NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
22 FEBRUARY 2018

Title	Care Quality Commission compliance update - Implementation of the action plan in response to the CQC comprehensive inspection June 2016
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Purpose of the Report:

The report provides the Board with assurance in relation to the implementation of the action plan generated in response to the Trust's comprehensive inspection that took place in June 2016.

Summary of Key Issues:

The report sets out the method by which assurance of implementation of actions was sought. It sets out those actions that have not been fully implemented to date, the reasons for arriving at that conclusion, and the action plan going forward.

Strategic priorities this paper supports (Please check box including brief statement)

Improving service user satisfaction	☒	The 'CQC action plan' supports the strategic priorities regarding service user satisfaction and staff satisfaction by providing detailed information on metrics used to understand, assure against and improve Quality across the Trust.
Improving staff satisfaction	☒	
Maintaining financial viability	☒	

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
6th Feb 2018	'Extraordinary' meeting of the Quality Committee

Implications:

Equality Analysis	This report has no direct impact on equalities
Risk and Assurance	There are no risks to the Trust based on the information presented in this report. The Trust is currently compliant with national minimum standards
Service User/Carer/Staff	The Quality report provides information related to experience and outcomes for service users, and experience of staff. As such, the information is pertinent to service users, carers and staff throughout the Trust.
Financial	None
Quality	The information and data presented in this report and accompanying dashboard help understand the quality of care being delivered, and our assurance and improvement activities to help provide high quality, continuously improving care.

Supporting Documents and Research material

N/A

1.0 Introduction

1.1 The Trust underwent its comprehensive inspection by the Care Quality Commission in June 2016.

1.2 The Trust received its outstanding rating and report in August 2016.

1.3 In the aftermath of the inspection and reporting process, the Trust was required to respond to the areas for improvement identified in the CQC's inspection report in the form of an action plan.

1.4 The report summary concludes; *"Although we have rated the trust outstanding overall, our inspection has identified a number of areas in core services rated good or outstanding where further improvement can be made. We expect the trust to continue its journey of continuous improvement and we will work with the trust to agree an action plan based on the findings of our inspection."*

1.5 The report identified 5 'must do' actions that the Trust is required to undertake to ensure that it complies with the regulations set out in the Health and Social Care Act (2008).

1.6 The report identified a further 79 actions that the Trust should undertake to improve the services it provides, and the Trust collated a comprehensive action plan that set out its response to all 84 of these actions.

1.7 Whilst it should be noted that the areas for improvement identified in the report are extremely diverse in their subject matter, scale and impact, and the services to which they apply, some themes and recurrences are evident, namely:

- Record keeping and the electronic patient record system
- Use and recording of physical restraint
- Evidencing the provision of information of legal rights to detained patients
- Recording of consent, capacity and best interest decisions
- Maintenance of equipment and medical devices

2.0 Review and scrutiny of the action plan

2.1 During the course of its implementation, progress has been monitored regularly by the Quality Committee, and periodically by the Quality Assurance Committee.

2.2 Each action has an allocated lead, who have provided updates on progress and amendments to the plan to the Head of Quality Assurance.

2.3 By December 2017 it was apparent that, in the view of the action leads, the vast majority of actions had been implemented. And a small number of actions had

proved difficult to progress to a point that either addressed the issue as originally identified and/or to the satisfaction of the action lead.

2.4 At this point it was decided with the Interim Chief Nurse to collate the evidence of implementation of those actions identified as complete, and to review those actions deemed to be not yet fully implemented to agree the way forward with them.

3.0 Method of assurance review

3.1 Graham Hinchcliffe, a bank inspector with the Care Quality Commission, who worked closely with the Trust in preparation for the 2016 inspection, was brought back to work with us again in preparation for the next phase of inspections as a 'quality and compliance advisor'.

3.2 His first task has been to conduct this assurance review of the action plan.

3.3 in collaboration with action leads and relevant clinical leads, Graham has reviewed in detail the evidence of implementation of all 84 of the actions for improvement identified by the Care Quality Commission.

3.4 To do so he met (in person or by phone) with all action leads, along with other parties who had a responsibility to provide evidence around implementation of specific actions.

