Lincolnshire Partnership NHS
NHS Foundation Trust

CQC Action Plan

Following publication of LPFT comprehensive inspection report

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Guide to colour code used in template

	Complete
	Action progressing/on-track
	Action off-track
	Complete & Evidence uploaded

	‘Must do’ actions

Introduction

The Trust was inspected by the Care Quality Commission (CQC) under their comprehensive inspection regime during the week of 30th November 2015. The CQC rate services against five key lines of enquiry:

- Are services safe?
- Ares services effective?
- Are services caring?
- Are services responsive?
- Are services well-led?

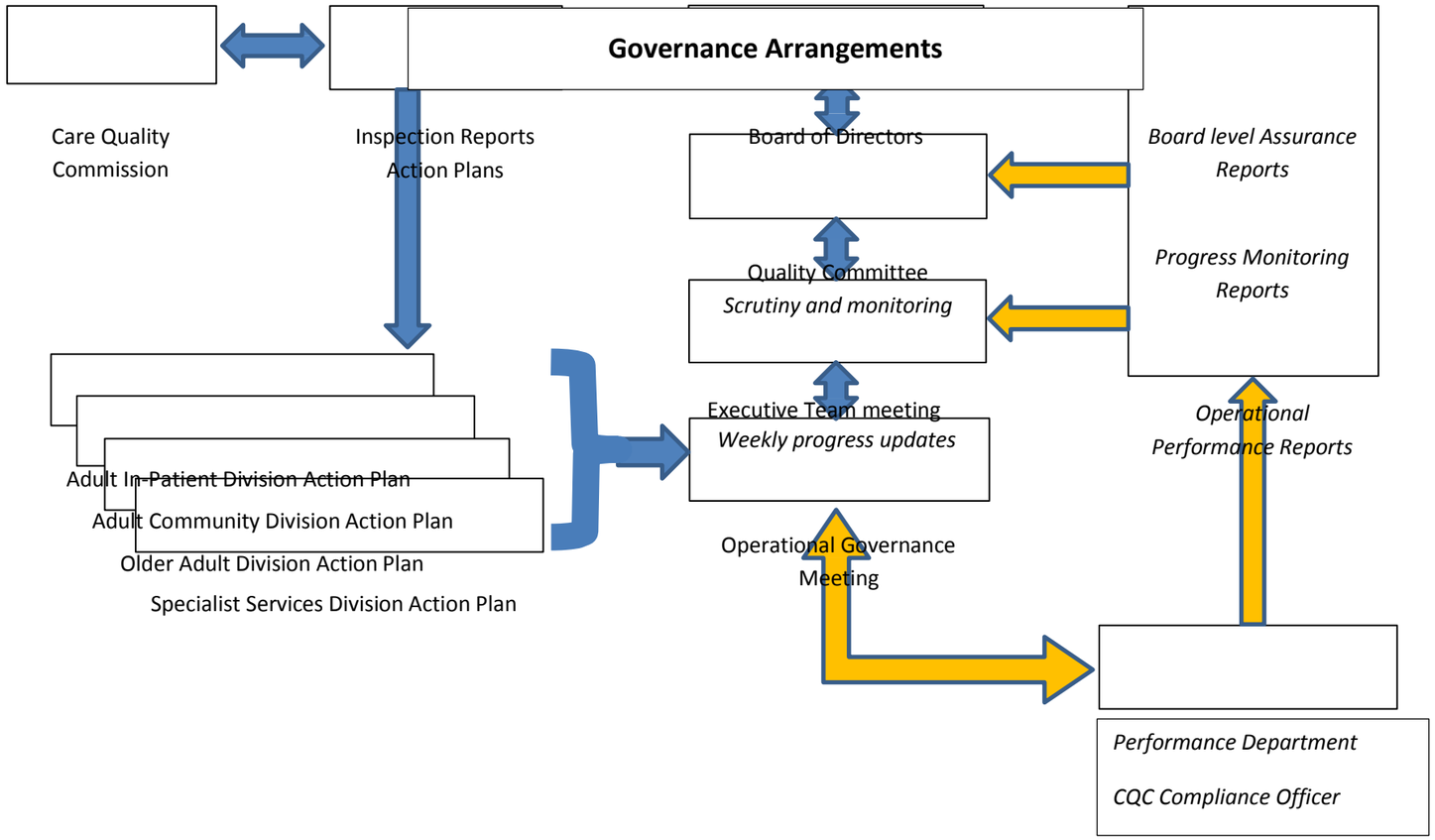
The CQC published the Trust's reports in April 2016; overall the Trust were rated as ***'Requires Improvement'*** because:

- Not all services were safe or effective and the board needs to take action to address areas of improvement.
- Some of the wards did not provide an environment that was safe or that preserved patients' dignity or privacy. The layout of some wards and ward garden areas meant that staff could not easily observe patients who might be at risk. They were concerned about the design of the place of safety and seclusion facilities at some units. Some wards had fixtures and fittings that people at risk of suicide could use as a ligature anchor point; the Trust had not addressed these risks adequately. Not all wards met the requirements of single sex accommodation guidance or the Mental Health Act (MHA) code of practice. Some seclusion rooms and dormitory areas did not promote privacy and dignity.
- Restrictive practices that amounted to seclusion were not reported or safeguarded appropriately.
- Staff on the acute, forensic and child and adolescent wards imposed blanket restrictions that were not based on an assessment of the risks of individual patients.
- Some wards in the rehabilitation, forensic and children's mental health services had too few staff on duty at times to keep patients safe and others relied heavily on the use of bank and agency staff.
- Staff were not always receiving supervision in line with the Trust policy.
- The CQC were concerned that information management systems did not always ensure the safe management of people's risks and needs.
- Access arrangements needed improvement. There was a lack of availability of acute beds. There were delays for assessment from community adult teams and there was limited access to psychological therapy.
- While performance improvement tools and governance structures were in place these had not always brought about improvement to practices.
- While the board and senior management had a vision with strategic objectives in place, morale was found to be poor in some areas, particularly community teams, and some staff told the CQC that they did not feel engaged by the Trust.

The Trust responded to the CQC's findings at a quality summit in May 2015 addressing ligatures; same sex accommodation, ward environments; safe staffing; restrictive interventions; supervision; access and leadership. Following the summit the Trust were requested to produce an action plan to the CQC by early June 2016. The Trust welcomes scrutiny of its plans and support of all those involved in the summit in addressing these issues, in the interests of continuing to improve the quality of its services for the benefit of service users / patients, carers, staff and other stakeholders.

The Trust is developing an overarching Quality Improvement Plan and associated methodology. The CQC action plan, along with all other quality improvement plans, resulting from serious incident investigations for example, will feed into and be reflected in the Trust Quality Improvement Plan.

The action plan will be presented to the Trust Board on a monthly basis providing updates and assurances against each of the actions identified as detailed in the governance flowchart below:



Blue arrows indicate lines of accountability: Yellow arrows indicate performance and assurance reports

Trust Wide Issues:

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
1	All ligature risks must be identified on ligature risk audits with steps in place to do all that is reasonably practicable to mitigate any such risks.	Ian Jerams – Director of Operations	Zoë Rowe - Associate Director of Quality & Safety	**Action 1 cross references with actions: 13; 21; 33; 34; 37; 53; 54 & 80** 1.1 The Trust will review its ligature audit process to ensure that all inpatient audits are supported by a member of the Quality and Safety Team.	Complete.	30/05/2016	30/04/2016	Copy of Clinical Care Policy, with updated audit process. Copy of forward plan identifying leads from Quality & Safety Team supporting audit process	Evidence uploaded.
				1.2 Director of Operations to lead a task and finish group to ensure that services are able to interpret best practice ligature guidance in the context of the service provided.	• First meeting of task and finish group was held on 06/05/2016. Revised process agreed for ligature audits, to include front sheet template, setting out context of service provided. Approach agreed for Maple Lodge regarding compliance works. Future of Ashley House as inpatient unit to be considered. Compliance works to be agreed in this context. • A meeting took place on the 21/07/2016 during which it was agreed to further review the Trust's ligature policy and include further refinements. Also to include a section for each inpatient service area which sets the context of the environment and service user group along with the acceptable risk type for the environment. Due to this piece of work having been identified there is a revised completion date of 30/09/2016. • Guidance on assessment and management of ligature risks and an assessment and management of ligature risks have been devised and are out for consultation with clinical areas and the ligature policy is being updated to reflect the changes. • A ligature risk workshop was delivered to ward managers on Friday 16th September.	30/09/2016		Copy of audit template. Link to revised policy. Copies of processes. Copy of workshop slides.	
				1.3 Review current audit tool and ensure outside spaces are included.	Complete.	30/04/2016	30/04/2016	Link to clinical care policy (Section 11).	Evidence uploaded
				1.4 A member of the quality and safety team to identify and visit an 'outstanding' rated Trust to gain insight into good practice around ligature audits.	• Quality & Safety Team have identified Trust/s and are in the process of setting up a visit. Target completion date amended to support realistic achievement timeline. • Director of Quality and Nursing visited North East London Trust to look at best practice.	30/09/2016	09/09/2016	North East London Trust Friday 09/09/2016	Visit took place on 09/09/2016 by Director of Quality and Nursing
				1.5 A quality review of the current audits in place and corresponding action plans will be carried out and those not meeting the required standard will be prioritised for immediate re-audit.	Quality & Safety Team have completed a schedule of inspections to improve related quality governance and have prioritised units identified with issues by CQC – namely Maple Lodge, Ash Villa and Ashley House.	31/07/2016	05/07/2016	Copy of schedule of inspections – Link to audits/action plans.	Evidence uploaded.
				1.6 Review of capital works approval process.	Working Group set up to review process; this is complete and is now being embedded in practice within the operational divisions.	31/07/2016	18/07/2016	Evidence of Working Group Membership	Evidence uploaded.

Trust Wide Issues:

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
2	All mixed sex accommodation must meet guidance and promote patient safety and dignity.	Anne-Maria Olphert - Director of Nursing and Quality	Zoë Rowe – Associate Director of Nursing & Quality	**Action 2 cross references with actions 34; 52; 81 & 92** 2.1 Director of Nursing to lead a task and finish group to review the Trust's safety, privacy and dignity policy and cross match with national guidance.	Task and finish group meeting held and actions agreed for reporting of sleeping breaches and for divisions to submit business cases for environmental issues leading to bathroom breaches.	31/08/2016	12/07/2016	Copies of communication sent to wards advising on reporting of sleeping.	Evidence uploaded.
				2.2 Develop local guidance in respect to implementing policy and reporting non-compliance.	• Meeting at national level between NHSE and CQC was held in June 2016 regarding implications of CQC judgements for specialist commissioning of CAMHS Tier 4 services. The outcomes of this will be used to develop the LPFT guidance. • Director of Operations seeking update via commissioners on outcome of the meeting. • No feedback received from Commissioners, the Trust will move forward with developing guidance documentation, revised completion date.	31/10/2016		Copy of New LPFT guidance required.	
				2.3 To brief staff on the outcomes of policy development work.	Revised completion of draft policy guidance inclusive of going out to consultation is 31/10/2016; therefore completion date revised.	31/11/2016		Copy of revised policy.	
				2.4 Trust Quality Governance visits to include privacy and dignity assurance checks.	Complete, this will take place on all future checks; template updated.	30/04/2016	30/04/2016	Copy of updated template.	Evidence uploaded.
3	All seclusion facilities must be safe and appropriate and that seclusion is managed within the safeguards of the Mental Health Act Code of Practice.	Ian Jerams – Director of Operations	Chris Ashwell – Divisional Manager	**Action 3 cross references with actions 16 & 84** 3.1 All seclusion facilities to be subject to an immediate assurance check by a member of the Estates team in partnership with a member of the Quality and Safety Team.	Confirmation by the Associate Director of Estates and Facilities that this assurance check has taken place. The outcome of this is: the rooms in Discovery House meet requirements. Ward 12 seclusion room requires work and this is addressed in action point 16. A review of PHC has flagged capital works that are required and these are being picked up in action 3.2. The door on FWU is inward opening and a CN1 has been submitted.	31/05/2016	25/05/2016	Confirmation from Associate Director of Estates.	Progress update within this action plan.
				3.2 Both seclusion rooms at Peter Hodgkinson Centre need to be improved with regard to a lack of a de-escalation area and lack of privacy regarding the intercom. Geoff Badger to carry out an option appraisal for how to address this, in conjunction with Martin Addlesee.	All options have been considered regarding the re-siting of the intercoms. It has been concluded that they will remain where they are, however a nurse is present at all times so will ensure when communicating with the patient in seclusion their privacy and dignity is always considered and this will include requesting other patients in the vicinity leave the area.	31/08/2016	08/08/2016	Copy of seclusion room protocol that includes managing privacy.	Evidence uploaded.
				3.3 All ward managers and staff to be provided with briefing on the MHA Code of Practice relating to seclusion.	Action completed.	31/07/2016	12/07/2016	Seclusion guidance.	Evidence uploaded.
4	The Trust must ensure there are sufficient and appropriately qualified staff at all times to provide care to meet patients' needs.	Ian Jerams – Director of Operations	Divisional Managers/ Associate Director of HR	**Action 4 cross references with actions 17; 18; 26; 27; 35; 36; 43;44; 56; 63; 71 & 72** 4.1 Immediate review of current inpatient safe staffing levels and assurance that wards have sufficient WTE to meet these.	Complete – all services are monitored and compliant with safe staffing levels. Additional staff deployed as needs arise.	31/05/2016	30/04/2016	Confirmation from Divisional Managers.	Progress update within this action plan.
				4.2 Review of community mental health team staffing for safety assurance.	Immediate workforce review carried out to assure safe staffing levels.	30/06/2016	30/04/2016	Confirmation from Divisional Manager – Community Services.	Progress update within this action plan.

