 2017 | The risk assessment form changed to online in June 2016 |
| The trust should ensure that the London wards are applying the thresholds for safeguarding alerts  consistently. | Acute wards for adults of working age and psychiatric intensive care units – East London | 1. Review current mandatory training provision to ensure emphasis on thresholds for reporting safeguarding concerns and process. 2. Review safeguarding policy and procedures to ensure thresholds for raising safeguarding concerns is clear. 3. Design and distribute ‘’Quick guide to safeguarding adults procedures’’ as a reference for staff and service users. 4. Staff receive safeguarding supervision 5. Monitor data on safeguarding incidents and feed into the CHN QAG where required. | Jonathan Warren – Director of Nursing | April 2017  April 2017  November 2016  April 2017  on-going |  |
| The trust should ensure that staff working in the London acute wards are making the most of opportunities to learn from incidents across directorates. | Acute wards for adults of working age and psychiatric intensive care units – East London | 1. Learning lessons will be part of all lead nurse meetings with the Lead Nurses ensuring that the information is further disseminated towards staff. 2. Learning lessons summarised to be part of ward away days. 3. Borough Lead Nurses to ensure that there is nurse representation at all directorate learning lesson sessions. Staff to be released from clinical duties in order to attend. 4. Current newsletters which highlight learning lessons  to be discussed in staff meetings and away days  and added to ward pink folders which are accessible to all staff. 5. Borough Lead Nurses to take learning from Serious Incident Committee and share learning with ward staff. | Lorraine Sunduza – Deputy Director of Nursing | Ongoing | All actions in place from October 2016 |
| The trust should ensure that it continues to review the numbers of beds on its wards in Luton and Bedfordshire so they are in line with national guidelines. | Acute wards for adults of working age and psychiatric intensive care units – Luton and Bedfordshire | 1. A review of the utilisation of beds across Bedfordshire and Luton will be undertaken 2. The profile of patients using the Luton acute wards to be identified including, diagnosis, origin of admission, length of stay, alternatives to admission identified. 3. The function of CRHT and Psychiatric Liaison, especially out of hours, to be reviewed to examine opportunities to harmonise and enhance decision making gatekeeping out of hours. 4. In- patient Consultant leading QI project to reduce bed occupancy. 5. Data being collated to inform sustainability model for beds across Bedfordshire and Luton | Dr Richard Evans – Deputy Medical Director, Luton and Bedfordshire | November 2016  On-going  March 2017 | The Associate Clinical Director (Luton) to review opportunities to reduce the number of acute beds in Luton drawing upon the relevant analysis and information - Female bed reduction has occurred with 2 beds being reduced on Onyx ward from 22 to 20. |
| The trust should ensure that it completes the review of psychology services in Luton and Bedfordshire to  improve access to services. | Acute wards for adults of working age and psychiatric intensive care units – Luton and Bedfordshire | 1. A review of Psychology Services to be completed. 2. Head of Psychology post has been agreed with plans to be in post in October 2016. 3. Head of Psychology to undertake review of Psychology in each area | Dr Richard Evans – Deputy Medical Director, Luton and Bedfordshire | November 2016 | Review of Psychology in each area has commenced |
| The trust should ensure that it continues to work on reducing the clinic room temperature in the areas  where there were high temperatures in the clinic rooms. | Acute wards for adults of working age and psychiatric intensive care units | 1. AC to be included in all treatment rooms across the trust – process underway to identify optimum solution. | Jenny Melville – Chief Pharmacist  John Hill – Director of Estates and Facilities | Nov 2016  Feb 2017 | A number of surveys are being commissioned to establish a variety of installation solutions for the various treatment rooms across trust premises.  A bid for funding is to be prepared for submission to the Capital Development Steering Group (CPSG) |
| The trust should ensure that it implements the programme of mandatory training on the Mental  Capacity Act to support ward staff having a consistently good understanding of the Mental  Capacity Act and being able to apply these principles in practice. | Acute wards for adults of working age and psychiatric intensive care units | 1. Identify staff groups for whom training on the Mental Capacity Act is required learning. 2. Update the Trust’s online learning records platform (OLM) accordingly. 3. Identify appropriate training delivery | Guy Davis – Associate Director for Mental Health Law | December 2016 | Staff groups have been identified for the following required learning requirements:   * ‘Overview of the Mental Capacity Act’ * ‘Overview of the Deprivation of Liberty Safeguards’ * ‘Overview of the Mental Health Act’   All three of the above will be delivered in face to face sessions and/or via three separate e-learning modules.  Mental Capacity Act and Deprivation of Liberty Safeguards e-learning packages have been identified, tested and are available via OLM.  A MHA e-learning module has been identified, tested and purchased. Work is underway to customise it to the Trust’s requirements. |
| The trust should ensure that staff are recording restraint comprehensively on Keats ward so that accurate numbers can be determined. | Acute wards for adults of working age and psychiatric intensive care units - Bedfordshire | 1. Clear local guidelines on reporting of restraint developed and shared with staff teams 2. Audit of incidents and records to be completed to assess gaps and assure accurate recording | Shaun Wright – Lead Nurse, Bedfordshire | Complete | Clear guidance has been given to staff regarding reporting. This is assured by over-sight by Matron, Clinical Nurse Manager and Lead Nurse.  An audit of incidents and records in the past 3 months since the inspection has revealed no further gaps |
| The trust should ensure the mirrors to improve lines of sight on the wards at the John Howard Centre are installed | Forensic Inpatient | 1. All wards have the mirrors for line of sight installed. The ward Matrons have completed a review of the ligature audits and all blind spots on the wards have been addressed by installation of mirrors as well as other risk management strategies. | Paul Gilluley – Head of Service, Forensic Services | Completed 24th of June and reviewed annually through the ligature audit process | Completed 24th of June 2016  Ligature audits completed yearly to review the risks |
| The trust should ensure regular bank staff at the John Howard Centre receive training so they can support  patients with their evacuation in the event of a fire. | Forensic Inpatient | 1. All bank staff training is being monitored by the directorate with responsibility of monthly review 2. All bank staff have been supported to attend the fire Marshal course 3. All bank staff will be supported in revisiting the fire competency training through the already set up Group supervision | Paul Gilluley – Head of Service, Forensic Services | Completed 30th of July 2016 , Monitoring of this is ongoing | Bank staff in the service have all their mandatory training monitored in the service  Reminders sent to bank staff of training about to expire |