3.5 A range of evidence was reviewed, protocols and procedures, audit and spot checks, performance data etc. However alongside this 'desktop exercise', site visits were also undertaken to view physical changes, and review other evidence in its day to day context, where this was necessary.

3.6 A summary report of the findings of this exercise was produced and presented, alongside the action plan in full, to an 'Extraordinary' meeting of the Quality Committee on 6th February 2018, chaired by the Interim Chief Nurse and additionally attended by action leads and other key contributors.

3.7 The Committee reviewed all actions where there was found to be insufficient evidence of implementation, or the issue identified had been found not to have been fully addressed.

3.8 The Committee was asked to scrutinise the issues, actions and evidence of implementation in those cases, and to:

- confirm those actions that are complete
- confirm those actions that are believed complete but require further evidence
- confirm those actions that are not complete
- agree a refreshed action plan for those actions not yet complete

4.0 Conclusions of the assurance review

4.1 The Committee were assured that 4 ‘must do’ actions and 73 ‘should do actions had been fully and effectively implemented.

4.2 The Committee concluded that 1 ‘must do’ and 6 ‘should do’ actions were not yet fully and effectively implemented, and these are set out below:

Must do action

Ref	Core Service	Action required	Current position
M4	Community mental health services for older people	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.	Significant progress has been made in reducing waiting times in Memory Clinics across the Trust. However, waiting times in the Bedford service are not as yet meeting target times (6 weeks for referral to assessment, 18 weeks to diagnosis). A quality improvement project is underway to bring about further reduction in waiting times in Bedfordshire

Should do actions

Ref	Core Service	Action required	Current position
S1	Trustwide	The trust should continue to reduce the use of prone restraint	After initial success in reducing the use of prone restraint, bringing use to as close to nil as possible continues to prove challenging. The Directors of Nursing have recently refreshed and relaunched a restraint reduction strategy. Quality Committee will be monitoring its implementation and effectiveness.
S9	Acute and PICU inpatient services for adults	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.	The long term solution to excessive warmth in clinic rooms is installation of cooling systems. A successful bid has been made to the CPSG to fund a

			feasibility study in relation to a rolling project of installation of air conditioning in15 wards per year
S10	Acute and PICU inpatient services for adults	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.	At the time of the comprehensive inspection the Trust launched Mental Capacity Act Training as a mandatory course for relevant clinical staff. Training was successfully designed and rolled out. In common with some other mandatory training courses compliance is currently less than the target, and at the end of December stood at around 60%. Improving compliance is part of wider plan to improve mandatory training compliance, however a range of immediate remedial actions are planned to target this particular course.
S27	Crisis services and health based places of safety –	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	Regular audit has identified that completeness of records relating to those detained under section 136 are still not what the Trust would expect. Whilst audit will naturally continue, a remedial plan has been put in place by the Associate Director for Mental Health Law, and will be implemented in collaboration with the Directors of Nursing and Lead Nurses.
S28	Crisis services and health based places of safety	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.	This will continue to be monitored in light of the above.
S68	Community health services	The trust should continue to take steps to improve client	The gap in services for those age 16-18yrs

	for children, young people and families	transition from paediatric to adult community services to ensure continuity of care and access to timely and appropriate provision for all clients.	and moving to adult services reflects complexity of commissioning and providing arrangements. It is not fully under the control of ELFT. Work with commissioners and between Adult and Children and Young Peoples services is ongoing to ensure the safety of transitions and the quality of services for young people.

4.3 The full action plan, incorporating all 84 issues raised, is attached for reference in Appendix A. It is proposed that the CQC action plan as it stands is superseded by a 'focused action plan' addressing just these outstanding issues. It can be found in Appendix B.

5.0 Next Steps

5.1 The Interim Chief Nurse will meet individually with each action lead for those actions still outstanding, to review, and where necessary refresh, each plan of action.

5.2 The 'focused action plan' addressing those issues not yet fully addressed by the Trust Board will be monitored by Quality Assurance Committee going forward.

5.3 'Action plan progress summaries' will be circulated to clinical teams in a readily digestible format, setting out in a straight forward way what was asked of us by the CQC, and what we have done in response.

6.0 Action being requested

6.1 The Trust Board is asked to **RECEIVE and APPROVE** the findings of the assurance review set out in the paper, and the resulting 'focused action plan'.