Trust Wide Issues:

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
				4.3 Review of community mental health team staffing levels in the context of the transformational service model and the consequent changing demands on the workforce.	• Pathways are on target for being completed by the end of September 2016. • An interim review has taken place to ensure current staff levels are safe and provided by appropriately qualitied staff. Therefore the action is complete, however in the longer term, the ongoing CMHT transformation programme will make recommendations about staffing but to ensure the correct levels of staff and service user engagement, and this will not be complete before Aril 2017.	30/09/2016	15/09/2017	Copy of new service model.	
				4.4 The Trust to develop a recruitment protocol to ensure minimum number of vacancies is held at any time.	Recruitment and Retention Working Group has commenced. Recruitment protocol to be developed within 6 months; completion date reviewed from 30/06/2016 to 31/12/2016.	31/12/2016		Copy of recruitment protocol.	
				4.5 To review current processes for providing bank and agency staff for short notice staffing shortfalls.	Bank Staffing Unit in place since December 2015. Processes in place and reviewed for bank and agency staffing, and protocols exist for the management of shifts being sent for agency cover, however severe limited supply of registered nursing staff in Lincolnshire has an impact on fill rates for both bank & agency.	30/07/2016	31/05/2016	Copy of protocols.	Evidence uploaded.
5	The Trust must ensure that all risk assessments and care plans are updated consistently in line with changes to patients' needs or risks.	Anne-Maria Olphert – Director of Nursing & Quality	Steve Lidbetter – Deputy Director of Informatics/ Divisional Quality Assurance Leads	**Action 5 cross references with actions 13.6; 37; 49; 53; 68 & 76** 5.1 The Trust will review current CPA and record audit action plans and where actions have not been completed, escalate to service managers.	Assessment & Care Planning Audit • Outstanding actions and common themes have been aggregated into a single list to inform a business case for a trust-wide records/clinical audit (Liz Bainbridge). • Regular CPA/assessment & care planning audits continue as part of site governance/mock CQC visits and audit programme – plan for quarterly divisional report in conjunction with safeguarding/records which will include divisional audits. • In future action plans that have not been received back with confirmation of completion will be resent to service managers.	31/07/2016	07/07/2016	Copy of audits/common themes	Evidence uploaded.
				5.2 A simple guidance on care plan and risk assessment completion to be developed to include samples of good quality plans and to be shared with all clinical staff; this will reflect the need for care planning to be increasingly patient/service user centre, and led.	Risk Assessments • Examples of good practice have been developed by the Risk Champions Forum, and put in a folder on Sharon to be available to service areas. This was set up on 7th July and range of templates will be added. This will be further added to over time and will be publicised once care planning handbook is available to add. Care Plans • Trust has purchased a licence for the CCA Writing Good Care Plans handbook which will be made available to staff via Sharon. • Building on some current examples of good quality care planning, will create a library on Sharon of care planning examples. • Folder set up on 7th July & range of templates added. Will be added over time and will be publicised once care planning handbook is available.	31/07/2016	07/07/2016	Link to folders on Sharon. Risk Champion Forum notes.	Evidence uploaded.

Trust Wide Issues:

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
				5.3 During supervision of all clinicians, 3 randomly selected patient records to be quality checked and findings documented in supervision notes.	Discussed at Divisional Management/Quality Forums and all managers reminded to communication this to all teams.	30/06/2016	27/06/2016	Copy of DMT Meetings/Quality Forums where this was discussed.	Evidence uploaded.
				5.4 Where clinicians are identified as having poor quality care plans and risk assessments appropriate support will be identified by managers.	Discussed at Divisional Management/Quality Forums and all managers reminded to communication this to all teams.	30/06/2016	27/06/2016	Copy of DMT meetings/quality forums where this was discussed.	Evidence uploaded.
				5.5 Service Managers to undertake an audit in 6 months.		31/12/2016		Copy of audit results.	
6	Trust systems must be effective for the management of medications.	Sue Elcock – Medical Director	Joan Spencer - Head of Pharmacy	**Action 6 cross references with actions 25 & 83** 6.1 Issue briefings to Trust medical staff and managers of their obligations under Trust medication management policy.	• Discussed at Divisional Management/Quality Forums. • Reiterated through an email to Doctors from the Medical Director.	30/06/2016	27/06/2016	Email from Medical Director.	Evidence uploaded.
				6.2 Carry out an immediate assurance audit of all Trust medication storage areas.	• Safe and secure handling of medicines audit complete and action plan developed. • Two ward areas identified for additional Pharmacy support. • Trust-wide temperature monitoring – additional monitoring implemented due to summer month temperatures. Potential to move incubators to ensure appropriate storage. • Rapid tranquilisation training update for new policy. • Re-audit of action plan scheduled for September/October 20016.	30/06/2016	14/07/2016	Copy of medication audit/action plan. Copy of rapid tranquilisation training.	Evidence uploaded.
				6.3 Trusts Quality Governance visits to include assurance checks on standards of prescribing and storage of medication.	Complete, this will take place on all future visits.	31/05/2016	30/04/2016	Copy of updated templates.	Evidence uploaded.
7	The Trust must ensure that there are no significant delays in treatment and that access is facilitated to psychological therapy in a timely way.	Ian Jerams – Director of Operations	Rob Harvey – Divisional Manager	**Action 7 cross references with action 26** 7.1 To develop a recovery plan to address current waits for psychological therapies.	Waiting list recovery plan for psychological therapies approved by Trust Board on 30 April 2016.	30/04/2016	30/04/2016	Copy of recovery plan.	Evidence uploaded.
				7.2 To develop trajectories for reducing waiting times for psychological therapy services to acceptable levels.	Waiting list recovery plan for psychological therapies approved by Trust Board on 30 April 2016, including a trajectory to eradicate historical waits within 12 months.	30/04/2016	30/04/2016	Copy of recovery plan.	Evidence uploaded.
				7.3 Roll out of plan to reduce psychological waits.	The project is underway; recruitment action has been taken to fill new Psychology and CBT posts.	30/09/2017		Staff in post. Evidence of reducing waiting times.	
8	The Trust must ensure that food meets the standard required by patients.	Ian Jerams – Director of Operations	Divisional Managers for inpatient services	**Action 8 cross references with actions 20; 24 & 39** 8.1 The Trust will review its current arrangement for providing lighter foods at one meal time (e.g. salads and sandwiches) – and ensure compliance with document 'Hospital Food Standards'.	• This is being looked at by the divisions to ensure any changes are locally relevant. • Discussed at Specialist Services DMT on Fri 17th June. Specialist Services representative from Ash Villa on Group. • Discussed at inpatient division quality meeting in July and July DMT. This subject is a standard agenda item on all adult inpatient local team meetings.	30/09/2016	05/09/2016	Notes of DMT meeting (17/6/2016) Copy of Adult Inpatient quality and DMT notes (July meetings).	Evidence uploaded.

Trust Wide Issues:

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response		Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
				8.2	All wards to include discussions in regard to menus at patient meetings.	All wards are now aware of the importance of including patients in menu planning discussions and this will continue to be reinforced and monitored through the quality governance visits. As a result of this, specifically: • Healthy snacks available between meals on Ash Villa. • Suppliers of cook chill food are being invited in to do menu planning with patients in the rehabilitation services. • This is now a standing agenda item at Adult Inpatient DMT.	31/07/2016	31/07/2016	Reports of quality governance visits. Adult division DMT agenda/notes.	Evidence uploaded.
				8.3	PLACE assessment comments relating to standard of food provision to be reported and actioned via the Operational Governance meeting.	To be included as a standing agenda item.	30/06/2016	27/06/2016	Copy of operational governance meeting agenda.	Evidence uploaded.
				8.4	Contract for food provision is being reviewed over the coming 12 months.	Still to commence but the Trust is to consider cook freeze instead of cook chill as part of the new tender. This will give more options but will require investment for freezers.	30/04/2017		Outcome of Trust-wide review of food provision.	
9	The Trust must ensure that there are systems in place to monitor quality and performance and that governance processes lead to required and sustained improvement.	Jane Marshall – Director of Strategy and Performance	Chris Higgins – Deputy Director of Strategy & Business Planning/ Divisional Managers	9.1	The divisional accountability reviews to be used to challenge and monitor under performance and concerns around quality.	Complete. Divisional accountability reviews held quarterly for each division.	30/04/2016	03/05/2016	Copy of minutes for each divisional review.	Evidence uploaded.
				9.2	The Trust to develop integrated performance reports for each operational division.	A Trust project has been commissioned to build unique integrated performance reports for each division.	31/12/2016		Copy of divisional integrated performance reports.	
10	The Trust must ensure that learning and improvements to practice are made following incidents.	Anne-Maria Olphert – Director of Nursing and Quality	Mark Halsall – Head of Quality	10.1	The Trust will develop a continuous quality improvement plan at a divisional and Trust level, pulling together learning from all incidents with assurance of learning evidenced.	• The Trust has employed a fixed term lead to develop the continuous quality improvement plan. • A database is being developed but due to some interface issues with SharePoint, completion has been delayed resulting in a revised date of 30/10/2016. • There are a number of organisational issues to be agreed prior to implementation and these are to be discussed at a time out on the 19/09/2016.	30/10/2016		Copy of the continuous quality improvement plan.	
				10.2	The Trust will continue to produce and promote a bimonthly lessons learnt bulletin.	Complete, this is an ongoing process.	30/04/2016	30/04/2016	Copy of bimonthly lessons learnt bulletins.	Evidence uploaded.

Trust Wide Issues:

Action no.	Should do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
11	The Trust should review its procedures for maintaining records, storage and accessibility.	Karen Berry – Director of Finance & Information	Steve Lidbetter – Deputy Director of Informatics	11.1 The Trust will review the current policies and ensure they are fit for purpose.	• Records Management Policy revised and approved at IM&T 09/02/2016 • Records Management Strategy revised and approved at IM&T 10/5/16	30/07/2016	07/07/2016	Copies of records management policy & strategy.	Evidence uploaded.
				11.2 Mental Health Act paperwork will be stored in a centralised location.	Clinical teams scan MHA documents into Silverlink and then return original documents to MHA Admin team at Trust HQ.	31/05/2016	30/04/2016	Documentation stored on Silverlink and centrally by MHA Admin Team.	Evidence uploaded.
				11.3 Through the annual records audit process; areas/ individuals who are consistently not following policy will be addressed through supervision processes.	• Managers are being reminded about this through the Divisional Management Team meetings. • Specific issues noted in audit are raised with the manager responsible or for more serious issues a Datix incident is completed for investigation.	31/07/2016	07/07/2016	Copy of DMT meeting notes. Copy of summarised DATIX report for quarter 1 and quarter 2 to be run in November 2016.	DMT notes uploaded.
12	The Trust should ensure all staff including bank and agency staff have completed statutory, mandatory and where relevant specialist training, and are supervised.	Anne-Maria Olphert - Director of Nursing & Quality	Tony Kavanagh – Associate Director of HR & Leadership/ Divisional Managers	**Action 12 cross references with actions 17; 18; 22 & 24** 12.1 All clinical areas to refresh their training needs analysis and ensure they have a sufficient number of staff with the correct skills and, where there are deficits, ensure training is provided.	An audit currently been commissioned through internal audit to review training processes. Terms of reference agreed in July 2016; a draft report to be available by the end of September.	30/09/2016		Copy of internal audit. Copy of service TNA.	Terms of reference uploaded.
				12.2 Mandatory training programme to be reviewed to ensure there are sufficient places for all.	Sufficient places are provided on an annual basis; however there are significant numbers of places unfilled or staff withdrawn at short notice. Where possible as much mandatory training has been moved to e-learning platform so this can be undertaken flexibly.	31/07/2016	30/04/2016	Copy of mandatory programme for 2016 and number of places available.	Induction & Mandatory training block 2016/17 uploaded.
				12.3 Trust supervision policy to be refreshed to ensure mandatory training is included as a standing and recorded item and any non-compliance addressed.	Policy has been updated and managers are promoted to do this through divisional management team meetings.	30/07/2016	10/08/2016	Link to refreshed supervision policy.	Evidence uploaded.

Trust Wide Issues:									
Action no.	**Should do's**	**Accountabilities**	**Responsible person**	**Trust actions/response**	**Progress update**	**Date to be completed by**	**Date completed**	**Type of assurance required**	**Evidence received**
				12.4 BSU to maintain register of all non LPFT bank staff to show mandatory training compliance.	BSU maintains mandatory training records for all bank staff and will only place bank staff in areas where the individual has the required compliances or informs the area that an individual does not have the full mandatory compliances and asks if they are in agreement that the individual can take the shift. The individual cannot self-book if they do not meet the required competencies. For agency staff – all agencies currently supplying staff in Lincolnshire are required to inform the BSU of the staff name and their compliance levels against the Trust Mandatory Training framework.	30/07/2016	30/06/2016	Copy of BSU protocol.	Evidence uploaded.
				12.5 Data quality issues within reports to be addressed.	Issues regarding compliance levels for staff who are on maternity and long term sickness are currently in place.	31/07/2016	30/06/2016	Copy of Operational Governance Meeting notes.	Evidence uploaded.