| The trust should ensure at the John Howard Centre that all the control drugs are included on the control  drug registers. | Forensic Inpatient | 1. The service has carried out a review of the controlled drugs on all wards 2. A reminder of the control drugs processes has been given to all staff working in the service 3. Control Drugs registers are audited every quarter by Pharmacy department to ensure the wards are working within policy | Paul Gilluley – Head of Service, Forensic Services | Completed 31st August | Ongoing audits in the service |
| At the John Howard Centre the trust should continue to try to keep the amount of cancelled leave due to  staff shortages as low as possible. At Wolfson House the trust should monitor the amount of cancelled  leave. | Forensic Inpatient | 1. Leave monitoring is completed on the ward through the review of weekly leave planners to leave completed 2. When leave is cancelled, reasons for this are documented and reviewed by the service 3. The service is encouraging staff to report these incidents on Datix as a clinical incident to ensure there is full and proper review | Paul Gilluley – Head of Service, Forensic Services | Ongoing | Ongoing ward leave audits |
| The trust should review staffing levels on Shoreditch ward at the John Howard Centre as there are a high  number of incidents of physical interventions on this ward. | Forensic Inpatient | 1. The service is in the process of reviewing establishments for Shoreditch ward 2. Shoreditch ward is piloting safe care processes to support the establishment review 3. Shoreditch ward will be completing contact time observations to support the establishment review in October 2016. | Paul Gilluley – Head of Service, Forensic Services | December 2016 | Safe care programme started on Shoreditch ward  Ward establishment reviews being completed by November 2016  Contact time to support |
| The trust should ensure that new staff are introduced to Shoreditch ward as planned in order to provide  consistent standards of care. | Forensic Inpatient | 1. New staff have started on Shoreditch ward as planned. 2. Shoreditch ward has a full complement of permanent staff in all positions. | Paul Gilluley – Head of Service, Forensic Services | October 2016 | COMPLETE Shoreditch has a full complement of regular Permanent staff |
| The trust should work to reduce the incidents of patients sexually intimidating female staff at the John  Howard Centre | Forensic Inpatient | 1. Awareness to raise incidents of sexual aggression is being supported in the service 2. A Quality Improvement project has been started on Shoreditch ward to reduce incidents of sexually intimidating behaviour. 3. To develop a training programme for staff on the LD wards to manage sexually inappropriate behaviour | Paul Gilluley – Head of Service, Forensic Services | Due to start in October 2016 but ongoing. | Quality Improvement project outline has been completed and ready to start. |
| The trust should ensure at Wolfson House that all equipment used for physical health checks is in good  working order. | Forensic Inpatient | 1. All physical health Equipment in Wolfson house has been reviewed 2. An inspection of all medical devices in Wolfson house was completed in August 2016 3. The service has an annual review of all medical equipment which either passes or fails equipment 4. All medical equipment will be reviewed monthly by the wards to ensure it remains in good working order | Day Njovana – Head of Nursing, Forensic Services | September 2016  Ongoing  Ongoing | Completed the annual health inspection in August 2016.  Medical equipment is reviewed monthly by each ward to ensure it is in good working order and has a pass certificate from external inspectors |
| The trust should ensure that staff recognise when patients assaulting other patients should be reported  as a safeguarding incident and when steps need to be taken to keep people safe. | Forensic Inpatient | 1. The service is rolling out training for staff outside of the mandatory training which will be delivered on all wards and is forensic specific relating to safeguarding issues 2. Directorate management team is picking up incidents and supporting staff to consider safeguarding alerts if indicated 3. Safeguarding is an agenda item for all ward Clinical improvement groups | Paul Gilluley – Head of Service, Forensic Services | January 2017 | Training scheduled to be delivered between October and December to complement the safeguarding training  Directorate management team monitoring safeguarding issues through the safety and security meeting for the service |
| The trust should ensure that for patients detained under the Mental Health Act that the record of their  authorised medication is attached to their medication administration record | Forensic Inpatient | 1. All ward Clinical nurse Managers audit medication authorisation on a minimum monthly basis 2. Medication Authorisation and concordance is discussed in ward rounds to ensure compliance 3. Mental Health Act services audit medication authorisation on every quarter and this is fed back to ward teams | Day Njovana – Head of Nursing, Forensic Services | October 2016  ongoing reviews | On-going audits on every ward  Quarterly audits by the mental health act department |
| The trust should ensure that Clissold ward at Wolfson House displays the full range of information for patients including how to access advocacy services | Forensic Inpatient | 1. The advocacy contact details are clearly displayed in the nursing station window, on a notice board in the communal area and on the door of the telephone box. Information on complaints is displayed by the servery shutter 2. Patients are given this information as part of the admission pack for the ward and kept in their personal folder which they have access to at all times 3. Patients receive information every 12 weeks when their rights are read to them. | Day Njovana – Head of Nursing, Forensic Services | Completed  20th June 2016 | COMPLETED |
| The trust should work with commissioners to ensure  patients who are receiving care in a low secure setting are cared for in a more appropriate setting. | Forensic Inpatient | 1. Ongoing discussion with NHSE on present estate 2. Adopting low secure policies with Clerkenwell ward. | Paul Gilluley – Head of Service, Forensic Services | Ongoing | Ongoing |
| The trust should ensure it consults with and listens to the views of staff when making decisions about  significant changes in how care is delivered, for example the use of electronic devices for patients taking leave. | Forensic Inpatient | 1. Ongoing review and improvement of management staff communication.   2.       Consult with staff and service user when making significant changes to care and treatment through forensic ear the internal communication system.  3.       Directorate management team to carry out roadshow for changes in service provisions to wards impacted   1. 4.       Receive feedback from the Clinical improvement groups from each area impacted by the change in service provision | Paul Gilluley – Head of Service, Forensic Services | Ongoing | Ongoing |