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RWK - CQC Comprehensive Inspection – June 2016

Action Plan

Actions the Trust MUST take to improve

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Status
M1	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	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Status
M2	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 Alarm systems have been reviewed and set to sound on individual wards All wards have 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	Completed
M3	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	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Status
M4	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 Michelle Bradley - Service Director, Bedfordshire	Ongoing

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Status
			The longest wait was: Bedford – 181 weeks Mid Beds – 54 weeks South Beds – 54 weeks No waiting more than 18 weeks were: Bedford – 113 patients Mid Beds – 29 patients South Beds – 12 patients **Additional issue – high number on waiting list generally.** At time of inspection the waiting list was: Bedford – 273 patients Mid Beds – 117 patients South Beds – 86 patients **Additional issue – number waiting more than 6 weeks for a first face to face appointment.** At time of inspection the waiting list was: Bedford – 239 patients Mid Beds – 51 patients South Beds – 63 patients		
M5	The trust must ensure all patient records are maintained appropriately.	Community Health	1. Raise awareness of the action point and improvement priority, inviting change ideas from front line	Michael McGhee – Service Director,	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Status
	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.	Services	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. 2. 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. 3. 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.	CHN and MHCOP	

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Status
			4. 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. 5. 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. 6. Re-distribution of the documentation fact sheet for staff. 7. EMIS provision of appropriate templates such as care plans and risk assessments (to be extended to teams who are currently on RiO). 8. 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.		