Adult Mental Health Inpatient Services:

Adult Acute Inpatient Wards

Action no.	Must Do's	Accountabilities	Responsible Person	Trust Actions/Response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
13	**Safe care and treatment:** **Ligature points:** Ensure all Wards and courtyard areas are fully managed or mitigated	Ian Jerams – Director of Operations	Geoff Badger – Associate Director of Estates & Facilities/ Chris Ashwell - Divisional Managers	**Action 13 cross references with action 1 – Trust-wide issues** 13.1 Ward 12: Resolve siting of anti-ligature wardrobes.	• Ward 12: Wardrobes need to be against the wall, not partition, to ensure they are anti-ligature. • Meeting on site 12 May 2016 and various options were discussed. Insufficient space to place wardrobes against the walls and forming partitions would severely reduce the space and impede observation. Risk to be managed locally, no further action taken.	13/05/2016	12/05/2016	Copy of local protocols	Evidence uploaded.
				13.2 Ward 12: To install anti-ligature hand rails on stairs and in garden.	Installation completed on 20 May 2016.	06/05/2016	20/05/2016	Photograph of handrail.	Evidence uploaded.
					Garden works installation completed.	20/05/2016	19/05/2016	Photograph of garden.	Evidence uploaded.
				13.3 Ward 12: Sanitary fittings in dormitory areas to be replaced.	Basins to be replaced.	31/07/2016	17/07/2016	Photograph of basin.	Evidence uploaded.
				13.4 Charlesworth seclusion room door handle to be replaced.	Complete: the handle was replaced on the 02/12/2015.	02/12/2015	02/12/2015	Photograph of door handle.	Evidence uploaded.
	All ligature risks, including outdoor spaces must be identified on ward ligature risk audits, local management plans and risk assessments and regularly reviewed and updated.	Ian Jerams – Director of Operations	Zoe Rowe – Associate Director of Nursing & Quality	13.5 Review all ligature audits, to include outdoor spaces.	All wards have redone ligature assessments ensuring outside spaces have been included.	30/04/2016	30/04/2016	Copy of reviewed and updated ligature audits.	Evidence uploaded.
					Cross reference with action 14.1 Leads from operational services have agreed to conduct a full review within their areas and report finding to Associate Director of Estates & Facilities; completion date for action revised to end of August 2016.	31/08/2016	31/08/2016	Copy of reviews.	Evidence will be uploaded week commencing 26/09/2016.
					Maple Lodge bathrooms and bedrooms capital works are currently out to tender with an expected start on site date of December 2016. Patients are risk assessed and any risk included within care plan. Patients are only admitted who are not deemed as being high risk of ligation.	31/01/2017		Confirmation work has been completed.	
					Work is ongoing to review the use of Ashley House and therefore no plans are currently in place to change the unit. Patients are risk assessed and any risk included within care plan. Patients are only admitted who are not deemed as being high risk of ligation.	31/10/2016		Outcome of review.	
				13.6 Review risk assessments of patients in respect of ligature risks.	• Individual patient risk assessments to identify ways ligatures will be managed if it is not possible to remove them. This will be shared with Managers via Divisional Management Team meetings. • All ward managers in the adult inpatient division are aware of this and all patients being nursed in areas where there are ligatures have individual care plans and risk assessments.	31/07/2016	12/07/2016	Copy of sample risk assessments. – Anita Lewin to provide.	Evidence uploaded

Adult Mental Health Inpatient Services:

Adult Acute Inpatient Wards

Action no.	Must Do's	Accountabilities	Responsible Person	Trust Actions/Response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
				Cross references with action 1 – Trust-wide issues 13.7 Quality review of current audits and action plans to be completed and those requiring improvement to have responsible managers informed and supported to reassess and plan.	Quality & Safety Team have completed a schedule of inspections to improve related quality governance and have prioritised units identified with issues by CQC – namely Maple Lodge, Ash Villa and Ashley House. These have been completed with Ward/Unit Managers.	30/07/2016	05/07/2016	Copy of schedule of inspections completed – Mark Halsall to provide.	Copy of forward plan uploaded
				Cross references with action 1 – Trust-wide issues 13.8 On-going programme of ligature audits conducted by clinical staff throughout 2016/17 to be monitored by Quality & Safety Team Leader.	New ligature audits have jointly been undertaken by ward managers and quality and safety team leader. Areas completed are PHC, Ward 12 and Maple Lodge.	30/06/2016	27/06/2016	Copy of completed ligature audits - Mark Halsall to provide.	Evidence uploaded.
14	**Courtyards – uneven floor surfaces:** All external floor surfaces must be free from trips and falls hazards.	Ian Jerams – Director of Operations	Geoff Badger – Associate Director of Estates & Facilities	14.1 Review all external patient areas and put right any trip hazards.	• CN1 completed for PHC smoking area in November 2015; design agreed by all parties involved. • Design agreed and costed and currently out to tender; completion date revised to 30/11/2016.	30/11/2016		Confirmation work is complete.	
					Cross reference with action 13.5 Nominated person from Estates services to conduct audit of all outdoor courtyard areas across the trust and report findings; completion date revised to 30/09/2016.	30/09/2016		Copy of completed review.	
				14.2 Develop plans to rectify issues raised.	Not to be put in place until action 14.1 is complete.	31/10/2016			
15	**Courtyards – observations:** All external areas must be able to be observed by staff so staff can immediately respond if needed.	Ian Jerams – Director of Operations	Geoff Badger – Associate Director of Estates & Facilities	15.1 Review all courtyards and ensure there is good observation available.	Courtyards have been reviewed, in particular at PHC: CCTV and intercom in place and staff report this to be working well.	28/01/2016	28/01/2016	Photograph of CCTV camera.	Evidence uploaded.
					Although not identified on CQC inspection, same CCTV risk exists on Pilgrim site for Ward 12; CN1 submitted to address this. Associate Director of Estates & Facilities to chase progress against the CN1 submitted. Completion date revised to 31/08/2016.	31/08/2016	31/08/2016	Photograph of CCTV camera.	Evidence uploaded.

Adult Mental Health Inpatient Services:

Adult Acute Inpatient Wards

Action no.	Must Do's	Accountabilities	Responsible Person	Trust Actions/Response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
16	**Seclusion facilities:** All seclusion facilities must provide a safe and appropriate environment.	Ian Jerams – Director of Operations	Anita Lewin Quality and Assurance Lead	**Cross references with action 3 – Trust-wide issues** 16.1 The duration of any period of supervised confinement to be monitored and previous incidents similarly reviewed.	• The duration of seclusion is currently only recorded manually, and this data has been collated. • A seclusion audit has been undertaken by the divisional quality lead.	30/05/2016 30/05/2016	30/05/2016	Supervised confinement audit.	Evidence uploaded.
				16.2 Charlesworth ward seclusion suite (privacy concern): Ensure that staff are aware to maintain patient privacy when in use.	• All staff briefed by Ward Manager. • Curtains have been put on observation windows as an interim measure and blinds have been ordered.	29/04/2016	29/04/2016	Photograph of privacy measures – visit to unit by Compliance Officer (07/09/2016).	Evidence uploaded.
				16.3 Urgent works required to Ward 12: Seclusion suite to ensure access to safe shower/toilet.	Complete.	31/05/2016	20/04/2016	Confirmation from Quality & Assurance Lead.	Progress update within this action plan.
17	**Staffing:** Staff must receive regular supervision and appraisal in line with Trust policy, allowing staff the opportunity for raising ongoing professional development; and for identification of performance issues.	Chris Ashwell – Divisional Manager	Anita Lewin – Quality Assurance Lead	17.1 Mandatory training and appraisal rates will be monitored monthly at the divisional management team meeting.	This is now monitored at the Divisional Management Team meeting. There has been a measurable improvement in the ward areas that were of particular concern during the CQC visit.	30/06/2016	30/04/2016	Copy of DMT meeting notes required.	Evidence uploaded.
				17.2 Review and implementation of supervision, both clinical and managerial, will be addressed as part of the divisional quality programme for 2016/17.	• Review commenced and discussed at DMT; full implementation of both clinical and managerial supervision will take longer than the original timescale of 30/06/2016; revised completion date 30/09/2016. • All areas have implemented local plans for clinical supervision. These include group supervision being led by the nurse consultant, discussion of clinical cases following managerial supervision and staff being given details of how to access their own clinical supervisor. • Detailed discussion took place at the July adult inpatient divisional quality meeting. A full audit will be undertaken of the frequency and quality of management supervision throughout August/September 2016. • All ward managers are discussing clinical supervision in team meetings to ensure staffs are aware that they can access this. Some wards have implemented team clinical supervision.	30/09/2016		Copy of audit.	
				17.3 Division to develop a monthly report for discussion at the divisional management team (DMT) meetings.	This is now included as a standing agenda item at DMT.	30/04/2016	30/04/2016	Copy of DMT meeting notes.	Evidence uploaded.

Adult Acute Inpatient Wards

Action no.	Must Do's	Accountabilities	Responsible Person	Trust Actions/Response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
		Anne-Maria Olphert – Director of Nursing & Quality	David Knight – Head of Workforce & Development	**Cross references with actions 36.3 & 44.5** 17.4 Implement a system of centralised recording of supervision dates and times via ESR.	• Management supervision recording pilot on health roster carried out in June/July across a range of clinical and corporate services. Clinical Supervision to be recorded and audited through clinical systems (predominantly Silverlink). • Implementation of centralised system for recording of supervision will commence in January 2017. In the meantime managers are being given an opportunity to use the system on a voluntary basis to get used to the system. Reports to be run from 2017. In view of this, completion date has been revised.	31/01/2017			Email with Healthroster guidance uploaded.
18	**Staffing:** All staff must receive mandatory training in line with Trust targets to enable them to be appropriately trained for their role.	Chris Ashwell – Divisional Manager	Anita Lewin – Quality Assurance Lead	18.1 Monitoring will be put in place to ensure compliance.	Monitoring is in place via DMT and is a standard agenda item.	31/07/2016	27/06/2016	Copy of DMT meeting notes.	Evidence uploaded.
				18.2 Additional MCA training to be made available.	• Additional MCA training has been made available.	31/07/2016	26/05/2016	Copy of MCA training dates.	Evidence uploaded.
19	**Good governance:** Wards to ensure that changes are made and embedded to ward protocols following lessons learned.	Chris Ashwell – Divisional Manager	Anita Lewin – Quality Assurance Lead	19.1 Division to develop processes and protocols to ensure learning from serious incidents and any other concerns.	• Division now has a quality governance meeting where all serious incidents and all other issues of concern are discussed. • All acute ward protocols were reviewed on 16/04/16 and common protocols agreed. This process to be replicated for rehab inpatient services. • This work has also been completed for the rehabilitation wards.	30/06/2016	27/06/2016	Notes of quality governance meetings Copy of new ward protocols .	Evidence uploaded.
				19.2 Local learning lessons bulletin in format of Trust wide version to be implemented by June 2016.	This has been developed and will be shared bi-monthly.	30/06/2016	19/05/2016	Copy of bulletins.	Evidence uploaded
20	**Meeting nutritional and hydration needs:** As a standard procedure, ensure patients are involved in menu planning, including their preference for serving of hot meals; to ensure patients' dietary preferences are met, wherever possible and they receive food of a sufficient standard.	Ian Jerams – Director of Operations	Geoff Badger - Associate Director of Estates & Facilities	**Cross reference with action 8 - Trust-wide issues** **Adult acute inpatient specific** 20.1 Ensure that patients are involved in any decisions in regard to menu planning and choice.	• Regular meetings, which are in most cases weekly, are held on the units involving unit staff, facilities staff and patients. Meetings are documented and include open discussions on menu variations including healthy options. • All final decisions about food on wards will be made by the Divisional Nutrition Group, led by Modern Matron and comprising representatives from clinical services, with patient input.	31/07/2016	28/07/2016	Copies of ward meeting notes required. Copies of Divisional Nutrition Group notes.	Evidence uploaded.

