CLOSED ACTIONS

Action No	MUST do/SHOULD do Wording	Context	Location	Action
MD1 / 2021	The trust must ensure that all wards are compliant with guidance on mixed sex accommodation. Female patients must not have to walk through areas used by male patients in order to use bathrooms. Regulation 10 (paragraph 10(2)(a))	*South Wing accommodated four male and four female patients. Male and female bedrooms, with ensuite toilets and sinks, were situated on separate corridors. However, female patients had to walk through areas used by male patients in order to have a shower. We raised this matter with the trust. They said that they would review the use of flexible beds on South Wing and submit a capital bid to install showers on both corridors if that was feasible.*	Older Peoples Wards	An additional doorway will be installed that will create an airlock between male and female bedrooms, allowing privacy on accessing existing shower room. The additional door way will be placed outside one Bedroom. This will allow direct acccess from both bedroom corridors without crossing existing bedrooms. Works will also be undertaken to improve communal areas and create female specific lounge. Bedrooms will be allocated for female use and bedrooms for males. Shower access will be facilitated and service users approach staff to request access. This is also for health and safety reasons such as risk of slips and falls.
SD4 / 2021	The trust should ensure that all wards providing mixed sex accommodation have an area designated for the use of female patients only	*On two wards, there were separate corridors for male and female bedrooms, but there were no female only lounges as they had been redeployed as activities rooms as part of the wards response to COVID 19.*	Older Peoples Wards	To install permanent signage on female only lounges on two wards. now have female lounges allocated. There is clear signage on the door indicating 'Female Only Lounge'. This will be monitored with environmental audits.
SD9 / 2021	The trust should ensure staff monitor the fridges within the ADL kitchens on two wards to ensure food is fit to be consumed.	*Fridge temperatures were not always monitored. This meant that patients could be at risk of eating food that was not fit for consumption. This was raised with ward teams at the time of inspection and all out of date food was disposed of. The trust also took immediate action to share this finding with other wards within the directorate to ensure good food hygiene was being practiced.*	Forensic Wards	1. .Standardise the environmental security checks for all wards to include ADL and patient communal fridge monitoring twice a day 2.All perishable food to have label and expiry date, unlabelled to be disposed of 3.Night chores schedule for staff to report in daily hand over
SD10 / 2021	The service should ensure that oxygen bottles are secured appropriately when not in use on one ward. The trust should also ensure that appropriate arrangements for managing medical equipment, to ensure it is suitable for use, are established on two wards.	*Improvements were needed to ensure that equipment was stored correctly and regularly checked to ensure it was working correctly. Two bottles oxygen was not stored securely on one ward.* *On another ward, a blood pressure machine and a pulse oximeter had not been checked to see if they were suitable for use.* *Staff had identified issues with this equipment in July 2021, but this had not been followed up in a timely way.* *On another ward whilst blood glucose meters were checked daily, staff did not always take action when the readings were out of range.*	Forensic Wards	1.All matrons to ensure that there is a register of all medical equipment 2.Register to monitor when equipment last serviced 3.Register to be reviewed every quarter by the ward matrons and CNMs

SD11 / 2021	The service should ensure that medicines fridge temperatures are maintained between 2° and 8°C. Appropriate actions should be recorded if temperatures are recorded outside of this, as per trust guidance. The service should also ensure that ambient room temperatures, where medicines are stored, are below 25°C. Appropriate actions should be recorded if temperatures are recorded outside of this, as per trust guidance.	*On three wards, on some occasions, when fridge temperatures were out of range, it was not recorded what actions had been taken to safeguard the efficacy of medicines.* *On two wards, we found out of range ambient room temperature readings where staff had not recorded the appropriate action taken. This was raised with staff and to address this the service redesigned its fridge and clinic room temperature recording templates to improve their ease of use and updated the relevant policies and communicated this to all staff within the service.*	Forensic Wards	1.Standardise the environment hourly security checks for all wards to include Fridge Temperature Checks and treatment room checks 2.Weekly Checks by CPLs & CNMs 3.Monthly Checks by Matrons when completing the environmental report (to be discussed at away days & Matrons) Meeting 4.Monthly audits of the above by physical health leads CS & CR and report monthly to FQC forum 5. Monthly checks by the pharmacist
SD13 / 2021	The trust should consider improving the format of information displayed on two wards to ensure is it easy to read.	*On two wards some of the notices contained a lot of information and were hard to read for anyone with deteriorating sight and would benefit from review, given the age profile of the wards*	Forensic Wards	1.Wards to review all the information Display in liaison with colleagues from Directorate Learning Disability and People Participation 2. Lead Nurse and Head of Occupational Therapy to review 31/03/2022 3. Action to be monitored through Bi annual Quality Reviews.
SD5 / 2021	The trust should ensure that all staff have completed the appropriate level of mandatory training in safeguarding	*Compliance with mandatory training on safeguarding at level two varied between 89% and 100% across the five wards. However, on one ward, seven of the ten staff (70%) required to complete level three safeguarding training had done so. On another ward, eight of the 11 staff (73%) required to complete level three training had done so. Compliance with level three training on other wards ranged from 85% to 100%.*	Older Peoples Wards	a. Corporate Safeguarding Team will offer targeted training for staff working on the Older Peoples ward to achieve full compliance within the next three months. b. Corporate Safeguarding Team has set up quarterly refresher training for staff and the first training will be delivered on 1st February 2022. c. Safeguarding Training Compliance in older peoples wards will be reviewed in each Safeguarding Committee
SD2 / 2021	The trust should continue its work identified in the estates strategy to ensure that all areas where patients receive care and treatment are an appropriate standard.	*The November 2021 BAF showed five red rated risks including: management of commissioning responsibilities, recruitment and retention of staff, ensuring a positive staff experience, embedding and maintaining financial sustainability and infrastructure projects including digital and estates.*	Trustwide	The new Estates Strategy will continue to focus on ensuring that areas of patient care are to an appropriate standard, within the confines of CEDL and on a prioritised basis. The John Howard Centre options analysis Masterplan will ensure that any recommendations reflect appropriate patient care and treatment The Bedfordshire Health Village Masterplan project is has been approved from our partners in L&D / Beds and will ensure that any recommendations reflect appropriate care and treament A new forum of collaboration and regular update / feedback shall be established between COO, Chief Nurse, CFO and Director of Estates - to openly discuss and resolve estates, esates operations and estates environment matters