Actions the Trust SHOULD take to improve

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
S1	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
S2	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	Completed
S3	The trust should ensure the seclusion room on Gardiner ward has a fully	Acute wards for adults of	Works to be completed as required	John Hill – Director of Estates	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
	working two way intercom and a visor to preserve the privacy of patients using the toilet.	working age and psychiatric intensive care units – City and Hackney		and Facilities	
S4	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	Completed
S5	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	Completed
S6	The trust should ensure that staff working in the London acute wards are making the most of opportunities	Acute wards for adults of working age	1. Learning lessons will be part of all lead nurse meetings with the Lead Nurses ensuring that the information is further disseminated towards staff.	Lorraine Sunduza – Deputy Director of Nursing	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
	to learn from incidents across directorates.	and psychiatric intensive care units – East London	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.		
S7	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	Completed
S8	The trust should ensure that it completes the review of psychology services in Luton and Bedfordshire to	Acute wards for adults of working age	1. A review of Psychology Services to be completed. 2. Head of Psychology post has been agreed with plans	Dr Richard Evans – Deputy Medical Director, Luton	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
	improve access to services.	and psychiatric intensive care units – Luton and Bedfordshire	to be in post in October 2016. 3. Head of Psychology to undertake review of Psychology in each area	and Bedfordshire	
S9	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	Ongoing
S10	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	Ongoing
S11	The trust should ensure that staff are recording restraint comprehensively on Keats ward so that accurate	Acute wards for adults of working age	1. Clear local guidelines on reporting of restraint developed and shared with staff teams	Shaun Wright – Lead Nurse, Bedfordshire	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
	numbers can be determined.	and psychiatric intensive care units - Bedfordshire	2. Audit of incidents and records to be completed to assess gaps and assure accurate recording		
S12	The trust should ensure the mirrors to improve lines of sight on the wards at the John Howard Centre are installed	Forensic Inpatient	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
S13	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	All bank staff training is monitored by the directorate with responsibility of monthly review All bank staff have been supported to attend the fire Marshal course All bank staff are supported in revisiting the fire competency training through the already set up Group supervision	Paul Gilluley – Head of Service, Forensic Services	Completed
S14	The trust should ensure at the John Howard Centre that all the control drugs are included on the control drug registers.	Forensic Inpatient	The service has carried out a review of the controlled drugs on all wards A reminder of the control drugs processes has been given to all staff working in the service 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
S15	At the John Howard Centre the trust should continue to try to keep the amount of cancelled leave due to	Forensic Inpatient	Leave monitoring is completed on the ward through the review of weekly leave planners to leave completed When leave is cancelled, reasons for this are documented and	Paul Gilluley – Head of Service, Forensic Services	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
	staff shortages as low as possible. At Wolfson House the trust should monitor the amount of cancelled leave.		reviewed by the service The service is encouraging staff to report these incidents on Datix as a clinical incident to ensure there is full and proper review Quarterly audits on cancelled leave are carried out and action plans put in place to address "hot" areas.		
S16	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	The service is in reviewed establishments for Shoreditch ward Shoreditch ward is piloting safe care processes to support the establishment review Shoreditch ward will be completing contact time observations to support the establishment review in October 2016.	Paul Gilluley – Head of Service, Forensic Services	Completed
S17	The trust should ensure that new staff are introduced to Shoreditch ward as planned in order to provide consistent standards of care.	Forensic Inpatient	New staff have started on Shoreditch ward as planned. Shoreditch ward has a full complement of permanent staff in all positions. Shoreditch has a full complement of regular Permanent staff	Paul Gilluley – Head of Service, Forensic Services	Completed
S18	The trust should work to reduce the incidents of patients sexually intimidating female staff at the John Howard Centre	Forensic Inpatient	Awareness to raise incidents of sexual aggression is being supported in the service A Quality Improvement project has been started on Clerkenwell ward to reduce incidents of sexually intimidating behaviour. To develop a training programme for staff on the LD wards to manage sexually inappropriate behaviour	Paul Gilluley – Head of Service, Forensic Services	Completed
S19	The trust should ensure at Wolfson House that all equipment used for physical health checks is in good working order.	Forensic Inpatient	All physical health Equipment in Wolfson house has been reviewed An inspection of all medical devices in Wolfson house was completed in August 2016 The service has an annual review of all medical equipment which either passes or fails equipment	Day Njovana – Head of Nursing, Forensic Services	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
			All medical equipment will be reviewed monthly by the wards to ensure it remains in good working order		
S20	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	The service is rolled out training for staff outside of the mandatory training which will be delivered on all wards and is forensic specific relating to safeguarding issues Directorate management team is picking up incidents and supporting staff to consider safeguarding alerts if indicated Directorate management team monitoring safeguarding issues through the safety and security meeting for the service Safeguarding is an agenda item for all ward Clinical improvement groups	Paul Gilluley – Head of Service, Forensic Services	Completed
S21	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	All ward Clinical nurse Managers audit medication authorisation on a minimum monthly basis Medication Authorisation and concordance is discussed in ward rounds to ensure compliance 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	Completed
S22	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	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 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 Patients receive information every 12 weeks when their	Day Njovana – Head of Nursing, Forensic Services	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
			rights are read to them.		
S23	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	Ongoing discussion with NHSE on present estate Adopting low secure policies with Clerkenwell ward.	Paul Gilluley – Head of Service, Forensic Services	Completed
S24	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	Ongoing review and improvement of management staff communication. Consult with staff and service user when making significant changes to care and treatment through forensic ear the internal communication system. Directorate management team to carry out roadshow for changes in service provisions to wards impacted Receive feedback from the Clinical improvement groups from each area impacted by the change in service provision	Paul Gilluley – Head of Service, Forensic Services	Completed
S25	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	4. Review of current risk assessment training to include recording of risk as the format has changed. 5. Recording of risks to be highlighted to all staff in safety huddles and away days. 6. Deputy Director of Nursing to audit monthly for 3 months to review progress	Lorraine Sunduza – Deputy Director of Nursing	Completed
S26	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	Karl Marlowe – Clinical Director, Tower Hamlets	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
			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.		
S27	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	Ongoing
S28	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	Ongoing