| The trust should ensure there is a consistent approach to recording and storing risk assessments to improve  the safe care and treatment of patients | Crisis services and health based places of safety | 1. Review of current risk assessment training to include recording of risk as the format has changed. 2. Recording of risks to be highlighted to all staff in safety huddles and away days. 3. Deputy Director of Nursing to audit monthly for  3 months to review progress | Lorraine Sunduza – Deputy Director of Nursing | December 2017  On-going  January 2017 | The risk assessment form changed to online in June 2016 |
| The trust should ensure that serious incidents and the lessons from them are discussed in the Tower Hamlets  home treatment team similarly to the other teams. | Crisis services and health based places of safety | 1. Tower Hamlets Home Treatment Team will have yearly internal training session for SI and suicides (if any) 2. Tower Hamlets HTT would have a session on risk assessment and learning lesson incorporated in their yearly away-day 3. Tower Hamlets HTT will link up with local Personality Disorder service to have at least 2 sessions per year (6monthly) of training on approaching risk and reflecting on practice 4. In case of SI / suicide staff will be supported and encouraged to attend SI feedback session and SI report to be shared with staff 5. TH Directorate is now holding regular (quarterly) learning lessons seminar which TH HTT staff would have access to and encouraged to attend. | Karl Marlowe – Clinical Director, Tower Hamlets | 1)Completed & on-going  2)Completed  3)Completed & on-going  4)completed & on-going  5) 22/09/16 | 1. First session was held ad hoc in December 2015 by Dr Sally Daly locum consultant. Further session to be planned for later in 2016.  2. Associate Clinical director for TH and Appointed lead for Quality for Nursing for the Trust offered a session on risk assessment linking to recent SI investigations on 2/9- away day- ACTIONED  3. Deancross Personality Disorder service specialist staff has offered training and reflective session with TH HTT on 8th March and then on 28th July and has agreed on twice yearly sessions. Next session 24th November- ACTIONED  4. ON-GOING  5. The current frequency of TH Learning Lesson seminar is Quarterly and the next seminar is scheduled for the 22nd September. TH HTT staff would be encouraged to attend |
| The trust should ensure that all records relating to patients admitted to health based places of safety are  completed in full to ensure that the care of people using this service can be accurately monitored | Crisis services and health based places of safety | 1. All staff to be reminded of the need to record information in full 2. 136 process to be discussed at all Duty senior nurse aways days . 3. MHA office staff to flag up any incomplete paperwork they received as soon as possible to clinical lead | Guy Davis – Associate Director for Mental Health Law  Lorraine Sunduza – Deputy Director of Nursing | Immediate  December 2017  Ongoing | All staff working in health based places of safety have been reminded of the Trust’s policy on places of safety and specifically paragraph 8.1 which states that “for patients brought to a place of safety, the police should complete their relevant form and give a copy to staff at the place of safety who in turn should record the person’s time of arrival, details of assessments carried out and care given, outcomes and the time that detention under sections 135(1) or 136 ended.”  Mental Health Law staff will check each record and where there are gaps in information, ask staff to complete that information.  A quality improvement project has begun in Hackney to ultimately improve the experience of patients who are brought to the place of safety. If successful, any new approaches will be rolled out to other places of safety in the area. |
| The trust should ensure that records relating the patients admitted to health based places of safety are  regularly audited to identify potentially unlawful practice and practice that is inconsistent with the  Mental Health Act 1983 Code of Practice and that this is raised where needed at crisis care liaison meetings. | Crisis services and health based places of safety | 1. Audits of compliance with the law and Mental Health Act Code of Practice to be undertaken, and serious issues brought to the attention of relevant practitioners and forums to ensure appropriate actions taken. | Guy Davis – Associate Director for Mental Health Law  Lorraine Sunduza – Deputy Director of Nursing | October 2016 - ongoing | The Mental Health Law department collects data relating to detention in places of safety and this is recorded monthly as the basis for a quarterly report for the London Partnership Board for Mental Health. This data will also be used to form part of a quarterly audit report on the use of sections 135(1) and 136, for presentation at local crisis care/police liaison meetings, where instances of potentially unlawful practice will be highlighted. Staff working in and responsible for health based places of safety have been advised of this.  A quality improvement project has begun in Hackney to ultimately improve the experience of patients who are brought to the place of safety. If successful, any new approaches will be rolled out to other places of safety in the area. |
| The trust should ensure that patients receive information about their rights under the Mental Health Act when they are on leave under the care of home treatment team. | Crisis services and health based places of safety | 1. Clinical Directors to remind services of the need to ensure that patients are reminded of their rights whilst on leave. 2. Mental Health Law team to include the standard in regular clinical audit | Kevin Cleary – Medical Director | October 2016 |  |
| The trust should ensure that staff fully complete medicines administration charts in all CMHTs to reduce the risks of errors in medicines administration | Community based mental health services for adults of working age | 1. Pharmacist and Operational Lead in Newham to undertake brief training with all staff to refresh standards for documenting administration of depot medication 2. Weekly audit of medicines administration to be undertaken for the next 3 months to ensure improvement | Jonathan Warren – Director of Nursing | Dec 2016 |  |
| The trust should ensure there are robust arrangements in all CMHTs to ensure there are adequate records on the outcome of referrals to ensure patients receive appropriate follow up. | Community based mental health services for adults of working age - Luton | 1. All patient records to be migrated to RiO electronic patient record system 2. Data checking exercise to be undertaken to ensure completeness of migration and ensure all referrals to point of migration followed up as required 3. RIO coding to be used to track new referrals 4. Tracking spreadsheet to be put in place and updated by Team Administrators 5. Team administrators to provide weekly activity/monitoring reports 6. Referral pathway and roles and responsibilities algorithms to be put in place 7. Regular audit of referrals to be undertaken to ensure all followed up appropriately | Eugene Jones – Service Director, Luton | July 2016 | COMPLETE |