Adult Mental Health Inpatient Services:

Forensic Unit (Francis Willis Unit)

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
21	**Safe care and treatment:** Unit and courtyard areas must have a ligature risk assessment identifying all risks; and have local management protocols in place.	Ian Jerams – Director of Operations	Geoff Badger – Associate Director of Estates & Facilities	**Action 21 cross references with action 1 – Trust-wide issues** 21.1 Quality review of current audits and action plans to be completed and those requiring improvement to have responsible managers informed and supported to reassess and plan.	Completed.	30/04/2016	30/04/2016	Copies of audits/actions plans required.	Link to report on Sharon uploaded
				21.2 On-going programme of ligature audits conducted by clinical staff throughout 2016/17 to be monitored by Quality & Safety Team Leader.	FWU will be part of the schedule of ligature audits planned for 2016/17. Date of audit to be confirmed.	31/03/2017		Copy of audit/action plan.	
Action no.	**Should Do's**	**Accountabilities**	**Responsible person**	**Trust Actions/Response**	**Progress update**	**Date to be completed by**	**Date completed**	**Type of assurance required**	**Evidence received**
22	All staff should receive mandatory training in line with Trust policy to enable them to be appropriately trained for their role.	Chris Ashwell – Divisional Manager	Anita Lewin – Quality & Assurance Lead	22.1 Mandatory training and appraisal rates will be monitored monthly at the divisional management team meeting. This will be added as a standing agenda item.	This is now included as a standing agenda item.	30/06/2016	30/04/2016	Copy of DMT agenda – Anita Lewin to provide	Evidence uploaded.
23	Develop systems for ensuring that all emergency equipment is in date and maintained.	Chris Ashwell – Divisional Manager	Jos White – Ward Manager	23.1 Take action to address specific issues raised at time of inspection.	Issues identified at inspection addressed immediately during inspection week.	04/12/2015	04/12/2015	Verbal assurance received from Adult Divisional Manager	Progress update within this action plan.
				23.2 Develop a system for monitoring all emergency and medical equipment has had annual service/maintenance.	• Annual service checks are in place. • Wards review their grab bags daily to ensure they are complete and working correctly.	30/06/2016	30/04/2016	Copy of recording sheet for grab bag.	Evidence uploaded.
	Review the provision and quality of food to patients: As a standard procedure, ensure patients are involved in menu planning, including their preference for serving of hot meals; to ensure patients' dietary preferences are met, wherever possible and they receive food of a sufficient standard.	Ian Jerams – Director of Operations	Chris Ashwell – Divisional Manager	**Action 24 cross references with action 8 – Trust-wide issues FWU specific** 24.1 Ensure that patients are involved in any decisions in regard to menu planning and choice.	• Regular meetings are held on the unit involving unit staff, facilities staff and patients. Meetings are documented and include open discussions on menu variations including healthy options. • All final decisions about food on ward will be made by the Divisional Nutrition Group, led by Modern Matron and comprising representatives from Clinical services, with patient input.	30/06/2016	30/04/2016	Copies of FWU Ward meetings.	Evidence uploaded.
				24.2 Review current meal choices at FWU.	• The Trust is to consider cook freeze instead of cook chill as part of the new tender. This will give more options but will require investment for freezers.	31/04/2017			

Adult Mental Health Inpatient Services:

Crisis Services & Health Based Places of Safety

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response		Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
25	**Safe care and treatment:** Ensure that the identified safety concerns in the current HBPoS are addressed in the new unit being built, including: • Appropriate number of doors • Lines of sight • Medications storage • Weighted furniture	Ian Jerams – Director of Operations	Geoff Badger – Associate Director of Estates & Facilities	25.1	Replace the Section 136 suite with a facility which addresses the identified concerns.	• All issues identified in the HBPOS have been rectified with the new build. • The new 136 suite is now fully functioning.	01/04/2016	01/04/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
26	**Staffing:** Undertake a review of staffing to ensure all crisis teams include or have access to the full range of mental health professional backgrounds, including: • occupational therapists • psychologists • social workers	Ian Jerams – Director of Operations	Chris Ashwell – Divisional Manager	26.1	Review level of vacancies and cover arrangements.	Meeting held to identify % of vacant posts. In the interim, redeployment of staff across division and use of agency to augment staffing. This remains an issue but plans have been put in place to continually monitor this.	01/04/2016	01/04/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
				26.2	Future staffing plans and opportunities through turnover to address any identified skill mix shortfalls.	Workforce plans to include, wherever possible, staff with varying professional skills.	01/04/2016	01/04/2016	Confirmation received from Divisional Manager.	Progress update within this action plan.
				26.3	Ensure that the full range of mental health professionals is available from the community mental health services.	• Agreed in principle between Divisional Managers. • When advertising posts consideration is now given to the range of skills required. • Any skill mixing is being referenced to best practice guidance such as AIMS.	01/04/2016	01/04/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
27	**Staffing:** Ensure that rapid access to a psychiatrist is always available to all teams when required in a mental health crisis.	Sue Elcock – Medical Director	Chris Ashwell – Divisional Manager	27.1	Ensure that any vacancies or absences of medical staffing are addressed.	Consultant is now in post in Lincoln Crisis team which was the identified area of concern.	31/01/2016	31/01/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
Action no.	**Should do's**	**Accountabilities**	**Responsible person**	**Trust actions/response**		**Progress update**	**Date to be completed by**	**Date completed**	**Type of assurance required**	**Evidence received**
28	Review policies, procedure and practice on the use of S.136 to ensure adherence to the MHA Code of Practice.	Chris Ashwell – Divisional Manager	Helen Norris – Legal Services Manager	28.1	All staff will be reminded of the Code of Practice relating to detention under section 136 of the Mental Health Act.	The AMHP lead has provided confirmation of the 136 guidance which has been forwarded to all qualified staff who work in the section 136 suite.	31/07/2016	27/06/2016	Copy of guidance issued to staff.	Evidence uploaded.
				28.1	MHA Manager to review policy.	Operational protocol is reviewed annually by the S.136 Operational Group which. The protocol does not form part of the MHA policy The local protocol is used by EMAS, LPFT and Lincs Police. Quality Lead meets monthly with the police to discuss processes, issues and improve communication between the two organisations.	31/07/2016	29/07/2016	Copy of operational protocol – Anita Lewin to provide.	Evidence uploaded.
29	Ensure that medicines are stored at the correct temperature.	Chris Ashwell – Divisional Manager	Joan Spencer – Head of Pharmacy	29.1	Purchase a new medication storage cupboard.	New cupboard has now been purchased and sited in Ward 12 clinic room.	30/04/2016	30/04/2016	Confirmation has been received from Quality & Assurance Lead.	Progress update within this action plan.

Adult Mental Health Inpatient Services:

Crisis Services & Health Based Places of Safety

Action no.	Should do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
30	Ensure that people using crisis services are able to move on to other mental health services when appropriate.	Ian Jerams – Director of Operations	Rob Harvey, Divisional Manager	30.1 Transition to community mental health services to be prioritised for patients who have been in receipt of crisis services.	• CRHT are working closely with the community division leadership team to address the matter, within the transformational redesign of the community mental health services. • Divisional Manager of community services has confirmed that inpatients will be prioritised for Care Coordinator allocation.	31/08/2016	27/06/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
31	Review the need for a mental health crisis helpline.	Ian Jerams – Director of Operations	Chris Ashwell – Divisional Manager	31.1 To raise the need for a crisis helpline again with commissioners and through the Crisis Care Concordat.	The crisis teams continue to provide 24/7 helpline support when available. This was discussed and Commissioners have confirmed that funding will not be allocated, therefore the action is closed.	30/06/2016	27/06/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
				31.2 Carry out a time and motion study to identify volume and nature of crisis calls.	The crisis service commenced this work on the 23/05/16. The data collection for this work has commenced; data analysis is now taking place.	30/06/2016	07/07/2016	Data analysis report.	Evidence uploaded.
				31.3 Look at areas of good practice in other Trusts.	• Visit undertaken to Northumberland Tyne and Wear. • Teleconferences held with Birmingham and Bradford mental health trusts. • Visit has taken place to Birmingham.	30/06/2016	25/05/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
32	Review lone working protocols in the crisis resolution teams to ensure risks to staff are minimised.	Chris Ashwell – Divisional Manager	Anita Lewin – Quality Assurance Lead	32.1 A review of lone working procedures across the four crisis teams will take place to ensure adherence to Trust standards.	• Reviewed as part of the time and motion study that began on 23/05/2016. • Wherever possible appointments are carried out at base.	30/06/2016	27/06/2016	Copy of lone working protocol required.	Evidence uploaded.

Adult Mental Health Inpatient Services:

Inpatient Rehabilitation Wards

Action no.	Must do's	Accountabilities	Responsible person	Trust Actions/Response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
33	**Safe care and treatment:** All ligature risks must be identified on the ligature risk audit and local management protocols in place to ensure all that is reasonably practicable is being done to mitigate such risks.	Ian Jerams – Director of Operations	Chris Ashwell – Divisional Manager	**Action 33 cross references with action 1 – Trust-wide issues** 33.1 Quality review of current audits and action plans to be completed and those requiring improvement to have responsible managers informed and supported to reassess and plan. This includes any actions required.	Director of Operations has led work on review of all anti-ligature processes (action 1.1 above).	31/05/2016	30/04/2016	Meetings notes copies of emails required.	Evidence as per action 1.1.
					Detailed ligature audits have been completed for these areas.	30/06/2016	27/06/2016	Copy of audits completed.	Evidence uploaded.
					• Maple Lodge: Some replacement work completed on ligature points internally. Some more to do (curtain rails in communal areas/cabinet handles) and this will be expedited. • Curtain rails on Maple Lodge replaced. • Additional ligature work identified in rehab areas have been completed.	31/07/2016	31/07/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
					• Maple Lodge bathrooms and bedrooms capital works are currently out to tender with an expected start on site date of December 2016. • Patients are risk assessed and any risk included within care plan. Patients are only admitted who are not deemed as being high risk of ligation.	31/01/2017		Confirmation work has been completed.	
					• Work is ongoing to review the use of Ashley House and therefore no plans are currently in place to change the unit. • Patients are risk assessed and any risk included within care plan. Patients are only admitted who are not deemed as being high risk of ligation.	31/10/2016		Outcome of review.	
					Bedroom door handles on wards at Discovery House identified as ligature risk. These handles are used across the Trust and considered as anti-ligature standard. This was discussed at task and finish group chaired by Director of Operations and it was confirmed these are an acceptable fitting and will remain in situ.	29/04/2016	06/05/2016	Door handles identified as anti-ligature.	Progress update within this action plan.
34	**Safe care and treatment:** Ensure compliance with the Department of Health guidance in relation to mixed sex accommodation at both Ashley House and Maple Lodge.	Anne-Maria Olphert – Director of Nursing and Quality	Chris Ashwell – Divisional Manager	**Actions 34 cross references with action 2 – Trust-wide issues** 34.1 **Maple Lodge and Ashley House** Ensure risk assessment is carried out prior to allocating patients a bedroom.	This information is included within each care plan for the patient.	31/07/2016	12/07/2016	Confirmation provided by Quality & Assurance Lead.	Progress update within this action plan.
				34.2 Fit electronic locks between male and female bedrooms on Ashley House.	Door between male/female bedrooms provided with electronic lock, with females only having a key.	31/03/2016	31/03/2016	Photograph of electronic lock.	Evidence uploaded.
				34.3 Make DDA bedrooms and bathrooms on ground floor at Ashley House single sex.	The two DDA bedrooms and bathrooms on ground floor now only used as single sex.	31/07/2016	30/04/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
				34.4 Male and female bathrooms to be allocated at Maple Lodge, with clear signage on doors.	Bathrooms allocated as single sex and signage in place.	31/05/2016	16/05/2016	Photograph of signage.	Evidence uploaded.
35	**Staffing:** Review staffing levels to ensure that there are sufficient staff to safely manage the service including access to: • Occupational therapists • Psychological input	Anne-Maria Olphert – Director of Nursing and Quality	Chris Ashwell – Divisional Manager	35.1 Review staffing levels to ensure safety standards are met.	Ward areas during the day are sufficiently staffed to meet safety standards and are compliant with agreed local standards. (See 35.4 for night shifts).	31/07/2016	30/04/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
				35.2 Ensure access to full range of mental health professions, including occupational therapy and psychology.	Rehab wards have access to psychology and OT. An option appraisal is being completed regarding psychology on the acute admission wards.	31/09/2016	07/09/2016	Confirmation from Adult Divisional Manager.	Evidence uploaded.

Adult Mental Health Inpatient Services:

Inpatient Rehabilitation Wards

Action no.	Must do's	Accountabilities	Responsible person	Trust Actions/Response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
				35.3 Open rehab to rewrite ward care pathways to be clear about requirement for OT and psychology provision.	• Care pathways are being developed by lead clinical psychologist.	31/09/2016		Copy of pathways upon completion.	
	Review night shift rotas to ensure sufficient staff on duty to safely manage the service in emergency situations.	Chris Ashwell – Divisional Manager	Anita Lewin – Quality Assurance Lead	35.4 Review night shift rotas and availability of support staff in respect of responding to emergency situations.	• Maple and Ashley are stand-alone units. There is a tension between being able to provide local units and centralising services on one site in the county to provide cross-cover arrangements and this is being reviewed. • In emergency situations additional cover can be sourced from the crisis teams and this is being written into their protocols.	31/07/2016	07/07/2016	Copy of protocols.	Evidence uploaded.
	Ensure sufficient medical input across the rehabilitation services.	Sue Elcock – Medical Director	Chris Ashwell – Divisional Manager	35.5 Address any temporary vacancies or absences in medical staffing across the rehabilitation services.	Medical staffing across the rehabilitation units has been addressed. Consultant psychiatrists are now in place for all of the units.	31/05/2016	30/04/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
36	**Staffing:** Clinical staff must receive regular supervision and appraisal in line with Trust policy, allowing staff the opportunity for raising ongoing professional development; and for identification of performance issues.	Chris Ashwell – Divisional Manager	Anita Lewin – Quality Assurance Lead	36.1 Supervision and appraisal rates will be monitored monthly at the divisional management team meeting.	These are now monitored at the DMT meeting. There has been a measurable improvement in the ward areas that were of particular concern during the CQC visit.	30/06/2016	30/04/2016	Copy of DMT meeting minutes – Anita Lewin to provide.	Evidence uploaded.
				36.2 Review and implementation of supervision, both clinical and managerial, will be addressed as part of the divisional quality programme for 2016/17.	Review commenced and discussed at DMT; full implementation of both clinical and managerial will take longer than the original timescale of 30/06/2016; revised completion date 30/09/2016.	30/09/2016		Copy of review required.	July DMT notes uploaded.
		Anne-Maria Olphert – Director of Nursing & Quality	David Knight – Head of Workforce & Development	**Cross references with 17.4 & 44.5** 36.3 Implement a system of centralised recording of supervision dates and times via ESR.	• A pilot exercise has commenced within the Boston Crisis Team. • Management supervision recording pilot on Health Roster to commence in June/July across a range of clinical and corporate services. Clinical Supervision to be recorded and audited through clinical systems (predominantly Silverlink). • Implementation of centralised system for recording of supervision will commence in January 2017. In the meantime managers are being given an opportunity to use the system on a voluntary basis to get used to the system. Reports to be run from 2017. In view of this, completion date has been revised.	31/01/2017		Centralised system for recording of supervision.	
37	**Safe care and treatment:** All multidisciplinary assessments must be completed prior to patients' admission to highlight risks. Clinical risk assessments must be completed and reviewed with appropriate plans in place to both identify and manage risk.	Chris Ashwell – Divisional Manager	Anita Lewin – Quality Assurance Lead	37.1 Maple Lodge to ensure that all multidisciplinary assessments are completed prior to admissions.	• Reinforced at staff meeting on 21/12/2015 where it was highlighted with the team that individual care plans are to be put place.	31/12/2015	31/12/2015	Sample of assessments – to be reviewed by Deputy Director of Operations/Compliance Manager (14/09/2016).	Following a review of risk assessments and wellbeing plans on the 14/09/2016, there is some further work to be done on the plans and this will be completed by the 30/09/2016.