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
S29	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	Completed
S30	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	Completed
S31	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	Completed
S32	The trust should review the systems	Community	1. Notices to be displayed in clinical areas to reinforce	Eugene Jones –	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
	for the use of alarms at the Luton CMHT premises to keep lone workers safe.	based mental health services for adults of working age – Luton	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	Service Director, Luton	
S33	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	Completed
S34	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	Henry Iwunze – Service Manager, CAMHS	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
			estates and facilities department		
S35	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	Henry Iwunze – Service Manager, CAMHS	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
			Department to complete quarterly audits		
S36	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	Completed
S37	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	Completed
S38	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	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
S39	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	Completed
S40	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	Completed
S41	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	Completed
S42	The trust should ensure that service user meetings take place on	MHCOP Inpatient -	1. Service User meetings occur every week on the ward, however the meetings will be formalised and	Carmel Stevenson – Lead Nurse,	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
	Leadenhall ward to provide a forum for patients to express their views	East London	outcomes from the meeting will be captured on the 'You said – We did' board.	MHCOP	
S43	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	Completed
S44	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	Completed
S45	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	2. 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	Completed
S46	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	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	Michael McGhee – Service Director, CHN and MHCOP Gabrielle Faire –	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
		London	monitored by the Clinical Director for MHCOP.	Clinical Director, MHCOP	
S47	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	Completed
S48	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	Completed
S49	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	Completed
S50	The trust should continue to implement the changes to enable	Mental health ward for	1. Full review of multi-disciplinary capacity within The Coppice	Michelle Bradley – Service Director,	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
	improved access to psychology and therapy staff.	people with learning disability	2. Review of SPLD services model	Bedfordshire	
S51	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	Completed
S52	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	Completed
S53	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	Completed
S54	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	Completed
S55	The trust should ensure that all	Community	1. Identify staff groups for whom training on the Mental	Guy Davis –	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
	relevant staff receive training relating to the Mental Capacity Act (2005).	mental health learning disability services	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.	Associate Director for Mental Health Law	
S56	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	Completed
S57	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	Completed
S58	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	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
S59	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	Completed
S60	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	Completed
S61	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	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	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
		young people			
S62	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	Completed
S63	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	Completed
S64	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	Linda Hurst, Development Manager - CAMHS	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
			6. Quarterly admin peer groups to be held – to be chaired by the admin lead and supported by the CAMHS Manager across each site		
S65	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	Completed
S66	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	Completed
S67	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/	Sarah Wilson – Service Director, Specialist services for children and young people	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
			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)		
S68	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	1. Ensure a transition pathway is in place to support children from children to adult community nursing which is audited annually. 2. Conduct a gap analysis for NICE guidance NG43 and put in place an action plan to work with EPCT to enable us to adequately prepare our children and young people for transition to adult services 3. Work with CCG and other stakeholders to review contractual/commissioning arrangements to support transition across services	Sarah Wilson – Service Director, Specialist services for children and young people	Ongoing
S69	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	Completed
S70	The trust should work with the organisations that are responsible for the health centre buildings, where the clinics are provided to improve their	Community health services for children,	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	Sarah Wilson – Service Director, Specialist services for	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
	safety for children and make them more child-friendly	young people and families	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	children and young people John Hill – Director of Estates and Facilities	
S71	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	Completed
S72	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	Completed
S73	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	Michael McGhee – Service Director CHN and MHCOP	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
			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.		
S74	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	Completed
S75	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	Ben Braithwaite – Clinical Director, CHN Michael McGhee – Service Director CHN and MHCOP	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
			Ulcer Seminar. 4. Process to be set up for increased support from MHCOP with regards to complex MCA cases in CHN Adult Services.		
S76	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	Completed
S77	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	Completed
S78	The trust should continue to improve the waiting times for a wheelchair service	Community health services for	1. One Band 6 specialist vacancy (Physio/Occupational Therapist) within service - on 3rd round of recruitment and interviews to take place in October	Michael McGhee – Service Director CHN and MHCOP	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
		adults	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.		
S79	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	Michael McGhee – Service Director CHN and MHCOP	Completed

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Completion
			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		

RWK - CQC Comprehensive Inspection – June 2016

Focused action plan – Actions outstanding February 2018

Must do actions

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Target completion date	Progress
M4	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	BEDFORDSHIRE Wide-ranging action plan in place: The longest wait was: Bedford – 181 weeks Mid Beds – 54 weeks South Beds – 54 weeks No waiting more than 18 weeks were: Bedford – 113 patients Mid Beds – 29 patients South Beds – 12 patients **Additional issue – high number on waiting list generally.** At time of inspection the waiting list was: Bedford – 273 patients Mid Beds – 117 patients South Beds – 86 patients **Additional issue – number waiting more**	Michelle Bradley - Service Director, Bedfordshire	June 2018	• Action plan for Bedford memory clinic was instigated with significant results • QI project in Bedford underway to specifically address the delays in diagnosis, but slowed by preparation work for MSNAP • Where possible diagnosis to be made at the first appointment • Referrals screened and declined if information missing that will prevent diagnosis being made • Scans now being requested in South Beds and reviewed before initial appointment. • HEAT (GP training event) planned for 8.2.18 to discuss quality of referrals and GP's diagnosing where suitable • Bedford- OT returned from maternity leave – now full time equivalent of OT in