SD1 / 2021	The trust should ensure that its work around identifying recurring themes linked to serious incidents continues, with the aim of embedding learning and minimising the repetition of poor practice.	*There were recurring themes linked to serious incidents. The trusts own recent deep dive had recognised this and identified actions to improve. The report identified four lessons to implement across the trust, including; feedback of findings to all staff and considering how QI projects may be able to strengthen the trusts existing physical health strategy; development of an e-observations platform to replace paper observation records. The report also identified the need for improvements to assurance systems to ensure more sophisticated, consistent analysis of serious incidents and deaths to ensure that themes and learning from incidents could be identified and applied quickly and more consistently across the trust.A patient safety forum had been developed to support this work.*	Trustwide	1) Appointment of Director of Patient Safety (expected Summer 2022) 2) Immediate learning from any SI is shared across services if there is an indication that the circumstances of the incident have the potential to repeat in services. DoNs and Patient Safety Specialists alert the Service Directors, Lead Nurses and Clinical Directors immediately for dissemination of relevant information and action. 3) SI committee process refocussed on themes and learning inline with the new Patient Safety Incident Review Process this is regularly fed back through DMTs to local teams – by January 2022 4) Patient Safety Forum – provides assurance to the Quality Committee that actions related to themes from Serious Incidents are appropriate, timely, fit for purpose and completed. This forum also examines the Mortality Review themes and learnings. Any Prevention of Future Deaths reports and their subsequent action plans are monitored via this forum. 5) Review of mechanisms and tools used to communicate patient safety issues and learning from incidents within the Trust. – New Director of Patient Safety; June 2022 6) E-obs: Need to establish project board established and scope of project defined – for completion Dec 2023 for design and roll out across the Trust. Update at next meeting re timescales. 7) Commission a further deep-dive with Public Health colleagues into the determinants of health within ELFTs patient population and specifically those who have died unexpectedly or with long term conditions. Results to inform any future improvement work. 8) Review physical health strategy to identify any areas of activity/intervention that might benefit from a QI approach. 9) Each inpatient service has a forum (Time to Think) where safety issues related to violence and aggression, safeguarding, sexual safety and clinical practice are explored and disucssed. This forum has a solid link to QI work and assurance around
SD6 / 2021	The trust should ensure that all time sensitive medication is administered to patients at the correct time	*At Cazaubon Ward, medicine administration rounds sometimes went on for a long time. Time sensitive medicines were being given at different times without an appropriate gap between each dose.*	Older Peoples Wards	1. An extra medication trolley has been ordered to allow two nurses to administer medication at the same time. This will reduce admistration time by half. 2. An audit form has now been devised for nurses to record their medication administration start and finish times as part of the improvement process, these are audited by the ward manager on a weekly basis. 3. An electronic report on time sensitive medication admistration will be run weekly to check for administration times for the ward to seek further improvements. This will be reviewed at the ward's CIG meetings.
SD18 / 2023	The trust should ensure that staff on a City &Hackney ward meet its targets for compliance with staff appraisals		City & Hackney wards	(a) weekly checks of compliance with appraisal requirements via weekly inpatient senior nurses meeting (from July 2023); (b) monthly updates at monthly Inpatient Management meeting, with corrective action agreed, as required (from July 2023); (c) monthly review at Quality DMT (from July 2023).
SD07 / 2021	The trust should ensure that staff take appropriate action when temperatures in clinic rooms rise about the recommended range.		Older Peoples Wards	1. The ward has gone through the policy and expectations with all registered nurses 2. Work is currently underway to move the clinic room to a room with good ventilation and air conditioning will be installed. 3. The ward manager is doing weekly audits on temperature recordings and in addition, the Matrons' completes monthly audit. 4. Pharmacy departments also carry out separate audits and this will be discussed in the Clinical Improvement group.