Adult Mental Health Inpatient Services:

Inpatient Rehabilitation Wards

Action no.	Must do's	Accountabilities	Responsible person	Trust Actions/Response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
				37.2 Maple Lodge to complete and review clinical risk assessments.	• All risk assessments now include specific section on ligature risks and are reviewed regularly. • Staff are engaged and understand rationale for doing this; includes outside ligature risks. • New Ward Manager in post who has reinforced the need to complete and review clinical risk assessments.	30/04/2016	01/04/2016	Sample of risk assessment to be reviewed by Deputy Director of Operations/Compliance Manager (14/09/2016).	Following a review of risk assessments and wellbeing plans on the 14/09/2016, there is some further work to be done on the plans and this will be completed by the 30/09/2016.
38	**Good governance:** Wards must have de-briefs and review practice and process following all serious untoward incidents.	Chris Ashwell – Divisional Manager	Anita Lewin – Quality Assurance Lead	38.1 Ward Managers to be reminded to use the Trust de-brief system.	• Ward Managers have been reminded to use the Trust de-brief service. • In addition to Trust de-brief service the Divisional Quality Assurance Lead is available to provide team or individual debrief sessions at any time.	30/04/2016	01/04/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.
				38.2 The division to put in process to review practice following SI's.	The Division has a Quality Governance meeting; this reviews all serious incidents and ensures lessons are being learnt in practice.	30/04/2016	01/04/2016	Copy of quality governance meetings notes required.	Evidence uploaded.

Action no.	Should do's	Accountabilities	Responsible Person	Trust actions/response	Progress update	Date to be completed by	Dated Completed	Type of assurance required	Evidence received
	Meeting nutritional and hydration needs: As a standard procedure, ensure patients are involved in menu planning, including their preference for serving of hot meals; to ensure patients' dietary preferences are met, wherever possible and they receive food of a sufficient standard.	Chris Ashwell – Divisional Manager	Donna Bradford – Rehab Service Manager	**Action 39 cross references to action 8 – Trust-wide issues** **Rehab inpatient specific:** 39.1 Ensure that patients are involved in any decisions in Regard to menu planning and choice.	• Regular meetings are held on the units involving unit staff, facilities staff and patients. Meetings are documented and include open discussions on menu variations including healthy options. • All final decisions about food on wards will be made by the Divisional Nutrition Group, led by Modern Matron and comprising representatives from clinical services, with patient input.	31/07/2016	29/07/2016	Copies of units meeting notes. Copies of notes of Nutrition Group.	Nutrition Steering Group notes uploaded. Maple Lodge notes uploaded.
40	Evaluate the outcomes of the interventions used on the wards.	Chris Ashwell – Divisional Manager	Donna Bradford – Rehab Service Manager	40.1 Consider implementation of an appropriate outcome tool across all rehabilitation wards	• All rehabilitation wards have now fully implemented the recovery star. This is the outcome tool of choice of our commissioners.	30/08/2016	07/09/2016	Confirmation from Quality & Assurance Lead.	Progress update within this action plan.
41	Formalise pre-admission assessment process at Maple Lodge.	Chris Ashwell – Divisional Manager	Donna Bradford – Rehab Service Manager	41.1 Implement appropriate pre-admission process.	Ward Manager has embedded an assessment process that ensures all of the concerns that have been identified are addressed.	30/04/2016	30/04/2016	Copy of assessment process.	Evidence uploaded.
42	Review management provision at Maple Lodge.	Chris Ashwell – Divisional Manager	Donna Bradford – Rehab Service Manager	42.1 Appoint experienced Ward Manager.	Experienced Ward Manager now in post.	29/02/2016	31/03/2016	Confirmation received from Adult Divisional Manager.	Progress update within this action plan.

Adult Community Mental Health Services:

Adult CMHT's

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
43	**Staffing:** Review CMHT staffing levels to ensure teams operate at safe levels at all times.	Ian Jerams – Director of Operations	Rob Harvey - Divisional Manager	43.1 RAG rating tool to be re-established in teams. This is to be used to work with staff to assess capacity and ensure appropriate staffing levels are in place.	• Data request submitted to informatics. • Divisional Manager meeting staff on 20/06/2016 and RAG rating tool developed.	30/09/2016	11/08/2016	Copy of RAG rating tool.	Evidence uploaded.
				43.2 Review of community mental health team staffing for safety assurance.	Immediate workforce review carried out to assure safe staffing levels.	30/06/2016	30/04/2016	Confirmation received from Community Divisional Manager.	Progress update within this action plan.
44	**Staffing:** In line with Trust policy all staff employed must receive training, development, supervision and annual appraisal to support them to carry out the duties they are employed to perform.	Rob Harvey – Divisional Manager	Claire Dilley – Quality Assurance Lead	44.1 Ensure that all staff are provided with appropriate: ○ training ○ development ○ supervision ○ annual appraisal	• The division has completed a clinical supervision audit looking at current practice in line with policy and to forecast future demand for clinical supervision. • The division has devised a supervision tree and this has been sent to all teams. • This is being monitored through DMT meetings.	30/09/2016		Copy of supervision tool. Copy Supervision tree. DMT meeting notes.	Supervision tool uploaded.
				44.2 Carry out a training need analysis of all CMHT staff.	Still to commence, this will be part of the planned transformation work.	30/09/2016		Copy of training needs analysis.	
				44.3 Procure suitable training for band 4 staff.	This is underway.	30/09/2016		Implementation of training.	
				44.4 Ensure all staff have clear job descriptions.	Service Manager is developing job descriptions and personal specifications in line with service needs.	30/09/2016		Copy of job descriptions/ person specifications.	
		Anne-Maria Olphert – Director of Nursing & Quality	David Knight – Head of Workforce & Development	**Cross references with actions 17.4 & 36.3** 44.5 Implement a system of centralised recording of supervision dates and times via ESR.	• Management supervision recording pilot on Health Roster to commence in June/July across a range of clinical and corporate services. Clinical Supervision to be recorded and audited through clinical systems (predominantly Silverlink). • Implementation of centralised system for recording of supervision will commence in January 2017. In the meantime managers are being given an opportunity to use the system on a voluntary basis to get used to the system. Reports to be run from 2017. In view of this, completion date has been revised.	31/01/2017		Copy of audit.	
45	**Safe care and treatment:** Ensure patients are assessed and receive treatment in a timely manner to mitigate risks.	Rob Harvey – Divisional Manager	Claire Dilley – Quality Assurance Lead	45.1 Develop emergency, urgent and routine waiting time standards with CMHT Transformation Board.	A meeting was held on 20/06/2016; RAG rating tool developed, incorporating waiting times.	30/09/2016	11/08/2016	Copy of waiting time standards.	
				45.2 Ensure effective performance monitoring is available for compliance with this.	A transformation board meeting was held on 21/07/2016 which is commissioner led and 3 groups developed, one of which is outcomes.	30/11/2016		Implementation of performance monitoring system.	
				45.3 Review Meridian RAG rating tool; to have this for pre assessment, post assessment and during intervention.	A RAG rating tool has been developed and was launched on 18th July and is with teams for consultation.	30/11/2016		Copy of RAG rating tool.	RAG rating tool uploaded.

Adult Community Mental Health Services:

Adult CMHT's

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response		Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
46	**Good governance:** Review procedures to ensure that the learning from investigations and actions are taken and embedded within all CMHT teams.	Rob Harvey – Divisional Manager	Claire Dilley – Quality Assurance Lead	46.1	Develop procedures to ensure learning from investigations across CMHTs.	The division has started Quality Meetings which include Service Managers, Team Co-ordinators and enhanced band 6 roles. The standing agenda items include themes from serious incidents and complaints, and will address practical methodology to embed lessons learned within the teams.	31/05/2016	30/04/2016	Copy Quality meeting notes.	Evidence uploaded.
47	**Good governance:** Ensure that governance systems are in place for informing detained patients under a Community Treatment Order of their legal rights, with regard to the MHA and Code of Practice.	Rob Harvey – Divisional Manager	Claire Dilley – Quality Assurance Lead	47.1	Quality meetings to address this as a specific agenda item.	To be added as a standing agenda item. The community team heat maps including CTO details is now circulated to the RC, PA and Team Co-ordinator which ensures all of the team are aware of anyone subject to a CTO. The MHA Team Manager attended the Clinical Management Meeting on 20th June; the community heat maps and processes regarding practice around CTOs were discussed. A training event for all doctors took place on 30 June.	30/06/2016	27/06/2016	Copy of standing agenda for Quality meetings. Copy of heat map.	Evidence uploaded
				47.2	Ensure effective procedures in place to inform patients subject to a CTO of their legal rights	Teams were reminded through the quality team meetings and DMT.	30/06/2016	27/06/2016	Notes of meetings of Quality Team and DMT	Quality Meeting Agenda uploaded to evidence file.
				47.3	Mental Health Act office representative to be invited to Quality meeting.	• The Quality Forum discussed attendance of a representative from the MHA office and it was decided this was not a requirement. • Teams to ascertain if they would like a refresher on CTOs, bring back feedback to next Quality Forum.	30/06/2016	27/06/2016	Copy of notes of Quality forum meeting – Claire Dilley to provide.	Will be uploaded week commencing 26/09/2016.

Action no.	Should do's	Accountabilities	Responsible person	Trust actions/response		Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
48	Ensure that regular environment health and safety checks take place for the Gainsborough team.	Rob Harvey – Divisional Manager	April Harrison -	48.1	Health and safety inspections to be coordinated between service manager and estates team.	• The Trust has a rolling programme for health and safety inspections at all sites and Gainsborough team is included. •	31/08/2016	31/08/2016	Confirmation received from Quality & Assurance Lead.	Progress update within this action plan.
49	Ensure that patients' risk assessments and care plans are regularly reviewed by staff and updated to reflect current needs.	Rob Harvey – Divisional Manager	Claire Dilley – Quality Assurance Lead	49.1	Ensure during supervision process that a random sample of files is audited.	Communicated through DMT.	30/06/2016	07/07/2016	Copy of DMT meeting notes. – Claire Dilley to provide.	Will be uploaded week commencing 26/09/2016.
				49.2	CPA and records audits are audited on an annual basis by Records Manager and CPA lead.	This is an ongoing process.	30/09/2016	ongoing	Link to CPA and records audits.	Evidence uploaded.
				49.3	Develop a performance tool to look at whole caseload of every clinician to identify when care plans are due for review, and overdue.	• This will take place as a dedicated piece of work in September 2016. • A tool/report has been developed for all overdue and upcoming CPA; this does not include those not on CPA, however the report will be updated to reflect non CPA.	30/09/2016	07/09/2016	Copy of performance tool.	Evidence uploaded.
				49.4	Use the tool to address non-compliance with individual clinicians.	Will commence when 49.3 is complete.	31/10/2016		As above.	
				49.5	Service Managers to undertake audit of supervision notes to evidence sample files audited during staff supervision.	Being included as part of the division's quality forum.	30/12/2016		Copy of supervision audit.	

Adult CMHT's

Action no.	Should do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
50	Ensure adequate engagement with staff regarding proposed changes to their service.	Ian Jerams – Director of Operations	Rob Harvey – Divisional Manager	50.1 Staff to be invited to each transformation locality meeting to discuss high level future model.	• Completed initial staff engagement workshops (January 2016). • Staff Governor representatives have been invited to Community Transformation Board which will oversee the transformation project.	30/04/2016	30/04/2016	Copy of notes from staff engagement workshops. Notes of transformation board.	Evidence uploaded.
				50.2 Clinical staff engagement plans to be included in transformation paper to Board.	Staff involved with clinical pathway redesign.	30/04/2016	30/04/2016	Copy of Board paper. Copy of division improvement plan Copy of transformation plan.	Evidence uploaded.
				50.3 Re-establish team brief.	Trust team brief has commenced.	30/04/2016	30/04/2016	Copy of team brief.	Evidence Uploaded.
Action below from Substance Misuse Report: - Adult CMHT's to ensure compliance from 1st August 2016:									
51	**Safe care** Ensure that there are suitable fire marshals at all locations.	Rob Harvey – Divisional Manager	To be confirmed	51.1 Identify fire marshals.	Fire marshals identified.	30/06/2016	11/07/2016	Names of identified fire marshals identified.	Evidence uploaded.
				51.2 Provide fire marshal training.	Training dates allocated.	31/08/2016	07/07/2016	Copy of training dates required.	