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Target completion date	Progress
			than 6 weeks for a first face to face appointment. At time of inspection the waiting list was: Bedford – 239 patients Mid Beds – 51 patients South Beds – 63 patients			place. • Bedford- weekly monitoring of the MAS caseload, with top 10 longest waiters getting priority discussion at weekly MDT. • Bedford QI project addressing whole pathway • South Beds and Mid Beds continue to monitor caseload weekly • Bedford- Consultants have been asked to not cease MAS assessments when covering fountains court due to leave. • Recruit Dementia nurse specialist for Mid Beds (currently covered by 0.5wte from south Beds DNS postholder)

Should do actions

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Target completion date	Progress
S1	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.	Andy Cruickshank – Director of Nursing	December 2018	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, some reduction in the use of prone restraint has been seen, but in order to make further progress this work has been incorporated into the QI violence reduction work. Refreshed restraint reduction strategy approved December 2017, and to be monitored by Quality Committee
S9	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	Acute wards for adults of working age and psychiatric intensive care	1. AC to be included in all treatment rooms across the trust – process	Jenny Melville – Chief Pharmacist John Hill –	December 2017	A bid for funding has been prepared for submission to the Capital Development Steering Group (CPSG) to provide

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Target completion date	Progress
	rooms.	units	underway to identify optimum solution. 2. Advice on mitigating actions in the meantime provided in attached poster	Director of Estates and Facilities	Feb 2017	permanent solutions in those areas worst affected.
S10	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 4. Deliver training to all relevant staff	Guy Davis – Associate Director for Mental Health Law	June 2018	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 are delivered in face to face sessions and/or via three separate e-learning modules. Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards e-learning packages have been identified, tested and are available via OLM. Compliance continues to build as training is rolled out. At 59% as of December 2017.
S27	The trust should ensure that all	Crisis services	1. All staff to be reminded of the	Guy Davis –	Immediate	**Recording process clarified**

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Target completion date	Progress
	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	and health based places of safety	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	Associate Director for Mental Health Law Lorraine Sunduza – Interim Chief Nurse	December April 2018	• Patient arrives at Place of Safety (PoS) • Police give form to Duty Senior Nurse (DSN) • DSN organises attendance by doctor and Approved Mental Health Professional (AMHP) • DSN / Assessors complete form • Form placed in red box for pick up by MHL office • If information missing, MHL office contact DSN/Assessors (cc BLN) to return information within 7 days • MHL office actions recorded on d/b • MHL Manager checks d/b weekly and follows up outstanding information with BLN to return information within 24 hours

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Target completion date	Progress
						• MHL Manager actions recorded on d/b • If information not received within 24 hours, escalate to Associate Director of Mental Health Law (and ? Deputy Director of Nursing) **Audit to be undertaken regularly to monitor process** • Recording of rights increased from 59% to 66% • Modify audit tool re extensions of detention • Audit weekly until further notice
S28	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	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 – Interim Chief Nurse	October 2016 - ongoing	In light of above, to continue to monitor.

Ref	Issue	Relevant Directorate or Core Service	Action required	Action owner	Target completion date	Progress
	liaison meetings.					
S68	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	1. Develop a transition protocol which will set out how young people approaching their 16th birthday will have their health needs met. They will have a transition plan which will be shared with them, parents/carers/GP/schools etc 2 This will be overseen by a transition panel which will meet monthly to plan for individual young people and resolve disputes 3. The issue of resourcing will continue to be discussed with the CCG , and in the context of how scarce resources are prioritised , however we are clear that each child needs a clear plan for what services need to be delivered.	Sarah Wilson - Service Director	April 2018	CHN adults and Children and Young people's services are working together to ensure smooth transitions on a case by case basis.