| The trust should review the systems for the use of alarms at the Luton CMHT premises to keep lone workers safe. | Community based mental health services for adults of working age – Luton | 1. Notices to be displayed in clinical areas to reinforce the need for staff to carry lone worker devices. 2. The personal safety of staff and lone worker devices to become a standing item on the CMHT Business Meeting agenda 3. The risks involved in Lone Working to be a subject within all clinical supervision sessions. 4. Audit of the use of Lone Worker Devices to be undertaken | Eugene Jones – Service Director, Luton | October 2016 | Notices have been designed and are being displayed in interview spaces and staff awareness has been raised.  CMHT Business meeting agenda now incorporates Lone Working and keeping safe and professional responsibility.  Audit tool has been designed and will begin from November 2016. |
| The trust should ensure that the length of time a patient is restrained is recorded and a duty doctor always attends to review patients after episodes of prone restraint. | CAMHS Inpatient | 1. All staff (nursing and medical) informed of requirements and expectations discussed in nurses’ business meeting 2. An audit tool to be created to audit the length of restraint and review of patient post restraint | Henry Iwunze – Clinical Service Manager, Coborn | September 2016  September 2016 | Completed  Completed |
| The trust should improve the choice of meal options to ensure they are positively received by the young people. | CAMHS Inpatient | 1. Team to review current menus to be more ‘adolescent friendly’. 2. Team to collect regular feedback about the food from young people and analyse regularly for themes 3. Service manager to raise concerns about food with GFM facilities company and agree improvement actions 4. Ward therapy programme to include more opportunities for young people to prepare own meals 5. Unit to make available a variety of snacks to young people 6. Catering working group to be established, the membership, of this group to include the trust dietician, various clinicians from the wards and the service provider GFM and representatives from the estates and facilities department | Henry Iwunze – Service Manager, CAMHS | Sept 2016  Oct 2016  Oct 2016  Sept 2016  Oct 2016  December 2016 | Completed  Feedback form devised and ready for implementation  Agreement to employ a dedicated chef specific to the Coborn Centre  Completed. Timetable in place.  Budget allocation to Occupational Therapy Lead for regular purchase of healthy range of snacks. |
| The trust should ensure that rights are read to detained patients promptly after admission or detention according to section 132 of the Mental  Health Act. | CAMHS Inpatient | 1. Introduce use of new RIO 132 forms to allow comments to be added when patients’ rights cannot be read or specifying reasons for delay. 2. The Trust has recently developed and implemented a new online S132 Rights form. The form has a free text comments box allowing staff to record the patient’s responses, give reasons for any delays in reading patients’ rights, as well as stipulating a review date for re addressing patients’ rights. 3. In line with the Code of Practice paragraph 4.28. Rights to be read as soon as possible after the patient’s detention. If the patient is able to understand the information explained to them explanation of their rights to be revisited at regular intervals throughout their detention. 4. If the patient is unable to understand the information given to them, rights to be re-read on a daily basis, up to a period of 3 to 5 days (dependent on Section detained under). If at this point the information is still not understood or retained staff will refer the person to an IMHA. Staff will also develop a care plan incorporating the frequency at which rights should be re-read and any tools/aids required to assist the person in understanding the information given to them. 5. Weekly MHA audit by service Mental Health Law Department to complete quarterly audits | Henry Iwunze – Service Manager, CAMHS | Sept 2016  Sept 2016  Sept 2016  Sept 2016  Sept 2016 | In place.  In place.  In place.  In place.  In place. |
| The trust should ensure that details of patient’s nearest relative and their address are provided in Mental Health Act applications and leave forms. | CAMHS Inpatient | 1. Mental Health Law Department HA to complete full scrutiny of papers once these are received from the AHHP and to address any issues identified. 2. On receipt of detention papers the Mental Health Law Department to carry out full scrutiny of the documents. Any errors identified to be rectified under S15 of the MHA where applicable. The MHL Department to liaise with the professionals involved in the assessments and consult the AMHP report to confirm reasons as to why any information may have been omitted from the detention papers. 3. Mental Health Law Department to complete quarterly audit to ensure compliance. 4. Weekly MHA audits by ward staff with clear action plan | Henry Iwunze – Clinical Service Manager, Coborn | Sept 2016  Sept 2016  Sept 2016  Sept 2016 | In place.  In place.  In place.  In place. |
| The trust should ensure that recorded risk assessments contain detailed information, so that care and support is delivered safely. | MHCOP Inpatient | 1. Audit of inpatient risk assessments to be carried out and findings to be discussed at the MHCOP Healthcare Governance Meeting, SMART recommendations to be agreed where appropriate. 2. Any quality issues linked to risk assessments will be discussed during supervision with relevant staff. | Michael McGhee – Service Director CHN and MHCOP  Gabrielle Faire – Clinical Director, MHCOP | January 2017 |  |
| The trust should ensure that ligature audits detail a timeframe for work completion. | MHCOP Inpatient | 1. Action plans generated from Ligature Audits will be SMART with clear deadlines for actions, which will be implemented and monitors by Ward Matrons. | Carmel Stevenson – Lead Nurse, MHCOP | February 2017 |  |
| The trust should ensure that records are maintained so that staff can find information with ease where needed. | MHCOP Inpatient | 1. To address process and protocol for storing/filing of records with staff at team meetings. 2. Memo of storing/filing of records to be circulated to all staff and included on the MHCOP/CHN Newsletter. | Michael McGhee – Service Director CHN and MHCOP  Gabrielle Faire – Clinical Director, MHCOP | December 2016 |  |
| The trust should review the composition of the multidisciplinary  team on Cedar Lodge to ensure patients receive appropriate occupational therapy support to  meet their needs | MHCOP Inpatient – East London | 1. Community Occupational Therapist when in post will provide input into occupational therapy on Cedar Lodge. 2. Current Occupational Therapist Assistant to provide occupational therapy support on Cedar Lodge. 3. Exploring art therapy resource to further support occupational therapy on Cedar Lodge. | Michael McGhee – Service Director CHN and MHCOP  Gabrielle Faire – Clinical Director, MHCOP | December 2016 |  |