Specialist Services:

Ash Villa Inpatient Ward

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
52	**Dignity and respect:** Ensure compliance with the Department of Health guidance in relation to mixed sex accommodation.	Anne-Maria Olphert – Director of Nursing & Quality	Roni Swift – Divisional Manager	**Action 52 cross references with action 2 – Trust wide issues** 52.1 Undertake ward specific option appraisal to identify resolution for the issues raised during the inspection.	• Architect plans for options appraisal presented back to the Trust on 12.07.2016. The plans did not meet the need of the service and did not follow the brief provided. New architect appointed, initial meeting took place with new architect has taken place. In view of this the completion date has been extended to 30/09/2016. • The option appraisals have been completed and the preferred option is now being costed prior to being sent for approval by the Executive Team.	30/09/2016		Copy of option appraisal.	Evidence uploaded.
				52.2 Discuss inspection findings with NHSE specialist commissioners (to be cross referenced with action 2.2).	• Discussed with NHSE Specialist Commissioners who expressed concern at the CQC judgement due to implications for other CAMHS units, notably those still configured in bays. • Continue to await feedback from NHS E and the CQC challenge; the CQC have written to the Trust to confirm they are still considering this and a further progress update would be provided within one month, therefore the completion date has been amended to reflect this.	30/09/2016		Outcome of meeting between NHSE & CQC.	
	Safe care and treatment: Review the environmental and ligature assessment tools are fit for purpose. Risk assessments should cover all areas, including outside spaces.	Ian Jerams – Director of Operations	Roni Swift - Divisional Manager	**Action 53 cross references with action 1 – Trust-wide issues** 53.1 Complete ligature audit, to include outdoor areas.	Indoor and outdoor audit completed by Ash Villa staff, the Quality & Safety Team and a health & safety rep on 25/05/2016.	30/06/2016	25/05/2016	Copy of audit.	Evidence uploaded.
				53.2 Address internal ligature risks identified at inspection.	Bathroom blind removed during the inspection.	04/12/2016	04/12/2016	Visit to unit by Director of Strategy	Progress update within this action plan.
				55.3 Fire door external door closures to be removed and internal door closure mechanisms fitted.	All non-conforming door closers removed.	13/05/2016	13/05/2016	Visit to unit by Director of Strategy	Evidence uploaded.
				53.4 Quality review of current audits and action plans to be completed and any outstanding issues addressed.	A joint review with Quality & Safety Team undertaken.	30/06/2016	07/07/2016	Copy of audit/action plan required.	Evidence uploaded.
54	**Safe care and treatment:** Ensure all staff are fully trained to identify any safety concerns.	Roni Swift – Divisional Manager	Nige Dixon – Quality Assurance Lead	**Action 54 cross references with action 1 – Trust-wide issues** 54.1 To work with training department to establish what training is available or can be established to train managers in both internal and external assessment of environments and ligatures.	• Ligature workshop for all inpatient managers and their deputies booked for the 15/06/16. • The workshop was postponed due to lack of attendance and has been rescheduled to 16/09/2016.	16/09/2016	16/09/2016	Copy of list of attendees. Copy of workshop slides.	Evidence uploaded.
	Review the safety of the outside space and ensure access is not restricted.	Ian Jerams – Director of Operations	Roni Swift – Divisional Manager	54.2 Construct safe outdoor area.	Fencing was completed prior to the end of March 2016 but currently requiring further work to be fit for purpose. Additional work completed.	30/06/2016	30/06/2016	Area inspected by Head of Quality and ligature audit completed for this area.	Evidence uploaded.

Specialist Services:

Ash Villa Inpatient Ward

Action no.	Should do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
55	Ensure capacity and consent is recorded and fully individualised to the young person's needs and treatment.	Roni Swift – Divisional Manager	Nige Dixon – Quality Assurance Lead	55.1 Staff to be reminded to ensure capacity and consent is recorded for each young person that is personalised to individual needs.	Capacity and consent forms now in place.	31/05/2016	30/04/2016	Visit to Unit by Deputy Director of Operations/Compliance Officer (22/09/2016).	
56	Review staffing levels on the unit.	Ian Jerams – Director of Operations	Roni Swift – Divisional Manager	56.1 Review staffing levels, notably during evenings.	Additional staff member provided on shift during the evenings.	31/12/2015	31/05/2015	Confirmation received from Specialist Services Divisional Manager.	Progress update within this action plan.
57	Review the pressure on psychology within the unit.	Ian Jerams – Director of Operations	Roni Swift – Divisional Manager	57.1 Review provision of psychology.	Psychology increased by 0.1wte and Art Therapist increased by 0.2wte since the time of the inspection.	31/03/2016	31/03/2016	Confirmation received from Specialist Services Divisional Manager.	Progress update within this action plan.
58	Ensure that access to hot drinks and snacks is not restricted.	Roni Swift – Divisional Manager	Ward Manager	58.1 Provide effective access to drinks and snacks through the day.	• Healthy snacks are now freely available in the form of fruit; access to drinking water is now available throughout the day. • A risk assessment was completed and deemed not safe for flasks/kettles to be readily available; therefore posters displayed advising service users to request hot drinks via staff.	31/05/2016	30/04/2016	Visit to Unit by Deputy Director of Operations/Compliance Officer (22/09/2016).	
59	Ensure that staff have an understanding of how the MCA applies to the under 18's.	Nige Dixon – Quality Assurance Lead	Liz Bainbridge	59.1 Develop and implement appropriate MCA training.	Training developed and implemented.	30/06/2016	30/06/2016	Copy of training package.	Evidence uploaded.

Community CAMHS

Action no.	Must do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
	NIL			N/A			N/A		

Action no.	Should do's	Accountabilities	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance received	Evidence
60	In conjunction with commissioners review the waiting times and level of provision for young people with learning disabilities.	Ian Jerams – Director of Operations	Roni Swift – Divisional Manager	60.1 Consider access and waiting times for young people with learning disabilities.	The Trust has worked with commissioners to undertake a full service model review and a new service model was implemented on 04.04.16 with additional staff.	04/04/2016	31/03/2016	Copy of service model.	Evidence uploaded.
61	Review the access to safeguarding training from the local safeguarding board.	Roni Swift – Divisional Manager	Amanda Newman, Service Manager	61.1 Access to safeguarding training to be reviewed.	Safeguarding Level 3b: as of 27th June 17 staff trained (1 of these staff due refresher on 7th July, awaiting update dates from training centre); 6 staff booked on the next available dates which are November 2016. Only one staff non-compliant due to long term sick and currently not working in CAMHS; therefore this action is closed.	30/06/2016	27/06/2016	Email confirmation.	Evidence uploaded.

Specialist Services:

Community Learning Disabilities and Autism

Action no.	Must do's	Accountability	Responsible person	Trust actions/response		Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
62	**Good governance:** Ensure that all information related to patients is accessible to staff on one electronic recording system.	Karen Berry – Director of Finance & Information	Roni Swift – Divisional Manager	62.1	Ensure patient information is only held on one system.	• Awaiting system providers of SystemOne to undertake data migration to Silverlink. • Delay due to SystemOne provider, therefore completion date revised to the end of September. • The first stage of data migration has been completed (current cases). Historical data still to migrate.	30/09/2016	07/09/2017	Confirmation from Specialist Services Divisional Manager.	Email correspondence uploaded re confirmation of current data migration.
63	**Staffing:** Review staffing levels to ensure that there are sufficiently qualified and experienced speech and language therapists available each day to carry out the assessments required.	Ian Jerams – Director of Operations	Roni Swift – Divisional Manager	63.1	Review level of speech and language therapy provision.	• Band 5 SLT now appointed. • SLT referrals now a part of the integrated multi-disciplinary team processes.	31/03/2016	31/03/2016	Confirmation received from Specialist Services Divisional Manager.	Progress update within this action plan.
				63.2	Ensure staffing levels reflect outcome of review.	• Staffing levels agreed recruitment ongoing. • One SALT commenced beginning of June • Second post out to advert, closing date 04.08.16. Hours increased to 22.5hrs from 18.75hrs to make it more attractive to potential candidates. Completion date reviewed to reflect recruitment • The SALT post has been advertised on two occasions with no applicants. There is a shortage of SALTs across Lincolnshire, and no agency availability. This issue will be sent to the new recruitment and retention lead for advice. Contingency plans in place to manage and longer term the Trust looking into training existing staff.	31/08/2016	07/09/2016	Confirmation from Specialist Services Divisional Manager.	Progress update within this action plan
Action no.	**Should do's**	**Accountability**	**Responsible person**	**Trust actions/response**		**Progress update**	**Date to be completed by**	**Date completed**	**Type of assurance received**	**Evidence**
64	Review plans bring forward the relocation of the speech and language therapy service with the Long Leys Road community learning disability base.	Roni Swift – Divisional Manager	Nige Dixon, Quality Assurance Lead	64.1	Review and ensure adequate provision of speech and language therapy in the Long Leys community base.	• Increased SLA with Nott's Healthcare. • S&LT vacancies have been recruited to. • Speech and Language Therapist are now fully embedded as a part of the wider multi-disciplinary team under the new service model.	31/07/2016	27/06/2016	Copy of SLA required.	Evidence uploaded
65	Ensure that all staff are trained in recovery focused care planning.	Roni Swift – Divisional Manager	Nige Dixon, Quality Assurance Lead	65.1	Ensure principles of the recovery approach are embedded in all training.	• Work ongoing with the recovery focussed and outcome based model of care. • Training week delivered to all LD staff in April 2016 with specific focus on positive behavioural support and the embedding of the new service model. • Model discussed at team away day on 04/07/2016.	30/06/2016	04/07/2016	LD away day agenda. Details of goal setting outcome measures.	Evidence uploaded.
				65.2	Trust-wide recovery conference to be held in May 2016.	Complete.	31/05/2016	27/05/2016	Agenda of recovery conference held in May 2016.	Evidence uploaded.
66	Ensure that all key information is available in easy read format and readily available within the service.	Roni Swift – Divisional Manager	Nige Dixon, Quality Assurance Lead	66.1	Ensure that easy read information is comprehensive and widely available.	New processes are now in place for all new paperwork to be transferred into easy read. All existing Service User documents are being been transferred into easy read	31/07/2016	31/07/2016	Details of accessible standards task and finish group.	Evidence uploaded.

Specialist Services:

Substance Misuse Services

Action no.	Must do's	Accountability	Responsible person	Trust actions/response		Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
67	**Safe care and treatment:** Ensure that a prescriber sees people accessing medication from the service every 12 weeks.	Sue Elcock – Medical Director	Roni Swift – Divisional Manager	67.1	Audit to be undertaken for all service users in LPFT DART prescribing to ensure timely review.	Action plan formulated regarding review by prescribers. Audit undertaken regarding Consultant reviews from 1/04/15 to 30/11/15. During this period 80% of service users seen within 12 review period.	30/06/2016	27/06/2016	Copy of audit.	Evidence uploaded.
				67.2	At each review another appointment to be made for a 12 week review at time.	Medical secretary keeping an electronic record of review appointments for all consultant clinics countywide and these are kept at each resource site with the prescribing notes. Action closed due to transfer of service.	30/06/2016	27/06/2016		
				67.3	Discussion to be undertaken with medical prescribers about written medical records.	Complete.	30/06/2016	27/06/2016	Confirmation received from Specialist Services Divisional Manager.	Progress update within this action plan.
				67.4	Further audit of consultant's prescribing reviews to be undertaken to ensure new practice is embedded.	Audit undertaken. Action closed due to transfer of service.	30/06/2016	11/05/2016		
68	**Safe care and treatment:** Ensure that staff update risk assessments routinely and when risk to people using the service changes.	Roni Swift – Divisional Manager	Nige Dixon – Quality Assurance Lead	68.1	Risk assessment and planning training to be provided for all staff.	• All staff have completed online risk assessment training. • In every supervision with staff two risk assessments are checked for quality and transference to recovery plans Action closed due to transfer of service.	30/06/2016	30/04/2016		
				68.2	Individual support to be provided to staff.	• Individual staff member being managed within supervision and informal improvement plan in place. Action closed due to transfer of service.	30/06/2016	30/04/2016		
69	**Safe care and treatment** Ensure that prescribing is in line with guidelines detailed in the Drug Misuses and Dependence: UK Guidelines on Clinical Management (2007).	Sue Elcock – Medical Director	Roni Swift – Divisional Manager	69.1	Service wide audit of prescribing to take place against the Drug Misuses and Dependence: UK Guidelines on Clinical Management (2007).	Audit Complete.	30/06/2016	27/06/2016	Copy of prescribing audit.	Evidence uploaded.
				69.2	Audit to random sample 10% of all prescribing records. Service to work with audit department to design audit.	Audit Complete.	31/07/2016	27/06/2016	Copy of prescribing audit.	Evidence as 69.1.
70	**Good governance:** Ensure that clinical records are comprehensive and reflect the content of contact with service users.	Anne-Maria Olphert, Director of Nursing & Quality	Roni Swift – Divisional Manager	70.1	Ensure sample of records is reviewed within supervision.	• During supervision of all clinicians, three randomly selected patient records are being quality checked and findings documented in supervision notes. • Discussed at SS DMT on Fri 17th June.	30/06/2016	27/06/2016	Copy of SS DMT notes.	Evidence uploaded.
				70.2	Address any shortfalls through supervision, training and other support actions.	• Clinical records have been discussed with staff; discussed at SS DMT on Fri 17th June. Action closed due to transfer of service	30/06/2016	27/06/2016	Discussed at DMT meeting.	
71	**Staffing:** Ensure that staff access substance misuse specific training and attendance is recorded.	Roni Swift – Divisional Manager	Lee Scigala, Acting Service Manager	71.1	Establish baseline of training received.	• Data base established to collate individuals' specific training to evidence knowledge and skills in specific areas of practice. This training record is being backdated to evidence training already completed. • Completed as part of decommissioning plan.	30/06/2016	27/06/2016	Copy of de-commissioning plan.	Evidence uploaded.
				71.2	Address shortfalls.	• DANOS package available for staff to complete to evidence their individual competencies. • Completed as part of decommissioning plan.	30/06/2016	27/06/2016	Copy of de-commissioning plan.	Evidence uploaded.
72	**Staffing:** Ensure that staff are supervised in line with Trust policy.	Roni Swift – Divisional Manager	Nige Dixon Quality Assurance Lead	72.1	Ensure that required frequency of supervision is achieved.	Supervision tracker now in place on SHARON DART site that can be overseen by the Divisional Manager and Quality Assurance Lead.	31/03/2016	07/03/2016	Copy of supervision tracker.	Evidence uploaded.