SD15 / 2023	The trust should ensure one ward's ligature audit and risk assessment includes all potential ligature risks and associated risk mitigation		City & Hackney wards	(a) Further ligature audit work to be undertaken to include bedroom doors and windows (this cycle to be completed by July 2023); (b) Further review by H&S lead (by end July 2023); (c) Updated report to be submitted to Quality DMT (25.07.23) for review; (d) Introduction of anti-ligature windows (by June 2023); (e) Ongoing review of ligature action plans at monthly Inpatient Managment meetings (from October 2023);
SD17 / 2023	The trust should continue its work to ensure maintenance issues on one ward are addressed quickly		Tower Hamlets wards	Following the CQC visit; the identified kitchen refurbishment is completed and bedroom door replacement has begun - 3 bedroom doors have been completed a) Estate jobs are logged on ward electronic database and tracked by the ward admin to ensure that jobs are not closed before they are completed. b) Weekly matron environmental walk around and Monthly walk about visits with estates monitor c) The London's Estates and Facilities Manager attends daily unit huddle – gives opportunity for wards escalate works reported within a 24hour period d) This is monitored in monthly estates meeting (co-chaired by Borough Lead Nurse and Deputy Director of Estates) e) Director of Estates and Service Director attending Mile End meetings
SD14 / 2023	The trust should ensure that daily ward environmental checks are completed and recorded consistently in line with the service's protocols to ensure ward environments are safe.		City & Hackney wards	(a) A template has been developed and implemented to enable consistency of checks (in place from June 2023); (b) Process agreed for 1 environmental check per shift, added to the matron audit (from June 2023); (c) further twice weekly process for supplementary spot checks by managers (from July 2023); (d) weekly reviews at inpatient senior nurses meetings (from July 2023)

MD3 / 2023	The trust must ensure that staff meet its targets for compliance with mandatory training, in particular basic life support, immediate life support and invention and prevention for the management of violence and aggression training (Regulation 12(2)(c)).		We will be working with subject matter experts to ensure we have the required capacity of training spaces Exploring how we can add Statutory and Mandatory training records into the Health Roster system to enable staff, particularly those in clinical settings, to view compliance when rostering. We plan to have this to be in place by the end of November 2023 Recognizing that not all front-line staff use e-mail we have written to non-complaint staff at their home to addresses to encourage completion. Our current trajectory based on improvements seen so far, shows that we hope to reach 90% compliance by the end of January 2024. We have ensured that there is sufficient capacity and will support services to release staff to attend the relevant training. Locally, directorates will share compliance data with all managers fortnightly and review the compliance data in quality meetings. Staff will also be reminded using supervision to attend training where required.
SD19 / 2023	The trust should continue its work to ensure that risk mitigation is included in all patients' risk assessments	Trustwide	The Clinical Risk Assessment and Management Policy is up for review. We have within that a plan to review the way in which we consider risk, and how we formulate this and document our mitigations of it. This is involving our local suicide lead, who has been exploring systems in use elsewhere. That is partly in response to a PFD notice issued by a coroner, but is work we are keen to do in any case. That policy review is likely to lead to changes in the way we record risk assessments on RiO. We anticipate a timeframe of around 5 months for this to be completed. In the interim, we are exploring a system in which we create a new section on our existing risk forms focusing specifically on risk mitigation. That should be in place considerably sooner.