| The trust should ensure that at Fountains Court staff engage with patients to promote their wellbeing. | MHCOP Inpatient – Bedfordshire | 1. Reflective sessions to be conducted with individuals concerned and ward team 2. Development Plan for staff team to be agreed and implemented, including ,communication and engagement with older adults 3. Peoples Participation Leads and OT’s to review ward based activities 4. Fountains Court Support Group to be established and to meet regular with senior team to enhance service provision 5. QI project to reduce violence and aggression in the service to go live | Michelle Bradley – Service Director, Bedfordshire | October 2016  October 2016  October 2016  September 2016  October 2016 | Individual sessions completed  Fountains Court Support Group now in place meeting monthly. Team sessions held fortnightly last held 13th September 2016.  Training planned at next team day based on Star Wards ‘Brief Encounters’  PPL scheduled to audit ward on unannounced visit by end September  QI project commenced by team staff to reduce violence and aggression on the ward. |
| The trust should ensure that service user meetings take place on Leadenhall ward to provide a forum for patients to express their views | MHCOP Inpatient - East London | 1. Service User meetings occur every week on the ward, however the meetings will be formalised and outcomes from the meeting will be captured on the ‘You said – We did’ board. | Carmel Stevenson – Lead Nurse, MHCOP | October 2016 | Underway |
| The trust should ensure that ward level risk registers are in place, as one was not completed. | MHCOP Inpatient | 1. CHN/MHCOP Governance Manager to meet with each Team Manager (Inpatient and Community Services) to discuss governance work streams, which will include the risk register process and review. 2. Spot check to be carried out on the risk register process to ensure they are in place, updated and risks escalated appropriately. | Michael McGhee – Service Director, CHN and MHCOP | March 2017  On-going |  |
| The trust should ensure all first aid boxes are fully stocked, as one was missing some items | Community mental health services for older  people | 1. Email will be sent to each risk officer to ensure first aid boxes are checked on a weekly basis and that they take responsibility for replenishment after use 2. Health, Safety and Security Lead to undertake periodic spot checks of stock levels | Richard Harwin – Health, Safety and Security Lead | October 2016  On-going |  |
| The trust should ensure there are clear timescales in place for the migration of the patient electronic  records to the new system | Community mental health services for older  people | 1. The Trust has completed the roll out of the RiO clinical system to the service. All active patient records were migrated into RiO and are up to date. Inactive records are available in the legacy systems which ELFT still has access to via an SLA with SEPT. All staff have received training on RiO, but ongoing refresher sessions and support are currently underway to assist clinical teams in recording data in an accurate and timely manner | Daniel Woodruffe – Chief Information Officer | March 2017 | RiO roll out completed. RiO facilitators are employed full time to provide ongoing support |
| The Trust should ensure that patient consent is sought before treatments are initiated or that discussions were held in this regard, and that patient records reflect this. | Community mental health services for older  People – East London | 1. Memo to be sent to all prescribing clinicians to request that a section on capacity and consent is included on all clinical correspondence templates and that this is clearly documented. 2. Confirmation of this action being completed will be monitored by the Clinical Director for MHCOP. | Michael McGhee – Service Director, CHN and MHCOP  Gabrielle Faire – Clinical Director, MHCOP | January 2017 |  |
| The trust should ensure that staff carry out and record risk assessments of detained patients before they take  agreed section 17 leave. They should also ensure that staff record clearly the limits of section 17 leave for  detained patients and this is adhered to. | Rehabilitation mental health wards | 1. The Clinical Team to ensure that a thorough checklist has been completed prior to authorising Section 17 leave and or renewing it. The checklist will include reference to Risk Assessment and clearly define the boundaries of Section 17 leave including the definition of local leave. 2. The Units will monitor monthly and audit the use of Section 17 leave to determine levels of complaint against the checklist standards and take where required remedial action to address. | Michelle Bradley – Service Director, Bedfordshire  Eugene Jones – Service Director, Luton | October 2016 | A checklist has been designed and is being discussed with the clinical team this will be implemented in October 2016 and monitoring of the standard will begin in November 2016. |
| The trust should ensure that all patients have clear recovery goals and that outcomes of care and treatment can be measured | Rehabilitation mental health wards | 1. Audit of care plans to be completed 2. Refresh on the recovery goals and outcomes to be delivered by the Deputy Director of Nursing Training 3. Re-audit of care plans to be completed | Michelle Bradley – Service Director, Bedfordshire  Eugene Jones – Service Director, Luton | October 2016  October 2016  January 2017 | The audit tool has been designed and shared with staff.  Deputy Director of Nursing to provide sharing of key principles of this outcome and recovery goals. |
| The provider should ensure that patients are referred for evidence based psychological therapies when this is appropriate. | Rehabilitation mental health wards | 1. Review of Psychology provision across Bedfordshire to be undertaken 2. Rehabilitation Services to provide representation at Recovery Board 3. Review of Rehabilitation Services to be completed | Michelle Bradley – Service Director, Bedfordshire  Eugene Jones – Service Director, Luton | October 2016  September 2016  April 2017 | A review of Psychological provision and workforce has been undertaken within the Directorate. A programme of recruitment is taking place 2 appointments have been made to vacant positions to date |
| The trust should continue to implement the changes to enable improved access to psychology and therapy staff. | Mental health ward for people with learning disability | 1. Full review of multi-disciplinary capacity within The Coppice 2. Review of SPLD services model | Michelle Bradley – Service Director, Bedfordshire | November 2016  April 2017 | The Coppice has 1 session of clinical psychology per week with additional capacity that can be accessed via the Community LD team  The Coppice has 1 session of arts therapy per week.  Each person admitted to the Coppice now has a brief psychological assessment completed.  Plans are in place to integrate a full time Speech and Language Therapist into the Coppice and IST. We anticipate this will be in place by end of October.  Meeting has been established and now meeting monthly. Review planned for completion in March 2017 |
| The trust should ensure that the planned training on positive behaviour support is fully delivered to the staff  team to inform their approach with patients | Mental health ward for people with learning disability | 1. All staff in IST/The Coppice will receive formal training on Positive Behaviour Support | Michelle Bradley – Service Director, Bedfordshire | October 2016 | BILD are providing PBS training for all IST/Coppice staff on 23rd Sept, 30th Sept & 7th October. |