Specialist Services:

Substance Misuse Services

Action no.	Must do's	Accountability	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
73	**Safe care** Ensure that there are suitable fire marshals at all locations.	Roni Swift – Divisional Manager	Lee Scigala, Acting Service Manager	73.1 Identify fire marshals.	Action transferred to Adult Community services (01/08/2016).	30/06/2016	07/07/2016	Fire marshals identified by Adult Community Team.	Evidence uploaded see 50.1.
				73.2 Provide fire marshal training.	Training dates allocated – action transferred to Adult Community services (01/08/2016).	31/08/2016	07/07/2016	See evidence as per action 50.1.	
Action no.	**Should do's**	**Accountability**	**Responsible person**	**Trust actions/response**	**Progress update**	**Date to be completed by**	**Date completed**	**Type of assurance required**	**Evidence received**
74	Should record the content of prescribing appointments with the electronic case management system.	Sue Elcock – Medical Director	Roni Swift – Divisional Manager	74.1 Ensure electronic record completed in respect of content of prescribing appointments.	• Consultant discussed these issues about his individual practice with the Medical Director. Action closed due to transfer of service.	30/06/2016	27/06/2016		

Older Adult Mental Health Services:

Older Adult CMHTs

Action no.	Must do's	Accountability	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Action no.	**Should do's**		**Responsible person**	**Trust actions/response**		**Date to be completed by**	**Date completed**	**Type of assurance received**	**Evidence**
75	Continue the planned review of caseloads and identify ways to reduce these.	Steve Roberts – Divisional Manager	Dawn Parker – Quality Assurance Lead	75.1 Review Band 4/Shared Care Protocol caseloads.	Caseloads relate to B4 associate practitioners supporting dementia medication review patients under shared care protocol (SCP). These SCP requirements are under review with lead MH commissioner and CCGs to decide upon service resource demand/utilisation and potential for reviews occurring within primary care.	30/10/2016		Review of SCP requirements.	
				75.2 Service to review use of any available caseload weighting and review tools to support case-load management.	Developing proposal to support Shared Care Protocol via fast-track discharge process with reduction in practitioner case-load.	30/10/2016		Implementation of Shared Care Protocol/fast-track discharge process.	
76	Ensure that staff in the CMHT always record the patient risk assessment in the same location on the electronic patient record system.	Steve Roberts – Divisional Manager	Dawn Parker – Quality Assurance Lead	76.1 Put system in place for records to be checked through supervision.	Supervision template has been amended to include monitoring of record keeping and quality.	31/07/2016	30/04/2016	Copy of supervision template required.	Evidence uploaded.
				76.2 Team Co-ordinators to audit risk assessments prior to supervision sessions.	The service is carrying out ongoing monitoring of record keeping.	31/07/2016	30/04/2016	Confirmation received from Divisional Manager.	Progress update within this action plan.
	Ensure capacity is clearly and consistently recorded, whether a patient has capacity or whether a patient lacks capacity.	Steve Roberts – Divisional Manager	Dawn Parker – Quality Assurance Lead	77.1 Put in place system to ensure that all staff have completed/are compliant with the Trust MCA mandatory training.	All staff/teams have been reminded of requirement to record any MCA/capacity assessments and decisions clearly in the clinical notes using approved Trust process.	31/07/2016	07/07/2016	Confirmation received from Divisional Manager.	Progress update within this action plan.
				77.2 Conduct spot audits for reassurance across teams.	• Audit of all admissions across inpatient units to review capacity on admission information. • Audit completed in July 2016, this demonstrated a very low rate of compliance, therefore a further audit to be conducted in September on new referrals to community teams to ascertain if there is an improvement on new referrals coming through; therefore the completion date has been revised.	31/09/2016		Copy of audit required.	July audit uploaded.
78	Review processes for ensuring support groups are available for carers and patients receiving services.	Steve Roberts – Divisional Manager	Dawn Parker – Quality Assurance Lead	78.1 Improve availability and access to carer and patient support groups.	• The service is undertaking a phased development/roll-out of county-wide carer support groups linked to service user CST provision. • Co-development of carer support sessions between OA division and Recovery College. Two courses already being delivered 2 more under development inclusive of Dementia First Aid and Living Well with Dementia (6-8 sessions).	31/12/2016		Copy of Recovery college prospectus.	
79	Should ensure that all areas that patients are accessing are dementia friendly.	Ian Jerams – Director of Operations	Steve Roberts – Divisional Manager	79.1 Review dementia friendly access to all shared buildings used by Older Adult Mental Health services.	• Properties under sole management of OA division already adapted to support dementia friendly use i.e. Manthorpe Centre & Witham Court. • Trust wide-issue as many OA-Community services are now co-located with adult/CAMHS/CRHT services; this will be picked up through the Older Adult Steering Group.	31/12/2016		Steering Group to review community environments.	

Older Adult Mental Health Services:

Older Adult Inpatient Wards

Action no.	Must do's	Accountability	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
80	**Safe care and treatment:** Review all potential ligature risks and take the appropriate action to remove and mitigate where there are poor lines of sight.	Ian Jerams – Director of Operations	Steve Roberts – Divisional Manager	**Actions 79 cross references with action 1 – Trust-wide issues** **Service specific actions:** 80.1 Quality review of current audits and action plans to be completed and those requiring improvement to have responsible managers informed and supported to reassess and plan.	**Brant: Anti-ligature wardrobes:** • Wardrobes have now been put back to back as per CQC feedback.	31/12/2016	11/12/2015	Visit by Director of Finance – January 2016.	
				80.2 On-going programme of ligature audits conducted by clinical staff throughout 2016/17 to be monitored by Quality & Safety Team Leader.	Programme of audits agreed.	31/07/2106	07/07/2016	Copies of completed audits.	Evidence uploaded.
81	**Safe care and treatment:** Ensure compliance with the Department of Health guidance in relation to mixed sex accommodation on Langworth Ward.	Anne-Maria Olphert – Director of Nursing and Quality	Steve Roberts – Divisional Manager	**Actions 81 cross references with action 2 – Trust-wide issues** 81.1 Resolve mixed sex accommodation breach on Langworth Ward.	• Addressed at time of inspection. • No further female patients will be placed in the bedrooms that caused the issue. • New signage installed.	31/12/2015	05/12/2015	Photograph of signage.	Signage uploaded.
82	**Safe care and treatment:** Must ensure patients have access to nurse call systems in dormitories on the Brant Ward.	Steve Roberts – Divisional Manager	Geoff Badger – Associate Director of Estates & Facilities	82.1 Identify effective nurse call system to each bed area in dormitories.	• Site and call options reviewed and now awaiting quote for installation of x 4 nurse call bells per service user bay/dormitory (1 per service user). • Tenders received; service user/carer feedback sought; systems identified.	30/06/2016	27/06/2016	Confirmation received from Older Adult Divisional Manager.	Progress update within this action plan.
				82.2 Once quote for bells received; Business Manager to complete capital bid and progress bid via Trust capital bid process.	• Evaluation required on the system for suitability; completion date extended to 30/09/2016. • The contract is being awarded to ARM; work is expected to be complete by mid October 2016, therefore the completion date has been revised.	15/10/2016		Confirmation from Older Adult Divisional Manager.	
				82.3 Install call system.	Awaiting outcome of 82.1 and 82.2. Work expected to be completed by 31/10/2016.	31/10/2016		Installation of nurse call system.	
83	**Safe care and treatment:** Review the management of medication on both Manthorpe and Rochford Units. Ensure staff follow dispensing instructions to medicine patches and accurately record medicines charts for patients being discharged. Stock must be managed effectively and the drugs fridge used appropriately.	Sue Elcock – Medical Director	Dawn Parker – Quality Assurance Lead	83.1 Ensure all OA qualified staff have undertaken the required Trust Medicines Management training and are aware of and working to Trust Policy with regards ordering and dispensing.	• All teams have been asked to provide a training status update. • Compliance is being monitored through the Divisional Management Team.	30/09/2016	07/09/2016	Medications management audit.	Evidence uploaded.
				83.2 Undertake review of processes and medications recording compliance in partnership with pharmacy services to identify scope, pattern and/or identified staff members. Use this to inform locality/staff specific support and management to address training/performance needs related to medicines management.	• Meeting with Pharmacy, Matron, and Quality Lead, and Ward Managers to discuss outcome of CQC findings and current themes held on the 10th May 2016. • Pharmacy attending OA Steering Group to discuss themes with MDT members across the division. • Flow charts developed by pharmacy to support access to medication and dispensing guidance • Individuals identified as breaching meds management to be raised through supervision. • Actions for themes and trends identified and development plan commenced to improve practice.	30/09/2016	07/09/2017	Copy of review of management of medications undertaken.	Evidence uploaded.

Older

Adult Mental Health Services:

Older Adult Inpatient Wards

Action no.	Must do's	Accountability	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
84	**Safe care and treatment:** Undertake a review the use of the de-escalation rooms, described as comfort rooms and used like seclusion rooms.	Steve Roberts – Divisional Manager	Dawn Parker – Quality Assurance Lead	84.1 Undertake full review of use of comfort suites/de-escalation rooms.	Review has commenced and the findings are being overseen by a task & finish group.	30/09/2016	07/09/2016	Copy of review of use of comfort suites undertaken.	Manthorpe Environment review documentation uploaded.
				Cross reference with 84.1 and 84.4) 84.2 Following the review in 83.1; develop service specific protocol/pro-active care policy for de-escalation.	Discussion took place at the Trust's restrictive interventions group and it has been agreed to provide a greater level of detail/ guidance in the Trust's policy.	30/10/2016	07/09/2016	Copy of protocol/policy for de-escalation.	De-escalation & safety action plan uploaded.
				84.3 Ensure unified compliance and practice to service protocol (and broader Trust policy and NICE Guidance)	• Divisional review/identification of associated NICE/RCP/MHA best-practice and guidance standards related to de-escalation practice completed to inform task & finish group. • Review of existing de-escalation service protocols external to LPFT undertaken to inform local protocol development by T&F group.	30/06/2016	27/05/2016	Copy of local protocol. Meeting notes/relevant email.	De-escalation protocol uploaded.
				84.4 Review of physical environments of comfort suites.	A review of the comfort suite environments has commenced.	30/09/2016	**07/07/2016**	Copy of review of comfort suite environment undertaken.	Evidence uploaded.
85	**Good governance:** Review process and systems for reporting incidents when patients use the comfort rooms for de-escalation.	Steve Roberts – Divisional Manager	Dawn Parker – Quality Assurance Lead	85.1 Remind all staff of the requirement to complete a Datix on every occasion de-escalation requiring use of comfort suite and/or application of restrictive interventions (RI's) utilised.	• Staff have been reminded to complete a Datix following de-escalation and restrictive interventions. • The issue has been discussed in the restrictive interventions group and it has been agreed to explore the possibility of improving the interface between Datix and Silverlink.	31/07/2016	07/07/2016	Method of communication – was it an email –	Evidence uploaded.
				85.2 Remind all staff (embed and monitor) to ensure that new Silverlink incidents reporting field is completed in parallel with Datix for every occasion de-escalation requiring use of comfort suite and/or application of restrictive interventions (RI's) utilised.	Email sent to all staff by DM reminding staff of responsibilities. Steering Group held on 7th July reviewed all CQC actions.	31/07/2016	07/07/2016	Copy of email Copy of steering group notes.	Evidence uploaded
				85.3 Work with clinical systems to support all service managers to ensure they are able to run local reports from new incidents field showing RI/incident history.	• All incident reports are distributed to Quality Lead and Ward Managers and discussed at Steering Group. • Further work to be undertaken through DATIX review, therefore completion date reviewed to 30/09/2016. • Work has been undertaken to support improvement in environment, culture and recording of incidents whilst awaiting Datix project completion project to be able to record use of de-escalation room	30/09/2016		Copy steering group notes.	DMT notes/agenda uploaded.
				85.4 For review of above; local reports to be included as standing agenda item for in-patient management team meeting and Divisional Team meeting on a quarterly basis	Agreed to add as a standing agenda item.	30/09/2016	07/09/2016	Copy of DMT agenda.	Evidence uploaded.
				85.5 Older Adult Steering Group to monitor themes and trends across the service and feed into Patient Safety Group as necessary/appropriate.	Added as a standing agenda item.	31/07/2016	07/07/2016	Copy of steering group agenda.	Evidence uploaded.