MD2 / 2023	The trust must ensure that the services meet its targets for compliance with staff supervision (Regulation 18(2)(a))	Trustwide	Luton and Bedforshire a) Email reminder sent by Lead Nurse to re-iterate supervision compliance target of 100%. b) Audit of supervision training record by Deputy lead nurse to ensure all responsibile staff have completed the training provided by HR. c) Monthly audits by Matron on compliance with supervision traget for each area. d) Monthly audit by Deputy lead nurses. e) Monthly monitoring at our senior nurses Quality Meeting. F) Current supervision Data for april is 83.4% and May 88.4% respectively . . C & H actions: Directorate target of 95% by 31st October 2023 (accounting for exclusions re sickness, maternity leave, etc.). Actions: (a) utilisation of the on-line supervision form (from June 2023); (b) regular communication of the requirement to line managers via supervision and leads meetings (from June 2023); (c) weekly monitoring reports at inpatient senior nurses meetings (from June 2023); (d) monthly monitoring updates to Inpatient Management meetings with agreed correctove action, as required (from July 2023); (e) Monthly updates to Quality DMT (from July 2023); Tower Hamlets Directorate Target is 100% by 31st of August 2023, Roman ward average is currently at 88% a) Supervision is monitored in the Inpatient Nursing Managers Governance meeting and Inpatient Performance and Governance meeting b) Minuted Monthly Bank staff supervision which also reviews training needs c) Monthly audit of supervision compliance in the third week by Deputy Borough Lead Nurse (BLN)/BLN
SD20 / SD21 / SD22 / 2023	The trust should ensure that where actions from serious incident reports evolve to be successfully applied the relevant action plans are updated to include any changes. The trust should ensure that actions from serious incident reports are fully discussed between staff responsible for delivering those actions and the senior managers and central serious incident team to ensure actions was correctly interpreted The trust should continue its work on serious incident governance systems to ensure actions and recommendations from serious incident 48 hour	Trustwide	Work being undertaken to ensure governance processes for each directorate are mapped out where actions are reviewed. Overdue actions will be taken for oversight at Service Delivery Board Overdue actions added to Quality Dashboard for oversight at Quality Committee Ensure there is a SOP for processes around monitoring actions which sets expectations for directorates for InPhase roll out

SD8 / 2021	The trust should ensure a programme of rolling decoration works is developed for the John Howard Centre.		Forensic Wards	1. We have embarked on a programme to redecorate some of the areas at JHC using non recurrent funds. 2.Half yearly reviews to be led by Estates & Facilities , IPC & Lead Nurses to report on state of the buildings , wards , estates work- Report to E & F and DMT 3.To get dates for the Trust , Painting and decorating Programme 4. Half yearly reviews by HoS & Hon 5.Environment & Estates to be part of daily handover 6. Three monthly visit to wards with the nurse managers/Matron and another ward manager/Matron, Estates, Facilities & Capital Development, G4S
SD16 / 2023	The trust should ensure that staff on one ward are informed by any learning from ligature risks and serious incidents from other wards across the trust		City & Hackney wards	(a) identify learning alerts and general learning points (Governance Lead) and discussion at bi-monthly inpatient risk governance meetings (from September 2023); (b) targeted regular communications highlighting learning points from Governance Lead (from September 2023);

OPEN ACTIONS

Year	Action No	MUST do/SHOULD do Wording	Context	Location	Action	Achievement Goal	Status Update	Lessons Learnt

2021	SD3	The trust should continue its work on improving the experience of staff when using IT and the associated systems.	*Several staff told us about the frustrations they experienced in using trust IT systems. A chief digital officer had been appointed, a digital strategy was in place and work to improve the connectivity of teams and wards was underway. Systems to enable staff teams to access live data to inform their day to day*	Trustwide	The Trust has reviewed your request for information under the Freedom of Information Act (FOI) 2000. *Section 31(1)(a) of the FOI Act states:* *31(1) Information which is not exempt information by virtue of section 30 is exempt information if its disclosure under this Act would, or would be likely to, prejudice* *(a) the prevention or detection of crime,* The information requested, if released into the public domain, could have the potential to identify weaknesses within the Trust's	To improve staff experience of using IT and associated systems.	The Trust has reviewed your request for information under the Freedom of Information Act (FOI) 2000. *Section 31(1)(a) of the FOI Act states:* *31(1) Information which is not exempt information by virtue of section 30 is exempt information if its disclosure under this Act would, or would be likely to, prejudice* *(a) the prevention or detection of crime,* The information requested, if released into the public domain, could have the potential to
	SD12	The trust should consider improving local broadband and mobile connectivity to ensure staff can connect to online systems.	*Local broadband and mobile connectivity could, at times, present staff with problems. Staff said on occasion poor connections had interfered with external meetings and staff take to go to another ward to connect to the trust system. Managers were aware of this issue and discussions were taking place to improve this across the*	Forensic Wards	The Trust has reviewed your request for information under the Freedom of Information Act (FOI) 2000. *Section 31(1)(a) of the FOI Act states:* *31(1) Information which is not exempt information by virtue of section 30 is exempt information if its disclosure under this Act would, or would be likely to, prejudice* *(a) the prevention or detection of crime,* The information requested, if released into the public domain, could have the potential to identify weaknesses within the Trust's	To improve local boardband and mobile connectivity at Forensic sites.	The Trust has reviewed your request for information under the Freedom of Information Act (FOI) 2000. *Section 31(1)(a) of the FOI Act states:* *31(1) Information which is not exempt information by virtue of section 30 is exempt information if its disclosure under this Act would, or would be likely to, prejudice* *(a) the prevention or detection of crime,* The information requested, if released into the public domain, could have the potential to