| The trust should ensure that improvement in the documentation of best interest decisions for people who are unable to consent to care and treatment. | Mental health ward for people with learning disability | 1. Staff to receive appropriate training in MCA/DOLS 2. Regular audits of practice to be undertaken | Michelle Bradley – Service Director, Bedfordshire | November 2016  January 2017 | Training around MCA/DoLs is being completed by the LD MCA champion.  Person Centred paperwork is in place for all patients in the Coppice.  Trust MCA/best interest decisions paperwork is routinely implemented. |
| The trust should ensure that a choice of more activities is provided to patients at the Coppice, and these should be monitored and reviewed. These should include support with activities of daily living to ensure that people maintain or develop their  independence skills | Mental health ward for people with learning disability | 1. 1WTE Assistant Practitioner dedicated to The Coppice and leading on improved implementation of activities including independent skills and ADL’s. 2. Meeting between AP and OT – plans and recording mechanisms have been developed 3. Every patient has an activity timetable 4. All patients gym risk-assessments have been signed by consultant and gym equipment is in regular use | Michelle Bradley – Service Director, Bedfordshire | September 2016 | Completed |
| The trust should review if all members of the multidisciplinary team would benefit from having a portable alarm to take with them when visiting patients, to protect them during lone working. | Community mental health learning disability services | 1. The LD team to undertake a review of lone working practices | Michelle Bradley – Service Director, Bedfordshire | October 2016 | All discipline leads have identified the number of alarms needed for their areas and provided those figures to the Deputy Director for MH and LD services. The requirements have been communicated to the Trust Health, safety, Security and Emergency Planning Manager |
| The trust should ensure that all relevant staff receive training relating to the Mental Capacity Act (2005). | Community mental health learning disability services | 1. Identify staff groups for whom training on the Mental Capacity Act is required learning. 2. Update the Trust’s online learning records platform (OLM) accordingly. 3. Identify appropriate training delivery 4. Services for People who have a Learning Disability have identified a Champion for MCA and DOLs, who has attended the Trust training, and will be providing further training for all staff working within the learning disability service and support the audits of practice going forward. | Guy Davis – Associate Director for Mental Health Law | December 2016 | Staff groups have been identified for the following required learning requirements:   * ‘Overview of the Mental Capacity Act’ * ‘Overview of the Deprivation of Liberty Safeguards’ * ‘Overview of the Mental Health Act’   All three of the above will be delivered in face to face sessions and/or via three separate e-learning modules.  Mental Capacity Act and Deprivation of Liberty Safeguards e-learning packages have been identified, tested and are available via OLM.  A MHA e-learning module has been identified, tested and purchased. Work is underway to customise it to the Trust’s requirements. |
| The trust should continue to implement the changes to enable improved access to psychology and therapy staff. | Community mental health learning disability services | 1. To review multi-disciplinary capacity within SPLD 2. To review SPLD services model | Michelle Bradley – Service Director, Bedfordshire | November 2016  April 2017 | All service users who were on the waiting list at the time of the CQC visit have been screened\triaged and have appointments booked.  The team are using a clinic based approach to increase capacity for short term interventions.  DMT continues to monitor waiting times across disciplines on a monthly basis.  QI project in place to reduce waiting times across disciplines  Meeting has been established and now meeting monthly. Review planned for completion in March 2017 |
| The trust should ensure that the training on positive behaviour support is provided to the staff team to inform their approach with patients and this is always used in care planning for patients with challenging behaviour. | Community mental health learning disability services | 1. All staff in IST, including all disciplines of staff to receive formal training on Positive Behaviour Support | Michelle Bradley – Service Director, Bedfordshire | October 2016 | All staff within the Intensive Support Team, including their community staff, are booked to attend PBS training.by 7th October 2016. |
| The trust should ensure that a strategic lead is recruited for the learning disability teams to give the  service direction and support the care of people with learning disabilities across the trust. | Community mental health learning disability services | 1. Lead Consultant role to be created to act as Strategic Lead for the LD Service. | Richard Evans – Deputy Medical Director, Luton and Bedfordshire | Nov 2016 | Role specified, and currently at advert stage. |
| The trust should ensure that staff are clear about the lone working protocols and ensure that staff  undertaking home visits have breakaway training | Specialist community mental health services for children and young people | 1. Organise lone working workshops in each community CAMHS service to ensure staff familiarisation with the lone working policy 2. Ensure lone working is a regular item for discussion at all team and service business meetings 3. Monthly monitoring of breakaway training levels to ensure Trust target compliance rate is met 4. Staff showing as ‘red’ on monitoring returns to be required to book on training with immediate effect 5. Staff showing as ‘amber’ on monitoring returns (within 3 months of expiry) to be required to book on training within the next three months 6. Monitoring of breakaway training compliance to be a regular item in line management supervision meetings 7. Breakaway training sessions delivered locally to be organised by CAMHS general managers | Dermot Ryall – Associate Director CAMHS | October 2016  September 2016  September 2016  September 2016  September 2016  September 2016  Ongong | Workshops already held or planned in all community CAMHS services  In place  In place  In place  In place  In place  In place |
| The trust should ensure that staff keep records of when toys are cleaned | Specialist community mental health services for children and young people | 1. Implement new toy cleaning policy including record keeping on when toys are cleaned | Sarah Wilson – Director of Specialist Services | October 2016 |  |
| The trust should ensure that the physical health monitoring equipment in the Luton and Bedfordshire CAMHS is calibrated regularly | Specialist community mental health services for children and young people | 1. Implement physical health monitoring log record sheet and put in place across each of the clinics 2. Regular monitoring by the CAMHS Managers / admin leads to ensure compliance | Linda Hurst, Development Manager - CAMHS | September 2016  September 2016 | In place  In place |