Older Adult Mental Health Services:

Older Adult Inpatient Wards

Action no.	Must do's	Accountability	Responsible person	Trust actions/response		Progress update	Date to be completed by	Date completed	Type of assurance received	Evidence
86	**Safe care and treatment:** Must ensure staff receive mandatory safeguarding training.	Steve Roberts – Divisional Manager	Dawn Parker – Quality Assurance Lead	86.1	Work with training department to identify safeguarding training capacity and dates.	Compliance monitored via monthly reports and at local level via training records and managerial supervision.	31/07/2016	07/07/2016	Monitoring sheet.	Evidence uploaded.
				86.2	Inpatient service manager to work with wards to support access of and staff attendance/completion of required training.	Underway and being monitored through DMT meetings.	31/07/2016	07/07/2016	Monitoring sheet as per 86.1	Evidence uploaded.
Action no.	**Should do's**	**Accountability**	**Responsible person**	**Trust actions/response**		**Progress update**	**Date to be completed by**	**Date completed**	**Type of assurance received**	**Evidence**
87	**Privacy and dignity:** Must review the arrangements for the patients in Manthorpe centre to make and receive phone calls in private.	Steve Roberts - General Manager	Mark Challinor - Inpatient Services Manager	87.1	Ensure provision for telephone calls to be made and received in private.	• Interim hand-held mobile phone in place. • Portable patient pay-phone ordered.	31/05/2016	30/04/2106	Confirmation from Divisional Manager	Progress update within this action plan.
88	Ensure patients at the Rochford Unit have access to outdoor space.	Ian Jerams – Director of Operations	Steve Roberts – Divisional Manager	88.1	Consider access to outdoor space in future service plans.	• Rochford ward has no allocated/dedicated or appropriate outside space: none available on hospital site (ULHT). • Divisional service development plans in place and part of external Lincolnshire Health and Care public consultation with proposal to change service model with redeployment of Rochford inpatient resource and into community resource with closure of Rochford unit.	30/04/2017		Copy of LHAC consultation.	
				88.2	Review access to outdoor space for individual patients.	• Plans to support access to outside space to be included in individual care-plans. • Review undertaken; the ward is located on the first floor and does not afford easy access to fresh air, therefore this action is closed.	30/06/2016	27/06/2016	N/A – environment does not allow easy access to fresh air.	
89	Ensure that written information relating to CCTV's in the communal areas of Langworth, Brant and Manthorpe wards is made available to patients, carers and relatives.	Steve Roberts – Divisional Manager	Mark Challinor – Inpatient Services Manager	89.1	Provide information in relation to CCTV.	Information is given to carers and patients on admission to inform them of CCTV and answer any questions are answered, this will remain in place until plans for service re-design are agreed.	30/04/2016	30/04/2016	Copy of information that is provided on admission.	Evidence uploaded.
90	Ensure staff have access to dementia training at an appropriate level.	Steve Roberts – Divisional Manager	Dawn Parker – Quality Assurance Lead	90.1	Service Manager and Quality Assurance Lead to review training records to identify compliance with identified mandatory dementia e-learning modules.	• Review of records is underway. • Staff have had refresher best practice in dementia training; once new trainers have received their training there will be a roll out programme. • Meeting with new trainers arranged for October – roll out programme to commence post this date. Training unable to be undertaken in block format which makes implementation more problematic, this is being revisited.	30/09/2016		Copy of records review.	
						• Information request submitted to the Training Department to identify completion of learning modules. • Training plan in place; refresher training programme commissioned and commences in September; second session to be held in October.	31/10/2016		Copy of list of attendees.	

Older Adult Inpatient Wards

Action no.	Should do's	Accountability	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
				90.2 Information from review outlined in 90.1 to be used to support all team managers in review, support and monitoring of staff requirement to undertake SCIE Dementia Training Modules via Trust OLM system.	To commence on completion of 90.1.	31/10/2016			
				90.3 Following review of current status of Best Practice in Dementia Care trainers on all dementia wards; secure further training to increase number of qualified facilitators/trainers across dementia wards.	Training has been commissioned in 'Best Practice in Dementia Care'; dates confirmed. Refresher training to commence in September 2016 and new facilitator training to commence in October 2016; completion date amended to reflect training dates.	31/10/2016		Copy of dementia care training. List of staff attended.	Enhanced practice in dementia care and facilitator event summary uploaded.
				90.4 To secure and deliver RAID (Challenging Behaviour Training) to 60 older adult in-patient staff.	• Training has been commissioned in RAID; dates have not yet been confirmed due to funding not being secured. • Business Manager is looking at funding options to support understanding and improve practice through training.	30/09/2016		Copy of RAID training. List of staff attended.	
91	Ensure the duration of the multidisciplinary team meetings on Rochford unit allow sufficient time for full discussions of patients' needs.	Steve Roberts – Divisional Manager	Mark Challinor – Inpatient Service Manager	91.1 Review multidisciplinary team meeting time allocation.	Required time for MDT meeting increased to ensure adequate time proportional to number of patients reviewed and presenting needs.	31/03/ 2016	31/03/2016	Confirmation received from Older Adult Divisional Manager.	Progress update within this action plan.
	Ensure patients' privacy and dignity are met on the dormitories on Brant ward and Rochford unit.	Steve Roberts – Divisional Manager	Mark Challinor – Inpatient Service Manager	**Actions 92 cross references with action 1 – Trust-wide issues** 92.1 Review current privacy and dignity measures.	• Older adult review undertaken and measures are in place to respect privacy and dignity. In the longer term the buildings will not be fit for purpose with the Trust transformation plans.	31/08/2016	31/08/2018	Assurance given by Director of Operations.	Progress update within this action plan.
				92.2 Consider patient privacy and dignity in future development plans.	• Inclusion of single rooms for Brant ward proposed for the Trust capital plan. • Review to inform options appraisal completed for bays/ dormitories on Rochford ward. • Divisional service development plans in place and part of external Lincolnshire Health and Care public consultation with proposal to change service model with redeployment of Rochford in-patient recourse and into community resource with closure of Rochford Unit.	31/03/2017		Copy of option appraisal. Copy of divisional service development plans.	

Older Adult Inpatient Wards

Action no.	Should do's	Accountability	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
93	Review governance systems relating to staff engagement with senior management team.	Ian Jerams – Director of Operations.	Steve Roberts, Divisional Manager	93.1 Full review of attendance and engagement between staff and senior management (OA Service). Divisional Manager: ○ To be booked for attendance at all service team meetings on a rolling basis. ○ To undertake/facilitate group clinical supervision on all in-patient wards. ○ To continue delivery/chairing of B4 forum.	• Discussed at DMT. • Dates have now been booked for these sessions. • This is in place • Complete; this is an established process.	30/06/2016	26/05/2016	Copy of notes of relevant meeting(s).	Evidence uploaded.
				93.2 Service Managers/Quality Lead to attend locality meetings.	Managers are attending locality team meetings.	31/08/2016	10/08/2016	Copy of locality meetings notes.	Evidence uploaded.
				93.3 Service Managers/Quality Lead to develop Best Practice Conference in OA to support engagement, development and celebration of successes.	Due to some pressures in the older adult services currently, coordination of the best practice conference has been delayed; a provisional date has been set for 16/06/2017.	31/08/2016	16/08/2016	Email correspondence confirming date of conference.	Evidence uploaded.

Well led domain:

Board level actions and leadership on well led									
Action no.	**CQC key line of questioning**	**Accountability**	**Responsible person**	**Trust actions/response**	**Progress update**	**Date to be completed by**	**Date completed**	**Type of assurance required**	**Evidence received**
94	Is there a clear **vision** and a credible **strategy** to deliver good quality?	Trust Board of Directors	Jane Marshall Director of Strategy and Performance	94.1 Board led statement of vision of the organisation complete and shared 94.2 Translation of vision into strategy through early production of draft clinical strategy for next five years, aligned with quality priorities. Clinical strategy and quality priorities are measurable. 94.2 Clinical strategy covers next five years and aligns with system wide strategic direction. 94.3 Engagement of clinical teams, public, staff and stakeholders as part of the production of the clinical strategy. 94.4 Board of Directors and Council of Governors involved in design and sign off of clinical strategy and quality priorities 94.5 Alignment of clinical strategy with Clinical Divisional priorities for service improvements and quality. 94.6 Production of the Clinical Divisional priorities is part of the OD activity. 94.7 Clear mechanism for monitoring the implementation of the clinical strategy and quality priorities. 94.8 Enabling strategies (estates, IM&T, workforce) are aligned with the clinical strategy and quality priorities. 94.9 Board Assurance Framework revised with new clinical strategy and quality priorities and risks to delivery. 93.10 Annual Plan submission and Financial Plan submission to Trust Board, NHS Improvement and CCG aligns with clinical strategy. 93.11 Board monitors progress on implementation at six month stage.	All of these actions are complete.	31/03/2016	31/03/2016	Clinical strategy Quality priorities Annual Plan Financial Plan Estates strategy IM&T strategy Workforce, OD and People strategy Board Assurance Framework Papers to Board of Directors Notes of Board of Directors meetings Minutes of Council of Governors meetings Report on public feedback on the clinical strategy Evidence of changes to quality priorities as a result of feedback NHS I feedback Six month update to Board of Directors on progress ILP session Accountability Review notes	Evidence uploaded.
95	Does the **governance** framework ensure that **responsibilities** are clear and that **quality, performance and risks** are understood and managed?	Trust Board of Directors	Peter Howie Trust Secretary	95.1 Board Assurance Framework is the overall governance framework for delivery of all objectives of the organisation. 95.2 Monitored monthly at Board of Directors/independently assessed by Trust Secretary 95.3 Risks on quality and performance identified in the BAF 95.4 Work programme of sub-committees of the Board is derived from the BAF	All of these actions are complete.	30/06/2016		BAF Board minutes Performance Report Risk Reports Forward Agenda MHA administration Internal Audit External Audit	Evidence uploaded.

Board level actions and leadership on well led

Action no.	CQC key line of questioning	Accountability	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
96	How does the **leadership** and **culture** reflect the vision and values, encourage openness and transparency and promote good quality care?	John Brewin, CEO	Anne-Maria Olphert, Director of Nursing	96.1 Culture and leadership session, led by the Chair of the Trust, part of the Inspirational Leadership Programme. 96.2 Results of the session in Divisional Business Plans and incorporated into the refreshed Clinical Strategy 96.3 Review of the Inspirational Leadership Programme for 2016 onwards is underway, led by the Director of Nursing 96.4 Staff Forum Meetings in place 96.5 Recognition and rewards initiatives refreshed 96.6 Cultural Barometer in place to ask key questions of staff about feeling valued and respected. The feedback is then used to inform action 96.7 Staff communication mechanisms reviewed and new arrangements in place for improved Team Briefing and face to face briefing of staff and cascade 96.8 Involvement and Engagement (Participation) plan being developed in conjunction with patients and staff (Sep 2016)* 96.9 Review of Complaints Processes complete and new leadership in place 96.10 Staff well-being service in place 96.11 Renewed focus on quality and staff involvement in seeking solutions to issues through the new Divisional Management Structure and particularly the work of the Divisional Manager, Clinical Director and Quality Lead 96.12 Clinical and Quality Governance meetings in place 96.13 Clinical Leaders sessions in place led by the CEO 96.14 Accountability Reviews in place 96.15 Duty of Candour embedded	All of these actions are complete.	30/06/2016		ILP programme review People and OD strategy Divisional Business Plans Accountability Reviews Performance Reporting at Divisional Level Balanced scorecards Staff Forums Team Briefing process Involvement Plan Complaints policy Feedback from Staff Well Being service on themes Divisional Structure review underway Duty of Candour – positive recording Accountability Review minutes Steering Groups Quality Forums	Evidence uploaded.

Board level actions and leadership on well led

Action no.	CQC key line of questioning	Accountability	Responsible person	Trust actions/response	Progress update	Date to be completed by	Date completed	Type of assurance required	Evidence received
97	How are **people** who use the service, the **public** and **staff engaged** and **involved?**	Executive Team	Executive Directors	97.1 Process for developing a new Involvement Strategy and Plan for the organisation was launched in early 2016 97.2 The development of this strategy directly involves users of services, carers and families as well as staff 97.3 Clinical Strategy 2016 to 2019 was developed in consultation with service users, carers, families, Governors, the public and staff 97.4 Staff developed Divisional Plans, which are part of the Clinical Strategy, at the Inspirational Leadership Programme meeting in February 2016 97.5 Arrangements for staff to raise concerns were already in place through the Speak Up Campaign and are being reviewed 97.6 People and Organisational Development Plan in place	• All actions complete, other than the Participation and Involvement Strategy which is on track for end of September	30/09/2016		Clinical strategy Participation workshops Board and Governor participation and involvement workshop held Output and proposal for extending this approach is approved Speak Up Campaign Whistle blowing policy Staff Well Being Service OD and People Strategy Cultural Barometer Governor sessions Recruitment panels including patients/service users	People & organisational development plan uploaded.
98	How are services **continuously improved** and **sustainability** ensured?	John Brewin CEO	Anne-Maria Olphert, Director of Nursing Ian Jerams, Director of Operations Sue Elcock, Medical Director Jane Marshall Director of Strategy and Performance Karen Berry Director of Finance and Information	98.1 Transformational Programme 98.2 Transformational initiatives completed for CAMHS and LD Services with new service models in place 98.3 Quality Impact Assessment process complete for 2016/17 CIP and will be reviewed again at six month stage for any impact on quality 98.4 Review of Divisional Structure six months in is planned 98.5 Visits to other organisations completed to compare innovation work with peers 98.6 Innovation Fund launched and bids support service innovation 98.7 Quality Forums and Steering Groups in place 98.8 Transformation plans for MH, LD and Autism in STP	98.3 This is already planned and in process – with retrospective CIP QIA on a sample of schemes implemented prior to November 2015 (16/11/2016).	31/12/2016		Transformation plans QIA CIP plans Divisional Structure review Continuous Quality Improvement Action Plan	

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