| The trust should ensure that the fridge used to store medicines at the Tower Hamlets CAMHS office is fit for purpose and is regularly checked to ensure that the medicines stored in it are in date. | Specialist community mental health services for children and young people | 1. Order suitable fridge for storage of medicines 2. Implement monthly checking and monitoring log to ensure all medicines stored are in date | Bill Williams, General Manager – Tower Hamlets CAMHS | September 2016  October 2016 | Completed |
| The trust should ensure that BME staff are supported as part of their diversity action plan. | Specialist community mental health services for children and young people | 1. Develop BME staff development plan to include: 2. Data analysis on BME staff in CAMHS: where they are - grade/team/discipline 3. Focus on staff development – particularly Clinical staff bands 6 and 7 and admin staff 4. Setting up a mentoring programme 5. Implementing unconscious bias training 6. Establishing a BME forum across the whole of CAMHS services 7. Establish a small group with representation from each service to take this forward | Sarah Wilson, Director of Specialist Services | Nov 2016 | Initial discussions have taken place and a proposal will be taken to Oct DMT |
| The trust should ensure that the administrative staff receive ongoing support during the period of their roles being reviewed | Specialist community mental health services for children and young people | 1. Appoint to Admin leads posts 2. Fully recruit into all admin posts as per the revised structure 3. Admin Leads to receive fortnightly supervision from the CAMHS managers 4. Admin staff reporting to the admin leads to receive monthly supervision 5. Supervision dates to be entered on the CAMHS supervision tracker 6. Quarterly admin peer groups to be held – to be chaired by the admin lead and supported by the CAMHS Manager across each site | Linda Hurst, Development Manager - CAMHS | August 2016  September 2016  September 2016  September 2016  September 2016  September 2016 | COMPLETED |
| The trust should ensure that staff complete training in safeguarding children levels 2 and 3 as planned | Specialist community mental health services for children and young people | 1. Monthly monitoring of safeguarding children training levels to ensure Trust target compliance rate is met 2. Staff showing as ‘red’ on monitoring returns to be required to book on training with immediate effect 3. Staff showing as ‘amber’ on monitoring returns (within 3 months of expiry) to be required to book on training within the next three months 4. Monitoring of safeguarding training compliance to be a regular item in line management supervision meetings 5. Trust to continue to publicise Level 3 safeguarding courses provided by LSCBs | Dermot Ryall, Associate Director - CAMHS | September 2016  September 2016  September 2016  September 2016  Ongoing | COMPLETED |
| The trust should ensure that staff are all familiar with the term, ‘duty of candour’ and their responsibilities,  even though they were applying this in practice | Community health services for children, young people and families | 1. Draft and circulate a joint briefing to all CYPSRH service staff (***Action:*** Ian McKay) 2. Team leads to raise awareness in team meetings (***Action:*** All CYPSRH service leads) | Sarah Wilson – Service Director, Specialist services for  children and young people | September 2016  November 2016 | * Completed. Briefing circulated * Team leads required to return minutes of team meetings as evidence that this has been raised. Examples retained in evidence bank |
| The trust should ensure staff know how to respond to potential incidents of domestic abuse | Community health services for children, young people and families | 1. Survey of knowledge and skills to inform training programme (***Action:*** Agnes Adentan/ Francis Kudjoe) 2. Assessment of service status against NICE Domestic Violence and Abuse guidelines [2016] (***Action:*** Agnes Adentan/ Francis Kudjoe) 3. DA policy for CYPSRH services drafted, ratified and lodged on the intranet (***Action:*** Agnes Adentan/ Francis Kudjoe) 4. Hold awareness sessions (***Action:*** Agnes Adentan/ Safeguarding Team) 5. Incorporate new policy information in to safeguarding training session plans (***Action:*** Agnes Adentan/ Safeguarding Team) | Sarah Wilson – Service Director, Specialist services for  children and young people | Jul/ Aug 16  May 2016  September 2016  Scheduled 7/10/16 - 4/11/16  Oct’16 and continuing | * Completed * Completed * For ratification at the CYPSRH governance group on 28/9/16 and subsequent lodging on the Trust intranet |
| The trust should continue to take steps to improve client transition from paediatric to adult community  services to ensure continuity of care and access to timely and appropriate provision for all clients. | Community health services for children, young people and families |  | Graeme Lamb – Clinical Director, Specialist services for  children and young people |  | * The new specification for the Children and Young People Service was published by commissioners in Aug’16. The 16-18 age cohort is included in the specification   *(A transition pathway is in place to support children from children to adult community nursing which is audited annually. A gap analysis for NICE guidance NG43 has been completed and an action plan is in place to work with EPCT to enable us to adequately prepare our children and young people for transition to adult services)* |
| The trust should provide communication skills training to ensure practitioners communicate with all clients clearly and appropriately. | Community health services for children, young people and families | 1. The service will investigate options for communication skills training that meet the brief (***Action:*** Ian McKay/ Sarah Rolfe/ Evangelia Theochari-Boateng) 2. Deploy a chosen option to staff who have service user contact | Sarah Wilson – Service Director, Specialist services for  children and young people | October 2016  Nov’16 - Jan’16 |  |
| The trust should work with the organisations that are responsible for the health centre buildings, where the  clinics are provided to improve their safety for children and make them more child-friendly | Community health services for children, young people and families | 1. Estates will work with the various service and premises leads to establish a Trust wide minimum standard for ‘Child Friendly Environments’ within its Health Centres 2. Once the standard has been agreed, a survey will be carried out to identify the scope of works necessary to meet the required standards 3. A programme of action and bid for funding will be compiled and submitted to the CPSG for consideration | Sarah Wilson – Service Director, Specialist services for  children and young people  John Hill – Director of Estates and Facilities | November 2016  December 2016  February 2017 | Estates will work with the various service and premises leads to establish a Trust wide minimum standard for ‘Child Friendly Environments’ within its Health Centres.  Once the standard has been agreed, a survey will be carried out to identify the scope of works necessary to meet the required standards.  A programme of action and bid for funding will be compiled and submitted to the CPSG for consideration |
| The trust should develop and document standardised operating procedures for referrals to ensure  consistency across services | Community health services for children, young people and families | 1. SOPs drafted for the Child Development Service and the Children’s Community Nursing Service (***Action:*** Sophy Njiri [CDS] and Rebecca Daniels [CCNS]) 2. SOPs ratified by the CYPSRH governance group and lodged on the intranet or shared folder as appropriate | Sarah Wilson – Service Director, Specialist services for  children and young people | December 2016  January 2016 |  |
| The trust should continue to promote staff engagement and consultation, particularly around  service and estates redesign | Community health services for children, young people and families | 1. The working groups overseeing building developments and redesigns will continue to include members of the relevant staff teams | Sarah Wilson – Service Director, Specialist services for  children and young people | On-going | * There are no new building projects underway |
| The trust should ensure that staff are all familiar with the term, ‘duty of candour’ and their responsibilities,  even though they were applying this in practice | Community health services for adults | 1. All Team Managers to raise awareness of Duty of Candour with staff using key resources available on the Trust Intranet. 2. Fact sheet on duty of candour to be designed and distributed to staff via the CHN/MHCOP Newsletter. 3. Contact Communications Team / Assurance Department for information posters and merchandise (such as pens) which are branded with the term Duty of Candour for distribution to staff. 4. Contact Incident Reporting Team to obtain data on Duty of Candour such as number of letters completed and if this was done in a timely manner, report to be shared with all Service Managers. | Michael McGhee – Service Director CHN and MHCOP | January 2017  February 2017  November 2016  November 2016 |  |
| The trust should ensure that staff have greater clarity of the thresholds for making safeguarding alerts. | Community health services for adults | 1. Review current mandatory training provision to ensure emphasis on thresholds for reporting safeguarding concerns and process. 2. Review safeguarding policy and procedures to ensure thresholds for raising safeguarding concerns is clear. 3. Design and distribute ‘’Quick guide to safeguarding adults procedures’’ as a reference for staff and service users. 4. Staff receive safeguarding supervision 5. Monitor data on safeguarding incidents and feed into the CHN QAG where required. | Michael McGhee – Service Director CHN and MHCOP |  | April 2017  April 2017  November 2016  April 2017  on-going |
| The trust should ensure that staff working in the community health services for adults have an improved confidence in using the Mental Capacity Act | Community health services for adults | 1. Performance Manager to address MCA training during monthly meetings with team managers and re send training dates for staff where a gap or need has been identified 2. Set up a Survey Monkey for staff to understand better the gap in confidence with regards to Mental Capacity Act. Discuss findings at CHN QAG to agree actions required to further support staff. 3. MCA training refresher session to be organised for EPCT staff, as part of the outcome from Pressure Ulcer Seminar. 4. Process to be set up for increased support from MHCOP with regards to complex MCA cases in CHN Adult Services. | Ben Braithwaite – Clinical Director, CHN  Michael McGhee – Service Director CHN and MHCOP | January 2017  February 2017  January 2017  December 2016 |  |
| The trust should ensure that staff working in the community health services for adults make more use  of outcome measures to monitor the progress made by patients using the service | Community health services for adults | 1. QI project to be set up to focus on improving the uptake of the PREMs/FFT and PROMs survey by people who access the service. 2. PREM and PROM workshop to take place to support staff with the launch of the Patient Experience Dashboard, how to interpret the data and how the data is used to respond to service users/carers (You said - We did) 3. Promote the Kings Fund publication: Understanding Quality In District Nursing Services (2016) to inform the development of meaningful outcome measures which are sensitive to district nursing care services. | Ben Braithwaite – Clinical Director, CHN  Michael McGhee – Service Director CHN and MHCOP | January 2017  October 2016  January 2017 |  |
| The trust should aim to provide patients with more information about the time of their district nursing appointment | Community health services for adults | 1. To research into technology, which is EMIS compliant, to support provision of appointment times within EPCT | Michael McGhee – Service Director CHN and MHCOP | February 2017 |  |
| The trust should continue to improve the waiting times for a wheelchair service | Community health services for adults | 1. One Band 6 specialist vacancy (Physio/Occupational Therapist) within service - on 3rd round of recruitment and interviews to take place in October 2016. Locum being requested to cover period of recruitment. Bank staff not available and not suitably skilled. 2. Demand/capacity exercise underway with Business Transformation team to ascertain appropriate clinical staffing requirements. Business case to be completed and submitted to Newham CCG. 3. Contract to be reviewed for Contour clinics once service relocated to East Ham Care Centre which could potentially allow more specialist clinics to run if the capacity increases appropriately. 4. Service Specification also under review to ensure efficient use of resources. Findings of the review to be shared with CHN QAG for actions to be agreed. 5. Head of Therapies working with Performance Lead on efficient recording of data - RIO and Optimum databases utilised in the service. 6. For service users with LD the clinicians are requested to undertake the postural assessments within their teams to prevent duplication - the wheelchair service can then order the appropriate equipment. 7. Joint work being undertaken between paediatrics/LD and Wheelchair services where possible to reduce duplication and expedite through the care pathway. | Michael McGhee – Service Director CHN and MHCOP | February 2017  November 2016  December 2016  November 2016  On-going – review January 2017  On-going – review January 2017  On-going – review February 2017 |  |
| The trust should ensure staff all have opportunities to attend team meetings on a regular basis | Community health services for adults | 1. To implement the six monthly away day model in CHN adults services. Plan to be devised and presented to the DMT for approval. 2. CHN QAG to review all team meeting agendas and devise a minimum governance item list for managers to include 3. Ensure handover checklist includes incidents/ complaints/serious incidents 4. All managers to ensure they follow the crib sheet for running Datix incident reports and review this information with staff at team meetings (to be validated by QAG checking team meeting agendas). 5. Contact Assurance Team for an update on Datix web up for complaints, allowing more accessible complaints information for staff | Michael McGhee – Service Director CHN and MHCOP | December 2016  March 2017  December 2016  December 2016  October 2016 |  |